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PART L - COST REPORT STATUS					372772013 12.3	
	ort			Date: 5/29/20	15 Time: 12:	51 pm
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3.[0]If this is an amended report 4.[F]Medicare Utilization. Enter "	enter the numb F" for full or	er of times the "L" for low.	e provider resu	bmitted this c	ost report	
use only (1) As Submitted 7. Contr	actor No. Initial Doport	for this Dravi	don CCN 12 [ 0	tractor's Vendo	or Code:	4 tor
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CERTIFICATION BY OFFICER OR ADMINI	STRATOR OF PROV	/I DER(S)				
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SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		HOSPI TAL Provi der (	CCN: 151304 F	Period:		Workshe		2552-1
			F	rom 01/01. o 12/31.		Part I Date/Ti		
			'			5/29/20	<u>)15 11:</u>	00 am
				Urban/Ru 1.00		<u>Date of</u> 2.(		-
00 Enter your standard geographic classification (not wa	age) stat	tus at the beg	inning of the		2	2.0	50	26.0
cost reporting period. Enter "1" for urban or "2" for 00 Enter your standard geographic classification (not wa	rural.	tuc at the and	of the cost		2			27.0
reporting period. Enter in column 1, "1" for urban or	r "2" for	r rural. If ap	plicable,		2			27.0
enter the effective date of the geographic reclassifi	cation i	n column 2.						
00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number	of periods SC	H status in		0			35.0
				Begi nni		Endi		
00 Enter applicable beginning and ending dates of SCH st	tatus Si	ubserint line	26 for number	1.00	)	2. (	00	36.0
of periods in excess of one and enter subsequent date		ubscript rifle						30.0
00 If this is a Medicare dependent hospital (MDH), enter	the num	mber of period	s MDH status		0			37.0
in effect in the cost reporting period. 00 Enter applicable beginning and ending dates of MDH st	atus. Su	ubscript line	38 for number					38.0
of periods in excess of one and enter subsequent date	es.	•		× (1)				
				Y/N 1.00	)	Y/ 2.0		-
00 Does this facility qualify for the inpatient hospital						N		39.0
hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req	·		2					
CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	or "N" f	for no. (see i	nstructions)					
00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob				N		N		40. (
no in column 2, for discharges on or after October 1.								
					V	XVIII	XIX	-
Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
00 Does this facility qualify and receive Capital paymen	nt for di	sproporti onat	e share in ac	cordance	N	N	N	45.0
with 42 CFR Section §412.320? (see instructions) 00 Is this facility eligible for additional payment exce	ention fo	or extraordina	rv circumstan	ces	N	N	N	46.
pursuant to 42 CFR §412.348(f)? If yes, complete Wkst								
Pt. III. 00 Is this a new hospital under 42 CFR §412.300 PPS capi	tal 2 Er	ator "V for vo	c or "N" for	20	N	N	N	47.
00 Is the facility electing full federal capital payment					N	N	N	48.
Teaching Hospitals				6	N	1	1	
00 Is this a hospital involved in training residents in or "N" for no.	approved	d GME programs	? Enter Y	ror yes	N			56.0
00 If line 56 is yes, is this the first cost reporting p								57.
GME programs trained at this facility? Enter "Y" for	r yes or							
is a did residents start training in the first mont	h of thi							
is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	(", compl	s cost report ete Worksheet	ing period?	Enter "Y"				
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<ul> <li>for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III &amp; IV and D-2, Pt. II</li> <li>OI If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wk</li> <li>OA re costs claimed on line 100 of Worksheet A? If yes</li> <li>OA re you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"</li> <li>OI Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)</li> <li>OI Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)</li> <li>O2 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)</li> <li>O3 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)</li> <li>O4 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).</li> <li>O5 Enter the difference between the baseline primary</li> </ul>	(", compl , if app pursement (st. D-5. s, comple costs for for yes Y/N 1.00	s cost report ete Worksheet olicable. t for physicia ete Wkst. D-2, or a program t or "N" for no IME 2.00 0.00 0.00	ing period? E-4. If colu ns' services Pt. I. hat meets the (see instru Direct GME 3.00 0.0 0.0	Enter "Y" mn 2 is as ctions) IME 4.00	N N		00	59. 60. 61. 61. 61. 61.
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ealth Financial Systems HOSPITAL AND HOSPITAL HEA	ALTH CARE COMPI		TA Provi der	FI To	eriod: rom 01/01/2014 o 12/31/2014	5/29/2015 11:	pared:
			Program Name	Program Code		Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
specialty, if any, for each new progr column 1, the prog program code, ente unweighted count a FTE unweighted count of the FTEs in lin program specialty, residents for each instructions) Ente enter in column 2,	and the numbe am. (see instr ram name, ente r in column 3, nd enter in co nt. e 61.05, speci if any, and t expanded prog r in column 1, the program c eighted count	r in column 2, the the IME FTE lumn 4, direct GME fy each expanded he number of FTE ram. (see the program name, ode, enter in column and enter in column			0.00		61. 10
						1.00	-
ACA Provisions Aff	ecting the Hea	Ith Resources and Ser	vices Administration	(HRSA)		1.00	
		s that your hospital			od for which	0.00	62.00
		funding (see instructs that rotated from a					(2.0)
during in this cos	t reporting pe	s that rotated from a <u>riod of HRSA THC proc</u> sidents in Nonprovide	pram. (see instruction		your nospitai	0.00	62.0 <sup>°</sup>
3.00 Has your facility	trained reside	nts in nonprovider se umn 1. If yes, comple	ettings during this c	instructions)		N	63.0
				Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der Si te	Hospi tal	2))	
				1.00	2.00	3.00	
		r FTE Residents in No uly 1, 2009 and befor		This base year	is your cost r	eporting	
04.00 Enter in column 1, in the base year p resident FTEs attr settings. Enter i resident FTEs that	if line 63 is eriod, the num ibutable to ro n column 2 the trained in yo	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir 1 + column 2)). (see	y trained residents -primary care all nonprovider i non-primary care n column 3 the ratio instructions)	0. OC			
		Program Name	Program Code	Unweighted FTEs Nonprovider Site		Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00 0.000000	
55.00 Enter in column 1, is yes, or your fa trained residents year period, the p associated with pr FTEs for each prim program in which y residents. Enter i the program code, column 3, the numb unweighted primary residents attribut rotations occurrin non-provider setti column 4, the numb unweighted primary resident FTEs that your hospital. Ent 5, the ratio of (c divided by (column	cility in the base rogram name imary care ary care ou trained n column 2, enter in er of care FTE able to g in all ngs. Enter in er of care trained in er in column olumn 3			0. 00	0.00		

Heal th	Financial Systems	RUSH M	MEMORIAL HOS	SPI TAL		I	n Lieu	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA	Provi der		Period: From 01/01, To 12/31,		Workshe Part I Date/Ti 5/29/20	me Pre	pared:
					Unweighted FTEs Nonprovider Site 1.00	Unwei gh FTEs i Hospi t 2.00	n al	Ratio (c (col. 1 2)) 3.0	:ol. 1/ + col. )	
	Section 5504 of the ACA Current		n Nonprovide	er Setting						
66.00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider sett ry care resi 3 the ratio	ings. dent	0. 0	00	0. 00	0.	000000	66.00
		Program Name	Program	1 Code	Unweighted FTEs Nonprovider Site	Unwei gh FTEs i Hospi t	n	Ratio (c (col. 3 4))	+ col.	
		1.00	2. (	00	3.00	4.00		5.0		
67.00	Enter in column 1, the program 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)				0.0		0.00	0.	000000	67.00