payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION	Provider CCN: 15-1304	Peri od:	Worksheet S
AND SETTLEMENT SUMMARY		From 01/01/2019	
		To 12/31/2019	Date/Time Prepared
			8/26/2020 12:31 pm

				10 12/31/2017		
					8/26/2020 1	12:31 pm
PART I - COST	REPORT STATUS					
Provi der	1. [X] Electronically prepar	red cost report		Date: 8/26/20	20 Time:	12: 31 pi
use only	2. [] Manually prepared cos	st report				
	3. [0] If this is an amended 4. [F] Medicare Utilization.	report enter the number of Enter "F" for full or "L"	of times the provider ' for low.	resubmitted this co	ost report	
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	7. Contractor No.	11 r this Provider CCN 12	O.NPR Date: 1.Contractor's Vendo 2.[O]If line 5, co number of tim	olumn 1 is 4:	

PART II - CERTIFICATION

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 CHIEF FINANCIAL 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 (15-1304) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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.

[]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

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

			Title	XVIII			
Cost Center Description		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	122, 808	-627, 432	0	153, 238	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	29, 828	0		0	5. 00
6.00	Swing Bed - NF	0				0	6. 00
10.00	RURAL HEALTH CLINIC (RHC) I	0		0		0	10.00
200.00	Total	0	152, 636	-627, 432	0	153, 238	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex 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 Provider CCN: 15-1304 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 8/26/2020 12:31 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1300 NORTH MAIN STREET 1.00 PO Box: 1.00 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 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 RMH HEALTHCARE ASSOC 158539 99915 O 06/12/2019 0 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) 01/01/2019 12/31/2019 20.00 21.00 Type of Control (see instructions) 21.00 1. 00 2. 00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for Ν 22.00 disproportionate 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 §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.

Did this hospital receive interim uncompensated care payments for this 22. 01 22 01 N Ν cost reporting 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) Is this a newly merged hospital that requires final uncompensated care 22.02 N 22 02 Ν payments to be 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. Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas 22.03 Ν Ν Ν 22.03 adopted by CMS in FY2015? 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 rring on or ofter October

23. 00	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 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 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? In column 2, enter "Y" for yes or "N" for no.				0			23. 00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medi cai d days	
		1.00	2. 00	3. 00	4. 00	5. 00	6.00	
24. 00	If this provider is an IPPS hospital, enter the 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.	0	0	0	0	0	0	24.00

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1304 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 8/26/2020 12:31 pm 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 days paid days el i gi bl e Medi cai d Medi cai d unpai d paid days eligible days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 25.00 If this provider is an IRF, enter the in-state 25, 00 \cap 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. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the 26. 00 cost reporting period. Enter "1" for urban or "2" for rural. Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37 01 37 01 instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 | Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 'N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1. 00 2. 00 3 00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν Ν 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Ν Ν Ν 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 N Ν 48.00 Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA Ν 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 2. If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, 59.00 Pt. NAHE 413.85 Pass-Through Worksheet A Y/N Line # Oual ification Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1304 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 8/26/2020 12:31 pm Y/N IME Direct GME IME Direct GME 1.00 2.00 3. 00 4.00 5.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0 00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA \$5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 3.00 1.00 2.00 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. Enter in column 4, the 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. Enter in column 4, the 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) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01

02.01	during in this cost reporting period of UPCA TIC program (cost instructions)							
	during in this cost reporting period of HRSA THC program. (see instruction	15)						
	Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this co			N	63.00			
	"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through (<u>67. (see instru</u>	ctions)					
		Unwei ghted	Unwei ghted	Ratio (col. 1/				
		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 n	eporting				
	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	0.00	0.00	0. 000000	64.00			
	in the base year period, the number of unweighted non-primary care							
	resident FTEs attributable to rotations occurring in all nonprovider							
	settings. 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)							
		•						

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1304 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 8/26/2020 12:31 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in 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 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. 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) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs 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) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

HUSPII	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	N: 15-1304	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part I Date/Time Pro 8/26/2020 12	epared:
					1.00	
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			ng period? Enter	N N	80.00
5. 00 6. 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 0 86. 0
7. 00	Is this hospital an extended neoplastic disease care hospital [1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified u	nder section	١	N	87. 0
	1000(d) (1)(b) (v1): Enter 1 101 yes 01 N 101 110.			V 1. 00	XI X 2. 00	
	Title V and XIX Services					-
	Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.			N	Y	90.0
1. 00	Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the appli		either in	N	Y	91.0
2. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual instructions) Enter "Y" for yes or "N" for no in the applicate	al certificati	on)? (see		N	92. 0
3. 00	Does this facility operate an ICF/IID facility for purposes o		XIX? Enter	N	N	93. 0
4. 00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, a	and "N" for no	in the	N	N	94.0
5. 00	applicable column. If line 94 is "Y", enter the reduction percentage in the appl	icable column		0. 00	0.00	95. (
	Does title V or XIX reduce operating cost? Enter "Y" for yes			N	N	96. 0
	applicable column. If line 96 is "Y", enter the reduction percentage in the appl			0. 00	0.00	97. 0
8. 00	Does title V or XIX follow Medicare (title XVIII) for the int stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo			Y	Y	98.0
8 N1	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the rep	orting of cha	raes on Wkst	Y	Y	98. 0
0. 01	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit				1	70.0
8. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.			Y	Y	98. 0
8. 03	Does title V, and In Column 2 for title XVIII) for a criti reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.				N	98. 0
8. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH r outpatient services cost? Enter "Y" for yes or "N" for no in			N N	N	98. 0
8. 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co				Y	98. 0
8. 06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98.0
	Rural Providers					
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-i	nclusive meth	od of paymer	nt N		105. C
07 00	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cos	st reimburseme	nt for L&R	N		107. 0
<i>37</i> . oc	training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do y approved medical education program in the CAH's excluded IPF	1. (see inst ou train I&Rs and/or IRF u	ructions) in an			107. 0
08. 00	Enter "Y" for yes or "N" for no in column 2. (see instruction Is this a rural hospital qualifying for an exception to the COCFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sched				108. 0
		Physi cal 1.00	Occupationa 2.00	Speech 3.00	Respi ratory 4.00	-
00.00	If this hospital qualifies as a CAH or a cost provider, are	N	2.00	3.00 N	4.00 N	109. 0

	1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A	N	110. 00
Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes,		
complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as		
appl i cabl e.	l	

are claimed, enter in column 2 the home office chain number. (see instructions)

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1304 Peri od: Worksheet S-2 From 01/01/2019 Part I 12/31/2019 Date/Time Prepared: To 8/26/2020 12:31 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143.00 Ci ty: State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν N 155.00 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00

campus enter the name in colum	ı							
0, county in column 1, state i	n							
column 2, zip code in column 3								
CBSA in column 4, FTE/Campus i	1							
column 5 (see instructions)								
					1.00			
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00 Is this provider a meaningful	ıser under §1886(n)? Er	nter "Y" for yes or "N"	' for no.		Y	167. 00		
168.00 If this provider is a CAH (lin	e 105 is "Y") and is a m	meaningful user (line 1	167 is "Y")), enter the		168. 00		
reasonable cost incurred for t	ne HIT assets (see instr	ructions)						
168.01 If this provider is a CAH and	s not a meaningful user	r, does this provider o	qualify for	r a hardship		168. 01		
exception under §413.70(a)(6)(i)? Enter "Y" for yes o	or "N" for no. (see ins	structions))				
169.00 If this provider is a meaningf	0.00	169. 00						
transition factor. (see instru	ctions)							

County

1.00

State Zip Code

3.00

2.00

165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs?

Name

0

170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting

1.00

N

FTE/Campus

5.00

Endi ng

2.00

CBSA

4.00

Begi nni ng

1.00

165.00

170.00

0.00 166.00

period respectively (mm/dd/yyyy)			
	1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N	0	171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			
1876 Medicare days in column 2. (see instructions)			

Multicampus

Enter "Y" for yes or "N" for no.

166.00 If line 165 is yes, for each

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1304 Peri od: Worksheet S-2 From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 8/26/2020 12:31 pm Date 1. 00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1. 00 2. 00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Υ Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 N 7.00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the N 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 N 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Ν 15.00 see instructions Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data Was the cost report prepared using $\overline{\text{the PS\&R Report onl y?}}$ 02/18/2020 02/18/2020 16.00 Υ 16.00 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 Report for Ν N 17.00 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 made to PS&R Ν N 18.00 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. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 N N Report data for corrections of other PS&R Report

information? If yes, see instructions.

Heal th	Financial Systems RUSH MEMORIA	AL HOSPITAL		In Lie	u of Form CMS	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCI	N: 15-1304	Peri od: From 01/01/2019 To 12/31/2019	Worksheet Sapart II Date/Time Pi 8/26/2020 12	repared:
		Descri	pti on	Y/N	Y/N	21 0 1 p
		0		1. 00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
	The port data for other. Beserbe the other day astments.	Y/N	Date	Y/N	Date	
04.00	lw ii	1.00	2. 00	3.00	4. 00	04.00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS HO	SPI TALS)			
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to appraisa	als made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during t	this cost re	porting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost report	ting period?	'If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reportin	ng period? I	f yes, see	N	26. 00
27. 00	instructions. Has the provider's capitalization policy changed during the	e cost reporting	g period? If	yes, submit	N	27. 00
	copy. Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	ntered into duri	ng the cost	reporti ng	N	28. 00
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		ot Service R	eserve Fund)	Υ	29. 00
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.	N	30. 00			
31. 00	Has debt been recalled before scheduled maturity without is instructions.	N	31. 00			
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser		d through co	ntractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		g to competi	tive bidding? If	N	33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement with	provi der-ba	sed physicians?	Υ	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exi		ts with the	provi der-based	N	35. 00
	physicians during the cost reporting period? If yes, see in	ISTI UCTI ONS.		Y/N	Date	
				1.00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report?		661 -	N		36.00
	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.					37. 00
38. 00	If line 36 is yes , was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 00
39. 00	If line 36 is yes, did the provider render services to othe see instructions.	er chain compone	ents? If yes	, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office? I	f yes, see	N		40. 00
		1.0	00	2.	00	
	Cost Report Preparer Contact Information	1.0		Ζ.		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	LANDON		HACKETT		41.00
42. 00	Enter the employer/company name of the cost report	BLUE & CO., LLC				42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7929		LHACKETT@BLUEAI	NDCO. COM	43. 00

Heal th	Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der CC		Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Pre 8/26/2020 12:	pared:
			3. (00	_		
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		SENI OR MANAGER				41. 00
42. 00	Enter the employer/company name of the cost r preparer.	report					42. 00
43. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respective						43. 00

| Period: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Health Financial Systems RUSH MOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1304

						То	12/31/2019	Date/Time Pre 8/26/2020 12:	
								I/P Days / 0/P	<u> Б</u>
								Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V	
		Line Number			Avai I abl e				
		1. 00		2. 00	3. 00		4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 12	25	30, 768. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
0.00	for the portion of LDP room available beds)								0.00
2.00	HMO and other (see instructions)								2. 00 3. 00
3. 00 4. 00	HMO I PF Subprovi der								4. 00
5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF							0	5.00
6. 00	Hospital Adults & Peds. Swing Bed NF							0	6.00
7. 00	Total Adults and Peds. (exclude observation			25	9, 12	5	30, 768. 00	0	7. 00
7.00	beds) (see instructions)			23	7, 12		30, 700.00	O	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, 12	25	30, 768. 00	0	14.00
15.00	CAH visits							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								24. 00
24. 10	HOSPICE (non-distinct part)	30. 00							24. 10
25. 00	CMHC - CMHC								25. 00
26. 00	RURAL HEALTH CLINIC (RHC)	88. 00						0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		٥٢				0	26. 25
27. 00 28. 00	Total (sum of lines 14-26)			25	1			0	27. 00
28.00	Observation Bed Days							U	28. 00 29. 00
30.00	Ambulance Trips Employee discount days (see instruction)								30.00
31. 00	Employee discount days (see Histruction)								31.00
32. 00	Labor & delivery days (see instructions)			0		0			32.00
32. 00	Total ancillary labor & delivery room			O		٥			32. 00
JZ. UI	outpatient days (see instructions)				1				JZ. U1
33. 00	LTCH non-covered days								33. 00
	LTCH site neutral days and discharges								33. 01
	, , , , , , , , , , , , , , , , , , , ,	'	•		•		'		'

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1304

Peri od: Worksheet S-3 From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared:

33.01

8/26/2020 12:31 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 7.00 10.00 6.00 8.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 871 53 1, 282 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 10 31 3.00 HMO IPF Subprovider 0 C 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 56 56 Hospital Adults & Peds. Swing Bed NF 6.00 C 47 6.00 7.00 Total Adults and Peds. (exclude observation 927 53 1, 385 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 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 13.00 271.00 14.00 Total (see instructions) 927 53 1, 385 0.00 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 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 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 0 24. 10 CMHC - CMHC 25.00 25.00 26, 00 RURAL HEALTH CLINIC (RHC) 2, 622 0.00 5.12 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0 0.00 26. 25 Ω 26.25 27.00 Total (sum of lines 14-26) 0.00 276.12 27.00 28.00 Observation Bed Days 587 28.00 29.00 29.00 Ambul ance Trips 194 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room 0 32.00 32.00 0 C 0 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00

33.01 LTCH site neutral days and discharges

Provider CCN: 15-1304

					o 12/31/2019	Date/Time Prep 8/26/2020 12:	
		Full Time Equivalents		Di scl	narges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		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 Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		(403	1.00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			8	3 7 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00	Total (see instructions) CAH visits SUBPROVI DER - IPF SUBPROVI DER - IRF SUBPROVI DER SUBPROVI DER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	0. 00	(267	20	403	14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 10 25. 00
26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	RURAL HEALTH CLINIC (RHC) FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0. 00 0. 00 0. 00					26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges			(33. 00 33. 01

Heal th	Financial Systems	RUSH MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 15-1304	Peri od:	Worksheet S-8	
			Component	CCN: 15-8539	From 01/01/2019 To 12/31/2019	Date/Time Pre 8/26/2020 12:	
					RHC I	Cost	31 pili
					1.	00	
	Clinic Address and Identification				201 CONDAD HAD	COURT WAY	1 00
1.00	Street		Ci	tv	201 CONRAD HAR State	ZIP Code	1.00
				00	2. 00	3. 00	
2. 00	City, State, ZIP Code, County	_	RUSHVI LLE			46173	2. 00
	•				<u>.</u>		
0.00	Lucani Tali, Daoro Fallo, alli V. D. J.	"5" 6				1.00	
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for u		nt Award	Date 0	3.00
					1. 00	2. 00	
	Source of Federal Funds				1.00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS A						5. 00
6.00	Health Services for the Homeless (Section 34	O(d), PHS Act)					6. 00
7.00	Appalachian Regional Commission						7.00
8. 00 9. 00	Look-Alikes OTHER (SPECIFY)						9.00
7.00	JOHNER (SI ECHT)						7.00
					1. 00	2. 00	
10. 00	Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operation	ns in column	N	0	10.00
		Sur	nday	N	londay	Tuesday	
		from	to	from	to	from	
		1. 00	2.00	3. 00	4. 00	5. 00	
	Facility hours of operations (1)			00.00	05.00	00.00	11 00
11.00	CLINIC			08: 00	05: 00	08: 00	11. 00
					1. 00	2.00	
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. ´ umn 1. If yes,	100-04, chapter enter in colum	9, section nn 2 the	N N	0	12.00 13.00
				Provi	ider name	CCN number	
					1.00	2.00	
14. 00	RHC/FQHC name, CCN number	\/ (N		V0/11.1	VIV	T 1 1 10 11	14. 00
		Y/N 1.00	V 2. 00	3. 00	XI X 4. 00	Total Visits 5.00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		2.00	3.00	4. 00	3.00	15. 00
				unty			
0.60	0.1 0.1 710 0.1 0.1			00			0.5
2. 00	City, State, ZIP Code, County	Tuocdov	RUSH	esday	Thus	reday	2.00
		Tuesday to	from	esday to	from	sday to	
		6.00	7. 00	8.00	9. 00	10.00	
	Facility hours of operations (1)						
11. 00	CLINIC	05: 00	08: 00	05: 00	08: 00	05: 00	11. 00

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1304	Peri od:	Worksheet S-8	
				From 01/01/2019		
		Component	CCN: 15-8539	To 12/31/2019	Date/Time Pre	pared:
		·			8/26/2020 12:	31 pm_
			_	RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	05: 00				11. 00

	Financial Systems RUSH MEMORIAL HOSP TAL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN: 15-1304		u of Form CMS-2 Worksheet S-10				
10251	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	ovider CCN: 15-1304	Peri od: From 01/01/2019	worksneet S-10	U			
			To 12/31/2019	Date/Time Pre	pared:			
				8/26/2020 12:	31 pm			
				1. 00				
	Uncompensated and indigent care cost computation							
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ed by line 202 colur	mn 8)	0. 347509	1.0			
	Medicaid (see instructions for each line)			4 000 407				
2.00	Net revenue from Medicaid			1, 393, 186	2. 0			
3. 00 1. 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplemental	navments from Media	rai d2	Y	4. 0			
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from	car u :	, 0	1				
5. 00	Medi cai d charges		12, 086, 235					
7. 00	Medicaid cost (line 1 times line 6)		4, 200, 075					
3. 00	Difference between net revenue and costs for Medicaid program (li	nes 2 and 5; if	2, 806, 889	8.00				
	< zero then enter zero)							
	Children's Health Insurance Program (CHIP) (see instructions for	each line)		_				
9.00	Net revenue from stand-allone CHIP			0				
10.00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)			0				
12.00	Difference between net revenue and costs for stand-alone CHIP (li	ne 11 minus line 0	if / zero then	0	1			
12.00	enter zero)	rie il illinus illie 7,	TT < Zero then	0	12.00			
	Other state or local government indigent care program (see instru	ctions for each line	e)					
13.00	Net revenue from state or local indigent care program (Not include	ed on lines 2, 5 or	9)	0	13.0			
14.00	Charges for patients covered under state or local indigent care p	rogram (Not included	d in lines 6 or	0	14. 00			
	10)							
15.00	State or local indigent care program cost (line 1 times line 14)		45	0				
16. 00	Difference between net revenue and costs for state or local indig	ent care program (II	ne 15 minus line	0	16. 00			
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state/Local indi	gent care program	ns (see				
	instructions for each line)	and State, 1994. The	gont out o program	.5 (555				
17. 00	Private grants, donations, or endowment income restricted to fund			0				
18. 00	Government grants, appropriations or transfers for support of hos			0				
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local i 8, 12 and 16)	ndigent care program	ms (sum of lines	2, 806, 889	19.00			
	[0, 12 and 10)	Uni nsured	Insured	Total (col. 1				
		pati ents		+ col . 2)				
		1.00	2. 00	3. 00				
00 00	Uncompensated Care (see instructions for each line)	: + 122	(12)	122 (12	20.00			
20. 00	Charity care charges and uninsured discounts for the entire facil (see instructions)	i ty 123, (612 0	123, 612	20.00			
21. 00	Cost of patients approved for charity care and uninsured discount	s (see 42,	956 0	42, 956	21 00			
00	instructions)	.2,	,00	12, 700				
22. 00	Payments received from patients for amounts previously written of	f as	0 0	0	22. 00			
	charity care							
23. 00	Cost of charity care (line 21 minus line 22)	42,	956 0	42, 956	23.00			
				1 00				
24. 00	Does the amount on line 20 column 2, include charges for patient	days heyond a Length	of stay limit	1. 00 N	24.00			
24.00	imposed on patients covered by Medicaid or other indigent care pr		TOT Stay Trillet	IN	24.00			
25. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit	am's length of	0	25. 00				
26. 00	Total bad debt expense for the entire hospital complex (see instr	uctions)		4, 159, 362	26. 00			
27. 00								
	Medicare allowable bad debts for the entire hospital complex (see			1, 586, 163				
27. 01	Non-Medicare bad debt expense (see instructions)			2, 573, 199				
28. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exper	se (see instructions	s)	1, 449, 367	29.00			
27. 01 28. 00 29. 00 30. 00	· · · · · · · · · · · · · · · · · · ·		5)	1, 449, 367 1, 492, 323 4, 299, 212	30.00			

Heal th	Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der Co	CN: 15-1304 I	Peri od:	Worksheet A	
					From 01/01/2019		
					To 12/31/2019	Date/Time Pre	
				T	5	8/26/2020 12:	31 pm
	Cost Center Description	Sal ari es	Other		Reclassi fi cati	Reclassi fied	
				+ 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			•			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		2, 265, 015	2, 265, 01	5 0	2, 265, 015	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	374, 042	4, 714, 141	5, 088, 18		5, 095, 024	4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	2, 757, 190	7, 717, 440			10, 331, 583	5. 00
7. 00	00700 OPERATION OF PLANT	296, 793	748, 550		·	1, 072, 828	7. 00
							1
8.00	00800 LAUNDRY & LINEN SERVICE	0	97, 158			97, 158	
9. 00	00900 HOUSEKEEPI NG	380, 838	138, 297			546, 620	9. 00
10. 00	01000 DI ETARY	350, 983	155, 793	506, 77		155, 014	
11. 00	O1100 CAFETERI A	0	0		0 379, 247	379, 247	11. 00
13.00	01300 NURSING ADMINISTRATION	115, 710	2, 000	117, 710	0	117, 710	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	69, 348	65, 767	135, 11	5 11, 213	146, 328	14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	344, 631	66, 467			411, 098	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			,	-, -,	,	1
30. 00	03000 ADULTS & PEDIATRICS	1, 790, 948	87, 678	1, 878, 62	6 -727, 160	1, 151, 466	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	1, 770, 740	07,070	1,070,02	- 727, 100	1, 131, 400	30.00
FO 00		1 0/5 404	F 47 F (2	1 (12 04	/ 270 440	1 242 500	F0 00
50.00	05000 OPERATING ROOM	1, 065, 484	547, 562		· ·	1, 242, 598	
51. 00	05100 RECOVERY ROOM	0	13, 197	13, 19		44, 433	1
53. 00	05300 ANESTHESI OLOGY	0	0		0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 061, 193	627, 757	1, 688, 950	0 52	1, 689, 002	54.00
54. 01	05401 ONCOLOGY	462, 400	171, 531	633, 93	1 -8, 026	625, 905	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	o	0		ol ol	0	55. 00
60.00	06000 LABORATORY	635, 719	846, 459	1, 482, 178	-119	1, 482, 059	1
65. 00	06500 RESPI RATORY THERAPY	92, 398	24, 692			103, 279	1
66. 00	06600 PHYSI CAL THERAPY	279, 795	7, 974			321, 806	1
		l					1
67.00	06700 OCCUPATI ONAL THERAPY	192, 330	1, 866			228, 224	1
68. 00	06800 SPEECH PATHOLOGY	156, 302	2, 555			90, 705	1
69. 00	06900 ELECTROCARDI OLOGY	122, 190	3, 497	125, 68	7 -299	125, 388	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 444, 075	444, 075	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	165, 447	165, 44 ⁻	7 0	165, 447	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	560, 202	4, 622, 732	5, 182, 93	4 -3, 541	5, 179, 393	73. 00
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			· · · · · · · · · · · · · · · · · · ·		
88. 00	08800 RURAL HEALTH CLINIC (RHC)	1, 517, 289	93, 901	1, 611, 19	0 -307, 251	1, 303, 939	88. 00
90. 00	09000 CLINIC	792, 630	58, 595			1, 916, 963	
90. 01	09001 SURGI CAL ASSOCI ATES	i i					
		54, 013	555, 050			608, 403	
90. 02	09002 ORTHOPAEDI CS	33, 093	140, 033	173, 120		173, 126	
90. 03	09003 RHEUMATOLOGY	520, 745	10, 364			530, 788	1
90. 04	09004 SPECIALTY CLINIC	387, 195	234, 912			592, 017	1
90. 05	09005 PEDI ATRI CS	378, 825	10, 462	389, 28	7 -12	389, 275	90. 05
90.06	09006 WOMEN'S HEALTH	0	0		0	0	90.06
90. 07	09007 PALN MANAGEMENT	491, 617	7, 655	499, 27	2 -362	498, 910	90. 07
90. 08	09008 ONCOLOGY MD	0	283, 077			283, 077	90. 08
91. 00	1 1	1, 009, 986	1, 243, 131				
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,007,700	1, 243, 131	2, 233, 11	-55, 656	2,211,217	92.00
92.00				L			72.00
05 00	OTHER REIMBURSABLE COST CENTERS	74.000	04.774	00.40	0 500	00 5/5	05 00
95. 00	09500 AMBULANCE SERVICES	74, 332	24, 771	99, 10	-538	98, 565	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		16, 368, 221	25, 755, 526	42, 123, 74	7 0	42, 123, 747	118. 00
	NONREI MBURSABLE COST CENTERS						
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192. 00
	19300 NONPALD WORKERS	اً م	n		ol ŏl		193. 00
	19301 FOUNDATION	62, 401	4	62, 40	7 0		193. 01
		02, 401	0	02, 40	<u>,</u>		193. 01
	2 19302 OCCUPATI ONAL MEDI CI NE		0				
	07950 NON REIMBURSABLE	0	0 755 555	40 40 :=	0		194. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	16, 430, 622	25, 755, 532	42, 186, 15	4 0	42, 186, 154	[200. 00

 Health Financial
 Systems
 RUSH MEMORITY

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1304

Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 8/26/2020 12:31 pm

					/26/2020 12: 31 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 & FIXT	-167, 689	2, 097, 326		1. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	-247, 187	4, 847, 837		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-6, 085, 080	4, 246, 503		5. 00
7. 00	00700 OPERATION OF PLANT	-89	1, 072, 739		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	97, 158		8. 00
9. 00	00900 HOUSEKEEPI NG	-463	546, 157		9. 00
10.00	01000 DI ETARY	-1, 717	153, 297		10.00
11. 00	01100 CAFETERI A	-174, 795	204, 452		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-1, 030	116, 680		13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY	0	146, 328		14. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	-1, 200	409, 898		16. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	1 151 4//		30.00
30.00	03000 ADULTS & PEDIATRICS	0	1, 151, 466		30.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	-725, 146	517, 452		50.00
51. 00	05100 RECOVERY ROOM	-725, 146 0	44, 433		51.00
53. 00	05300 ANESTHESI OLOGY	0	44, 433		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-704, 416	984, 586		54.00
54. 01	05401 ONCOLOGY	-103, 200	522, 705		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	- 103, 200	0		55.00
60. 00	06000 LABORATORY	-1, 477	1, 480, 582		60.00
65. 00	06500 RESPI RATORY THERAPY	1, 7,	103, 279		65. 00
66. 00	06600 PHYSI CAL THERAPY	o o	321, 806		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	o o	228, 224		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	90, 705		68. 00
69. 00	06900 ELECTROCARDI OLOGY	-21	125, 367		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-8, 177	435, 898		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	165, 447		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-55, 338	5, 124, 055		73. 00
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC (RHC)	0	1, 303, 939		88. 00
90.00	09000 CLI NI C	-1, 523, 726	393, 237		90.00
90. 01	09001 SURGI CAL ASSOCI ATES	-542, 677	65, 726		90. 01
90. 02	09002 ORTHOPAEDI CS	-166, 910	6, 216		90. 02
90. 03	09003 RHEUMATOLOGY	-595, 252	-64, 464		90. 03
90. 04	09004 SPECIALTY CLINIC	-499, 776	92, 241		90. 04
90. 05	09005 PEDI ATRI CS	-324, 394	64, 881		90. 05
90.06	09006 WOMEN'S HEALTH	0	0		90. 06
90. 07	09007 PAIN MANAGEMENT	-495, 645	3, 265		90. 07
90. 08	09008 ONCOLOGY MD	-270, 577	12, 500		90. 08
91. 00	09100 EMERGENCY	0	2, 217, 279		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
	OTHER REIMBURSABLE COST CENTERS				
95. 00	09500 AMBULANCE SERVI CES	-3, 840	94, 725		95. 00
	SPECIAL PURPOSE COST CENTERS	40 (00 000	00 400 005		
118.00		-12, 699, 822	29, 423, 925		118. 00
100.00	NONREI MBURSABLE COST CENTERS				102.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.00
	19300 NONPAL D WORKERS	0	0		193. 00
	19301 FOUNDATION 19302 OCCUPATIONAL MEDICINE		62, 407		193. 01 193. 02
	19302 OCCUPATIONAL MEDICINE 07950 NON REIMBURSABLE		0		194. 00
200.00	1 1	-12, 699, 822	9		200. 00
200.00	TOTAL (30M OF LINES THE UNIOUGH 199)	- 12, 077, 022	27, 400, 332	I	1200.00

RECLASSI FI CATIONS

Provider CCN: 15-1304

Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

500.00

8/26/2020 12:31 pm Increases Cost Center Li ne # Sal ary 0ther 2.00 3.00 4.00 5.00 B - DIETARY/ CAFETERIA 1.00 CAFETERI A 11.00 262, 659 116, 588 1.00 262, 659 116, 588 - MED SUPPLY RECLASS 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 444, 075 1.00 PATI ENTS 2.00 CENTRAL SERVICES & SUPPLY 14.00 0 11, 213 2.00 3.00 0.00 0 3.00 4.00 0 0 0.00 4.00 5.00 0.00 0 0 5.00 6.00 0.00 0 0 6.00 0 7.00 0.00 0 7.00 0 8.00 0.00 0 8.00 9.00 0.00 0 0 9.00 0 0 10.00 0.00 10.00 0.00 0 11.00 11.00 12.00 0.00 0 0 12.00 13.00 0.00 0 0 13.00 0 0.00 0 14.00 14.00 0 15.00 0.00 15.00 16.00 0.00 o 0 16.00 0.00 0 0 17.00 17.00 0 0 18.00 0.00 18.00 19.00 0.00 0 19.00 20.00 0.00 0 0 20.00 21.00 0.00 0 21.00 ō 455, 288 SALARY RECLASS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 6, 871 1.00 7.00 2.00 OPERATION OF PLANT 27, 485 0 2.00 HOUSEKEEPI NG 9.00 27, 485 0 3.00 3.00 4.00 DI ETARY 10.00 27, 485 0 4.00 5.00 RECOVERY ROOM 51.00 38, 327 0 5.00 6.00 RADI OLOGY-DI AGNOSTI C 54 00 4 440 0 6 00 0 7.00 PHYSICAL THERAPY 66.00 34,076 7.00 8.00 OCCUPATIONAL THERAPY 67.00 34, 076 0 8.00 9.00 CLI NI C 90.00 27, 485 0 9.00 0 10.00 <u>EMERGENCY</u> 91.00 4, 440 10.00 232, 170 0 F - PHYSICIAN RECLASS 1.00 CLINIC 90.00 314, 427 0 1 00 2.00 RURAL HEALTH CLINIC (RHC) 88.00 394, 004 0 2.00 708, 431 Ō G - PHYSICIAN PRACTICE ADMIN RECLASS 1.00 90 00 1.00 CLINIC 11, 645 0 2.00 RURAL HEALTH CLINIC (RHC) 88. 00 14, 592 0 2.00 TOTALS 26, 237 H - RHC RECLASS 90. 00 1.00 1.00 CLI NI C 673, 427 41, 677 TOTALS 673, 427 41, 677

1, 902, 924

613, 553

500.00 Grand Total: Increases

RECLASSIFICATIONS

Provider CCN: 15-1304

Peri od: Worksheet A-6 From 01/01/2019

Date/Time Prepared:

12/31/2019

8/26/2020 12:31 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 B - DIETARY/ CAFETERIA DI ETARY 1.00 10.00 262, 659 116, 588 0 1.00 262, 659 116, 588 MED SUPPLY RECLASS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 30 0 1.00 2.00 ADULTS & PEDIATRICS 30.00 0 18, 729 0 2.00 0 3.00 OPERATING ROOM 50.00 ol 336, 561 3.00 0 7, 091 0 4.00 RECOVERY ROOM 51.00 4.00 5.00 RADI OLOGY-DI AGNOSTI C 54.00 0 4, 388 0 5.00 ONCOLOGY 0 0 6.00 54.01 8,026 6.00 7.00 LABORATORY 60.00 0 0 7.00 119 RESPIRATORY THERAPY 0 0 8.00 65.00 490 8.00 9.00 PHYSICAL THERAPY 66.00 o 39 0 9.00 10.00 OCCUPATIONAL THERAPY 67.00 0 48 0 10.00 ELECTROCARDI OLOGY 0 0 69 00 299 11 00 11 00 0 12.00 DRUGS CHARGED TO PATIENTS 73.00 3, 541 12.00 13.00 RURAL HEALTH CLINIC (RHC) 88.00 o 743 0 13.00 CLINIC 0 0 14.00 90.00 2, 923 14.00 0 15.00 SURGICAL ASSOCIATES 90.01 660 15.00 0 16.00 RHEUMATOLOGY 90.03 0 321 16.00 SPECIALTY CLINIC 90.04 o 30,090 0 17.00 17.00 0 PEDI ATRI CS 90.05 0 18.00 18.00 12 19.00 PAIN MANAGEMENT 90.07 0 362 0 19.00 20.00 EMERGENCY 91.00 0 40, 278 0 20.00 AMBULANCE SERVICES 95.00 0 21.00 21.00 538 0 455, 288 - SALARY RECLASS 1.00 ADMINISTRATIVE & GENERAL 116, 810 0 1.00 5.00 OPERATING ROOM 50.00 33, 887 2.00 0 2.00 0 0 RESPIRATORY THERAPY 3 00 65 00 13, 321 0 3 00 4.00 SPEECH PATHOLOGY 68.00 68, 152 0 0 4.00 5.00 0.00 0 0 0 5.00 0 6.00 0.00 0 0 6.00 0 7.00 0.00 0 0 7.00 8.00 0.00 0 0 0 8.00 0 9.00 0.00 0 0 9.00 10.00 0.00 0 0 10.00 232, 170 - PHYSICIAN RECLASS 1.00 ADULTS & PEDIATRICS 30.00 708, 431 0 0 1.00 2.00 0.00 0 0 2.00 708, 431 0 G - PHYSICIAN PRACTICE ADMIN RECLASS 1.00 ADMINISTRATIVE & GENERAL 5.00 26, 237 0 0 1.00 2.00 0.00 0 0 2.00 TOTALS 26, 237 H - RHC RECLASS RURAL HEALTH CLINIC (RHC) 88. 00 1.00 673, 427 4<u>1, 6</u>77 0 1.00 TOTALS 673, 427 41, 677 500.00 Grand Total: Decreases 1, 902, 924 613, 553 500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS RUSH MEMORIAL HOSPITAL

Provider CCN: 15-1304

				Ī	o 12/31/2019	Date/Time Prep 8/26/2020 12:	
			<u> </u>	Acqui si ti ons			•
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	188, 708	0	(0	0	1. 00
2.00	Land Improvements	455, 968	20, 680	(20, 680	0	2. 00
3.00	Buildings and Fixtures	18, 469, 048	252, 421	(252, 421	0	3. 00
4.00	Building Improvements	0	0	(0	0	4. 00
5.00	Fixed Equipment	1, 748, 328	1, 697, 987	(1, 697, 987	859, 421	5. 00
6.00	Movable Equipment	16, 365, 047	762, 141	C	762, 141	0	6.00
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	37, 227, 099	2, 733, 229	C	2, 733, 229	859, 421	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	37, 227, 099	2, 733, 229	(2, 733, 229	859, 421	10.00
		Endi ng Bal ance	Fully				
			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	476, 648	0				2. 00
3.00	Buildings and Fixtures	18, 721, 469	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	2, 586, 894	0				5.00
6.00	Movable Equipment	17, 127, 188	0				6.00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	39, 100, 907	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	39, 100, 907	0				10. 00

Heal th	Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lieu of Form CMS-2552-10			
RECON	RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Period: From 01/01/2019 To 12/31/2019			
					12,01,201,	8/26/2020 12:		
			SL	JMMARY OF CAPI	TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)			
		9. 00	10.00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FLXT	1, 809, 551	0	192, 99	6 262, 468	0	1. 00	
3.00	Total (sum of lines 1-2)	1, 809, 551	0	192, 99	6 262, 468	0	3. 00	
		SUMMARY O	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 WOR	KSHEET A, COLUM	IN 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	2, 265, 015				1. 00	
3.00	Total (sum of lines 1-2)	0	2, 265, 015				3. 00	

Heal th	Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
					From 01/01/2019 To 12/31/2019		pared:
						8/26/2020 12: 3	31 pm
		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col			
		1.00	2.00	2)	4.00	F 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	1. 00	2.00	3.00	4. 00	5. 00	
1. 00	NEW CAP REL COSTS-BLDG & FIXT	39, 100, 907	1	39, 100, 90	7 1. 000000	0	1. 00
3. 00	Total (sum of lines 1-2)	39, 100, 907		39, 100, 90		-	3. 00
0.00	Total (Sam of Tries 1 2)		TION OF OTHER (_	F CAPITAL	0.00
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DADT III DECONOLILATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS	1 0		0 1 707 /11	0	1 00
1. 00 3. 00	NEW CAP REL COSTS-BLDG & FIXT Total (sum of lines 1-2)	0	0		0 1, 797, 611 0 1, 797, 611	0	1. 00 3. 00
3.00	Total (suil of Titles 1-2)	U	SI SI	I JMMARY OF CAPI		U	3.00
			30	NIMPART OF CALL	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	0ther	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	DART III DECONOLILIATION OF CARLTAL COCTO OF	11. 00	12.00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE		2/2 4/0			2 007 224	1 00
1. 00 3. 00	NEW CAP REL COSTS-BLDG & FIXT Total (sum of lines 1-2)	37, 247 37, 247			0 0	2, 097, 326 2, 097, 326	1. 00 3. 00
3.00	Total (Suiii of Titles 1-2)	37,247	J 202, 408		u _l u	2,097,320	3.00

| Period: | Worksheet A-8 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-1304

Cost Center Description Dests/Code (2) Amount Cost Center Line 4 Mest. A-7 Ref.					To	12/31/2019		
Cost Center Bescription					Expense Classification on	Worksheet A	0/20/2020 12.	s i pili
1.00 Investment Income - NFW CAP C					To/From Which the Amount is	to be Adjusted		
1.00 Investment Lincome - NFB CAM 1.00 2.00 8.00 4.00 5.00 0 1.00 0 1.0								
1.00 Investment Lincome - NFB CAM 1.00 2.00 8.00 4.00 5.00 0 1.00 0 1.0								
Three-Steiner Lincolnes — NEW CAP New CAP REL COSTS-BLDG & 1.00 0 1.00		Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
SIL COSTS-HURG A FIXE (Chapter 2) 1XX 2.00 0 2.00 0 2.00 0 3.00 0 3.00 0 3.00 0 3.00 0 4.00 0 5.00	1 00	I pyostmont i poemo NEW CAD	1.00					1 00
1	1.00			U		1.00	o o	1.00
SOSTS-MRELE COUP (chapter 2)	2 00			0	*** Cost Contor Doloted ***	2 00		2 00
Chapter 2) (Chapter 2) (Chapter 3) (Chapter 4) (Chapter 5) (Chapter 4) (Chapter 4) (Chapter 4) (Chapter 4) (Chapter 5) (Chapter 6) (Chapter 4) (Chapter 6) (Chapter 6) (Chapter 7) (Chapter 6) (Chapter 7) (Chapter 7) (Chapter 7) (Chapter 7) (Chapter 8) (Chapt	2.00			O	cost center bereted	2.00		2.00
1.00 Control	3.00			0		0.00	0	3. 00
Refunds and rebates of 0 0.00 0.5.00 0	4.00	Trade, quantity, and time		0		0. 00	0	4. 00
6. 00 Rental of growt der space by suppliers (Chapter 8) 7. 00 Ilei sphore services (Chapter 8) 8. 00 Tollevisi on and radio service (Chapter 21) 9. 00 Parking I oft (Chapter 21) 9. 00 Parking I oft (Chapter 21) 10. 00 Parking I oft (Chapter 22) 10. 00 Related organization (Chapter 10) 11. 00 Space of Scrap, waste, etc. (Chapter 23) 11. 00 Parking I oft (Chapter 10) 11. 00 Parking I oft (Chapter 22) 12. 00 Related organization (Chapter 10) 13. 00 Parking I oft (Chapter 22) 13. 00 Parking I oft (Chapter 23) 14. 00 Parking I oft (Chapter 23) 15. 00 Parking I oft (Chapter 24) 15. 00 Parking I oft (Chapter 24) 15. 00 Parking I oft (Chapter 24) 16. 00 Parking I oft (Chapter 24) 17. 00 Parking I oft (Chapter 24) 18.	5 00			0		0.00	0	5 00
Supplier's (chapter 8)		expenses (chapter 8)		O			Ĭ	
Telephone services (pay) Stations excluded) (chapter 21) Stations excluded) (chapter 22) Stations excluded) (chapter 23) Stations excluded) (chapter 24) Stations ex	6. 00			0		0. 00	0	6. 00
8. 00 Television and radio service	7. 00	Tel ephone servi ces (pay		0		0. 00	0	7. 00
Television and radio service (chapter 21) 0 0.00 0								
Parking lot (chapter 21) A-8-2 -5,799,580 0 0.00 0.00 0.10.00 0.00 0.10.00 0.00 0.10.00 0.00 0.10.00	8.00	Television and radio service		0		0. 00	О	8. 00
10.00 Provider-based physician A-8-2 -5,799,580 0 10.00 0 10.00 0 11.00 0 12.0	9. 00			0		0. 00	0	9. 00
11.00 Sale of Scrap, waste, etc. (Chapter 23) 12.00 Related organization A-8-1 0 12.00 12.00 13.00 13.00 13.00 14.00 14.00 14.00 16.00 16.00 14.00 14.00 16.00 16.00 14.00 16.00	10.00	Provi der-based physician	A-8-2	-5, 799, 580			0	10.00
(chapter 23)	11. 00	1 3		0		0. 00	0	11. 00
transactions (chapter 10) 13. 00 14. 00 14. 00 15.	12 00		A Q 1	0			0	12 00
14.00 Cafeteria-employees and guests 0 0.00 0 14.00	12.00		A-0-1	O				12.00
15.00 Rental of quarters to employee and others 0 0 0 15.00 0 15.00 0 16.00 0 16.00 0 16.00 0 16.00 0 17.00 0 17.00 0 18.00 0 19.00 0 17.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 19.00 19.00				0				
16.00 Sale of medical and surgical supplies to other than patients 0 0.00 0.			1	0			-	
Supplies to other than patients 17.00 Sale of drugs to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and alents 18.00 Sale of medical records and abstracts 19.00 Nursing and allied health education (fultion, fees, books, etc.) 20.00 Control (fultion) 20.00	14 00	II		0		0.00		14 00
17. 00 Sale of drugs to other than patients 0 0 0 0 0 0 0 0 0	10.00			O		0.00	o o	10.00
patients	17 00	1.		0		0.00	0	17 00
abstracts		patients		· ·				
19.00 Nursing and allied health education (tuit on, fees, books, etc.) 20.00 Vending machines 0 0.00	18. 00			0		0. 00	0	18. 00
books, etc.) Vending machines 0 Vending machines 0 0.00 0.	19. 00	Nursing and allied health		0		0. 00	0	19. 00
20.00 Vending machines 0 0.00								
Interest, finance or penal ty charges (chapter 21)		Vending machines		0			-	
Charges (chapter 21) Chapter 14) Chapter 15) Chapter 16 Chapter 17) Chapter 17) Chapter 18 Chapter 19 Chapte	21.00			0		0.00	U	21.00
Overpayments and borrowings to repay Medicare overpayments A-8-3 ORESPIRATORY THERAPY 65.00 23.00	22.00	charges (chapter 21)				0.00		22.00
23. 00 Adj ustment for respiratory therapy costs in excess of limitation (chapter 14) 24. 00 Adj ustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - NEW CAP REL COSTS-BLDG & 1.00 0 26. 00 (Costs-BLDG & 1.00 0 27. 00 (Costs-BMBLE EQUIP Physicians' assistant 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22.00			0		0.00	U	22. 00
therapy costs in excess of limitation (chapter 14) 24.00 Adj ustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL COSTS-BLDG & 1.00 0 26.00 (COSTS-BLDG & FIXT 0 *** Cost Center Deleted *** 2.00 0 27.00 (COSTS-BLDG & FIXT 0 *** Cost Center Deleted *** 2.00 0 27.00 (COSTS-MVBLE EQUIP Non-physician Anesthetist 0 0 *** Cost Center Deleted *** 19.00 28.00 (Physicians' assistant 0 0 *** Cost Center Deleted *** 19.00 0 28.00 (Physicians' assistant 0 0 *** Cost Center Deleted *** 19.00 0 29.00 (Physicians' assistant 0 0 *** Cost Center Deleted *** 19.00 0 29.00 (Physicians' assistant 0 0 *** Cost Center Deleted *** 19.00 0 29.00 (Physicians' assistant 0 0 *** Cost Center Deleted *** 19.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22 00	1 1 3	Λ Ο 2	0	DESDI DATODY THEDADY	65.00		22 00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) A-8-3 0 PHYSICAL THERAPY 66.00 24.00 25.00 Utilization review - physicians' compensation (chapter 21) 0 *** Cost Center Deleted *** 114.00 25.00 26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT 0 NEW CAP REL COSTS-BLDG & 1.00 0 26.00 27.00 Depreciation - CAP REL COSTS-BLDG & FIXT 0 **** Cost Center Deleted *** 2.00 0 27.00 28.00 Non-physician Anesthetist 0 **** Cost Center Deleted *** 19.00 28.00 29.00 Physicians' assistant 0 **** Cost Center Deleted *** 19.00 28.00 29.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 0 OCCUPATIONAL THERAPY 67.00 30.00 30.99 Hospice (non-distinct) (see instructions) 0 ADULTS & PEDIATRICS 30.00 30.99 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 SPEECH PATHOLOGY 68.00 31.00 32.00 CAH HIT Adjustment for A -11,940 NEW CAP REL COSTS-BLDG & 1.00 9 32.00	23.00		A-0-3	O	RESTRATORT THERAFT	05.00		23.00
therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL COSTS-BLDG & 1.00 0 26.00 COSTS-BLDG & FIXT 0 Experience of the cost of	24 00		Δ_8_3	0	PHYSICAL THERAPY	66 00		24 00
25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL COSTS-BLDG & 1.00 0 26.00 0 0 0 0 0 0 0 0 0	21.00	therapy costs in excess of	7. 0 0	· ·	THISTORE THEIGHT	55. 55		21.00
physicians' compensation (chapter 21)	25. 00		-	0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00 Depreciation - NEW CAP REL COSTS-BLDG & 1.00 0 26.00 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 0 **** Cost Center Deleted **** 2.00 0 27.00 28. 00 Non-physician Anesthetist 0 **** Cost Center Deleted **** 19.00 28.00 29. 00 Physicians' assistant 0 CCUPATIONAL THERAPY 67.00 30.00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 0 ADULTS & PEDIATRICS 30.00 30.99 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 SPEECH PATHOLOGY 68.00 31.00 32. 00 CAH HIT Adjustment for A -11,940 NEW CAP REL COSTS-BLDG & 1.00 9 32.00		physicians' compensation						
27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 0 **** Cost Center Deleted *** 2.00 0 27.00 28. 00 Non-physician Anesthetist 0 **** Cost Center Deleted *** 19.00 28.00 29. 00 Physicians' assistant 0 .00 0 .00 0 .00 29.00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 0 OCCUPATIONAL THERAPY 67.00 30.00 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 SPEECH PATHOLOGY 68.00 31.00 32. 00 CAH HIT Adjustment for A -11,940 NEW CAP REL COSTS-BLDG & 1.00 9 32.00	26. 00			0	NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
COSTS-MVBLE EQUIP Non-physician Anesthetist O **** Cost Center Deleted *** 19.00 28.00 29.00 Physicians' assistant O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27.00					2 00	0	27.00
29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for A-8-3 OCCUPATIONAL THERAPY OADULTS & PEDIATRICS 30. 00 30. 99 OADULTS & PEDIATRICS 30. 00 31. 00 SPEECH PATHOLOGY OADULTS & PEDIATRICS 30. 00 31. 00 31. 00 32. 00 32. 00	27.00							
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for A A-8-3 OCCUPATIONAL THERAPY 67.00 30.00				0	*** Cost Center Deleted ***		0	
I i mi tati on (chapter 14) 30. 99 Hospi ce (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for A -11,940 NEW CAP REL COSTS-BLDG & 1.00 9 32.00		Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY			
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for A -11,940 NEW CAP REL COSTS-BLDG & 1.00 9 32.00								
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for A -11,940 NEW CAP REL COSTS-BLDG & 1.00 9 32.00	30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for A -11,940 NEW CAP REL COSTS-BLDG & 1.00 9 32.00	31 00		A-8-3	Ω	SPEECH PATHOLOGY	68 OO		31. 00
32.00 CAH HIT Adjustment for A -11,940 NEW CAP REL COSTS-BLDG & 1.00 9 32.00	00	pathology costs in excess of		Ü		55. 50		27.30
	32. 00		Α	-11, 940	NEW CAP REL COSTS-BLDG &	1. 00	9	32. 00
			<u> </u>					

Provider CCN: 15-1304 Peri od: Worksheet A-8 From 01/01/2019
To 12/31/2019 Date/Time Prepared:

				To	o 12/31/2019	Date/Time Prep 8/26/2020 12:	
	·			Expense Classification on	Worksheet A	0/20/2020 12.	3 i pili
				To/From Which the Amount is			
				To Troil will ell the Allourt 13	to be haj astea		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
33. 00	CAFETERI A	В		CAFETERI A	11. 00	0	33. 00
33. 01	JAIL MEALS	В		CAFETERI A	11. 00	0	33. 01
33. 02	VENDING MACHINES	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	SALE OF DRUGS	В		DRUGS CHARGED TO PATIENTS	73. 00	0	33. 03
33. 04	SALE OF SUPPLIES	В	·	MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 04
		_		PATIENTS		Ī	
33. 05	SALE OF PODIATRY SUPPLIES	В	-8. 144	MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 05
		_	-,	PATI ENTS		Ī	
33.06	PHYSICIAN APPLICATION FEES	В	-4, 400	ADMINISTRATIVE & GENERAL	5. 00	o	33. 06
33. 07	NSF FEES	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 07
33. 08	MEDICAL RECORDS TRANSCRIPTION	В		MEDICAL RECORDS & LIBRARY	16. 00	0	33. 08
	FEES		,				
33. 09	COPI ER FEES	В	-3, 823	ADMINISTRATIVE & GENERAL	5. 00	o	33. 09
33. 10	ATHLETIC TRAINER - SCHOOL REV	В		ADMINISTRATIVE & GENERAL	5. 00	o	33. 10
33. 11	OCCUPATI ONAL HEALTH	В	-100, 330		90.00	0	33. 11
33. 12	SALE OF SCRAP	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 13	SHUTTLE BUS SERVICES	В		AMBULANCE SERVICES	95. 00	0	33. 13
33. 14	MISC. INCOME	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	MISC. INCOME	В	·	RHEUMATOLOGY	90. 03	0	33. 15
33. 16	INTEREST INCOME	В	·	NEW CAP REL COSTS-BLDG &	1. 00	11	33. 16
		_	,	FIXT			
33. 17	TELEPHONE SALARY	A	-5, 340	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	TELEPHONE OTHER	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19	TELEPHONE BENEFITS	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 19
33. 20	ADVERTI SI NG	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 20
33. 21	IHA & AHA LOBBYING	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 21
33. 22	REBATES	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 22
33. 23	REBATES	В	·	OPERATION OF PLANT	7. 00	0	33. 23
33. 24	REBATES	В		HOUSEKEEPI NG	9. 00	0	33. 24
33. 25	REBATES	В		DI ETARY	10. 00	0	33. 25
33. 26	REBATES	В	·	NURSING ADMINISTRATION	13. 00	0	33. 26
33. 27	REBATES	В		OPERATING ROOM	50.00	0	33. 27
33. 28	REBATES	В	·	RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 28
33. 29	REBATES	В	·	LABORATORY	60. 00	0	33. 29
33. 30	REBATES	B		ELECTROCARDI OLOGY	69. 00	0	33. 30
33. 31	REBATES	В		DRUGS CHARGED TO PATIENTS	73. 00	Ö	33. 31
33. 32	HAF EXPENSE	A	·	ADMI NI STRATI VE & GENERAL	5. 00	0	33. 32
33. 33	PHYSI CLAN RECRUITMENTS	Ä		ADMINISTRATIVE & GENERAL	5. 00	0	33. 33
33. 34	BAD DEBTS	Ä		ADMINISTRATIVE & GENERAL	5. 00	0	33. 34
50. 00	TOTAL (sum of lines 1 thru 49)	1	-12, 699, 822	la contraction of the contractio	3.00		50. 00
50.00	(Transfer to Worksheet A,		12,077,022				30.00
	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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-1304

Peri od: Worksheet A-8-2 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

8/26/2020 12:31 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3. 00 4. 00 5. 00 6. 00 7. 00 50.00 OPERATING ROOM 749, 084 724, 144 24, 940 1. 00 1.00 0 0 2.00 54. 00 RADI OLOGY-DI AGNOSTI C 727, 252 703, 085 24, 167 0 2.00 3.00 54. 01 ONCOLOGY 0 3.00 103, 200 103, 200 4.00 60. 00 LABORATORY 38, 400 38, 400 0 0 4.00 90. 00 CLI NI C 5.00 1, 481, 076 1, 423, 396 57,680 0 5.00 6.00 90. 01 SURGI CAL ASSOCI ATES 550,000 542, 677 7, 323 6.00 7.00 90. 02 ORTHOPAEDI CS 168, 380 166, 910 1, 470 0 0 0 7.00 90. 03 RHEUMATOLOGY 8.00 0 563.071 545, 776 17, 295 8.00 9.00 90. 04 SPECIALTY CLINIC 534, 428 499, 776 34, 652 9.00 10.00 90. 05 PEDI ATRI CS 336, 435 324, 394 12,041 0 0 10.00 90. 07 PAIN MANAGEMENT 518, 199 495, 645 22, 554 11.00 0 11.00 90. 08 ONCOLOGY MD 283, 077 270, 577 12.00 12,500 12.00 13.00 91. 00 EMERGENCY 1, 140, 515 1, 140, 515 0 13.00 200.00 7, 193, 117 5, 799, 580 1, 393, 537 200.00 Wkst. A Line # Unadjusted RCE Physician Cost Cost Center/Physician 5 Percent of Cost of Provi der Memberships & of Malpractice I denti fi er Li mi t Unadjusted RCE Component Limit Conti nui ng Share of col Insurance Educati on 1. 00 2.00 8.00 9.00 13.00 14.00 12.00 1.00 50. 00 OPERATING ROOM 1. 00 0 54. 00 RADI OLOGY-DI AGNOSTI C 0 2.00 0 0 0 0 2 00 3.00 54. 01 ONCOLOGY 0 0 0 3.00 4.00 60. 00 LABORATORY o 0 0 0 4.00 0 90. 00 CLI NI C 0 0 0 5.00 5.00 90. 01 SURGI CAL ASSOCIATES o 0 6.00 6.00 7.00 90. 02 ORTHOPAEDI CS 0 0 0 0 0 0 7.00 90. 03 RHEUMATOLOGY o 0 8.00 8.00 90. 04 SPECIALTY CLINIC 0 9.00 0 0 9.00 90. 05 PEDI ATRI CS 10.00 0 0 0 10.00 90. 07 PALN MANAGEMENT 0 0 0 11.00 11.00 0 0 12.00 90. 08 ONCOLOGY MD 0 0 0 12.00 0 91. 00 EMERGENCY 13.00 13.00 200.00 200.00 Cost Center/Physician Wkst. A Line # Provi der Adjusted RCE RCE Adjustment I denti fi er Di sal I owance Component limit Share of col. 14 1.00 2.00 15.00 16.00 17.00 18.00 1.00 50.00 OPERATING ROOM 724, 144 1.00 0 703, 085 54. 00 RADI OLOGY-DI AGNOSTI C 0 2.00 2.00 0 54. 01 ONCOLOGY 0 0 0 3.00 103, 200 3.00 4.00 60. 00 LABORATORY 0 0 0 4.00 90. 00 CLI NI C 0 1, 423, 396 5.00 5.00 90. 01 SURGI CAL ASSOCIATES 0 0 6.00 6.00 0 542,677 7.00 90. 02 ORTHOPAEDI CS 0 0 166, 910 7.00 8.00 90. 03 RHEUMATOLOGY 0 545, 776 8.00 0 0 9.00 90. 04 SPECIALTY CLINIC 0 499, 776 9.00 90. 05 PEDI ATRI CS 0 0 10.00 0 324, 394 10.00 90. 07 PAIN MANAGEMENT 0 11.00 0 495, 645 11.00 90. 08 ONCOLOGY MD 0 0 12.00 270, 577 12.00 91. OO EMERGENCY 13.00 0 13.00 5, 799, 580 200.00 200.00

| Period: | Worksheet B | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1304

				Τ̈́	o 12/31/2019		pared:
			CAPI TAL			8/26/2020 12:	31 pm
			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			5.00	
	CENEDAL CEDVICE COST CENTEDS	0	1.00	4. 00	4A	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	2, 097, 326	2, 097, 326				1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 847, 837					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	4, 246, 503				5, 332, 962	5.00
7. 00	00700 OPERATION OF PLANT	1, 072, 739		·			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	97, 158	1				8. 00
9. 00	00900 HOUSEKEEPI NG	546, 157	1		1		1
10.00	01000 DI ETARY	153, 297	1				1
11. 00	01100 CAFETERI A	204, 452	21, 497	79, 590	305, 539	67, 462	11. 00
13.00	01300 NURSING ADMINISTRATION	116, 680	14, 293	35, 062	166, 035	36, 660	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	146, 328	45, 946	21, 014	213, 288	47, 093	14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	409, 898	30, 398	104, 429	544, 725	120, 273	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	T				T	
30. 00	03000 ADULTS & PEDI ATRI CS	1, 151, 466	152, 757	328, 020	1, 632, 243	360, 393	30. 00
F0 00	ANCILLARY SERVICE COST CENTERS	F47.450	40/447	040 500	05/ 400	044 400	F0 00
50.00	05000 OPERATING ROOM	517, 452			1		1
51. 00 53. 00	05100 RECOVERY ROOM	44, 433	1				51. 00 53. 00
54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	984, 586	l ~				54.00
54. 00	05401 ONCOLOGY	522, 705			1 ' '		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	322, 703	0				55. 00
60. 00	06000 LABORATORY	1, 480, 582	1			-	
65. 00	06500 RESPI RATORY THERAPY	103, 279		, , , , , ,			1
66. 00	06600 PHYSI CAL THERAPY	321, 806	1				1
67. 00	06700 OCCUPATI ONAL THERAPY	228, 224	1				67. 00
68.00	06800 SPEECH PATHOLOGY	90, 705	4, 206	26, 711	121, 622	26, 854	68. 00
69. 00	06900 ELECTROCARDI OLOGY	125, 367	9, 343	37, 026	171, 736	37, 919	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	435, 898	0	C	435, 898	96, 245	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	165, 447	0	C			1
73. 00	07300 DRUGS CHARGED TO PATIENTS	5, 124, 055	39, 415	169, 750	5, 333, 220	1, 177, 547	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	1 000 000	04.704	070 545	4 770 050	200 (00	00.00
88. 00	08800 RURAL HEALTH CLINIC (RHC)	1, 303, 939	1				
90. 00 90. 01	09000 CLINIC	393, 237	l ·				1
90.01	09001 SURGI CAL ASSOCI ATES 09002 ORTHOPAEDI CS	65, 726 6, 216	l ·				
90. 02	09003 RHEUMATOLOGY	-64, 464	33, 443		1		90.02
90. 04	09004 SPECIALTY CLINIC	92, 241	8, 366				
90. 05	09005 PEDI ATRI CS	64, 881	67, 768		1		90.05
90. 06	09006 WOMEN' S HEALTH	0.7551	0.7,700	1			90.06
90. 07	09007 PAI N MANAGEMENT	3, 265	Ō			-	1
90. 08	09008 ONCOLOGY MD	12, 500			1		
91.00	09100 EMERGENCY	2, 217, 279	89, 660	307, 387	2, 614, 326	577, 233	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	94, 725	86, 639	22, 524	203, 888	45, 018	95. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00	, ,	29, 423, 925	2, 077, 572	4, 844, 406	29, 385, 262	5, 310, 646	118. 00
	NONREI MBURSABLE COST CENTERS	_	_	_	1	_	
	19200 PHYSI CLANS' PRI VATE OFFI CES	0					192. 00
	19300 NONPALD WORKERS	(2.407	10.754				193. 00
	19301 FOUNDATION 19302 OCCUPATIONAL MEDICINE	62, 407	19, 754	18, 909	101, 070		193. 01
	007950 NON REIMBURSABLE						193. 02
200.00							200. 00
200.00			n	٠		n	201.00
202.00		29, 486, 332	2, 097, 326	4, 863, 315	29, 486, 332		
202.00	1.57.12 (56 1.1.55 116 till 64gil 261)	2., 100, 002	2,077,020	., 000, 010	27, 100, 002	1 3,002,702	,_02.00

Provider CCN: 15-1304

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2019	Part
To 12/31/2019	Date/Time Prepared:
8/26/2020 12:31 pm	

COST Centrol Poscription				' '	72/31/2017	8/26/2020 12:	
STRIKML SERVICE COST CENTERS 1.00 0.00 10.00 11.00	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		
GENERAL SERVICE COST CENTERS		PLANT	LINEN SERVICE				
1.00		7. 00	8. 00	9. 00	10.00	11. 00	
4.00 00400 [ENPLOYER BENEFITS DEPARTMENT							
0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000							
7.00 0.0700 OPERATION OF PLANT 1,619,725 152,510 152,510 1.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000							ı
0.0000 LAUNDRY & LINEN SERVICE 15, 203 152, 510 9.00 0.0000 DIETARY 64, 201 10, 7001 10, 801 9.00 10.0000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.000000 10.0000000000							1
9.00 00000 HOUSEKEPING 36, 910 10, 704 970, 801 10, 704 11, 705 11, 70							•
10.00 0 1000 DIETARY 64, 201 4, 389 37, 302 414, 834 10.00 10.00 0100 AFFERIA 11.00 10.00 CAFFERIA 11.00 10.00 10.00 CAFFERIA 11.00 10.00		1					
11.00 01100 CAFETERIA 21, 339 0 12, 398 0 406, 738 11.00 13.00 130.00 MISSIMS ADDINISTINATION 14, 1817 0 6, 243 0 2, 194 13.00 14.00 10.00 1		1					•
13.00 01300 NURSI NG ADMIN ISTRATION		1	4, 389		414, 834		
14. 00 01400 CENTRAL SERVICES & SUPPLY 45,608 0 26,499 0 4,607 14.00 10.00 10.00 MEDICAL RECORDS & LIBRARY 30,174 0 17.532 0 23,913 16.00 10.00 00.00		1	0		0		
16. 00 10.000 MEDICAL RECORDS & LIBRARY 30, 174 0 17, 532 0 23, 913 16. 00		1	0		0		
INPATIENT ROUTINE SERVICE COST CENTERS 30,000 20,00		1	0		0		•
30. 00		30, 174	0	17, 532	0	23, 913	16. 00
MACILLARY SERVICE COST CENTERS 50.00 50.00 50.00 50.00 50.00 50.00 50.00 60.00 PERATIN ROMO 125, 219 9, 982 72, 754 0 23, 693 50.00 51.00 50.00 65.00 RECOVERY ROM 14, 487 0 8, 417 0 1,755 51.00 53.00 53.00 0,530.00 ARSTHESI LOGCY 0 0 0 0 0 0 53.00 53.00 0,530.00 ARSTHESI LOGCY 50, 867 0 29, 554 0 18, 867 54.01 55.00 0,550.00 ARSTHESI LOGCY 50, 867 0 29, 554 0 18, 867 54.01 55.00 0,550.00 ARDIOLOGY-HERAPEUTI C 0 0 0 0 0 0 55.00 55.00 0,550.00 ARDIOLOGY-HERAPEUTI C 0 0 0 0 0 0 55.00 65.00 65.00 ARDIOLOGY-HERAPEUTI C 0 0 0 0 0 0 55.00 65.00 65.00 ARDIOLOGY-HERAPEUTI C 0 0 0 0 0 0 55.00 65.00 65.00 ARDIOLOGY-HERAPEUTI C 0 0 0 0 0 0 0 55.00 65.00 65.00 ARDIOLOGY-HERAPEUTI C 0 0 0 0 0 0 0 55.00 65.00 65.00 ARDIOLOGY-HERAPEUTI C 0 0 0 0 0 0 0 0 0							
50.00 05000 0FECHTING ROOM		151, 633	99, 442	88, 101	414, 834	39, 928	30.00
14. 487					1		
19.3 00 05.300 ANESTHESI OLOGY 0 0 0 0 0 0 0 5.3 0.0		1					•
54.00 05400 RADI OLOGY-DI AGNOSTIC 142,797 6, 449 82,967 0 28,520 54, 00 18,67 54, 01 05401 0NCOLOGY 50,867 6, 449 29,555 0 18,67 54, 01 155, 00 05500 RADI OLOGY-THERAPPUTI C 0 0 0 0 0 0 0 0 0		1	0		-		•
54.01 0S401 0NCOLOGY 50,867 0 29,554 0 18,867 54.01 0 55.00 0 0 0 0 0 0 0 0 0		1	0	1	0		•
55. 00 05.00 RADIOLOGY-THERAPEUTIC 0					0		
60. 00 00000 LABORATORY 48, 284 0 28, 053 0 30, 714 00. 00		50, 867	0	29, 554	0	- 1	1
65.00 06500 RESPI RATORY THERAPY 3, 022 1, 285 1, 756 0 3, 510 65, 00		0	0	0	0		1
66.00 06600 PHYSICAL THERAPY 50, 337 3, 003 29, 246 0 11, 408 66. 00			0		0		1
67:00 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06700 06100 0700		1			0		1
68.00 06800 SPEECH PATHOLOGY 4, 176 59 2, 426 0 2, 633 68. 00 69.00 06900 ELECTROCARDI OLOGY 9, 274 0 5, 388 0 5, 046 69. 00 70.00 07000 ELECTROCENCEPHALLOGRAPHY 0 0 0 0 0 0 71.00 07100 MOBIL CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72.00 072.00 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 0 73.00 072.00 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 0 73.00 072.00 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 39, 125 0 22, 732 0 16, 015 73.00 07300 DRUGS CHARGED TO PATIENTS 39, 125 0 22, 732 0 16, 015 73.00 07900 07900 07900 07900 07900 07900 07900 07900 79.00 07900 07900 07900 07900 07900 07900 07900 07900 07900 07900 79.00 07900					0		1
69.00 06900 ELECTROCARDI OLOGY		1			0		1
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 70. 00 071. 00 0710 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 39, 125 0 22, 732 0 16, 015 73. 00 7		1			0		1
71.00		9, 2/4	0	5, 388	0		1
72.00 07200 IMPL DEV. CHARGED TO PATI ENT 0 0 0 0 0 0 72.00		0	0	0	0		ı
73. 00 07300 DRUGS CHARGED TO PATIENTS 39, 125 0 22, 732 0 16, 015 73. 00		0	0	0	0		1
OUTPAT I ENT SERVI CE COST CENTERS		20 125	0	22 722	-	-	
88 00 08800 RURAL HEALTH CLINIC (RHC)		39, 125	0	22, 132	υ	16, 015	/3.00
90. 00 09000 CLINIC 274,408 0 159,435 0 62,084 90. 00 90. 01 09001 SURGI CAL ASSOCIATES 36,218 0 21,043 0 4,168 90. 01 90. 02 09002 ORTHOPAEDICS 24,868 0 14,449 0 219 90. 02 90. 03 09003 RHEUMATOLOGY 33,196 0 19,287 0 10,092 90. 03 90. 04 09004 SPECI ALTY CLINIC 8,305 0 4,825 0 12,505 90. 04 90. 05 09005 PEDI ATRICS 67,269 0 39,084 0 10,969 90. 05 90. 06 09006 WOMEN'S HEALTH 0 0 0 0 0 0 0 90. 07 09007 PAI N MANAGEMENT 0 0 0 0 0 0 0 90. 08 09008 ONCOLOGY MD 0 0 0 0 0 0 0 91. 00 09100 EMERGENCY 89,000 15,816 51,710 0 38,612 91.00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 95. 00 09500 AMBULANCE SERVI CES 86,001 0 49,968 0 3,730 95. 00 97. 00 09500 AMBULANCE SERVI CES 86,001 0 49,968 0 3,730 95. 00 97. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 193. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 193. 01 19301 FOUNDATION 19,609 0 11,393 0 2,194 193. 01 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 0 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 0 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 0 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 0 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 0 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 0 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 0 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 195. 00 00 00 00 00 00 00 00		04 000	0	54 672	٥	21 662	00 00
90. 01 09001 SURGI CAL ASSOCIATES 36, 218 0 21, 043 0 4, 168 90. 01 90. 02 09002 ORTHOPAEDI CS 24, 868 0 14, 449 0 219 90. 02 90. 03 09003 RHEUMATOLOGY 33, 196 0 19, 287 0 10, 092 90. 03 90. 04 SPECI ALTY CLINI C 8, 305 0 4, 825 0 12, 505 90. 04 90. 05 90. 05 90. 05 90. 05 PEDI ATRI CS 67, 269 0 39, 084 0 10, 969 90. 05 90. 06 90006 WOMEN'S HEALTH 0 0 0 0 0 0 0 0 0							•
90. 02 09002 0RTHOPAEDI CS 24,868 0 14,449 0 219 90. 02 90. 03 09003 RHEUMATOLOGY 33,196 0 19,287 0 10,092 90. 03 90. 04 09004 SPECI ALTY CLINI C 8,305 0 4,825 0 12,505 90. 04 90. 05 09006 O9006 WOMEN'S HEALTH 0 0 0 0 0 0 90. 06 09006 WOMEN'S HEALTH 0 0 0 0 0 0 90. 07 09007 PAI N MANAGEMENT 0 0 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 38,612 91. 00 95. 00 09500 AMBULANCE SERVI CES 86,001 0 49,968 0 3,730 95. 00 SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 193. 00 193. 01 19301 FOUNDATION 0 0 0 0 0 0 193. 00 193. 02 19302 OCCUPATI ONAL MEDI CI NE 0 0 0 0 0 0 194. 00 200. 00 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 194. 00 200. 00 00 00 NONREI MBURSABLE 0 0 0 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 201. 00 Nonrei MBURSABLE 0 0 0 0 0 201. 00 00 00 00 0 0 201. 00 00 00 0 0 20		1			0		•
90. 03 09003 RHEUMATOLOGY		1	0		0		
90. 04			0		0		1
90. 05		1	0		0		•
90. 06 09006 WOMEN'S HEALTH		1	0		0		•
90. 07 09007 PAI N MANAGEMENT 0 0 0 0 0 8, 337 90. 07 90. 08 09008 0NCOLOGY MD 0 0 0 0 0 0 0 0 90. 08 91. 00 09100 EMERGENCY 89, 000 15, 816 51, 710 0 38, 612 91. 00 92. 00 09200 OSSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 07HER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 86, 001 0 49, 968 0 3, 730 95. 00 09500 AMBULANCE SERVI CES 86, 001 0 49, 968 0 3, 730 95. 00 09500 AMBURSABLE COST CENTERS 992. 00 09500		1 1	0	37,004	0		•
90. 08		1	0	j o	0		•
91. 00			0	j o	0		•
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 86, 001 0 49, 968 0 3, 730 95. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1,600,116 152,510 899,408 414,834 404,544 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 193. 01 19301 FOUNDATI ON 19,609 0 11,393 0 2,194 193. 01 193. 02 19302 0CCUPATI ONAL MEDI CI NE 0 0 0 0 194. 00 194. 00 07950 NON REI MBURSABLE 0 0 0 0 194. 00 200. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00 0 0 0 0 0 0 0 0 0		89 000	15 816	51 710	0		
95. 00 OFFICE RELIMBURSABLE COST CENTERS 95. 00 OFFICIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117)		07,000	.0,0.0	0.,,	Ĭ	00,012	•
95. 00 09500 AMBULANCE SERVICES 86, 001 0 49, 968 0 3, 730 95. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1,600,116 152,510 899, 408 414,834 404,544 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 192. 00 193. 00 19300 NONRAID WORKERS 0 0 0 0 0 193. 00 193.00 19301 FOUNDATION 19,609 0 11,393 0 2,194 193. 01 193. 02 19302 OCCUPATIONAL MEDICINE 0 0 0 0 194. 00 194. 00 194. 00 195. 00							
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1,600,116 152,510 899,408 414,834 404,544 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 192. 00 193. 00 193. 00 193. 00 193. 00 193. 01 19301 FOUNDATION 194. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		86, 001	0	49, 968	0	3, 730	95. 00
NONREL MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.00	SPECIAL PURPOSE COST CENTERS						
192. 00	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 600, 116	152, 510	899, 408	414, 834	404, 544	118. 00
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 193. 01 19301 FOUNDATI ON 19,609 0 11,393 0 2,194 193. 01 193. 02 19302 OCCUPATI ONAL MEDI CI NE 0 0 0 0 0 193. 02 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 194. 00 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 201. 00							
193. 01 19301 FOUNDATION 19,609 0 11,393 0 2,194 193. 01 193. 02 19302 OCCUPATIONAL MEDICINE 0 0 0 0 0 193. 02 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 194. 00 200. 00 Cross Foot Adjustments 0 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 201. 00		0	0	0	0		
193. 02 19302 OCCUPATI ONAL MEDI CI NE 0 0 0 0 193. 02 194. 00 07950 NON REI MBURSABLE 0 0 0 0 194. 00 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00			0	0	0		
194. 00 07950 NON REIMBURSABLE 0 0 0 0 194. 00 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0		19, 609	0	11, 393	0		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00		0	0	0	0		
201.00 Negative Cost Centers 0 0 0 0 201.00		0	0	0	0	0	
202.00		0	0	0	0		
	202.00 101AL (sum lines 118 through 201)	1, 619, 725	152, 510	910, 801	414, 834	406, 738	202.00

| Period: | Worksheet B | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1304

				To	12/31/2019		
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	Subtotal	8/26/2020 12: Intern &	31 pm
		ADMI NI STRATI ON	SERVICES &	RECORDS &		Residents Cost	
			SUPPLY	LI BRARY		& Post	
						Stepdown	
		13.00	14.00	16. 00	24. 00	Adjustments 25.00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	10.00	24.00	25.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						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 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	227, 319					13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	0	337, 095				14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	438	737, 055			16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	37, 913	7, 723	316, 684	3, 148, 894	0	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	22, 492	95, 711	0	1, 517, 163		50.00
51.00	05100 RECOVERY ROOM	1, 578	1, 357	69, 645	183, 478	l	51.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 27, 094	9, 592	84, 324	2, 153, 540	0	53. 00 54. 00
54. 00	05401 ONCOLOGY	17, 853	6, 060	04, 324	2, 153, 540 994, 927	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0, 000	0	7,74,727		55. 00
60.00	06000 LABORATORY	29, 269	114, 121	Ö	2, 352, 477	i o	60.00
65.00	06500 RESPI RATORY THERAPY	3, 249	861	1, 562	174, 296	0	65. 00
66.00	06600 PHYSI CAL THERAPY	10, 837	1, 015	0	676, 720	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	6, 143	325	0	432, 539	l .	67. 00
68. 00	06800 SPEECH PATHOLOGY	2, 452	218	0	160, 440	l .	68. 00
69.00	06900 ELECTROCARDI OLOGY	4, 868	491	0	234, 722	l .	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0 0	0 24, 097	0	556, 240	0	70. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENT		37, 081	0	239, 058	l .	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	15, 291	3, 498	0	6, 607, 428		73. 00
	OUTPATIENT SERVICE COST CENTERS		97	-1	27 22 17 12 2		
88. 00	08800 RURAL HEALTH CLINIC (RHC)	0	3, 246	0	2, 357, 560	0	88. 00
90.00	09000 CLI NI C	0	12, 455	0	1, 999, 035		90. 00
90. 01	09001 SURGI CAL ASSOCI ATES	0	844	0	207, 035		90. 01
90. 02	09002 ORTHOPAEDI CS	0	9	0	89, 960		90. 02
90. 03 90. 04	09003 RHEUMATOLOGY		469	0	217, 808		90. 03 90. 04
90. 04	09004 SPECI ALTY CLI NI C 09005 PEDI ATRI CS	0	4, 413 1, 183	0	296, 100 420, 578		90.04
90. 06	09006 WOMEN'S HEALTH	0	1, 103	0	420, 370		90.06
90. 07	09007 PAIN MANAGEMENT	7, 929	716	0	202, 827	0	90. 07
90. 08	09008 ONCOLOGY MD	O	0	0	15, 260	0	90. 08
91.00	09100 EMERGENCY	36, 771	10, 193	264, 840	3, 698, 501	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS		1			1	
95. 00	09500 AMBULANCE SERVICES	3, 580	979	0	393, 164	0	95. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	227, 319	337, 095	737, 055	29, 329, 750		118. 00
110.00	NONREI MBURSABLE COST CENTERS	221, 319	337, 093	737,033	29, 329, 730	0	1110.00
192 00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	ol	0	0	0	192. 00
	19300 NONPALD WORKERS		o	o	0		193. 00
	19301 FOUNDATION	O	O	O	156, 582	l .	193. 01
	19302 OCCUPATIONAL MEDICINE	0	O	0	0	0	193. 02
	07950 NON REIMBURSABLE	0	0	0	0	l .	194. 00
200.00	1 1				0		200.00
201.00		0	337 005	727 055	20 404 222		201.00
202.00	TOTAL (Suil Titles 118 through 201)	227, 319	337, 095	737, 055	29, 486, 332	1 0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 RUSH MEMORIAL HOSPITAL

Provider CCN: 15-1304

Cost Center Description	Total	0/20/2020 12.	J I pili
oost contor boson peron	26. 00		
GENERAL SERVICE COST CENTERS			
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT			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 O1300 NURSING ADMINISTRATION			13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY			14. 00
16. 00 O1600 MEDICAL RECORDS & LIBRARY			16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			
30. 00 03000 ADULTS & PEDI ATRI CS	3, 148, 894		30. 00
ANCI LLARY SERVI CE COST CENTERS	4 547 4/0		F0.00
50. 00 05000 OPERATI NG ROOM	1, 517, 163		50.00
51. 00 05100 RECOVERY ROOM	183, 478		51.00
53. 00 05300 ANESTHESI OLOGY	0 152 540		53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	2, 153, 540		54.00
54. 01 05401 0NCOLOGY 55. 00 05500 RADI OLOGY-THERAPEUTI C	994, 927 0		54. 01 55. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C 60. 00 06000 LABORATORY	2, 352, 477		60.00
65. 00 06500 RESPI RATORY THERAPY	2, 352, 477 174, 296		65. 00
66. 00 06600 PHYSI CAL THERAPY	676, 720		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	432, 539		67. 00
68. 00 06800 SPEECH PATHOLOGY	160, 440		68. 00
69. 00 06900 ELECTROCARDI OLOGY	234, 722		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	254, 722		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	556, 240		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	239, 058		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	6, 607, 428		73. 00
OUTPATIENT SERVICE COST CENTERS			
88.00 08800 RURAL HEALTH CLINIC (RHC)	2, 357, 560		88. 00
90. 00 09000 CLI NI C	1, 999, 035		90.00
90. 01 09001 SURGI CAL ASSOCI ATES	207, 035		90. 01
90. 02 09002 ORTHOPAEDI CS	89, 960		90. 02
90. 03 09003 RHEUMATOLOGY	217, 808		90. 03
90. 04 09004 SPECIALTY CLINIC	296, 100		90. 04
90. 05 09005 PEDI ATRI CS	420, 578		90. 05
90. 06 09006 WOMEN' S HEALTH	0		90. 06
90. 07 09007 PAI N MANAGEMENT	202, 827		90. 07
90. 08 09008 0NCOLOGY MD	15, 260		90. 08
91. 00 09100 EMERGENCY	3, 698, 501		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
OTHER REIMBURSABLE COST CENTERS	200 1/1		
95. 00 09500 AMBULANCE SERVICES	393, 164		95. 00
SPECIAL PURPOSE COST CENTERS	20 220 750		110 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	29, 329, 750		118. 00
NONREI MBURSABLE COST CENTERS	0		102.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS	0		192. 00 193. 00
193. 00 19300 NONPATU WORKERS 193. 01 19301 FOUNDATION	156, 582		193. 00
193. 01 1930 1 FOUNDATION 193. 02 19302 0CCUPATIONAL MEDICINE	150, 582		193. 01
194. 00 07950 NON_RELIMBURSABLE	0		193. 02
200.00 Cross Foot Adjustments	0		200. 00
201.00 Negative Cost Centers	0		200.00
202.00 TOTAL (sum lines 118 through 201)	29, 486, 332		202. 00
202. 00 TOTAL (Sum TITIES TTO LITTOUGH 201)	27, 400, 332		1202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: | Peri od: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1304

				10	0 12/31/2019	8/26/2020 12:	
			CAPI TAL			0/20/2020 12.	J I pili
			RELATED COSTS				
	Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
	oost denter beschiptron	Assigned New	FIXT	Jubrotui	BENEFITS	& GENERAL	
		Capi tal	1171		DEPARTMENT	A OLIVLIAL	
					DEPARTMENT		
		Related Costs	1. 00	24	4.00	F 00	
	CENEDAL CEDVICE COCT CENTERS	0	1.00	2A	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS			I		T	1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT		15 470	15 470	15 470		1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	15, 478		15, 478		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	294, 338		2, 525		5. 00
7.00	00700 OPERATION OF PLANT	0	155, 778		313		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	15, 315		0		8. 00
9.00	00900 HOUSEKEEPI NG	0	37, 184	37, 184	394	8, 691	9. 00
10.00	01000 DI ETARY	0	64, 677	64, 677	112	3, 110	10. 00
11.00	01100 CAFETERI A	0	21, 497	21, 497	253	3, 755	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	14, 293	14, 293	112	2, 041	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	45, 946	45, 946	67	2, 622	14. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	30, 398	30, 398	332	6, 695	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	152, 757	152, 757	1, 044	20, 062	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	126, 147	126, 147	994	11, 753	50.00
51.00	05100 RECOVERY ROOM	0	14, 595	14, 595	37	868	51.00
53. 00	05300 ANESTHESI OLOGY	0	0	1	0		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	143, 856		1, 027	17, 838	54. 00
54. 01	05401 ONCOLOGY	0	51, 244	1	446		54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	01,211		0		55. 00
60. 00	06000 LABORATORY	0	48, 642		613	1	60.00
65. 00	06500 RESPIRATORY THERAPY		3, 044	1	76		65. 00
66. 00	06600 PHYSI CAL THERAPY		50, 710	1	303		ł
67. 00	06700 OCCUPATI ONAL THERAPY		20, 056	1	218		67. 00
68. 00	06800 SPEECH PATHOLOGY	0			85		68. 00
69. 00	06900 ELECTROCARDI OLOGY		4, 206		118		69.00
			9, 343 0				ı
70.00	07000 ELECTROENCEPHALOGRAPHY		0	1 4	0		70.00
71. 00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0	0	0		1
72. 00 73. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	20 415		-	_,	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		39, 415	39, 415	540	65, 544	73. 00
00 00	OUTPATIENT SERVICE COST CENTERS		04.704	04.70/	1 207	21.05/	00 00
88. 00	08800 RURAL HEALTH CLINIC (RHC)	0	94, 796		1, 207	21, 856	88. 00
90.00	09000 CLINIC	0	276, 441		1, 754		90.00
90. 01	09001 SURGI CAL ASSOCI ATES	0	36, 487		52		90. 01
90. 02	09002 ORTHOPAEDI CS	0	25, 053		32		90. 02
90. 03	09003 RHEUMATOLOGY	0	33, 443	1	502		90. 03
90. 04	09004 SPECIALTY CLINIC	0	8, 366	1	373		90. 04
90. 05	09005 PEDI ATRI CS	0	67, 768	1	365		90. 05
90.06	09006 WOMEN' S HEALTH	0	0	0	0	0	90. 06
90. 07	09007 PAIN MANAGEMENT	0	0	0	474	1, 871	90. 07
90. 08	09008 ONCOLOGY MD	0	0	0	0	154	90. 08
91. 00	09100 EMERGENCY	0	89, 660	89, 660	978	32, 133	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0			92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	86, 639	86, 639	72	2, 506	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		0	2, 077, 572	2, 077, 572	15, 418	295, 621	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
193.00	19300 NONPALD WORKERS	0	0	О	0	0	193. 00
193. 01	19301 FOUNDATI ON	0	19, 754	19, 754	60	1, 242	193. 01
	19302 OCCUPATI ONAL MEDI CI NE	0	0	0	0		193. 02
	07950 NON REIMBURSABLE	0	0	o	0		194. 00
200.00		1	1	Ö	_		200. 00
201.00			ი	o o	0		201. 00
202.00		0	2, 097, 326	2, 097, 326	15, 478		
					-,		

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To | 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1304

COST CONTOR DESCRIPTION					To	12/31/2019	Date/Time Pre 8/26/2020 12:	
PLANT LINEN SERVICE		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		J I DIII
SINURIAL SERVICE COST CUTILES 1.00 0010 MINE CAP REL COSTS-BLUG & FIXT		р	PLANT					
1.00			7. 00	8. 00	9. 00	10.00	11. 00	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 172,000 00500 00700 00FRATION OF PLANT 172,000 00700 00FRATION 107,000 007			T	T.				
5.00 00500 ADMINISTRATIVE & GENERAL 17.2, 398 8.00 9.00 00900 DERATION OF PLANT 1.1018 18, 315 7.00 0.0000 DERATION OF PLANT 1.1018 1.001								1
0.0000 OPERATION OF PLANT 172, 398 7, 00 000 0000 OPERATION OF PLANT 1, 1616 18, 315 1, 285 1, 2								1
B. 00 00800 LAUNDRY & LINEN SERVICE 1.618 18.315 9.00 10.000 00900 00900 00900 00900 00900 0157ARY 6.833 5.27 2.108 77.367 10.00 10.00 10.00 01.000 01.000 0157ARY 6.833 5.27 2.108 77.367 10.00 10.00 10.000 01.000 01.000 01.000 0.000 10.000 0.0000 0.0000 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.0000000 0.00000000								1
9.00 00900 HOUSEKEEPING 3, 929 1, 285 51, 483 77, 367 10, 00 100 1100 01100 CAFETERI A 2, 271 0 701 0 28, 477 11, 00 11, 00 1100 01100 CAFETERI A 2, 271 0 701 0 28, 477 11, 00 14, 00 1466 0 154 13, 00 1300 01300 MIRSI MAG ADMINISTRATION 1, 510 0 0 0 0 1, 498 0 323 14, 00 14, 00 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 498 0 323 14, 00 1, 408 0 1,				l e				1
10.00 0 1000 DIETARY 6, 833 527 2, 108 77, 367 2, 101 10, 101 10. 0 1010 CAFETERIA 2, 277 0								1
11.00 01000 CAFETERIA 2,271 0 701 0 28,477 11.00 14.00 15.00 13.				l				1
13.00 01300 NURSING ADMINISTRATION 1.510 0 466 0 154 13.00 16.00 1600 MEDICAL RECORDS & LIBRARY 3.212 0 991 0 1.674 16.00 18				l e			00 477	1
14. 00 01400 CENTRAL SERVICES & SUPPLY 4, 854 0 1, 498 0 3.23 14, 00 1.00						_	•	1
16. 00				l .		_		1
INPATIENT ROUTINE SERVICE COST CENTERS 16, 139 11, 942 4, 980 77, 367 2, 795 50. 00				l		-		1
30.00	16.00		3, 212		991	<u> </u>	1,074	16.00
MOCILLARY SERVICE COST CENTERS	30 00		16 130	11 0/2	4 080	77 367	2 705	30 00
50.00 05000 0FERTING ROOM	30.00		10, 137	11, 742	4, 700	77, 307	2, 175	30.00
1.0 05100 0500 0500 0500 0500 053 00 00	50 00		13 328	1 199	4 112	O	1 659	50 00
S3. 00 08.500 ABSTHESI OLOGY 0 0 0 0 0 5. 3. 00				ľ		-		1
54.00 0.05400 RADI OLOGY-DI AGNOSTIC 15, 199 775 4, 690 0 1, 997 54. 00			0	1		-		
54.01 05401 05001 05001 055.00 0500 0 0 0 0 0 0 0			15, 199	775		ol		
55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0			1	l		ol		
65.00 06500 RESPI RATORY THERAPY 3.22 15.4 99 0 2.46 65.00			1	O		o		
66. 00 06600 PVSI CAL THERAPY 5, 358 361 1,653 0 799 66. 00 67. 00 06700 OCLUPATI ONAL THERAPY 2,1119 166 654 0 445 67. 00 68. 00 06700 DELECTROCARDI OLOGY 444 7 137 0 184 68. 00 69. 00 06700 ELECTROCARDI OLOGY 987 0 305 0 353 69. 00 71. 00 07000 ELECTROCARDI OLOGY 987 0 0 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 07300 IMPL. DEV. CHARGED TO PATIENTS 4, 164 0 1, 285 0 1, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 164 0 1, 285 0 1, 121 73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 164 0 1, 285 0 1, 121 74. 00 07000 09000 CLINIC 29, 207 0 9, 012 0 4, 346 75. 00 07000 SURGI CAL ASSOCIATES 3, 855 0 1, 189 0 29, 207 75. 00 09000 SURGI CAL ASSOCIATES 3, 855 0 1, 189 0 29, 207 75. 00 09000 SURGI CAL ASSOCIATES 3, 855 0 1, 189 0 29, 207 75. 00 09000 09000 SURGI CAL ASSOCIATES 3, 855 0 1, 189 0 29, 207 75. 00 09000 09000 SURGIA CAL ASSOCIATES 3, 855 0 1, 189 0 29, 207 75. 00 09000 09000 09000 0, 0 0 0 0 0 0 75. 00 09000 09000 09000 0, 00 0 0 0 0 0 75. 00 09000 09000 09000 0, 00 0 0 0 0 0 75. 00 09000 09000 09000 09000 0, 00 0 0 0 0 75. 00 090000 09000 09000 090000 09000 09000 09000 09000 090000 090000 090000 090000	60.00	06000 LABORATORY	5, 139	0	1, 586	o	2, 150	60.00
67:00 06700 06700 06700 06700 0600 0 445 67:00 68:00 06800 SPEECH PATHOLOGY	65.00	06500 RESPI RATORY THERAPY	322	154	99	o	246	65.00
68.00 06800 SPEECH PATHOLOGY 4444 7 137 0 184 68.00 06900 ELECTROCARDI OLOGY 987 0 305 0 353 69.00 70.00 07000 ELECTROCENDE PHALOGRAPHY 0 0 0 0 0 0 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72.00 72.00 1992. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72.00 73.00 07200 1992. DEV. CHARGED TO PATIENTS 4,164 0 1,285 0 1,121 73.00 07300 DRUGS CHARGED TO PATIENTS 4,164 0 1,285 0 1,121 73.00 0740	66.00	06600 PHYSI CAL THERAPY	5, 358	361	1, 653	0	799	66. 00
69.00 06900 06900 06900 06900 0600 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 0700000 0700000 0700000000	67. 00		2, 119	166	654	0	445	67. 00
70.00 07000 ELECTROENCEPHALLOGRAPHY 0 0 0 0 0 0 77.00	68. 00		1	7	137	0	184	68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 72. 00 73. 00 72. 00 73. 00 72. 00 73. 00 72. 00 73. 00 73. 00 72. 00 73. 00 73. 00 72. 00 73.			987	0		0		1
72. 00 07200 IMPL DEV. CHARGED TO PATIENT 0 0 1, 285 0 1, 210 73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 164 0 1, 285 0 1, 211 73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 164 0 1, 285 0 1, 211 73. 00 07300 DRUGS CHARGED TO PATIENTS 7, 200 73. 00 07300 DRUGS CHARGED TO PATIENTS 7, 200 74. 200 200 200 200 200 200 200 200 200 75. 00 09000 200 200 200 200 200 200 200 200 76. 00 09000 200 200 200 200 200 200 200 200 77. 00 200 200 200 200 200 200 200 200 200 200 200 77. 00 200 200 200 200 200 200 200 200 200 77. 00 200 200 200 200 200 200 200 200 77. 00 200 200 200 200 200 200 200 200 77. 00 200 200 200 200 200 200 200 200 77. 00 200 200 200 200 200 200 200 200 200 77. 00 200 200 200 200 200 200 200 200 200 200 77. 00 200			0	0	- 1	-		1
73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 164 0 1, 285 0 1, 121 73. 00			0	ľ	- 1	-		1
OUTPAT I STENJICE COST CENTERS			0	l				1
88.00 08800 RURAL HEALTH CLINIC (RHC) 10,016 0 3,090 0 2,427 88.00 90.00 0000 CLINIC 29,207 0 9,012 0 4,346 90.00 90.00 09000 CLINIC 29,207 0 9,012 0 4,346 90.00 90.01 SURGI CAL ASSOCIATES 3,855 0 1,189 0 292 90.01 90.02 90902 ORTHOPAEDI CS 2,647 0 817 0 15 90.02 90.03 RIEUMATOLOGY 3,533 0 1,090 0 707 90.03 90.04 99.04 SPECI ALTY CLINIC 884 0 273 0 876 90.04 90.05 90.05 PEDI ATRI CS 7,160 0 2,209 0 768 90.05 90.06 90005 PEDI ATRI CS 7,160 0 0 0 0 0 0 90.06 90.07 PAIN MANAGEMENT 0 0 0 0 0 0 0 0 0	/3.00		4, 164	0	1, 285	U	1, 121	/3.00
90. 00 09000 CLINIC 29, 207 0 9, 012 0 4, 346 90. 00 90. 01 09001 SURGI CAL ASSOCIATES 3, 855 0 1, 189 0 292 90. 01 90. 02 09002 ORTHOPAEDI CS 2, 647 0 817 0 15 90. 02 90. 03 90. 03 RHEUMATOLOGY 3, 533 0 1, 090 0 707 90. 03 90. 04 90. 04 SPECI ALTY CLINIC 884 0 273 0 876 90. 04 90. 05 O9005 PEDI ATRI CS 7, 160 0 0 2, 209 0 768 90. 05 90. 05 O9005 PEDI ATRI CS 7, 160 0 0 0 0 0 0 0 0 0	00 NN		10 016		2 000	٥	2 427	00 00
90. 01 09001 SURGI CAL ASSOCIATES 3,855 0 1,189 0 292 90. 01 90. 02 09002 ORTHOPAEDI CS 2,647 0 817 0 15 90. 03 09003 RHEUMATOLOGY 3,533 0 1,090 0 707 90. 04 09004 SPECI ALTY CLINI C 884 0 273 0 876 90. 05 09005 PEDI ATRI CS 7,160 0 2,209 0 768 90. 06 09006 WOMEN'S HEALTH 0 0 0 0 0 0 90. 07 09007 PAI M MANAGEMENT 0 0 0 0 0 90. 08 09008 ONCOLOGY MD 0 0 0 0 0 91. 00 09100 EMERGENCY 9,473 1,899 2,923 0 2,703 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 2,824 0 261 95. 00 SPECI AL PURPOSE COST CENTERS 9,154 0 2,824 0 261 918. 00 SUBIOTALS (SUM OF LINES 1 through 117) 170,311 18,315 50,839 77,367 28,323 118. 00 19300 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 193. 01 19301 FOUNDATI ON 2,087 0 644 0 154 193. 00 193. 01 19302 OCCUPATI ONAL MEDI CI NE 0 0 0 0 0 193. 02 194. 00 O7950 NON REI MBURSABLE 0 0 0 0 0 0 194. 00 O7950 NON REI MBURSABLE 0 0 0 0 0 0 194. 00 O7950 NON REI MBURSABLE 0 0 0 0 0 194. 00 O7950 NON REI MBURSABLE 0 0 0 0 0 194. 00 O7950 NON REI MBURSABLE 0 0 0 0 0 194. 00 O7950 NON REI MBURSABLE 0 0 0 0 0 194. 00 O7950 NON REI MBURSABLE 0 0 0 0 0 194. 00 O7950 NON REI MBURSABLE 0 0 0 0 0 194. 00 O7950 NON REI MBURSABLE 0 0 0 0 0 194. 00 O7950 NON REI MBURSABLE 0 0 0 0 0 195. 00 0 0 0 0 0 0 195. 00 0 0 0 0 0 195. 00 0 0 0 0 0 195. 00 0 0 0 0 195. 00 0 0 0 0 195. 00 0 0 0 0 195. 00 0 0 0 0 195. 00 0 0 0 0 195. 00 0 0 0 0 195. 00 0 0 0 0 195. 00 0 0 0 0 195. 00 0 0 0 0 195. 00 0 0 0 0 195. 00 0 0 0 0 195. 00 0 0 0 0 195. 00 0 0 0				l .		_		1
90. 02 09002 0RTHOPAEDICS 2,647 0 817 0 15 90. 02 90. 03 09003 RHEUMATOLOGY 3,533 0 1,090 0 707 90. 03 90. 04 09004 SPECIALTY CLINIC 884 0 273 0 876 90. 04 90. 05 09005 PEDIATRICS 7,160 0 2,209 0 768 90. 05 90. 06 09006 WOMEN'S SHALTH 0 0 0 0 0 0 90. 06 90. 07 09007 PAIN MANAGEMENT 0 0 0 0 0 0 0 90. 08 09008 ONCOLOGY MD 0 0 0 0 0 0 0 91. 00 09100 EMERGENCY 9,473 1,899 2,923 0 2,703 91. 00 92. 00 09200 OSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 95. 00 09500 AMBULANCE SERVICES 9,154 0 2,824 0 261 95. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 170,311 18,315 50,839 77,367 28,323 118. 00 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 192. 00 193. 01 19301 FOUNDATION 2,087 0 644 0 154 193. 01 193. 02 19302 OCCUPATI ONAL MEDICINE 0 0 0 0 0 193. 02 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 194. 00 200. 00 Norestimbursable 0 0 0 0 0 0 194. 00 200. 00 Norestimbursable 0 0 0 0 0 0 0 201. 00 Norestimbursable 0 0 0 0 0 0 200. 00 Norestimbursable 0 0 0 0 0 200. 00 Norestimbursable 0 0 0 0 0 200. 00 Norestimbursable 0 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 200. 00 0 0 0 200. 00 0 0 200. 00 0 0 0 200. 00 0						_		
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90. 05 09005 PEDIATRICS 7, 160 0 2, 209 0 768 90. 05 90. 06 09006 Wolken's Health 0 0 0 0 0 0 0 90. 07 09007 PAI N MANAGEMENT 0 0 0 0 0 584 90. 05 90. 08 09008 0NCOLOGY MD 0 0 0 0 0 0 0 0 91. 00 09100 EMERGENCY 9, 473 1, 899 2, 923 0 2, 703 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 95. 00 09500 AMBULANCE SERVI CES 9, 154 0 2, 824 0 261 95. 00 SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 170, 311 18, 315 50, 839 77, 367 28, 323 118. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 193. 01 19301 FOUNDATI ON 2, 087 0 644 0 154 193. 01 193. 02 19302 OCCUPATI ONAL MEDI CI NE 0 0 0 0 0 194. 00 194. 00 OPOS NON REI MBURSABLE 0 0 0 0 0 194. 00 194. 00 OPOS NON REI MBURSABLE 0 0 0 0 0 0 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 200. 00 0 Negati ve Cost Centers 0 0 0 0 0 200. 00 0 Negati ve Cost Centers 0 0 0 0 0 200. 00 0 Negati ve Cost Centers 0 0 0 0 200. 00 0 Negati ve Cost Centers 0 0 0 0 200. 00 0 Negati ve Cost Centers 0 0 0 0 200. 00 0 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0				0		-		1
90. 06			1	O		o		1
90. 08	90.06	09006 WOMEN'S HEALTH	0	0		o	0	90. 06
91. 00	90. 07	09007 PAIN MANAGEMENT	0	0	0	o	584	90. 07
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 97. 154 0 27. 824 0 261 95. 00 0 0 0 0 0 0 0 0 0	90.08	09008 ONCOLOGY MD	0	0	0	o	0	90. 08
95. 00 OFFICE RELIMBURSABLE COST CENTERS 95. 00 OFFICE AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) SUBTOTA	91. 00	09100 EMERGENCY	9, 473	1, 899	2, 923	0	2, 703	91. 00
95. 00 09500 AMBULANCE SERVICES 9, 154 0 2, 824 0 261 95. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 170, 311 18, 315 50, 839 77, 367 28, 323 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 192. 00 193. 00 19300 NONRAID WORKERS 0 0 0 0 0 193. 00 193. 01 19301 FOUNDATION 2, 087 0 644 0 154 193. 01 193. 02 19302 OCCUPATIONAL MEDICINE 0 0 0 0 193. 02 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 0 194. 00 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 0 0 0	92.00							92. 00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 170,311 18,315 50,839 77,367 28,323 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 193.00 193.01 19301 FOUNDATION 2,087 0 644 0 154 193.01 193.01 19302 OCCUPATIONAL MEDICINE 0 0 0 0 0 0 193.02 193.02 19302 OCCUPATIONAL MEDICINE 0 0 0 0 0 0 0 194.00 194.00 195.00 1			1					
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 170, 311 18, 315 50, 839 77, 367 28, 323 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 192. 00 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 193. 00 193. 01 19301 FOUNDATI ON	95. 00		9, 154	0	2, 824	0	261	95. 00
NONREI MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.00	110 00		170 211	10.015	F0 020	77 0/7	20, 222	110 00
192. 00	118.00		170, 311	18, 315	50, 839	//, 36/	28, 323	1118.00
193. 00	102 00					ما	0	192 00
193. 01 19301 FOUNDATION 2, 087 0 644 0 154 193. 01 193. 02 19302 OCCUPATIONAL MEDICINE 0 0 0 0 0 193. 02 194. 00 07950 NON REIMBURSABLE 0 0 0 0 0 0 194. 00 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00						٥		
193. 02 19302 OCCUPATIONAL MEDICINE 0 0 0 0 193. 02 194. 00 07950 NON REIMBURSABLE 0 0 0 0 0 194. 00 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00			2 087		- 1	٥		
194. 00 07950 NON REIMBURSABLE 0 0 0 0 194. 00 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00			2,007	١		n N		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0			0	l 0	- 1	ol O		
201.00 Negative Cost Centers 0 0 0 0 201.00						Ĭ	· ·	
202.00 TOTAL (sum lines 118 through 201) 172,398 18,315 51,483 77,367 28,477 202.00			0	0	o	o		201. 00
	202.00	TOTAL (sum lines 118 through 201)	172, 398	18, 315	51, 483	77, 367	28, 477	202. 00

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To | 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1304

				T	12/31/2019	Date/Time Prep 8/26/2020 12:	
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	Subtotal	Intern &	J I DIII
	·	ADMI NI STRATI ON	SERVICES &	RECORDS &		Residents Cost	
			SUPPLY	LI BRARY		& Post	
						Stepdown	
		13.00	14.00	1/ 00	24.00	Adjustments	
	GENERAL SERVICE COST CENTERS	13.00	14. 00	16. 00	24. 00	25. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						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	10 57/					11. 00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	18, 576	55, 310				13. 00 14. 00
16. 00	01600 MEDICAL RECORDS & LI BRARY		72				16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	72	10, 07 1			10.00
30.00	03000 ADULTS & PEDI ATRI CS	3, 096	1, 267	18, 637	310, 086	0	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	1, 838	15, 704		176, 734	0	50.00
51.00	05100 RECOVERY ROOM	129	223	4, 098	22, 091	0	51.00
53. 00	05300 ANESTHESI OLOGY	0	0		0	1	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 214	1, 574		194, 132		54.00
54. 01	05401 ONCOLOGY	1, 459	994		71, 326		54. 01
55. 00 60. 00	05500 RADI OLOGY-THERAPEUTI C 06000 LABORATORY	2, 392	0 18, 725	_	0 100, 410		55. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	2, 392	16, 725	92	6, 041		65. 00
66. 00	06600 PHYSI CAL THERAPY	886	167		65, 985		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	502	53		28, 108		67. 00
68. 00	06800 SPEECH PATHOLOGY	200	36		6, 794		68. 00
69. 00	06900 ELECTROCARDI OLOGY	398	81	0	13, 696		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 954		9, 312		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	6, 084		8, 118		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 250	574	0	113, 893	0	73. 00
00 00	OUTPATIENT SERVICE COST CENTERS		F22		122 025		00 00
88. 00 90. 00	08800 RURAL HEALTH CLINIC (RHC) 09000 CLINIC	0	533 2, 044		133, 925 337, 812		88. 00 90. 00
90. 00	09001 SURGI CAL ASSOCI ATES		138		43, 470		90. 00
90. 02	09002 ORTHOPAEDI CS	0	1	l	29, 073		90. 02
90. 03	09003 RHEUMATOLOGY	0	77		40, 910		90. 03
90. 04	09004 SPECIALTY CLINIC	0	724	0	14, 175		90. 04
90. 05	09005 PEDI ATRI CS	0	194	0	81, 505	0	90. 05
90.06	09006 WOMEN'S HEALTH	0	0	0	0	0	90.06
90. 07	09007 PAIN MANAGEMENT	648	117		3, 694		90. 07
90. 08	09008 ONCOLOGY MD	0	0	_	154	0	90. 08
91.00	09100 EMERGENCY	3, 005	1, 672	15, 585	160, 031	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					0	92. 00
95 00	09500 AMBULANCE SERVICES	293	161	0	101, 910	0	95. 00
73.00	SPECIAL PURPOSE COST CENTERS	275	101		101, 710		73.00
118.00		18, 576	55, 310	43, 374	2, 073, 385	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	19300 NONPALD WORKERS	0	0		0		193. 00
	19301 FOUNDATION		0		23, 941		193. 01
	19302 OCCUPATI ONAL MEDI CI NE	0	0	0	0		193. 02
194. 00 200. 00	07950 NON REIMBURSABLE Cross Foot Adjustments		O	0	0		194. 00 200. 00
200.00			0	0	0		200. 00 201. 00
201.00		18, 576	55, 310	43, 374	2, 097, 326		201.00
	, , ,		55,510	1 .5,571	_, 0,,, 520	١	

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS RUSH MEMORIAL HOSPITAL

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To 12/31/2019 | Date/Time Prepared: | Part | Part | Prepared: | Part | Prepared: | Part | Prepared: | Part | Part | Prepared: | Part | Part | Prepared: | Part | Provider CCN: 15-1304

	Cost Center Description	Total	0/20/2020 12	J piii
		26. 00		
	GENERAL SERVICE COST CENTERS			
	00100 NEW CAP REL COSTS-BLDG & FIXT			1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
	00500 ADMINISTRATIVE & GENERAL			5. 00
	00700 OPERATION OF PLANT			7. 00
	00800 LAUNDRY & LINEN SERVICE			8. 00
	00900 HOUSEKEEPI NG			9. 00
	01000 DI ETARY			10.00
	01100 CAFETERI A			11.00
	01300 NURSI NG ADMI NI STRATI ON			13.00
	01400 CENTRAL SERVICES & SUPPLY			14.00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS			16. 00
30. 00	03000 ADULTS & PEDIATRICS	310, 086		30.00
	ANCILLARY SERVICE COST CENTERS	310,000		30.00
	05000 OPERATING ROOM	176, 734		50.00
	05100 RECOVERY ROOM	22, 091		51.00
	05300 ANESTHESI OLOGY	22,071		53. 00
	05400 RADI OLOGY-DI AGNOSTI C	194, 132		54. 00
	05401 ONCOLOGY	71, 326		54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		55. 00
	06000 LABORATORY	100, 410		60.00
65.00	06500 RESPI RATORY THERAPY	6, 041		65. 00
66.00	06600 PHYSI CAL THERAPY	65, 985		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	28, 108		67. 00
68.00	06800 SPEECH PATHOLOGY	6, 794		68. 00
69.00	06900 ELECTROCARDI OLOGY	13, 696		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 312		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	8, 118		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	113, 893		73. 00
	OUTPATIENT SERVICE COST CENTERS	400.005		
	08800 RURAL HEALTH CLINIC (RHC)	133, 925		88. 00
	09000 CLINIC	337, 812		90.00
	09001 SURGI CAL ASSOCI ATES	43, 470		90. 01 90. 02
	09002 ORTHOPAEDI CS 09003 RHEUMATOLOGY	29, 073 40, 910		90. 02
	09004 SPECIALTY CLINIC	14, 175		90.03
	09005 PEDI ATRI CS	81, 505		90.05
	09006 WOMEN' S HEALTH	01,000		90.06
	09007 PAIN MANAGEMENT	3, 694		90. 07
	09008 ONCOLOGY MD	154		90. 08
	09100 EMERGENCY	160, 031		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
	OTHER REIMBURSABLE COST CENTERS			
95.00	09500 AMBULANCE SERVICES	101, 910		95. 00
	SPECIAL PURPOSE COST CENTERS			
118. 00		2, 073, 385		118. 00
	NONREI MBURSABLE COST CENTERS			
	19200 PHYSICIANS' PRIVATE OFFICES	0		192. 00
	19300 NONPALD WORKERS	0		193. 00
	19301 FOUNDATION	23, 941		193. 01
	19302 OCCUPATI ONAL MEDI CI NE	0		193. 02
	07950 NON REI MBURSABLE	0		194. 00
200.00		0		200. 00
201.00		0 007 204		201.00
202. 00	TOTAL (sum lines 118 through 201)	2, 097, 326		202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1304 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 8/26/2020 12:31 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) SALARIES) 1.00 5A 5. 00 7. 00 4.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 90, 246 1 00 1 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 16, 049, 709 4.00 666 5.00 00500 ADMINISTRATIVE & GENERAL 12,665 2, 614, 143 -5, 332, 962 24, 153, 370 5.00 00700 OPERATION OF PLANT 70, 212 7 00 6,703 324, 278 1, 326, 778 7 00 C 00800 LAUNDRY & LINEN SERVICE 8.00 659 0 112, 473 659 8.00 9.00 00900 HOUSEKEEPI NG 1,600 408, 323 0 707, 069 1,600 9.00 01000 DI ETARY 2,783 115, 809 0 253, 066 2, 783 10.00 10.00 01100 CAFETERI A 0 925 262, 659 305, 539 925 11 00 11 00 13.00 01300 NURSING ADMINISTRATION 615 115, 710 0 166, 035 615 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 1.977 69, 348 213, 288 1.977 14.00 01600 MEDICAL RECORDS & LIBRARY 16, 00 1,308 344, 631 0 544, 725 16, 00 1, 308 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6,573 1, 082, 517 0 1, 632, 243 6, 573 30.00 ANCILLARY SERVICE COST CENTERS 5, 428 5, 428 05000 OPERATING ROOM 1.031.597 956, 189 50.00 0 50.00 51.00 05100 RECOVERY ROOM 628 38, 327 0 70, 642 628 51.00 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 6, 190 1,065,633 0 1, 451, 346 6, 190 54.00 54.01 05401 ONCOLOGY 2, 205 0 2, 205 54.01 462, 400 714, 064 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 55.00 2, 093 06000 LABORATORY 2,093 0 1, 721, 857 60.00 635, 719 60.00 06500 RESPIRATORY THERAPY 79, 077 130, 285 131 65.00 131 65.00 06600 PHYSI CAL THERAPY 0 467, 624 66.00 2.182 313, 871 2, 182 66,00 0 67.00 06700 OCCUPATI ONAL THERAPY 863 226, 406 316, 885 863 67.00 06800 SPEECH PATHOLOGY 68.00 181 88, 150 121, 622 181 68.00 69.00 06900 ELECTROCARDI OLOGY 402 122, 190 0 171, 736 402 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 C 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 435, 898 71.00 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 165, 447 0 72.00 07300 DRUGS CHARGED TO PATIENTS 560, 202 0 73.00 1,696 5, 333, 220 1, 696 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 4.079 1, 252, 458 1, 778, 250 4, 079 88.00 09000 CLI NI C 1, 819, 614 0 1, 221, 050 11, 895 90.00 11.895 90.00 09001 SURGI CAL ASSOCIATES 0 1, 570 1,570 118, 580 90.01 54, 013 90 01 90.02 09002 ORTHOPAEDI CS 1,078 33, 093 0 41, 297 1,078 90.02 90.03 09003 RHEUMATOLOGY 1, 439 520, 745 126, 773 1, 439 90.03 387, 195 217, 933 09004 SPECIALTY CLINIC 0 90 04 360 360 90 04 0 90.05 09005 PEDI ATRI CS 2,916 378, 825 247, 439 2, 916 90.05 90.06 09006 WOMEN'S HEALTH 0 90.06 09007 PAIN MANAGEMENT 90.07 0 491, 617 0 152, 233 0 90.07 90 08 09008 ONCOLOGY MD O 12 500 90.08 0 0 91.00 09100 EMERGENCY 3,858 1,014,426 0 2, 614, 326 3,858 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 3, 728 95. 00 95.00 09500 AMBULANCE SERVICES 3, 728 74, 332 0 203, 888 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 89, 396 -5, 332, 962 15, 987, 308 24, 052, 300 69, 362 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192, 00 193. 00 19300 NONPALD WORKERS 0 0 193.00 193. 01 19301 FOUNDATI ON 0 850 193. 01 850 62, 401 101, 070 0 193. 02 193. 02 19302 OCCUPATIONAL MEDICINE 0 0 194.00 07950 NON REIMBURSABLE 0 0 0 0 194.00 200.00 Cross Foot Adjustments 200. 00 Negative Cost Centers 201.00 201.00 2,097,326 1, 619, 725 202. 00 202.00 Cost to be allocated (per Wkst. B, 4, 863, 315 5, 332, 962 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 23. 240099 0.303016 0.220796 23. 069062 203. 00 204.00 Cost to be allocated (per Wkst. B, 15, 478 296, 863 172, 398 204. 00 Part II) 0.000964 205.00 2. 455392 205. 00 Unit cost multiplier (Wkst. B, Part 0.012291 11) 206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

| Period: | Worksheet B-1 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1304

					To	12/31/2019	Date/Time Pre	
		Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI ON (DI RECT	31 pm
			LAUNDRY)				NRSING HRS)	
	OENED	AL CERVI OF COCT OFFITERS	8. 00	9. 00	10. 00	11. 00	13. 00	
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT						1. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	1	ADMINISTRATIVE & GENERAL						5. 00
7. 00	1	OPERATION OF PLANT						7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	28, 495 2, 000	67, 953				8. 00 9. 00
10.00	1	DIETARY	820	2, 783	100			10.00
11. 00	01100	CAFETERI A	0	925		1, 854		11. 00
13.00		NURSI NG ADMI NI STRATI ON	0	615		10	226, 732	13.00
14. 00 16. 00	1	CENTRAL SERVICES & SUPPLY MEDICAL RECORDS & LIBRARY	0	1, 977 1, 308	0	21 109	0	14. 00 16. 00
10.00		I ENT ROUTI NE SERVI CE COST CENTERS	J	1,000	o _l	107	<u> </u>	10.00
30. 00		ADULTS & PEDIATRICS	18, 580	6, 573	100	182	37, 814	30. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	1, 865	5, 428	0	108	22, 434	50. 00
51. 00		RECOVERY ROOM	0	628		8	1, 574	51.00
53.00	05300	ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	1, 205	6, 190		130	27, 024	1
54. 01 55. 00	1	ONCOLOGY RADI OLOGY-THERAPEUTI C	0	2, 205 0	0	86 0	17, 807 0	54. 01 55. 00
60.00	1	LABORATORY	0	2, 093	Ö	140	29, 193	1
65. 00	1	RESPI RATORY THERAPY	240	131	0	16	3, 241	65. 00
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	561 258	2, 182	0	52 29	10, 809 6, 127	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	11	863 181	0	12	2, 446	ı
69. 00	06900	ELECTROCARDI OLOGY	0	402	0	23	4, 855	1
70.00		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0		Ö	73	15, 252	ł
		TIENT SERVICE COST CENTERS	_		_		_	
88. 00 90. 00		RURAL HEALTH CLINIC (RHC) CLINIC	0	4, 079 11, 895		158 283	0	88. 00 90. 00
90. 01	1	SURGI CAL ASSOCI ATES	0	1, 570	0	19	0	90.00
90. 02	1	ORTHOPAEDI CS	0	1, 078	0	1	0	90. 02
90. 03	1	RHEUMATOLOGY	0	1, 439		46	0	90. 03
90. 04 90. 05		SPECIALTY CLINIC PEDIATRICS	0	360 2, 916		57 50	0	90. 04 90. 05
90. 06	09006	WOMEN'S HEALTH	0	0	0	0	0	90. 06
90. 07		PAIN MANAGEMENT	0	0	0	38	7, 909	90. 07
90. 08 91. 00		ONCOLOGY MD EMERGENCY	2, 955	0 3, 858	0	0 176	0 36, 676	90. 08 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	2, 755	3,030	Ŭ	170	30, 070	92.00
		REIMBURSABLE COST CENTERS	_		_			
95. 00		AL PURPOSE COST CENTERS	0	3, 728	0	17	3, 571	95. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	28, 495	67, 103	100	1, 844	226, 732	118. 00
400.00		I MBURSABLE COST CENTERS						
		PHYSICIANS' PRIVATE OFFICES NONPAID WORKERS	0	0		0		192. 00 193. 00
		FOUNDATION	0	850		10		193. 01
	1	OCCUPATIONAL MEDICINE	0	0	0	0		193. 02
194. 00 200. 00	1	NON REIMBURSABLE	0	0	0	0	0	194. 00 200. 00
200.00	1	Cross Foot Adjustments Negative Cost Centers						200.00
202.00		Cost to be allocated (per Wkst. B, Part I)	152, 510	910, 801	414, 834	406, 738	227, 319	
203. 00 204. 00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	5. 352167 18, 315	13. 403396 51, 483		219. 384035 28, 477	1. 002589 18, 576	203. 00 204. 00
205. 00		Part II) Unit cost multiplier (Wkst. B, Part	0. 642744	0. 757627	773. 670000	15. 359763	0. 081929	205. 00
206.00)	NAHE adjustment amount to be allocated						206. 00
207. 00		(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
			,			!	1	

RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1304

					10 12/31/2019 Date/lime Pro 8/26/2020 12:	
		Cost Center Description	CENTRAL	MEDI CAL		
			SERVICES &	RECORDS &		
			SUPPLY	LI BRARY		
			(COSTED REQUIS.)	(GROSS REVENUE)		
			14. 00	16.00		
	GENER	AL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT				1. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00		ADMINISTRATIVE & GENERAL				5. 00
7.00	1	OPERATION OF PLANT				7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING				8. 00 9. 00
10.00	1	DIETARY				10.00
11. 00	1	CAFETERI A				11. 00
13. 00	1	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1, 504, 037			14. 00
16. 00		MEDICAL RECORDS & LIBRARY	1, 956	94, 400		16. 00
		I ENT ROUTINE SERVICE COST CENTERS	0.4.50	10.510		4
30. 00		ADULTS & PEDIATRICS	34, 458	40, 560)	30.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	427, 037	0		50.00
51. 00	1	RECOVERY ROOM	6, 055	8, 920		51.00
53. 00	1	ANESTHESI OLOGY	0,039	0, 720	1	53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	42, 796	10, 800	•	54. 00
54. 01	05401	ONCOLOGY	27, 039	0		54. 01
55. 00		RADI OLOGY-THERAPEUTI C	0	0	l control of the cont	55. 00
60.00		LABORATORY	509, 181	0	•	60.00
65. 00		RESPI RATORY THERAPY	3, 842	200	·	65. 00
66.00	1	PHYSI CAL THERAPY	4, 528	0	l control of the cont	66. 00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	1, 448 973	0	i e	67. 00 68. 00
69. 00		ELECTROCARDI OLOGY	2, 191	0	i e	69.00
70. 00		ELECTROENCEPHALOGRAPHY	2, 171	0	i e	70. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	107, 517	0		71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	165, 447	0		72. 00
73.00		DRUGS CHARGED TO PATIENTS	15, 605	0		73. 00
00.00		TIENT SERVICE COST CENTERS	44.405		·	
88. 00 90. 00		RURAL HEALTH CLINIC (RHC) CLINIC	14, 485 55, 572	0		88. 00 90. 00
90.00	1	SURGI CAL ASSOCI ATES	3, 766	0		90.00
90. 01	1	ORTHOPAEDI CS	3, 700	0		90. 02
90. 03		RHEUMATOLOGY	2, 094	0	l .	90. 03
90.04		SPECIALTY CLINIC	19, 691	0		90. 04
90. 05	1	PEDI ATRI CS	5, 279	0	l .	90. 05
90. 06	1	WOMEN'S HEALTH	0	0	•	90. 06
90. 07	1	PAIN MANAGEMENT	3, 194	0		90. 07
90. 08 91. 00	1	ONCOLOGY MD EMERGENCY	0 45 470	0 33, 920		90. 08 91. 00
91.00	1	OBSERVATION BEDS (NON-DISTINCT PART)	45, 478	33, 920		92.00
72.00		REIMBURSABLE COST CENTERS				72.00
95.00		AMBULANCE SERVICES	4, 366	0		95. 00
		AL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1, 504, 037	94, 400	<u> </u>	118. 00
100.00		I MBURSABLE COST CENTERS	al			100.00
		PHYSICIANS' PRIVATE OFFICES NONPAID WORKERS	0	0	l control of the cont	192. 00 193. 00
		FOUNDATION	0	0		193. 00
	1	OCCUPATIONAL MEDICINE	0	0		193. 02
		NON REIMBURSABLE	o	0		194. 00
200.00		Cross Foot Adjustments				200. 00
201.00	1	Negative Cost Centers				201. 00
202.00)	Cost to be allocated (per Wkst. B,	337, 095	737, 055		202. 00
202.00		Part I)	0 224127	7 007707		202 00
203. 00 204. 00	1	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 224127 55, 310	7. 807786 43, 374		203. 00 204. 00
204.00	Ί	Part II)	55, 510	43, 374		204.00
205.00		Unit cost multiplier (Wkst. B, Part	0. 036774	0. 459470		205. 00
		11)				
206.00)	NAHE adjustment amount to be allocated				206. 00
207.00		(per Wkst. B-2)				207.00
207. 00	'	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207. 00
	1	in and iv	ı		1	I

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304	Peri od: From 01/01/2019	Worksheet C Part I

						From 01/01/2019 To 12/31/2019	Part Date/Time Pre	pared:
							8/26/2020 12:	
				Title	XVIII	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	
		ENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	3, 148, 894		3, 148, 89	4 0	0	30. 00
		ARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	1, 517, 163		1, 517, 16		0	
51. 00		RECOVERY ROOM	183, 478		183, 47	8 0	0	51. 00
53.00		ANESTHESI OLOGY	0			0	0	53. 00
54.00		RADI OLOGY-DI AGNOSTI C	2, 153, 540		2, 153, 54	.0	0	54.00
54. 01	05401	ONCOLOGY	994, 927		994, 92	.7 0	0	54. 01
55.00	05500	RADI OLOGY-THERAPEUTI C	0			0 0	0	55. 00
60.00	06000	LABORATORY	2, 352, 477		2, 352, 47	7 0	0	60.00
65.00	06500	RESPI RATORY THERAPY	174, 296	0	174, 29	6 0	0	65. 00
66.00	06600	PHYSI CAL THERAPY	676, 720	0	676, 72	0 0	0	66. 00
67.00	06700	OCCUPATIONAL THERAPY	432, 539	0	432, 53	9 0	0	67. 00
68.00	06800	SPEECH PATHOLOGY	160, 440	0	160, 44	.0	0	68. 00
69.00	06900	ELECTROCARDI OLOGY	234, 722		234, 72	2 0	0	69. 00
70.00	07000	ELECTROENCEPHALOGRAPHY	0			0 0	0	70. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	556, 240		556, 24	0 0	0	71. 00
72.00		IMPL. DEV. CHARGED TO PATIENT	239, 058		239, 05	8 0	0	72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	6, 607, 428		6, 607, 42	8 0	0	73. 00
	OUTPAT	TIENT SERVICE COST CENTERS						1
88.00	08800	RURAL HEALTH CLINIC (RHC)	2, 357, 560		2, 357, 56	0 0	0	88. 00
90.00		CLINIC	1, 999, 035		1, 999, 03	5 0	0	90.00
90. 01	09001	SURGI CAL ASSOCI ATES	207, 035		207, 03	5 0	0	90. 01
90. 02		ORTHOPAEDI CS	89, 960		89, 96	0 0	0	90. 02
90. 03	09003	RHEUMATOLOGY	217, 808		217, 80	0 8	0	90. 03
90.04	09004	SPECIALTY CLINIC	296, 100		296, 10	0 0	0	90. 04
90.05	09005	PEDI ATRI CS	420, 578		420, 57	8 0	0	90. 05
90.06	09006	WOMEN'S HEALTH	0			0 0	0	90.06
90. 07	09007	PAIN MANAGEMENT	202, 827		202, 82	.7 0	0	90. 07
90. 08	09008	ONCOLOGY MD	15, 260		15, 26		0	90. 08
91.00	09100	EMERGENCY	3, 698, 501		3, 698, 50		0	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	958, 360		958, 36		0	
		REIMBURSABLE COST CENTERS				, '		1
95.00		AMBULANCE SERVICES	393, 164		393, 16	4 0	0	95. 00
200.00		Subtotal (see instructions)	30, 288, 110	0			0	200. 00
201.00		Less Observation Beds	958, 360		958, 36		0	201. 00
202.00		Total (see instructions)	29, 329, 750	0	29, 329, 75	0	0	202. 00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1304	Peri od: Worksheet C
		From 01/01/2019 Part I
		To 12/21/2010 Doto/Time December d.

Title Will Hospital Cost						rom 01/01/2019 o 12/31/2019	Part I Date/Time Pre 8/26/2020 12:	
Inpatient Outpatient Outpatient Total (Col. Cost or Other Ratio Inpatient Ratio Inpatient Ratio Inpatient Ratio Inpatient Ratio Inpatient Ratio Inpatient Ratio Inpatient Ratio				Title	XVIII	Hospi tal	Cost	
NAME SERVICE COST CENTERS 3, 284, 179 3, 284, 179 3, 284, 179 30. 00 5				Charges				
INPATI ENT ROUTI NE SERVI CE COST CENTERS 3, 284, 179 3, 284, 179 30.00		Cost Center Description	I npati ent	Outpati ent			Inpati ent	
30.00			6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS								
SOLO 050000 050000 050000 050000 05000 05000 05000 05000 05000 050000 050000 050000 050000 0500000 050000 050000 050000 050000 050000 0500000 0500000 0500000 0500000 05000000 05000000 050000000 050000000 0500000000	30.00		3, 284, 179		3, 284, 179			30.00
51.00 05100 RECOVERY ROOM 53.804 1,547.093 1,600.897 0.114609 0.000000 51.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0.000000 53.00 54.01 54.01 05401 NOCLOGY 0 792.283 792.283 1.255772 0.000000 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0.000000 0.000000 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0.000000 0.000000 56.01 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.000000								
53.00 05300 AMESTHESI OLOGY 0 0 0 0 0 0 0 0 0	50.00							
54. 01 05400 RADI 0LOGY - DI AGNOSTI C 597, 147 22, 753, 364 23, 350, 511 0.09227 0.000000 54. 01 05401 0NCOLOGY 0 792, 283 792, 283 1.255772 0.000000 54. 01 05500 05500 RADI 0LOGY - THERAPEUTI C 0 0 0.000000 0.000000 55. 00 000000 0.000000 0.000000 055. 00 000000 0.0000000 0.0000000 0.0000000 0.00000000	51.00		53, 804	1, 547, 093	1, 600, 897			
54.01 054.01 054.01 050.00 05	53.00		0	0	C		0.000000	53.00
55. 00 05500 RADI OLOGY—THERAPEUTI C 0 0 0 0 0 0 0 0 0	54.00	05400 RADI OLOGY-DI AGNOSTI C	597, 147	22, 753, 364	23, 350, 511	0. 092227	0.000000	54.00
60.0 0 06000 LABORATORY	54. 01	05401 ONCOLOGY	0	792, 283	792, 283	1. 255772	0.000000	
65. 00 06500 RESPIRATORY THERAPY 167, 652 2.47, 664 4.35, 316 0.400390 0.000000 65. 00 66. 00 06600 06600 0450	55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	0.000000	0.000000	55. 00
66.00 06600 PHYSI CAL THERAPY 265, 975 2, 328, 668 2, 594, 643 0. 260814 0. 000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 154, 312 1, 695, 652 1, 849, 964 0. 233809 0. 000000 67. 00 68. 00 06800 SPEECH PATHOLOGY 46, 096 301, 610 347, 706 0. 461424 0. 000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 294, 800 3, 623, 215 3, 918, 015 0. 059908 0. 000000 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0. 000000 0. 000000 70. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATI ENTS 124, 564 4, 007, 975 4, 132, 539 0. 134600 0. 000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 19, 566 825, 301 844, 867 0. 282953 0. 000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 872, 224 15, 282, 331 16, 154, 555 0. 409013 0. 000000 73. 00 88. 00 08800 RURAL HEALTH CLINIC (RHC) 2, 732 268, 286 271, 018		06000 LABORATORY	760, 055	10, 392, 832	11, 152, 887	0. 210930	0.000000	60.00
67. 00 66700 OCCUPATI ONAL THERAPY 154, 312 1, 695, 652 1, 849, 964 0. 233809 0. 000000 67. 00 68. 00 O6800 SPECCH PATHOLOGY 46, 096 301, 610 347, 706 0. 461424 0. 000000 68. 00 69. 00 O6900 ELECTROCARDI OLOGY 294, 800 3, 623, 215 3, 918, 015 0. 059908 0. 000000 69. 00 70. 00 O7000 ELECTROENCEPHALGGRAPHY 0 0 0 0. 000000 0. 000000 70. 00 71. 00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 124, 564 4, 007, 975 4, 132, 539 0. 134600 0. 000000 72. 00 73. 00 O7200 IMPL. DEV. CHARGED TO PATIENT 19, 566 825, 301 844, 867 0. 282953 0. 000000 72. 00 73. 00 O7300 DRUGS CHARGED TO PATIENTS 872, 224 15, 282, 331 16, 154, 555 0. 409013 0. 000000 73. 00 73. 00 O7300 DRUGS CHARGED TO PATIENTS 872, 224 15, 282, 331 16, 154, 555 0. 409013 0. 000000 73. 00 73. 00 O7300 DRUGS CHARGED TO PATIENTS 872, 224 15, 282, 331 16, 154, 555 0. 409013 0. 000000 73. 00 73. 00 O9000 CLI NI C 17, 181 513, 876 531, 057 3. 764257 0. 000000 90. 02 73. 00 O9000 CLI NI C 17, 181 513, 876 531, 057 3. 764257 0. 000000 90. 02 73. 00 O9000 CLI NI C 17, 181 513, 876 531, 057 3. 764257 0. 000000 90. 02 74. 00 O9000 SURGI CAL ASSOCIATES 0 22, 115 22, 115 4. 067827 0. 000000 90. 02 75. 00 O9000 SHEUMATOLOGY 0 107, 428 107, 428 2. 027479 0. 000000 90. 03 75. 00 O9000 SPECI ALTY CLI NI C 0 239, 126 239, 126 1. 238259 0. 000000 90. 03 75. 00 O9000 SOME NORMEN'S HEALTH 0 0 0 0. 000000 0. 000000 90. 05 75. 00 O9000 O9000 O90000 O90000 O9000000 O90000000000	65.00	06500 RESPI RATORY THERAPY	167, 652	267, 664	435, 316	0. 400390	0.000000	65.00
68. 00 06800 SPEECH PATHOLOGY 46,096 301,610 347,706 0.461424 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 294,800 3,623,215 3,918,015 0.059908 0.000000 69. 00 70. 00 70.00 CLECTROENCEPHALGGRAPHY 0 0 0 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 124,564 4,007,975 4,132,539 0.134600 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 19,566 825,301 844,867 0.282953 0.000000 72. 00 73. 00 07200 CLIPIC COST CENTERS 872,224 15,282,331 16,154,555 0.409013 0.000000 73. 00 88. 00 08800 RURAL HEALTH CLINIC (RHC) 2,732 268,286 271,018 88. 00 90. 01 09001 SURGI CAL ASSOCIATES 0 26,836 26,836 7.714823 0.000000 90. 01 90. 02 09002 ORTHOPAEDI CS 0 22,115 22,115 4.067827 0.000000 90. 01 90. 03 09003 RHEUMATOLOGY 0 107,428 107,428 2.027479 0.000000 90. 02 90. 04 09004 SPECI ALTY CLINIC (DECTION CONTROL C	66.00	06600 PHYSI CAL THERAPY	265, 975	2, 328, 668	2, 594, 643	0. 260814	0.000000	66. 00
69. 00 06900 ELECTROCARDI OLOGY 294, 800 3, 623, 215 3, 918, 015 0. 059908 0. 000000 69. 00 70. 00 7	67.00	06700 OCCUPATI ONAL THERAPY	154, 312	1, 695, 652	1, 849, 964	0. 233809	0.000000	67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0	68.00		46, 096	301, 610	347, 706	0. 461424	0.000000	68. 00
71. 00	69.00	06900 ELECTROCARDI OLOGY	294, 800	3, 623, 215	3, 918, 015	0. 059908	0.000000	69. 00
72. 00	70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0. 000000	0.000000	70.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	124, 564	4, 007, 975	4, 132, 539	0. 134600	0.000000	71. 00
SERVICE COST CENTERS SERVICE	72.00	07200 IMPL. DEV. CHARGED TO PATIENT	19, 566	825, 301	844, 867	0. 282953	0.000000	72. 00
88. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	872, 224	15, 282, 331	16, 154, 555	0. 409013	0.000000	73. 00
90. 00 09000 CLINIC 17, 181 513, 876 531, 057 3. 764257 0. 000000 90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 02 90. 02 90. 02 90. 02 90. 02 90. 02 90. 02 90. 02 90. 03 90. 03 90. 03 8 1 1 1 1 1 1 1 1 1								
90. 01 09001 09001 09001 09001 09002 0RTHOPAEDI CS 0 0 20, 836 26, 836 7. 714823 0. 000000 90. 01 09002 0RTHOPAEDI CS 0 22, 115 22, 115 4. 067827 0. 000000 90. 02 09002 09003 RHEUMATOLOGY 0 107, 428 107, 428 2. 027479 0. 000000 90. 03 09004	88.00	08800 RURAL HEALTH CLINIC (RHC)	2, 732	268, 286	271, 018			88. 00
90. 02 09002 0RTHOPAEDI CS 0 22, 115 22, 115 4. 067827 0. 000000 90. 02 90. 03 09003 RHEUMATOLOGY 0 107, 428 107, 428 2. 027479 0. 000000 90. 03 90. 04 09004 SPECI ALTY CLINI C 0 239, 126 239, 126 1. 238259 0. 000000 90. 04 90. 05 09005 PEDI ATRI CS 0 141, 141 141, 141 2. 979843 0. 000000 90. 05 90. 06 09006 WOMEN'S HEALTH 0 0 0 0. 000000 0. 000000 90. 05 90. 07 09007 PAI N MANAGEMENT 0 159, 264 159, 264 1. 273527 0. 000000 90. 07 90. 08 09008 0NCOLOGY MD 0 30, 494 30, 494 0. 500426 0. 000000 90. 08 91. 00 09100 EMERGENCY 23, 157 6, 378, 272 6, 401, 429 0. 577762 0. 000000 91. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 37, 877 920, 452 958, 329 1. 000032 0. 000000 92. 00 070000000000000000000000000000000	90.00	09000 CLI NI C	17, 181	513, 876	531, 057	3. 764257	0.000000	90.00
90. 03	90. 01	09001 SURGI CAL ASSOCI ATES	0	26, 836	26, 836	7. 714823	0.000000	90. 01
90. 04 09004 SPECIALTY CLINIC 0 239, 126 239, 126 1. 238259 0. 000000 90. 04 90. 05 90. 05 90. 06 90. 05 90. 06 90. 06 90. 06 90. 07 90. 07 90. 07 90. 07 90. 08	90. 02	09002 ORTHOPAEDI CS	0	22, 115	22, 115	4. 067827	0.000000	90. 02
90. 05 09005 09005 09005 09006 09006 09006 09006 09006 09006 09006 09006 09006 09006 09006 09000 090000000 0900000000	90. 03	09003 RHEUMATOLOGY	0	107, 428	107, 428	2. 027479	0.000000	90. 03
90. 06 0900b 0900b	90.04	09004 SPECIALTY CLINIC	0	239, 126	239, 126	1. 238259	0.000000	90. 04
90. 06 09006 09006 09006 09006 09006 09000 090000 090000 090000 090000 090000 090000 090000 09000000 090000000 0900000000	90.05	09005 PEDI ATRI CS	0	141, 141	141, 141	2. 979843	0.000000	90. 05
90. 08 09008 0NCOLOGY MD 0 30, 494 30, 494 0. 500426 0. 000000 90. 08 91. 00 09100 EMERGENCY 23, 157 6, 378, 272 6, 401, 429 0. 577762 0. 000000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 37, 877 920, 452 958, 329 1. 000032 0. 000000 92. 00 07HER REI MBURSABLE COST CENTERS 0 562, 379 562, 379 0. 699109 0. 000000 95. 00 200. 00 201. 00 Less Observation Beds 0 6, 846, 667 77, 553, 351 84, 400, 018 200. 00 201. 00	90.06	09006 WOMEN' S HEALTH	o			0. 000000	0.000000	90. 06
91. 00 09100 EMERGENCY 23, 157 6, 378, 272 6, 401, 429 0. 577762 0. 000000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 37, 877 920, 452 958, 329 1. 000032 0. 0000000 92. 00 92. 00 92. 00 93. 0	90. 07	09007 PAIN MANAGEMENT	o	159, 264	159, 264	1. 273527	0.000000	90. 07
91. 00 09100 EMERGENCY 23, 157 6, 378, 272 6, 401, 429 0. 577762 0. 000000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 37, 877 920, 452 958, 329 1. 000032 0. 0000000 92. 00 92. 00 92. 00 93. 0	90. 08		o	•				
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 37,877 920,452 958,329 1.000032 0.000000 92.00	91. 00		23, 157		· ·			
OTHER REI MBURSABLE COST CENTERS 95. 00								
95. 00			2., 2	,				1
200. 00 Subtotal (see instructions) 6,846,667 77,553,351 84,400,018 200.00 201. 00 Less Observation Beds 201.00 201.00	95. 00		0	562, 379	562. 379	0, 699109	0. 000000	95. 00
201.00 Less Observation Beds 201.00			1					
				, ,				
			6, 846, 667	77, 553, 351	84, 400, 018			

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1304	From 01/01/2019 Part I
		To 12/31/2019 Date/Time Prepared:

				12, 01, 201,	8/26/2020 12: 31 pm
			Title XVIII	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
	·	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
54. 01	05401 ONCOLOGY	0. 000000			54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
60. 00	06000 LABORATORY	0. 000000			60.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000			65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0. 000000			67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 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				
88. 00	08800 RURAL HEALTH CLINIC (RHC)				88. 00
90. 00	09000 CLI NI C	0. 000000			90.00
90. 01	09001 SURGI CAL ASSOCI ATES	0. 000000			90. 01
90. 02	09002 ORTHOPAEDI CS	0. 000000			90. 02
90. 03	09003 RHEUMATOLOGY	0. 000000			90. 03
90. 04	09004 SPECIALTY CLINIC	0. 000000			90. 04
90. 05	09005 PEDI ATRI CS	0. 000000			90. 05
90. 06	09006 WOMEN'S HEALTH	0. 000000			90.06
90. 07	09007 PAIN MANAGEMENT	0. 000000			90. 07
90. 08	09008 ONCOLOGY MD	0. 000000			90. 08
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	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Worksheet C
		From 01/01/2019	

					From 01/01/2019 To 12/31/2019		
			Ti +I	e XIX	Hospi tal	Cost	J I PIII
			11 (1	C XIX	Costs	0031	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	oust defiter beset per on	(from Wkst. B,	Adj.	10141 00313	Di sal I owance	10141 00313	
		Part I, col.	Adj.		Di Sai i Owanee		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00	2.00	0.00	1. 00	0, 00	
30.00	03000 ADULTS & PEDIATRICS	3, 148, 894		3, 148, 89	4 0	3, 148, 894	30.00
	ANCILLARY SERVICE COST CENTERS		l			.,,	
50.00	05000 OPERATI NG ROOM	1, 517, 163		1, 517, 16	3 0	1, 517, 163	50.00
51. 00	05100 RECOVERY ROOM	183, 478	ł	183, 47		183, 478	1
53. 00	05300 ANESTHESI OLOGY	0			0	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 153, 540		2, 153, 54	0	2, 153, 540	1
54. 01	05401 ONCOLOGY	994, 927		994, 92		994, 927	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0	0	1
60.00	06000 LABORATORY	2, 352, 477		2, 352, 47	7 0	2, 352, 477	60.00
65. 00	06500 RESPI RATORY THERAPY	174, 296	0			174, 296	
66. 00	06600 PHYSI CAL THERAPY	676, 720	l e			676, 720	1
67. 00	06700 OCCUPATI ONAL THERAPY	432, 539	l e			432, 539	
68. 00	06800 SPEECH PATHOLOGY	160, 440	l			160, 440	
69. 00	06900 ELECTROCARDI OLOGY	234, 722	Ĭ	234, 72		234, 722	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	556, 240		556, 24	0	556, 240	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	239, 058		239, 05		239, 058	1
	07300 DRUGS CHARGED TO PATIENTS	6, 607, 428		6, 607, 42			1
70.00	OUTPATIENT SERVICE COST CENTERS	0,007,120		0,00,,12	<u> </u>	0,00,1120	70.00
88. 00	08800 RURAL HEALTH CLINIC (RHC)	2, 357, 560		2, 357, 56	0	2, 357, 560	88. 00
90. 00	09000 CLI NI C	1, 999, 035		1, 999, 03		1, 999, 035	
90. 01	09001 SURGI CAL ASSOCI ATES	207, 035	l .	207, 03		207, 035	1
90. 02	09002 ORTHOPAEDI CS	89, 960		89, 96		89, 960	
90. 03	09003 RHEUMATOLOGY	217, 808		217, 80		217, 808	
90. 04	09004 SPECIALTY CLINIC	296, 100	ł	296, 10		296, 100	1
90. 05	09005 PEDIATRICS	420, 578		420, 57		420, 578	
90. 06	09006 WOMEN'S HEALTH	0		,	0	0	1
90. 07	09007 PAIN MANAGEMENT	202, 827		202, 82	7 0	202, 827	1
90. 08	09008 ONCOLOGY MD	15, 260		15, 26		15, 260	1
91. 00	09100 EMERGENCY	3, 698, 501		3, 698, 50		3, 698, 501	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	958, 360		958, 36		958, 360	
, 2. 50	OTHER REIMBURSABLE COST CENTERS	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		, ,,,,,,,	-1	, 55, 666	1 /2:00
95. 00	09500 AMBULANCE SERVICES	393, 164		393, 16	4 0	393, 164	95. 00
200.00	1 1	30, 288, 110	l e	1		30, 288, 110	
201.00		958, 360	ŀ	958, 36		958, 360	
202.00		29, 329, 750					
		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	,	1			

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304	Peri od: Worksheet C
		From 01/01/2019 Part I
		T- 10/01/0010 D-+-/T: D

				-	From 01/01/2019 Fo 12/31/2019	Part I Date/Time Pre 8/26/2020 12:	
				e XIX	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						1
30. 00	03000 ADULTS & PEDI ATRI CS	3, 284, 179		3, 284, 179	9		30. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	125, 346	4, 365, 694			0. 000000	
51. 00	05100 RECOVERY ROOM	53, 804	1, 547, 093	1, 600, 89		0. 000000	
53. 00	05300 ANESTHESI OLOGY	0	0	1	0. 000000	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	597, 147	22, 753, 364			0. 000000	
54. 01	05401 ONCOLOGY	0	792, 283	792, 283		0.000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0.000000	0.000000	
60.00	06000 LABORATORY	760, 055	10, 392, 832			0.000000	
65.00	06500 RESPI RATORY THERAPY	167, 652	267, 664	435, 316	0. 400390	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	265, 975	2, 328, 668	2, 594, 643	0. 260814	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	154, 312	1, 695, 652	1, 849, 964	0. 233809	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	46, 096	301, 610	347, 700	0. 461424	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	294, 800	3, 623, 215	3, 918, 01!	0. 059908	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0. 000000	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	124, 564	4, 007, 975	4, 132, 539	0. 134600	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	19, 566	825, 301	844, 86	0. 282953	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	872, 224	15, 282, 331	16, 154, 55!	0. 409013	0.000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						1
88. 00	08800 RURAL HEALTH CLINIC (RHC)	2, 732	268, 286	271, 018	8. 698906	0.000000	88. 00
90.00	09000 CLI NI C	17, 181	513, 876		3. 764257	0.000000	90.00
90. 01	09001 SURGI CAL ASSOCI ATES	0	26, 836	26, 836	7. 714823	0.000000	90. 01
90. 02	09002 ORTHOPAEDI CS	o	22, 115	22, 11!	4. 067827	0.000000	90. 02
90. 03	09003 RHEUMATOLOGY	o	107, 428	107, 428	2. 027479	0.000000	90. 03
90.04	09004 SPECIALTY CLINIC	O	239, 126	239, 120	1. 238259	0.000000	90. 04
90. 05	09005 PEDI ATRI CS	O	141, 141	141, 14 ⁻	2. 979843	0.000000	90. 05
90.06	09006 WOMEN'S HEALTH	o	0		0. 000000	0.000000	90.06
90. 07	09007 PAIN MANAGEMENT	o	159, 264	159, 26		0.000000	
90. 08	09008 ONCOLOGY MD	o	30, 494			0.000000	
91. 00	09100 EMERGENCY	23, 157	6, 378, 272			0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	37, 877	920, 452			0. 000000	1
	OTHER REIMBURSABLE COST CENTERS						1
95. 00	09500 AMBULANCE SERVI CES	O	562, 379	562, 379	0. 699109	0. 000000	95. 00
200.00		6, 846, 667	77, 553, 351			2. 223000	200.00
201.00		3, 3.3, 007	, 555, 661	3., .55, 610			201. 00
202.00		6, 846, 667	77, 553, 351	84, 400, 018	3		202.00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		,,	1 2.7 .227 9 11	- 1		

Health Financial Systems	RUSH MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304		Worksheet C Part I Date/Time Prepared:		

				12, 01, 201,	8/26/2020 12: 31 pr	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
	·	Ratio				
		11. 00				
I	NPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.	00
A	NCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000			50.	00
51.00 0	05100 RECOVERY ROOM	0. 000000			51.	00
53.00 0	05300 ANESTHESI OLOGY	0. 000000			53.	.00
54.00 0	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.	.00
54. 01 0	05401 ONCOLOGY	0. 000000			54.	01
55.00 0	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
	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.	. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.	. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.	. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.	. 00
0	OUTPATIENT SERVICE COST CENTERS					
88. 00 0	08800 RURAL HEALTH CLINIC (RHC)	0. 000000			88.	.00
90.00	09000 CLI NI C	0. 000000			90.	.00
90. 01	09001 SURGI CAL ASSOCI ATES	0. 000000			90.	01
90. 02	09002 ORTHOPAEDI CS	0. 000000			90.	02
90. 03	09003 RHEUMATOLOGY	0. 000000			90.	03
90. 04	09004 SPECIALTY CLINIC	0. 000000			90.	04
90.05	99005 PEDI ATRI CS	0. 000000			90.	05
90.06	09006 WOMEN'S HEALTH	0. 000000			90.	06
90. 07	99007 PAIN MANAGEMENT	0. 000000			90.	07
90.08	09008 ONCOLOGY MD	0. 000000			90.	. 08
91.00	99100 EMERGENCY	0. 000000			91.	00
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.	00
O	THER 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 MEMORIA	L HOS	PI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIE	NT ANCILLARY SERVICE	CAPI TAL	_ COSTS	Р	rovi der C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Pre 8/26/2020 12:	
					Ti tl e	: XVIII	Hospi tal	Cost	
Cost Center	Description		Capital Related Cost			Ratio of Cos to Charges		Capital Costs (column 3 x	

					To 12/31/2019	Date/Time Pre 8/26/2020 12:	pared: 31 pm
			Title	· XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		,				
50.00	05000 OPERATING ROOM	176, 734					
51. 00	05100 RECOVERY ROOM	22, 091	1, 600, 897	•	•	147	51.00
53.00	05300 ANESTHESI OLOGY	0	0	0.00000	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	194, 132	23, 350, 511	0. 00831	4 349, 620	2, 907	54. 00
54. 01	05401 ONCOLOGY	71, 326	792, 283			0	54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0				0	55. 00
60.00	06000 LABORATORY	100, 410	11, 152, 887	0.00900	3 465, 449	4, 190	60.00
65.00	06500 RESPI RATORY THERAPY	6, 041	435, 316	0. 01387	7 108, 706	1, 509	65. 00
66.00	06600 PHYSI CAL THERAPY	65, 985	2, 594, 643	0. 02543	1 157, 298	4, 000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	28, 108	1, 849, 964	0. 01519	4 85, 018	1, 292	67. 00
68.00	06800 SPEECH PATHOLOGY	6, 794	347, 706	0. 01953	9 34, 901	682	68. 00
69.00	06900 ELECTROCARDI OLOGY	13, 696	3, 918, 015	0.00349	6 214, 029	748	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 312	4, 132, 539	0. 00225	3 25, 570	58	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	8, 118	844, 867	0.00960	9 4, 965	48	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	113, 893	16, 154, 555	0.00705	0 510, 996	3, 603	73. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC (RHC)	133, 925	271, 018	0. 49415	5 0	0	88. 00
90.00	09000 CLI NI C	337, 812	531, 057	0. 63611	3 11, 800	7, 506	90. 00
90. 01	09001 SURGI CAL ASSOCI ATES	43, 470	26, 836	1. 61983	9 0	0	90. 01
90. 02	09002 ORTHOPAEDI CS	29, 073			8 0	0	90. 02
90. 03	09003 RHEUMATOLOGY	40, 910	107, 428	0. 38081	3 0	0	90. 03
90.04	09004 SPECIALTY CLINIC	14, 175	239, 126	0. 05927	8 0	0	90. 04
90.05	09005 PEDI ATRI CS	81, 505	141, 141	0. 57747	2 0	0	90. 05
90.06	09006 WOMEN'S HEALTH	0	0	0.00000	0 0	0	90. 06
90. 07	09007 PAIN MANAGEMENT	3, 694	159, 264	0. 02319	4 0	0	90. 07
90. 08	09008 ONCOLOGY MD	154	30, 494	0.00505	0	0	90. 08
91.00	09100 EMERGENCY	160, 031	6, 401, 429	0. 02499	9 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	94, 375	958, 329	0. 09847	9 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	1, 755, 764	80, 553, 460		2, 022, 426	28, 400	200. 00

Health Financial Systems	RUSH MEMORIAL H	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1304	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 8/26/2020 12:31 pm

				'	0 12/31/2019	8/26/2020 12:	
				XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	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	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54. 00
54. 01	05401 ONCOLOGY	0	0	(0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	55. 00
60.00	06000 LABORATORY	0	0	(0	0	60.00
65.00	06500 RESPI RATORY THERAPY	O	0		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	o	0		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	o	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	o	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	o	0		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0		0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	l ol	0	1 (0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	l ol	0	(0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	O	0		0	0	1
	OUTPATIENT SERVICE COST CENTERS	·					1
88. 00	08800 RURAL HEALTH CLINIC (RHC)	0	0	(0	0	88. 00
90.00	09000 CLI NI C	O	0		0	0	90.00
90. 01	09001 SURGI CAL ASSOCI ATES	O	0		0	0	90. 01
90. 02	09002 ORTHOPAEDI CS	0	0		0	0	90. 02
90. 03	09003 RHEUMATOLOGY	0	0		0	0	90. 03
90. 04	09004 SPECIALTY CLINIC	0	0		0	0	90. 04
90. 05	09005 PEDI ATRI CS	0	0		0	0	90. 05
90.06	09006 WOMEN' S HEALTH	0	0		0	0	90.06
90. 07	09007 PAIN MANAGEMENT	0	0		0	0	90. 07
90. 08	09008 ONCOLOGY MD	0	0		0	0	90. 08
91.00	09100 EMERGENCY	o	0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	o		(0	1
	OTHER REIMBURSABLE COST CENTERS				•		1
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	o	0		0	0	200. 00

Health Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	S Provider C		Period: From 01/01/2019 To 12/31/2019		pared: 31 pm
			e XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.		(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	(0 4, 491, 040	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	(0 1, 600, 897	0.000000	51.00
53. 00 05300 ANESTHESI OLOGY	0			0	0.000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	(0 23, 350, 511	0.000000	54.00
54. 01 05401 ONCOLOGY	0		ol	0 792, 283	0.000000	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	(0 0	0. 000000	

Health Financial System	15	RUSH MEMORIAL	HOSPI TAI		In lie	u of Form CMS-	2552-10
	IENT/OUTPATIENT ANCILLARY SEI		_		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV	pared:
				XVIII	Hospi tal	Cost	
Cost Cente	r Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8	5	Costs (col. 9	
		7) 9. 00	10.00	x col. 10) 11.00	12.00	x col . 12) 13.00	
ANCI LLARY SERVI C	E COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATING		0. 000000	43, 453		0	0	50.00
51. 00 05100 RECOVERY R		0.000000	10, 621	•		Ĭ	
53. 00 05300 ANESTHESI 0		0.000000	10, 02 1	1	0	0	
54. 00 05400 RADI 0LOGY-		0. 000000	349, 620			0	
54. 01 05401 0NC0L0GY	DIAGNOSTIC	0. 000000	347, 020	1		0	
55. 00 05500 RADI OLOGY-	THERAPEUTI C	0. 000000				0	
60. 00 06000 LABORATORY		0. 000000	465, 449			0	
65. 00 06500 RESPIRATOR		0. 000000	108, 706		0 0	0	
66. 00 06600 PHYSI CAL T		0. 000000	157, 298			0	
67. 00 06700 OCCUPATI ON		0. 000000	85, 018		0 0	0	
68. 00 06800 SPEECH PAT		0. 000000	34, 901		0 0	0	
69. 00 06900 ELECTROCAR		0. 000000	214, 029		o o	0	
70. 00 07000 ELECTROENC		0. 000000	, C		o o	0	
	PPLIES CHARGED TO PATIENTS	0. 000000	25, 570		0	0	1
	CHARGED TO PATIENT	0. 000000	4, 965	•	0	0	72. 00
73. 00 07300 DRUGS CHAR	GED TO PATIENTS	0. 000000	510, 996		0	0	73. 00
OUTPATIENT SERVI	CE COST CENTERS	<u> </u>					
88. 00 08800 RURAL HEAL	TH CLINIC (RHC)	0. 000000	C		0 0	0	88. 00
90. 00 09000 CLINIC		0. 000000	11, 800		0	0	90.00
90. 01 09001 SURGI CAL A	SSOCI ATES	0. 000000	C		0	0	90. 01
90. 02 09002 ORTHOPAEDI	CS	0. 000000	C		0	0	90. 02
90. 03 09003 RHEUMATOLO	GY	0. 000000	C		0	0	90. 03
90. 04 09004 SPECI ALTY		0. 000000	C)	0	0	90. 04
90. 05 09005 PEDI ATRI CS		0. 000000	C)	0	0	
90. 06 09006 WOMEN' S HE		0. 000000	C)	0	0	
90. 07 09007 PAI N MANAG		0. 000000	C)	0	0	
90. 08 09008 ONCOLOGY M	D	0. 000000	C)	0	0	
91. 00 09100 EMERGENCY		0. 000000	C	1	0	0	
	N BEDS (NON-DISTINCT PART)	0. 000000	C)[0 0	0	92. 00

2, 022, 426

0

0

95.00

0 200. 00

OTHER REI MBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVI CES

Total (lines 50 through 199)

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1304 Peri od: Worksheet D From 01/01/2019 Part V Date/Time Prepared: 12/31/2019 8/26/2020 12:31 pm Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From 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 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 337820 1, 964, 440 0 50.00 51.00 05100 RECOVERY ROOM 0.114609 0 365, 658 0 0 0 51.00 05300 ANESTHESI OLOGY 0.000000 53 00 0 53 00 C 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.092227 0 6, 907, 793 0 54.00 54.01 05401 ONCOLOGY 1. 255772 504, 763 0 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 0 0 0 55.00 06000 LABORATORY 3, 617, 306 60.00 0.210930 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.400390 84, 810 0 65.00 06600 PHYSI CAL THERAPY 66.00 0. 260814 871, 596 0 66.00 06700 OCCUPATIONAL THERAPY 0 233809 67 00 67 00 656, 621 0 06800 SPEECH PATHOLOGY 68.00 0.461424 45,078 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.059908 1, 532, 658 0 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 57, 181 0.134600 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 282953 0 204, 556 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.409013 8, 392, 340 32, 855 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 0.000000 88.00 0 90.00 09000 CLI NI C 3.764257 117,088 11, 520 0 90.00 09001 SURGI CAL ASSOCI ATES 7.714823 15, 486 90.01 90.01 0 0 09002 ORTHOPAEDI CS 13, 270 90.02 90.02 4.067827 0 0 0 09003 RHEUMATOLOGY 60, 798 90.03 90.03 2 027479 0 90.04 09004 SPECIALTY CLINIC 1. 238259 118, 581 0 0 90.04 09005 PEDI ATRI CS 90. 05 2. 979843 0 90.05 09006 WOMEN'S HEALTH 0.000000 0 90.06 90.06 0 0

1.273527

0.500426

0.577762

1.000032

0. 699109

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32, 950

26,828

366, 348

1, 396, 503

27, 352, 652

27, 352, 652

0 90.07

0 91.00

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90.08

92.00

95.00

201. 00

0 200.00

0 202.00

0

o

0

44, 375

44, 375

90.07

90.08

91.00

92.00

95.00

200.00

201.00

202.00

09007 PALN MANAGEMENT

09500 AMBULANCE SERVICES

Only Charges

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Subtotal (see instructions)

OTHER REIMBURSABLE COST CENTERS

09008 ONCOLOGY MD

09100 EMERGENCY

Health Financial Systems	RUSH MEMORIAL F	HOSPI TAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL.	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1304	Peri od:	Worksheet D

From 01/01/2019 Part V
To 12/31/2019 Date/Time Prepared: 8/26/2020 12:31 pm Titl<u>e XVIII</u> Hospi tal Cost Costs Cost Center Description Cost Cost Reimbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 663, 627 50.00 51.00 05100 RECOVERY ROOM 41, 908 0 51.00 53.00 05300 ANESTHESI OLOGY 0 53 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 637, 085 54.00 54.01 05401 ONCOLOGY 633, 867 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 762, 998 06000 LABORATORY 0 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 33, 957 65.00 06600 PHYSI CAL THERAPY 0 66.00 227, 324 66.00 06700 OCCUPATIONAL THERAPY 153 524 67 00 67 00 68.00 06800 SPEECH PATHOLOGY 20,800 0 68.00 69.00 06900 ELECTROCARDI OLOGY 91, 818 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7, 697 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 57,880 0 72.00 07300 DRUGS CHARGED TO PATIENTS 3, 432, 576 13, 438 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC (RHC) 88.00 88.00 90.00 09000 CLI NI C 440, 749 43, 364 90.00 90.01 09001 SURGI CAL ASSOCI ATES 119, 472 90.01 0 09002 ORTHOPAEDI CS 53, 980 90.02 0 90.02 09003 RHEUMATOLOGY 123, 267 0 90.03 90.03 90.04 09004 SPECIALTY CLINIC 146, 834 0 90.04 09005 PEDI ATRI CS 90. 05 90.05 09006 WOMEN'S HEALTH 0 90.06 90.06 0 09007 PAIN MANAGEMENT 41, 963 90.07 0 90.07 90.08 09008 ONCOLOGY MD 13, 425 90.08 09100 EMERGENCY 91.00 806, 846 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 366, 360 92.00 Λ 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 Subtotal (see instructions) 200.00 8, 877, 957 200.00 56,802 Less PBP Clinic Lab. Services-Program 201.00 201. 00

8, 877, 957

56, 802

202.00

Only Charges

Net Charges (line 200 - line 201)

202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | Part V | To 12/31/2019 | Date/Time Prepared: 8/26/2020 12:31 pm |
 Heal th Financial
 Systems
 RUSH MEMORI

 APPORTI ONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 RUSH MEMORIAL HOSPITAL Provider CCN: 15-1304 Component CCN: 15-Z304

Cost Center Description				Title	XVIII Si	wing Beds - SNF	Cost	
Ratio From Worksheet C, Part i . col 9		·			Charges		Costs	
Norksheet C, Part I, col 9		Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
Part I, col. 9 Subject To Ded & Colns. Subject To Ded & Colns. See Inst. Ded & Colns. Ded &		·	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
Ded. & Coins. Cose inst. See inst.			Worksheet C,	inst.)	Servi ces	Services Not		
NO See Inst.			Part I, col. 9		Subject To	Subject To		
NO See Inst.								
ANCILLARY SERVICE COST CENTERS								
50.00 05000 05000 05000 0 0 0			1.00	2.00	3.00		5. 00	
51.00 05100 RECOVERY ROOM 0.114609 0 0 0 0 51.00		ANCILLARY SERVICE COST CENTERS						
53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53.00	50.00	05000 OPERATI NG ROOM	0. 337820	0	0	0	0	50. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 0.092227 0 0 0 0 0 54. 00	51.00	05100 RECOVERY ROOM	0. 114609	0	0	0	0	51.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 0.092227 0 0 0 0 0 54. 00	53.00	05300 ANESTHESI OLOGY	0. 000000	0	l o	0	0	53. 00
54.01 054.01 054.01 050.0C CSY CST	54.00			0	0	0	0	
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60. 00 06000 LABORATORY		I I		l .		0	_	
65. 00 06500 RESPIRATORY THERAPY						0		•
66. 00 06600 PHYSICAL THERAPY 0.260814 0 0 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.233809 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.461424 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.569908 0 0 0 0 0 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0.000000 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.134600 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.282953 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENT 0.282953 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENT 0.282953 0 0 0 0 73. 00 0000 CLI NI C COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C (RHC) 0.000000 90. 01 09001 SURGI CAL ASSOCI ATES 7.714823 0 0 0 0 90. 01 09001 SURGI CAL ASSOCI ATES 7.714823 0 0 0 0 90. 02 09002 ORTHOPAEDI CS 4.067827 0 0 0 0 90. 03 09003 RHEUMATOLOGY 2.027479 0 0 0 0 90. 04 09004 SPECI ALTY CLI NI C 1.238259 0 0 0 0 90. 05 09005 PEDI ATRI CS 2.979843 0 0 0 0 90. 06 09006 WOMEN'S HEALTH 0.000000 0 0 0 90. 07 09007 PAI N MANAGEMENT 1.273527 0 0 0 0 90. 08 09008 ONCOLOGY MD 0.500426 0 0 0 0 91. 00 09100 EMERGENCY 0.577762 0 0 0 0 91. 00 09100 BMSERVATI ON BEDS (NON-DISTINCT PART) 1.000032 0 0 0 91. 00 OP100 BMSERVATI ON BEDS (NON-DISTINCT PART) 1.000032 0 0 0 91. 00 OP100 BMSERVATI ON BEDS (NON-DISTINCT PART) 1.000032 0 0 0 0 91. 00 OP100 EMERGENCY 0.577762 0 0 0 0 91. 00 OP100 EMERGENCY 0.577762 0 0 0 0 91. 00 OP100 EMERGENCY 0.577762 0 0 0 0 91. 00 OP100 EMERGENCY 0.577762 0 0 0 0 91. 00 OP100 EMERGENCY 0.577762 0 0 0 0 91. 00 OP100 EMERGENCY 0.577762 0 0 0 0 91. 00 OP100 EMERGENCY 0.577762 0 0 0						0	_	
67. 00 0670 0CCUPATI ONAL THERAPY 0.233809 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.461424 0 0 0 0 0 68. 00 0 0 0 0 0 0 0 0 0						0	_	
68. 00 06800 SPEECH PATHOLOGY						0		
69. 00 06900 ELECTROCARDI OLOGY 0. 059908 0 0 0 0 0 69. 00 70. 00 07000 ELECTROCREPHALOGRAPHY 0. 000000 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 134600 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0. 409013 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 409013 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 409013 0 0 0 0 88. 00 08800 RURAL HEALTH CLINIC (RHC) 0. 000000 90. 00 09000 CLINIC 3. 764257 0 0 0 0 90. 00 90. 01 09001 SURGI CAL ASSOCIATES 7. 714823 0 0 0 0 90. 01 90. 02 09002 ORTHOPAEDI CS 4. 4.67827 0 0 0 0 90. 02 90. 03 09003 RHEUMATOLOGY 2. 027479 0 0 0 0 90. 03 90. 04 09004 SPECIALTY CLINIC 1. 238259 0 0 0 0 90. 04 90. 05 09005 PEDI ATRI CS 2. 2979843 0 0 0 0 90. 05 90. 06 09006 WOMEN'S HEALTH 0. 0000000 0 0 0 90. 05 90. 07 09007 PAI N MANAGEMENT 1. 273527 0 0 0 0 90. 07 90. 08 09008 NOCLOGY MD 0. 500426 0 0 0 0 90. 07 90. 08 09008 NOCLOGY MD 0. 500426 0 0 0 0 90. 07 90. 09 09500 OBSERVATI ON BEDS (NON-DISTINCT PART) 1. 000032 0 0 0 0 0 90. 00 OP3000 SUBDITARI CS SERVICES 0. 699109 0 0 0 0 90. 00 OP3000 ONDISTINCT PART 1. 000032 0 0 0 0 90. 00 OP3000 ONDISTINCT PART 1. 000032 0 0 0 0 90. 00 OP3000 ONDISTINCT PART 1. 000032 0 0 0 0 90. 00 OP3000 ONDISTINCT PART 1. 000032 0 0 0 90. 00 OP3000 ONDISTINCT PART 1. 000032 0 0 0 0 90. 00 OP3000 ONDISTINCT PART 1. 000032 0 0 0 0 90. 00 OP3000 ONDISTINCT PART 1. 000032 0 0 0 0 90. 00 OP3000 ONDISTINCT PART 1. 000032 0 0 0 0 90. 00 OP3000 ONDISTINCT PART 1. 000032 0 0 0 0 90. 00 ONDISTINCT PART 1. 000032 0 0 0 0 90. 00 ONDISTINCT PART 1. 00003						0	_	•
70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 0 0 0					0	0	_	
71. 00			1	l .	0	0		
72. 00			1	l .	0	0		
73.00 07300 DRUGS CHARGED TO PATIENTS 0.409013 0 0 0 0 0 0 0 0 0					0	0	_	
SERVICE COST CENTERS SERVICES					·	_	_	
88. 00	73. 00		0. 409013	0	0	0	0	73.00
90. 00				T	ı	T	_	
90. 01					_	_	_	
90. 02			1	l .	0	0		•
90. 03			1	0	0	0	_	
90. 04 09004 SPECIALTY CLINIC 1. 238259 0 0 0 0 90. 04 90. 05 09005 PEDIATRICS 2. 979843 0 0 0 0 90. 05 90. 06 09006 WOMEN'S HEALTH 0. 000000 0 0 0 0 0 90. 07 09007 PAIN MANAGEMENT 1. 273527 0 0 0 0 0 90. 08 09008 0NCOLOGY MD 0. 500426 0 0 0 0 0 91. 00 09100 EMERGENCY 0. 577762 0 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 000032 0 0 0 95. 00 OP500 AMBULANCE SERVICES 0. 699109 0 90. 00 Subtotal (see instructions) 0 0 0 00 0 0 0 00 0				0	0	0	_	
90. 05 09005 09006 09006 09006 09006 09006 09006 09006 09006 09006 09006 09006 09006 09006 09000					0	0		
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90. 07 09007 PAI N MANAGEMENT 1. 273527 0 0 0 0 90. 07 90. 08 09008 0NCOLOGY MD 0. 500426 0 0 0 0 90. 08 91. 00 09100 EMERGENCY 0. 577762 0 0 0 0 0 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 1. 000032 0 0 0 0 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0. 699109 0 0 200. 00 Subtotal (see i nstructions) 0 0 0 201. 00 Less PBP Clinic Lab. Servi ces-Program 0 0 0 0 0 0 0 200. 00 201. 00 0 0 0 0 0 0 0 0 0					0	0	0	1
90. 08 09008 0NCOLOGY MD 0. 500426 0 0 0 0 90. 08 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 1. 000032 0 0 0 0 0 92. 00 0 0 0 0 0 0 0 0 0				0	0	0	0	
91. 00 09100 EMERGENCY 0. 577762 0 0 0 0 0 91. 00 92. 00 0 0 0 0 0 0 0 0 0	90. 07	09007 PAIN MANAGEMENT	1. 273527	0	0	0	0	90. 07
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 1.000032 0 0 0 0 92.00	90.08	09008 ONCOLOGY MD	0. 500426	0	0	0	0	90. 08
OTHER REI MBURSABLE COST CENTERS 95. 00	91.00	09100 EMERGENCY	0. 577762	0	0	0	0	91.00
95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 000032	0	0	0	0	92.00
200.00 Subtotal (see instructions) 0 0 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 201.00			•	•				1
200.00 Subtotal (see instructions) 0 0 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 201.00	95.00		0. 699109		0			95. 00
201.00 Less PBP Clinic Lab. Services-Program 0 0 0 201.00 Only Charges	200.00	Subtotal (see instructions)		0	0	0	0	200. 00
Only Charges		1 /			0	0		•
	202.00			0	0	0	0	202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems RUSH MEMORIAL HOSPITAL APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1304 Peri od: Worksheet D From 01/01/2019 Part V

Component CCN: 15-Z304 12/31/2019 Date/Time Prepared: To 8/26/2020 12:31 pm Title XVIII Swing Beds - SNF Cost Costs 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.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 000000000000000 0 51.00 53. 00 05300 ANESTHESI OLOGY 0 53 00 54. 00 | 05400 | RADI OLOGY-DI AGNOSTI C 0 54.00 54.01 05401 ONCOLOGY 0 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 06000 LABORATORY 0 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 0 67 00 67 00 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 OUTPATIENT SERVICE COST CENTERS
08800 RURAL HEALTH CLINIC (RHC) 88.00 0 0 0 0 0 0 0 0 0 0 0 0 88.00 90.00 09000 CLI NI C 0 90.00 90. 01 09001 SURGI CAL ASSOCI ATES 0 90.01 0 09002 ORTHOPAEDI CS 90.02 90.02 09003 RHEUMATOLOGY 90.03 90.03 90.04 09004 SPECIALTY CLINIC 0 90.04 09005 PEDI ATRI CS 90. 05 90.05 09006 WOMEN'S HEALTH 0 90.06 90.06 09007 PAIN MANAGEMENT 90.07 0 90.07 90.08 09008 ONCOLOGY MD 0 90.08 09100 EMERGENCY 0 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 95.00 Subtotal (see instructions) 0 200.00 0 200.00

201. 00

202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1304	Peri od: From 01/01/2019	Worksheet D-1		
		To 12/31/2019	Date/Time Prepared: 8/26/2020 12:31 pm		
	Title XVIII	Hospi tal	Cost		

		Title XVIII	Hospi tal	8/26/2020 12: Cost	31 pm	
	Cost Center Description	THE AVIII	nospi tai	'		
	PART I - ALL PROVIDER COMPONENTS			1. 00		
	INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days			1, 972	1. 00	
2.00	Inpatient days (including private room days, excluding swing-b			1, 869	2.00	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pr	vate room days,	0	3. 00	
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		1, 282	4. 00	
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	31 of the cost	56	5. 00	
<i>(</i> 00	reporting period	om daya) after December	01 of the cost	0	/ 00	
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) arter becember :	si di the cost	0	6. 00	
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	47	7. 00	
0.00	reporting period			0	0.00	
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after becember 3	or the cost	0	8. 00	
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	871	9. 00	
40.00	newborn days) (see instructions)				40.00	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	56	10. 00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00	
	December 31 of the cost reporting period (if calendar year, er			_		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	Conly (including private	e room days)	0	12. 00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	13. 00	
	after December 31 of the cost reporting period (if calendar ye					
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0		
16. 00	Nursery days (title V or XIX only)	0				
	SWING BED ADJUSTMENT					
17. 00						
18. 00	reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				18. 00	
19. 00	00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period				19. 00	
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0.00	20. 00	
	reporting period					
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	3, 148, 894 0	1	
22.00	5 x line 17)	si Si di the cost reporti	ng perrou (Trie	O	22.00	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00	
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reportion	na period (line	6 070	24. 00	
24.00	7 x line 19)	31 of the cost reporting	ig perrou (Trile	0,070	24.00	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00	
26. 00	x line 20) Total swing-bed cost (see instructions)			97, 498	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		3, 051, 396		
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	1	
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	1	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 22) (:+	h!>	0.00	1	
34. 00 35. 00	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x line		Li ons)	0. 00 0. 00	1	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36.00	
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	ferential (line	3, 051, 396	37. 00	
	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			1, 632. 64	38. 00	
39. 00	Program general inpatient routine service cost (line 9 x line	•		1, 422, 029	1	
40.00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 1, 422, 029		
41.00	Trotal frogram general impatrent routine service cost (fille 39	11116 40)	l	1, 422, 029	1 41.00	

Heal th	Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-1304	Peri od:	Worksheet D-1	
					From 01/01/2019 To 12/31/2019		
			Ti +l 4	e XVIII	Hospi tal	8/26/2020 12: Cost	31 pm
	Cost Center Description	Total	Total	Average Per	<u>' </u>	Program Cost	
	·	Inpatient Cost	Inpatient Days	,	÷	(col. 3 x col.	
		1.00	2.00	3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)		2.00	0.00	11 00	0.00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units						1 42 00
43. 00 44. 00	INTENSIVE CARE UNIT						43. 00 44. 00
45. 00							45. 00
46.00	1						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			nc)		537, 941	•
49.00	PASS THROUGH COST ADJUSTMENTS	41 (111 Ough 46) (see mstructro) is)		1, 959, 970	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sur	m of Parts I and	0	50. 00
51. 00		atient ancillar	v services (fr	rom Wkst D «	sum of Parts II	0	51. 00
31.00	and IV)	atrent anerra	y services (ii	om wkst. D,	3411 01 141 (3 11	Ĭ	31.00
52.00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	5 1	rated, non-pny	sıcıan anestı	netist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	/					
54. 00 55. 00	Program discharges Target amount per discharge					0	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting ported	onding 1006 ı	indated and co	ampounded by the	0	58. 00 59. 00
39.00	market basket	por tring perrou	ending 1990, c	ipuateu anu ci	onipounded by the	0.00	39.00
60.00						0.00	•
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61. 00
	amount (line 56), otherwise enter zero (see		3 (TITIES OF X	00), 01 1% 0	the target		
62. 00 63. 00	,	ont (soo instru	ctions)			0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstru	Ctrons)			0	03.00
64. 00		ts through Dece	mber 31 of the	e cost reporti	ng period (See	91, 428	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the d	rost reporting	nerind (See	0	65. 00
00.00	instructions) (title XVIII only)			·		Ĭ	00.00
66. 00		ne costs (line	64 plus line 6	55)(title XVII	II only). For	91, 428	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
	(line 12 x line 19)						,,,,,,,
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00		routine costs (line 67 + line	e 68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil				1		70. 00
70.00	Adjusted general inpatient routine service c	-			,		70.00
72.00	Program routine service cost (line 9 x line	71)		ŕ			72. 00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	•			Part II, column		75. 00
7/ 00	26, line 45)	2)					7/ 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces			*.	aus Lino 70)		79.00
81.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost iimi tati 01	. (/0 11111	143 IIIIC /7)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .				82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		s)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASTOTAL observation bed days (see instructions					587	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 632. 64	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				958, 360	89. 00

Health Financial Systems	RUSH MEMORIAI	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	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	310, 086	3, 148, 894	0. 09847	5 958, 360	94, 375	90.00
91.00 Nursing School cost	0	3, 148, 894	0.00000	0 958, 360	0	91.00
92.00 Allied health cost	0	3, 148, 894	0.00000	0 958, 360	0	92.00
93.00 All other Medical Education	0	3, 148, 894	0.00000	0 958, 360	0	93. 00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1304	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prepared:
		1.0 1.2, 0.1, 2011	8/26/2020 12:31 pm
	Title XIX	Hospi tal	Cost

				8/26/2020 12:	31 pm
		Title XIX	Hospi tal	Cost	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		1, 972	1. 00
2.00	Inpatient days (including private room days, excluding swing-			1, 869	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	vate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		04 6 11	1, 282	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roomsting period	om days) through Decembe	r 31 or the cost	56	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) at ter becember	of the cost	ا	0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	47	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)				0.00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	53	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	nom days)	0	10. 00
.0.00	through December 31 of the cost reporting period (see instruct		Join day J		10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	(only (including privat	e room days)	0	12. 00
12 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	/ anly (including privat	a maam daysa)	0	12 00
13. 00	after December 31 of the cost reporting period (if calendar ve			ا	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(Ö	15. 00
16.00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	os after December 21 of	the cost		18. 00
10.00	reporting period	es al tel December 31 01	the cost		16.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period	3			
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0.00	20. 00
21 00	reporting period	- >		2 140 004	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing ported (Line	3, 148, 894 0	21. 00 22. 00
22.00	5 x line 17)	er 31 or the cost report	ing period (Time	ا	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)	•	,		
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
05.00	7 x line 19)				05.00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	si of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			91, 604	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		3, 057, 290	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0.000000	31.00
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x lin		,	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	3, 057, 290	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	IOTUFUTO			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 (25 72	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•		1, 635. 79 86, 697	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Progra	•		86, 697	40.00
	Total Program general inpatient routine service cost (line 39			86, 697	
	, 5 . 5		l		

Heal th	Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der C	CCN: 15-1304	Period: From 01/01/2019	Worksheet D-1	
					To 12/31/2019	Date/Time Pre	
			Ti t	le XIX	Hospi tal	8/26/2020 12: Cost	31 pm_
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	inpatient bays	col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
43. 00	INTENSIVE CARE UNIT						43. 00
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	1						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			anc)		66, 541	48. 00 49. 00
49.00	PASS THROUGH COST ADJUSTMENTS	41 through 48)(see mstructio	ons)		153, 238	49.00
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sur	n of Parts I and	0	50. 00
51. 00	<pre> Pass through costs applicable to Program inp</pre>	atient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	0	51. 00
F0 00	and IV)	FO F4)					F0 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated, non-ph	vsician anesth	netist, and	0	52. 00 53. 00
	medical education costs (line 49 minus line	9 1					
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge					0.00	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	o .			,	Ö	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996,	updated and co	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	60. 00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61. 00
	amount (line 56), otherwise enter zero (see		.3 (TITIES 54 X	00), 01 1% 01	the target		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ant (saa instri	ictions)			0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST						03.00
64. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reportino	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 nlus line	65)(title XVII	Lonly) For	0	66. 00
	CAH (see instructions)	·	·		3,		
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31 (of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	December 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs ((line 67 + line	e 68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (I					71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		n (line 14 v li	ine 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv						74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from \	Worksheet B, F	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		provi der recor	ds)			79. 00
80.00	Total Program routine service costs for comp		cost limitation	n (line 78 mir	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instruction	* .				83. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					587	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				1, 635. 79	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				960, 209	89. 00

Health Financial Systems	RUSH MEMORIAL	_ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2019	5	
				To 12/31/2019	Date/Time Prep 8/26/2020 12:	
		Ti +1	e XIX	Hospi tal	Cost	o i piii
Cook Cooks Beautiful	0+					
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	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	310, 086	3, 148, 894	0. 09847	5 960, 209	94, 557	90. 00
91.00 Nursing School cost	0	3, 148, 894	0.00000	960, 209	0	91. 00
92.00 Allied health cost	0	3, 148, 894	0.00000	960, 209	0	92.00
93.00 All other Medical Education	0	3, 148, 894	0.00000	960, 209	0	93. 00

Usel the Firemanial Contame	MEMODIAL HOCDITAL		la lia		2552 10
Health Financial Systems RUSH INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	MEMORIAL HOSPITAL Provider CO	N: 15 1204	Period:	u of Form CMS-2 Worksheet D-3	
THE ATTENT AND LEARLY SERVICE COST ATTORTIONWENT	Trovider co		From 01/01/2019	WOI KSHEET D-3	
			To 12/31/2019	Date/Time Pre 8/26/2020 12:	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		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	
30. 00 03000 ADULTS & PEDIATRICS			1, 441, 758		30.00
ANCI LLARY SERVI CE COST CENTERS			1, 441, 730		30.00
50. 00 OFERATING ROOM		0. 33782	0 43, 453	14, 679	50.00
51. 00 05100 RECOVERY ROOM		0. 33762		1, 217	51.00
53. 00 05300 ANESTHESI OLOGY		0. 00000		0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 09222		32, 244	1
54. 01 05401 0NCOLOGY		1. 25577		02,211	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 00000		0	55. 00
60. 00 06000 LABORATORY		0. 21093		98, 177	1
65. 00 06500 RESPIRATORY THERAPY		0. 40039		43, 525	1
66. 00 06600 PHYSI CAL THERAPY		0. 26081		41, 026	1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 23380		19, 878	
68. 00 06800 SPEECH PATHOLOGY		0. 46142		16, 104	1
69. 00 06900 ELECTROCARDI OLOGY		0. 05990		12, 822	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 13460	0 25, 570	3, 442	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 28295	3 4, 965	1, 405	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 40901	3 510, 996	209, 004	73. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC (RHC)		0. 00000		0	
90. 00 09000 CLI NI C		3. 76425		44, 418	
90. 01 09001 SURGI CAL ASSOCI ATES		7. 71482		0	
90. 02 09002 ORTHOPAEDI CS		4. 06782		0	
90. 03 09003 RHEUMATOLOGY		2. 02747		0	
90. 04 09004 SPECI ALTY CLI NI C		1. 23825		0	90. 04
90. 05 09005 PEDI ATRI CS		2. 97984		0	90. 05
90. 06 09006 WOMEN' S HEALTH		0.00000		0	90.06
90. 07 09007 PAI N MANAGEMENT		1. 27352		0	90. 07
90. 08 09008 0NCOLOGY MD		0. 50042		0	90. 08
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 57776		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		1. 00003	2 0	U	92.00
95. 00 09500 AMBULANCE SERVICES					95. 00
200.00 Total (sum of lines 50 through 94 and 96 through	iah 98)		2, 022, 426	537, 941	
201.00 Less PBP Clinic Laboratory Services-Program or			2, 022, 420	557, 741	201. 00
202.00 Net charges (line 200 minus line 201)	, sharges (11116-01)		2, 022, 426		202. 00
1,111 2,111 311 (1,110 200 11,110 201)	· · · · · · · · · · · · · · · · · · ·	1	_, 522, 120		,

PATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1304	Peri od:	Worksheet D-3	
		Component	CCN: 15-Z304	From 01/01/2019 To 12/31/2019	9 Date/Time Pre 8/26/2020 12: WF Cost Inpatient Program Costs (col. 1 x col. 2) 3.00	pared 31 pr
		Ti tl e		Swing Beds - SNF		
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Program Costs (col. 1 x col. 2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
00	03000 ADULTS & PEDI ATRI CS			0		30.
, 00	ANCI LLARY SERVI CE COST CENTERS		1			30.
0. 00	05000 OPERATI NG ROOM		0. 33782	20 0	0	50.
. 00	05100 RECOVERY ROOM		0. 11460		0	
. 00	05300 ANESTHESI OLOGY		0. 00000			
. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 09222	27 4, 575	422	54.
. 01	05401 ONCOLOGY		1. 2557	72 0	0	54.
. 00	05500 RADI OLOGY-THERAPEUTI C		0.00000	00	0	55.
00	06000 LABORATORY		0. 21093	7, 992	1, 686	60
00	06500 RESPI RATORY THERAPY		0. 40039	90 998	400	65
00	06600 PHYSI CAL THERAPY		0. 2608			
00	06700 OCCUPATI ONAL THERAPY		0. 23380		6, 493	
00	06800 SPEECH PATHOLOGY		0. 46142			
00	06900 ELECTROCARDI OLOGY		0. 05990			
00	07000 ELECTROENCEPHALOGRAPHY		0.00000		-	1
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 13460			
00	07200 I MPL. DEV. CHARGED TO PATIENT		0. 2829			1
00	07300 DRUGS CHARGED TO PATIENTS		0. 4090	13 11, 936	4, 882	73
00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC (RHC)		0.0000	20	0	88
00	09000 CLINIC		1			
01	09001 SURGI CAL ASSOCI ATES		3. 76425 7. 71482			
02	09002 ORTHOPAEDI CS		4. 06782			
03	09003 RHEUMATOLOGY		2. 0274			
04	09004 SPECIALTY CLINIC		1. 2382		_	90
05	09005 PEDI ATRI CS		2. 97984		-	
06	09006 WOMEN'S HEALTH		0.00000		0	
07	09007 PAIN MANAGEMENT		1. 27352		Ö	
08	09008 ONCOLOGY MD		0. 50042		0	
00	09100 EMERGENCY		0. 57776		0	91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 00003		0	
2.00	OTHER REIMBURSABLE COST CENTERS		1.0000	52 0	0	l
00	09500 AMBULANCE SERVICES					95
$^{\circ}$	Total (sum of lines 50 through 04 and 06 through 08)			07 208	25 3/2	

25, 342 200. 00 201. 00 202. 00

97, 208 0 97, 208

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

200. 00 201. 00 202. 00

	Financial Systems RUSH MEM ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1304	Peri od:	Worksheet D-3	
				From 01/01/2019	Doto/Time Dro	no-cod-
				To 12/31/2019	Date/Time Pre 8/26/2020 12:	
		Ti tl	e XIX	Hospi tal	Cost	от рііі
	Cost Center Description		Ratio of Cos		Inpatient	
	'		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					٠
30. 00	03000 ADULTS & PEDI ATRI CS			162, 689		30.0
-0.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		0.22702	20 / /07	2.250	
50. 00 51. 00	05100 RECOVERY ROOM		0. 33782		2, 259	
3. 00	05300 ANESTHESI OLOGY		0. 11460 0. 00000		629 0	•
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0.09222		6, 947	
4. 00	05401 ONCOLOGY		1. 25577		0, 947	1
5. 00	05500 RADI OLOGY-THERAPEUTI C		0. 00000		0	
0. 00	06000 LABORATORY		0. 21093		-	1
5. 00	06500 RESPI RATORY THERAPY		0. 40039			
6. 00	06600 PHYSI CAL THERAPY		0. 26081			
7. 00	06700 OCCUPATI ONAL THERAPY		0. 23380			1
8. 00	06800 SPEECH PATHOLOGY		0. 46142			1
9. 00	06900 ELECTROCARDI OLOGY		0.05990	5, 001	300	69. (
0.00	07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70.0
1. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 13460	5, 442	732	71. (
2. 00	07200 I MPL. DEV. CHARGED TO PATIENT		0. 28295		0	72.0
3. 00	07300 DRUGS CHARGED TO PATIENTS		0. 40901	56, 386	23, 063	73.0
	OUTPATIENT SERVICE COST CENTERS					1
8. 00	08800 RURAL HEALTH CLINIC (RHC)		8. 69890			
0.00	09000 CLI NI C		3. 76425			
0. 01	09001 SURGI CAL ASSOCI ATES		7. 71482		0	
0. 02	09002 ORTHOPAEDI CS		4. 06782		0	
0. 03	09003 RHEUMATOLOGY 09004 SPECI ALTY CLI NI C		2. 02747 1. 23825		0	90. (
0. 05	09005 PEDI ATRI CS		2. 97984		0	90.0
0.06	09006 WOMEN'S HEALTH		0. 00000		0	
0. 08	09007 PALN MANAGEMENT		1. 27352		0	90.
0. 07	09008 ONCOLOGY MD		0. 50042		0	
1. 00	09100 EMERGENCY		0. 57776			
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 00003			
00	OTHER REIMBURSABLE COST CENTERS			, 0		1
- 00	00500 AMBILLANCE SERVICES					05

95.00

66, 541 200. 00 201. 00 202. 00

237, 215

237, 215

95. 00 09500 AMBULANCE SERVICES

200. 00 201. 00

202.00

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

	Ti tle XVI	11	Hospi tal	8/26/2020 12: Cost	31 pm
			nospi tai	0031	
	DADT D. WEDLOW AND STUED WENTY SERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			8, 934, 759	1.00
2. 00	Medical and other services (see First detrois) Medical and other services reimbursed under OPPS (see instructions)			0, 754, 757	2.00
3. 00	OPPS payments			0	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000	5.00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)			0.00	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, Iir	ne 200		0	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			8, 934, 759	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			Ö	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for serv			0	15.00
16. 00	Amounts that would have been realized from patients liable for payment for se had such payment been made in accordance with 42 CFR §413.13(e)	ervices o	n a chargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18.00	Total customary charges (see instructions)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 ex	ceeds li	ne 11) (see	0	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete only if line 11 ex	recode Li	no 10) (coo	0	20. 00
20.00	instructions)	ceeus III	116 10) (366	١	20.00
21. 00	Lesser of cost or charges (see instructions)			9, 024, 107	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)			0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24. 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			71, 102	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, s	see instr	uctions)	4, 691, 826	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	4, 261, 179	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28. 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)			4, 261, 179	
31. 00	Primary payer payments			6, 093	
32. 00				4, 255, 086	32. 00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34. 00	Allowable bad debts (see instructions)			1, 575, 891	1
35. 00	Adjusted reimbursable bad debts (see instructions)			1, 024, 329	
36.00	,			1, 491, 179	
37. 00				5, 279, 415	
38. 00 39. 00				0	38. 00 39. 00
39. 50	, , , , ,			Ĭ	39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see	e instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			5, 279, 415 105, 588	•
40. 01	Demonstration payment adjustment amount after sequestration			0 103, 300	40. 01
40. 03					40. 03
41. 00	Interim payments			5, 801, 259	1
41. 01	Interim payments-PARHM				41. 01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			-627, 432	1
43. 01	Balance due provider/program-PARHM (see instructions)			,	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub	o. 15-2,	chapter 1,	0	44. 00
	§115. 2				
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
91.00	, ,			0	91.00
92. 00	· · · · · · · · · · · · · · · · · · ·			0.00	
93. 00	Time Value of Money (see instructions)			0	93. 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 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-1304

			'	0 12/31/2019	8/26/2020 12:3	
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	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, 373, 316		5, 420, 559	1. 00
2. 00	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		0		0	2. 00
3. 00	List separately each retroactive lump sum adjustment 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. 00
3. 01	ADJUSTMENTS TO PROVIDER	12/11/2019	140, 300	12/11/2019	272, 800	3. 01
3. 02		12/23/2019	55, 500		107, 900	3. 02
3. 03			0		0	3. 03
3.04			0		ol	3. 04
3. 05			0		ol	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		195, 800		380, 700	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)		1, 569, 116		5, 801, 259	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					0.00
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		122, 808		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1 0		627, 432	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 691, 924		5, 173, 827	7. 00
	,		, , , , , , , , , , , , , , , , , , , ,	Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
		1		1	'	

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

		Component	CCN. 13-Z304 1	0 12/31/2019	8/26/2020 12:	
		Title	XVIII S	ving Beds - SNF		
		Inpatien	it Part A	Par	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		85, 750		0	1.00
2.00	Interim payments payable on individual bills, either		0		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	L	L		<u> </u>	1
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3. 54	Subtatal (sum of lines 2 01 2 40 minus sum of lines		0		0	3. 54 3. 99
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		85, 750		0	4.00
00	(transfer to Wkst. E or Wkst. E-3, line and column as		00,700			
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					1
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	T	1	T		
5. 01	TENTATI VE TO PROVI DER		0		0 0	5. 01 5. 02
5. 02 5. 03			0		0	5. 02
5.03	Provider to Program				0	3.03
5. 50	TENTATI VE TO PROGRAM		Ιο		0	5.50
5. 51	TENTITIVE TO TROOM III				Ö	5. 51
5. 52					Ö	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		l o		Ō	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		29, 828		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		115, 578		0	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8.00	Name of Contractor		J	1.00	2.00	8. 00
5. 50	maine of contractor	I		I .	I	1 0.00

Heal th	Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu				2552-10	
CALCUL					epared: 31 pm	
		Title XVIII	Hospi tal	Cost		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1. 00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12			2. 00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00	
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00	
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	Sequestration adjustment amount (see instructions)				9. 00	
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)				31.00	
22 00	Of Delegand day (Specify)					

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1304	Peri od: From 01/01/2019	Worksheet E-2
		Component CCN: 15-Z304		Date/Time Prepared:

		Component CCN: 15-Z304	To 12/31/2019	Date/Time Pre 8/26/2020 12:	
		Title XVIII	Swing Beds - SNF		31 piii
			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)		92, 342	0	
2.00	Inpatient routine services - swing bed-NF (see instructions)		05 505		2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		25, 595	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swire translations)	ng-bed pass-through, see			
3. 01	instructions) Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	1
4.00	instructions)	ng program (see		0.00	4.00
5.00	Program days		56	0	5. 00
6.00	Interns and residents not in approved teaching program (see in	nstructi ons)		0	6. 00
7.00	Utilization review - physician compensation - SNF optional met	thod only	o		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		117, 937	0	8. 00
9.00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		117, 937	0	
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	0	11. 00
	professional services)			_	
12.00	Subtotal (line 10 minus line 11)		117, 937	0	12.00
13. 00	Coinsurance billed to program patients (from provider records)	(exclude coinsurance	0	0	13. 00
14. 00	for physician professional services)			0	14. 00
15. 00	80% of Part B costs (line 12 x 80%) Subtotal (see instructions)		117, 937	0	1
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		117, 737	0	
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	:)	٥	O	16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr		0		16. 55
	adjustment (see instructions)	ati on, paymont			
16. 99	Demonstration payment adjustment amount before sequestration		o	0	16. 99
17.00	Allowable bad debts (see instructions)		0	0	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	
	Total (see instructions)		117, 937	0	
	Sequestration adjustment (see instructions)		2, 359	0	
	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
19. 03	Sequestration adjustment-PARHM pass-throughs		05 750	0	19. 03
	Interim payments		85, 750	0	20. 00
21. 00	Interim payments-PARHM Tentative settlement (for contractor use only)		0	0	1
	Tentative settlement (for contractor use only)		J G	U	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, a	and 21)	29, 828	0	1
22. 01	Balance due provider/program-PARHM (see instructions)	1110 21)	27,020	O	22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2.	0	0	
	chapter 1, §115.2			_	
	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration per	iod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
201. 00	Medicare swing-bed SNF inpatient routine service costs (from V	/kst. D-1, Pt. II, line			201. 00
202 00	66 (title XVIII hospital))	- WI+ D 21 2 1:			202 00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	1 WKSt. D-3, COL. 3, TINE	•		202. 00
303 00	200 (title XVIII swing-bed SNF)) Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204. 00
204.00	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curren	it 5-vear demonst		204.00
	peri od)	The year of the earter	it o your domonot		
205.00	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs	sement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1				208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 00
210. 00	Reserved for future use				210. 00
215 00	Comparision of PPS versus Cost Reimbursement	200 plus line 210) (5			215 00
∠15.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2 instructions)	prus rine 210) (See			215. 00
	instructions)		ı		I

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1304	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Prepared: 8/26/2020 12:31 pm

2.00 Nursing and Allied Health Managed Care payment (see instructions) 0 2.0 3.0 0.0 0.7 0.0					8/26/2020 12:3	31 pm
PART V - CALCILATION OF RELIBURISEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RELIBURISEMENT 1,959,970 1,00			Title XVIII	Hospi tal	Cost	
PART V - CALCULATION OF REMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RELIMBURSEMENT 1,959,970 1,00						
Inpatient services					1. 00	
2.00			RT A SERVICES - COST	REIMBURSEMENT		
3.00 Organ acquisition 0 3.00						1. 00
4.00 Subtotal (sum of lines 1 through 3) 1,95,970 4.00 5.00 Primary payer payments 0 5.00 5.00 Primary payer payments 1,979,570 6.00 7.00)			2. 00
Primary payer payments		9 1				3. 00
Total cost (line 4 less line 5). For CAH (see instructions) 1,979,570 6,00					1, 959, 970	4. 00
COMPUTATION OF LESSER OF COST OR CHARGES					0	5. 00
Reasonable charges 0	6.00				1, 979, 570	6. 00
Routine service charges						
Accillary service charges 0 8.00 0.0						
9.00 Organ acquisition charges, net of revenue 0 9.00 Organ acquisition charges 0 10.00 Organ acquisition charges 0 Organ acquisition charges 0 Organ acquisition charges 0 Organ acquisition charges 0 Organism 0						7. 00
10.00 Total reasonable charges 0 10.00						8. 00
Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge basis 11.00						9. 00
11.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 11.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 12.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 12.00 13	10. 00				0	10. 00
12.00 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)		, , , , , , , , , , , , , , , , , , , 				
had such payment been made in accordance with 42 CFR 413.13(e)						11. 00
13.00 Ratio of line 11 to line 12 (not to exceed 1.000000) Total customary charges (see instructions) 0.000000 14.00 15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 0.000000 16.00 17.00 17.00 18.00 18.00 19	12. 00		ayment for services o	n a charge basis	0	12. 00
14.00		1 3				
Excess of custómary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 15.00						
Instructions Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see						
16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 17.0	15. 00		if line 14 exceeds li	ne 6) (see	0	15. 00
Instructions Cost of physicians' services in a teaching hospital (see instructions) 17. 00					_	
17. 00	16. 00		if line 6 exceeds line	e 14) (see	0	16. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					_	
18. 00 Direct graduate medical education payments (from Worksheet E-4, line 49) 19. 00 Cost of covered services (sum of lines 6, 17 and 18) 1,979,570 19. 00 19. 00 Deductible se (exclude professional component) 259,112 20. 00 21. 00 Excess reasonable cost (from line 16) 21. 00 22. 00 Subtotal (line 19 minus line 20 and 21) 1,720,458 22. 00 23. 00 Coinsurance 682 23. 00 23. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 10, 272 25. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 6, 677 26. 00 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 3, 342 27. 00 29. 50 Coinsurance 682 23. 00 Coi	17.00		tions)		0	17.00
19.00 Cost of covered services (sum of lines 6, 17 and 18) 20.00 Deductibles (exclude professional component) 21.00 Excess reasonable cost (from line 16) 22.00 Subtotal (line 19 minus line 20 and 21) 23.00 Coinsurance 24.00 Subtotal (line 22 minus line 23) 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26.00 Adjusted reimbursable bad debts (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.99 Demonstration payment adjustment amount before sequestration 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Subtotal (see instructions) 31.00 Interim payments 31.00 Interim payments 32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)	10.00		1. 40)		0	40.00
20. 00 Deductibles (exclude professional component) 259, 112 20. 00 21. 00 Excess reasonable cost (from line 16) 0 21. 00 22. 00 Subtotal (line 19 minus line 20 and 21) 1, 720, 458 22. 00 23. 00 Coinsurance 682 23. 00 24. 00 Subtotal (line 22 minus line 23) 1, 719, 776 24. 00 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 10, 272 25. 00 26. 00 Adjusted reimbursable bad debts (see instructions) 6, 677 26. 00 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 3, 342 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 1, 726, 453 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 1, 726, 453 28. 00 29. 99 Pioneer ACO demonstration payment adjustment (see instructions) 0 29. 50 29. 99 Subtotal (see instructions) 30. 03 30. 03 30. 01 Sequestration adjustment (see instructions) 34, 529 30. 0 30. 02 Sequestration adjustment amount after sequestration 0			line 49)			
21.00 Excess reasonable cost (from line 16) 0 21.00						
22. 00 Subtotal (line 19 minus line 20 and 21) 1,720,458 22. 00 23. 00 Coinsurance 682 23. 00 24. 00 Subtotal (line 22 minus line 23) 1,719,776 24. 00 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 10,272 25. 00 26. 00 Adjusted reimbursable bad debts (see instructions) 6,677 26. 00 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 3,342 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 1,726,453 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 00 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29. 50 30. 01 Sequestration apyment adjustment amount before sequestration 0 29. 90 30. 02 Subtotal (see instructions) 34,529 30. 00 30. 03 Sequestration adjustment (see instructions) 34,529 30. 00 30. 03 Sequestration adjustment amount after sequestration 0 30. 00 31. 01 Interim payments 1,569,116 31. 00 31. 01 Interim payment						
23. 00 Coinsurance 682 23. 00 24. 00 Subtotal (line 22 minus line 23) 1,719,776 24. 00 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 10, 272 25. 00 26. 00 Adjusted reimbursable bad debts (see instructions) 6, 677 26. 00 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 3, 342 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 1,726, 453 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 00 29. 50 29.		1				
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§115. 2		[3110. 2		l		l

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1304	Peri od: Worksheet E-3 From 01/01/2019 Part VII To 12/31/2019 Date/Time Prepared:

				10 12/31/2019	8/26/2020 12:	
Inpatient Outpatient			Title XIX	Hospi tal		-
PART VII - CALCULATION OF RETMOURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
PART VIT - CACCULATION OF NET COST OF COMMENTS DESIDED SERVICES						
COMPUTATION OF NET COST OF COVERED SERVICES 153,228 1.00		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI			
Inpatient hospital/SNI/MF services						İ
Medical and other services 0 2.00	1.00			153, 238		1.00
Organ acquisition (certified transplant centers only)					0	
Subtotal (sum of lines 1, 2 and 3)				o		1
Inpat Inpat Inpat payer payments 0 0 0 0 0 0 0 0 0	4.00			153, 238	0	4.00
Subtotal (line 4 less sum of lines 5 and 6)	5.00	Inpatient primary payer payments		0		5. 00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 162,689 8.00	6.00	Outpatient primary payer payments			0	6. 00
Reasonable Charges	7.00	Subtotal (line 4 less sum of lines 5 and 6)		153, 238	0	7.00
Routine service charges 162,689 8.00 9.00 Anciliary service charges 237,215 0.9 0.00		COMPUTATION OF LESSER OF COST OR CHARGES				
9.00 Ancillary service charges 237,215 0 9.00 10.00 Organ acquist it in charges, net of revenue 0 11.00 10.00 Incentive from target amount computation 399,904 0 12.00 12.00 Total reasonable charges (sum of lines 8 through 11) 399,904 0 12.00 13.00 Amount actually collected from patients liable for payment for services on a charge 0 0 13.00 14.00 Amounts that would have been realized from patients liable for payment for services on a charge 0 0 14.00 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 0 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 0 0.00000 0.00000 16.00 16.00 Total customary charges (see instructions) 0 0 16.00 16.00 Total customary charges (see instructions) 0 0 18.00 10.00 Excess of customatomatomatomatomatomatomatomatomatoma						
10.00 Organ acquisition charges, net of revenue 0 10.0		Routi ne servi ce charges		162, 689		
11.00 Incentive from target amount computation 399,904 0 11.00 12.				237, 215	0	
12.00 Total reasonable charges (sum of lines 8 through 11) 12.00 12.00 12.00 13.00 13.00 13.00 13.00 14.00 14.00 15.00				0		
CUSTOMARY CHARGES 0				<u>۷</u>		
13. 00 Amount actually collected from patients liable for payment for services on a charge 0 0 13. 00	12. 00			399, 904	0	12. 00
basis						
14. 00 Amounts that would have been realized from patients Liable for payment for services on a large basis had such payment been made in accordance with 42 CFR §413. 13(e) 0.000000 0.000000 15. 00 16. 00 16. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 18. 00 18. 00 19. 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) 15. 00 Ratio of line 13 to line 14 (not to exceed 1.000000) 16. 00 Total customary charges (see instructions) 17. 00 Excess of customary charges (see instructions) 18. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 246.666 0 17.00 18. 00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19. 00 Interns and Residents (see instructions) 19. 00 Interns and Residents (see instructions) 19. 00 Interns and Residents (see instructions) 10. 00 Cost of physicians' services in a teaching hospital (see instructions) 10. 00 Cost of payments 20. 00 Cost of covered services (enter the lesser of line 4 or line 16) 21. 00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22. 00 Other than outlier payments 23. 00 Outlier payments 24. 00 Program capital payments 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 Converges (title V or XIX PPS covered services only) 29. 00 Titles V or XIX (sum of lines 21 and 27) 29. 00 Titles V or XIX (sum of lines 21 and 27) 20. 00 Excess of reasonable cost (from line 18) 20. 01 Excess of reasonable cost (from line 18) 20. 02 Deductibles 20. 03 Outlier and Ancillary service only in 153, 238 20. 03 Outlier and Ancillary service only in 153, 238 29. 00 Titles V or XIX (sum of lines 21 and 27) 20. 00 Excess of reasonable cost (from line 18) 20. 01 Files Publication review 20. 02 Excess of reasonable cost (from line 18) 20. 02 Or Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 20. 03 Or Or Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 20. 01 Or Or Excess of reasonable to the provider (sum of lines 38 and 39) 20. 02 Or Or Or Excess of reasonable to the provider (sum of lines 38 and 39) 20. 02 Or Or	44.00				0	44.00
15. 00	14.00			U	0	14.00
16.00	15 00		12 CFR 9413. 13(e)	0.000000	0.000000	15 00
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11			vifline 16 exceeds			
18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19.00 19.00 10.0	17.00		y IT TITLE TO exceeds	240, 000	O	17.00
16) (see instructions)	18 00		vifline 4 exceeds line	0	0	18 00
19.00 Interns and Residents (see instructions) 0 0 19.00 20.00 2	.0.00		ye . execuee		Ü	10.00
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PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22 .00 10 ther than outlier payments 0 0 23 .00 24 .00 25 .00 25 .00 25 .00 25 .00 25 .00 26 .00 27 .00 26 .00 27 .00 27 .00 28 .00 27 .00 28 .00 29 .00 20	20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	o	0	20.00
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COMPUTATION OF REIMBURSEMENT SETTLEMENT				<u>۷</u>		
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) 31.00 Deductibles 0 0 0 32.00 33.00 Coinsurance 0 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 0 33.00 35.00 Utilization review 0 0 0 35.00 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 0 0 41.00 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 43.00	29.00			153, 238	0	29.00
31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 32. 00 Coinsurance 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) 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 0 31. 00 0 32. 00 0 32. 00 0 32. 00 0 33. 00 0 34. 00 0 35. 00 0 35. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 41. 00 0 41. 00 153, 238 0 42. 00	20.00					1 20 00
32. 00 Deductibles 0 0 32. 00 33. 00 Coinsurance 0 0 0 33. 00 34. 00 Allowable 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) 153, 238 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 153, 238 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 153, 238 0 40. 00 41. 00 Interim payments 0 0 41. 00 42. 00 Balance due provider/program (line 40 minus line 41) 153, 238 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 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 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 153, 238 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 153, 238 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 153, 238 0 40. 00 41. 00 Interim payments 0 0 41. 00 42. 00 Balance due provider/program (line 40 minus line 41) 153, 238 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00						
34.00 Allowable bad debts (see instructions)				Ĭ		
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, 0 35. 00 35. 00 35. 00 36. 00 37. 00 38. 00 37. 00 38. 00 39				Ĭ		
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 37.00 153, 238 0 36.00 37.00 38.00 39.00 153, 238 0 40.00 41.00 153, 238 0 40.00 41.00 42.00 43.00				0	Ü	
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 37. 00 37. 00 37. 00 37. 00 37. 00 38. 00 38. 00 39. 00 40. 00 41. 00 41. 00 42. 00 43. 00 44. 00 43. 00			1 33)	153 238	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, 153, 238 0 40.00 41.00 41.00 42.00 43.00			, 33)	133, 230		
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 40.00 41.00 41.00 42.00 43.00				153 238		
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 41.00 153,238 0 40.00 41.00 42.00 43.00				0	O	
41.00 Interim payments 0 41.00 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				153. 238	Ω	
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 42.00		, , , , , , , , , , , , , , , , , , , ,		0		1
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				153, 238		
			nce with CMS Pub 15-2,			

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

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

Provider CCN: 15-1304 Period From

oni y)					8/26/2020 12:	31 pm
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	4, 513, 554	1	_	0	
2.00	Temporary investments	2, 191, 486		0	0	2.00
3. 00 4. 00	Notes recei vabl e Accounts recei vabl e	0 16, 921, 737	1	0	0	
5.00	Other recei vable	574, 333	1	0	0	
6. 00	Allowances for uncollectible notes and accounts receivable	-11, 379, 709	1	0	0	
7. 00	Inventory	1, 010, 523		0	0	1
8.00	Prepai d expenses	527, 965	0	0	0	8. 00
9.00	Other current assets	0	0	-	0	
10. 00	Due from other funds	0	0	-	0	1
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	14, 359, 889	0	0	0	11. 00
12. 00	Land	0	0	0	0	12. 00
13. 00	Land improvements		1		0	1
14. 00	Accumulated depreciation	0		_	0	
15. 00	Bui I di ngs	39, 166, 665	0	0	0	15. 00
16.00	Accumulated depreciation	-23, 654, 209	0	0	0	16. 00
17. 00	Leasehold improvements	0	0	0	0	17. 00
18.00	Accumulated depreciation	0	0	0	0	
19. 00 20. 00	Fixed equipment Accumulated depreciation	0	0	0	0	1
21. 00	Automobiles and trucks		0	0	0	1
22. 00	Accumulated depreciation	0	Ö	0	0	
23. 00	Major movable equipment	0	0	0	0	1
24.00	Accumul ated depreciation	0	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumul ated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable		0	-	0	
30. 00	Total fixed assets (sum of lines 12-29)	15, 512, 456		-	0	
00.00	OTHER ASSETS	10/012/100				00.00
31.00	Investments	0	0	0	0	31. 00
32. 00	Deposits on Leases	0	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	1
34. 00	Other assets	0	0	0	0	
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	29, 872, 345	0	0	0	
30.00	CURRENT LIABILITIES	29, 072, 343	0	0	0	30.00
37. 00	Accounts payable	1, 776, 272	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	0	1	0	0	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40. 00	Notes and Loans payable (short term)	634, 165	0	0	0	40.00
41.00	Deferred income	0	0	0	0	
42. 00 43. 00	Accel erated payments Due to other funds	0	o	0	0	42. 00 43. 00
44. 00	Other current liabilities	9, 458, 754			0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	11, 869, 191		_		45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0		0	
47. 00	Notes payable	3, 600, 538	1		0	1
48. 00	Unsecured Loans	0	0		0	1
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	3, 600, 538	0	0	0	1
51. 00	Total liabilities (sum of lines 45 and 50)	15, 469, 729			0	
01.00	CAPITAL ACCOUNTS	10, 107, 727		<u> </u>		01.00
52.00	General fund balance	14, 402, 616				52. 00
53.00	Specific purpose fund		0			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 57. 00	Governing body created - endowment fund balance			O	0	56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	1
55. 66	replacement, and expansion					55. 55
59. 00	Total fund balances (sum of lines 52 thru 58)	14, 402, 616	0	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	29, 872, 345	0	0	0	60. 00
	[59]	I	I		I	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-1304

					То	12/31/2019	Date/Time Prep 8/26/2020 12:	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	5 i piii
				·				
	I 	1. 00	2.00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		12, 309, 961			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2, 092, 655					2.00
3.00	Total (sum of line 1 and line 2)		14, 402, 616		_	0	0	3. 00
4. 00 5. 00	Additions (credit adjustments) (specify)	0			0		0	4. 00 5. 00
6.00		0			0		0	6. 00
7. 00					0		0	7. 00
8. 00					0		0	8. 00
9. 00					0		0	9. 00
10.00	Total additions (sum of line 4-9)		0			0	Ü	10. 00
11. 00	Subtotal (line 3 plus line 10)		14, 402, 616			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0	. 17 1027 010		0	J	0	12. 00
13. 00	, (, (, (, /, /, /, /	o			Ō		o	13. 00
14. 00		o			Ō		o	14. 00
15.00		O			0		0	15.00
16.00		0			0		0	16.00
17.00		O			0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0			0		18.00
19. 00	Fund balance at end of period per balance		14, 402, 616			0		19.00
	sheet (line 11 minus line 18)			L				
		Endowment Fund	PI ant	Funa				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0.00	7.00	0.00	0			1. 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)				Ĭ			2. 00
3.00	Total (sum of line 1 and line 2)	o			0			3. 00
4.00	Additions (credit adjustments) (specify)		0					4. 00
5.00			0					5.00
6.00			0					6.00
7.00			0					7.00
8.00			0					8.00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0					12.00
13. 00			0					13. 00
14.00			0					14.00
15.00			0					15. 00
16.00			0					16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)		O		0			17. 00 18. 00
19.00	Fund balance at end of period per balance				0			18.00
17.00	sheet (line 11 minus line 18)				J			17.00
	10.000 (1.1.0 11 111100 11110 10)	1		Ī				

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1304

			10 12/31/2019	8/26/2020 12:	
	Cost Center Description	Inpatient	Outpati ent	Total	
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u>.</u>	<u> </u>		
	General Inpatient Routine Services				1
1.00	Hospi tal	3, 284, 1	79	3, 284, 179	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				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	3, 284, 1	79	3, 284, 179	10.00
	Intensive Care Type Inpatient Hospital Services	, ,,,,,		0, =0 .,	
11. 00	INTENSIVE CARE UNIT				11.00
12. 00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of li	nes	0	0	16.00
10.00	11-15)				10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	3, 284, 1	79	3, 284, 179	17. 00
18. 00	Ancillary services	3, 481, 5			
19. 00	Outpatient services	63, 2			19.00
20. 00	RURAL HEALTH CLINIC (RHC)	2,7			
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	2, /	0 200, 200		21.00
22. 00	HOME HEALTH AGENCY			ľ	22. 00
23. 00	AMBULANCE SERVICES		0 562, 379	562, 379	23. 00
24. 00	CMHC		502, 577	302, 377	24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26.00
27. 00	PROFESSIONAL FEES	396, 9	9, 170, 523	9, 567, 445	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to				
20.00	G-3, line 1)	WKST. 7, 220, 5	00, 730, 074	73, 707, 403	20.00
	PART II - OPERATING EXPENSES				<u>.</u>
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		42, 186, 154		29. 00
30.00	ADD (SPECIFY)		0		30.00
31. 00	(SI ESTITY)		0		31. 00
32. 00			0		32.00
33. 00			0		33. 00
34. 00			0		34.00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)				36.00
37. 00	DEDUCT (SPECIFY)		0		37.00
38. 00	DEBOOT (SECONT)		0		38. 00
39. 00			0		39.00
40. 00			0		40.00
41. 00		1	0		41.00
41.00	Total deductions (sum of lines 37-41)	1	_		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	42, 186, 154		43. 00
45.00	to Wkst. G-3, line 4)		42, 100, 134		1 43.00
	100 mat. 0 0, 1710 4)	ı	I	I	ı

	n Financial Systems RUSH MEMORIA			u of Form CMS-2	2552-10
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-1304	Peri od:	Worksheet G-3	
			From 01/01/2019 To 12/31/2019	Date/Time Pre	nared:
			10 12/01/2017	8/26/2020 12:	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,	line 28)		93, 967, 463	1. 00
2.00	Less contractual allowances and discounts on patients' acc	ounts		51, 461, 580	2.00
3.00	Net patient revenues (line 1 minus line 2)			42, 505, 883	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, Ii	ne 43)		42, 186, 154	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			319, 729	5. 00
	OTHER INCOME				
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 communicat	ion services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10. 00				0	10.00
	Rebates and refunds of expenses			0	11.00
	Parking lot receipts			0	12.00
	Revenue from Laundry and Linen service			0	13.00
	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical supplies to othe	r than patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17. 00
	Revenue from sale of medical records and abstracts			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				0	21.00
22. 00	Rental of hospital space			0	22. 00
23. 00	· · · · · · · · · · · · · · · · · · ·			0	23. 00
	OTHER OPERATING EXPENSES/INCOME			496, 442	
	NON-OPERATING EXPENSES/INCOME			520, 163	
	CONTRACT PHARMACY			756, 321	
25 00	Total ather income (our of lines (24)			1 772 024	25 00

1, 772, 926

2, 092, 655

2, 092, 655 29. 00

25.00

55 26.00 0 27.00 0 28.00

24.02 CONTRACT PHARMACY
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

	Financial Systems	RUSH MEMORIA		ou 15 1001		eu of Form CMS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od: From 01/01/2019	Worksheet M-1	
			Component		To 12/31/2019	Date/Time Pre	
					RHC I	8/26/2020 12:	31 pm
		Compensation	Other Costs	Total (col :	Reclassificati	Reclassi fied	
		Compensation	Other Costs	+ col . 2)	ons	Trial Balance	
				1 (01. 2)	0113	(col. 3 + col.	
						4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS			•	-	•	
1.00	Physi ci an	328, 131	0	328, 13	1 394, 004	722, 135	1.00
2.00	Physici an Assistant	0	0		0 0	0	2. 00
3.00	Nurse Practitioner	106, 765	0	106, 76	5 0	106, 765	3. 00
4.00	Visiting Nurse	0	0		0	0	1 00
5.00	Other Nurse	43, 865	0	43, 86	5 0	43, 865	
6.00	Clinical Psychologist	0	0		0	0	0.00
7.00	Clinical Social Worker	0	0		0	0	7. 00
8.00	Laboratory Techni ci an	0	0		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	0		0	0	7.00
10. 00	Subtotal (sum of lines 1 through 9)	478, 761	0	478, 76	1 394, 004		
11. 00	Physician Services Under Agreement	0	0		0	0	
12. 00	Physician Supervision Under Agreement	0	0		0	0	1 00
13.00	3	0	0		0	0	1
14.00	Subtotal (sum of lines 11 through 13)	0	7 005	7.00	0	0	14.00
15.00	Medical Supplies	0	7, 335				
16.00		0	825	82	5	825	
17. 00 18. 00		0			0	0	
	Professional Liability Insurance Other Health Care Costs	155, 656		155, 65	4	155, 656	
20. 00		155, 656		155, 65	0	155, 656	20.00
21. 00	Subtotal (sum of lines 15 through 20)	155, 656	8, 160	163, 81	6 -1, 335	162, 481	
22. 00	,	634, 417	8, 160				
22.00	lines 10, 14, and 21)	034, 417	0, 100	042, 37	372,007	1,033,240	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00		0	0		0 0	0	23. 00
24. 00	Dental	0	O		0 0	0	24. 00
25. 00	Optometry	0	O		0 0	0	25. 00
25. 01	Tel eheal th	o	O		0 0	0	
25. 02	Chronic Care Management	o	O		0 0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0 0	0	26. 00
27. 00	Nonallowable GME costs						27. 00

209, 446

209, 446

843, 863

0

2, 246 251, 265

253, 511

896, 088

2, 246 41, 819

44, 065

52, 225

0 28.00

29.00

30.00

31.00

32.00

2, 836 265, 857

268, 693

1, 303, 939

590

14, 592

15, 182

407, 851

28.00 Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

through 27)
FACILITY OVERHEAD

29. 00 Facility Costs
30. 00 Administrative Costs

and 31)

31.00

32.00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Period: Worksheet M-1 From 01/01/2019
	Component CCN: 15-8539	To 12/31/2019 Date/Time Prepared: 8/26/2020 12:31 pm

			Component	JUN: 15-853	9 10	12/31/2019	8/26/2020 12:	
						RHC I	Cost	31 piii
		Adjustments	Net Expenses			1110 1	0031	
			for Allocation					
			(col. 5 + col.					
			6)					
		6.00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS			·				
1.00	Physi ci an	0	722, 135					1.00
2.00	Physician Assistant	o	0	•				2. 00
3.00	Nurse Practitioner	o	106, 765					3. 00
4.00	Visiting Nurse	o	0					4. 00
5.00	Other Nurse	o	43, 865					5. 00
6.00	Clinical Psychologist	o	0	i				6. 00
7.00	Clinical Social Worker	o	0					7. 00
8.00	Laboratory Techni ci an	o	0					8. 00
9.00	Other Facility Health Care Staff Costs	o	0					9. 00
10.00	Subtotal (sum of lines 1 through 9)	o	872, 765					10.00
11. 00	Physician Services Under Agreement	o	0					11.00
12. 00	Physician Supervision Under Agreement	o	0					12.00
13. 00	Other Costs Under Agreement	o	0					13.00
14.00	Subtotal (sum of lines 11 through 13)	o	0					14.00
15.00	Medical Supplies	o	6, 000					15. 00
16.00	Transportation (Health Care Staff)	o	825					16. 00
17.00	Depreciation-Medical Equipment	o	0					17. 00
18.00	Professional Liability Insurance	0	0					18. 00
19.00	Other Health Care Costs	0	155, 656					19. 00
20.00	Allowable GME Costs							20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	162, 481					21. 00
22. 00	Total Cost of Health Care Services (sum of	0	1, 035, 246					22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0					23. 00
24.00	Dental	0	0					24. 00
25. 00	Optometry	0	0					25. 00
25. 01	Tel eheal th	0	0					25. 01
25. 02	Chronic Care Management	0	0					25. 02
26.00	All other nonreimbursable costs	0	0					26. 00
27. 00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0					28. 00
	through 27)							
	FACILITY OVERHEAD							
	Facility Costs	0	2, 836					29. 00
30. 00	Administrative Costs	0	265, 857	1				30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	0	268, 693					31. 00
	30)							
32. 00	Total facility costs (sum of lines 22, 28	0	1, 303, 939					32. 00
	and 31)			I				

ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der Co		Peri od: From 01/01/2019	Worksheet M-2	
			Component (To 12/31/2019	Date/Time Prep 8/26/2020 12:	
		_			RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1. 00	Physi ci an	1. 80	l .				1. 00
2.00	Physici an Assistant	0. 00		_,			2.00
3.00	Nurse Practitioner	3. 32					3.00
4.00	Subtotal (sum of lines 1 through 3)	5. 12			14, 532	14, 532	4.00
5. 00	Visiting Nurse	0. 00				0	5.00
6.00	Clinical Psychologist	0.00	l e			0	6. 00
7. 00	Clinical Social Worker	0.00	l e			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l e			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0. 00	0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4 through 7)	5. 12	2, 622			14, 532	8. 00
9. 00	Physician Services Under Agreements		0			0	9. 00
	<u> </u>		-	I.		-	
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	D RHC/FQHC SER	VICES			
10. 00	0.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22)						10.00
11. 00	1.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						11. 00
12. 00	2.00 Cost of all services (excluding overhead) (sum of lines 10 and 11)						12.00
13. 00	, , ,						13.00
14. 00	· · · · · · · · · · · · · · · · · · ·						14.00
15. 00							
16. 00							
17. 00							17.00
18. 00	18.00 Enter the amount from line 16						18.00
19. 00	19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)						19.00
20 00	0.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)						20.00

Health Financial Systems RUSH MEMORIAL HOSPITAL CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC Provider CCN: 15-130/			Peri od:	In Lieu of Form CMS-2552 Worksheet M-3		
SERVICES			From 01/01/2019			
		Component CCN: 15-8539	To 12/31/2019	Date/Time Pre 8/26/2020 12:		
		Title XVIII	RHC I	Cost		
				1. 00		
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES					
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			2, 357, 560		
2. 00 3. 00	Cost of vaccines and their administration (from Wkst. M-4, lill Total allowable cost excluding vaccine (line 1 minus line 2)	ne 15)		0 2, 357, 560	2. 00 3. 00	
4. 00	, ,					
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, I	line 9)		0	5. 00	
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			14, 532 162. 23		
7.00	Adjusted cost per visit (iiie 3 divided by iiie 6)		Cal cul ati on		7.00	
			Prior to Jan. 1 (Rate Period	On or After		
			1)	Peri od 2)		
			1. 00	2. 00		
8.00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	.6 or your contractor)	0.00	0.00		
9. 00	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		162. 23	162. 23	9.00	
10. 00	Program covered visits excluding mental health services (from	contractor records)	0	0	10. 00	
11. 00					11. 00	
12.00	, , , , , , , , , , , , , , , , , , , ,				12.00	
13. 00 14. 00	i , , , , , , , , , , , , , , , , , , ,				13. 00 14. 00	
15. 00	Graduate Medical Education Pass Through Cost (see instructions			0	15. 00	
16. 00					16. 00	
16. 01					16. 01	
16. 02 16. 03					16. 02 16. 03	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0)	•		0		
	(Titles V and XIX see instructions.)			_		
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		0	0	16. 05 17. 00	
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0	18. 00	
	records)					
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		0	19. 00	
20. 00	Net Medicare cost excluding vaccines (see instructions)			0	20. 00	
21. 00					21.00	
22. 00 23. 00	Total reimbursable Program cost (line 20 plus line 21) Allowable bad debts (see instructions)			0	22. 00 23. 00	
23. 01	Adjusted reimbursable bad debts (see instructions)			0		
24. 00	,	ructions)		0		
25. 00 25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	->		0		
25. 50 25. 99	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration	5)		0		
26. 00	Net reimbursable amount (see instructions)			0		
26. 01	Sequestration adjustment (see instructions)			0		
26. 02	Demonstration payment adjustment amount after sequestration Interim payments			0		
28. 00	' '			0		
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0	02, 27, and 28)		0		
30.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-II	1	0	30.00	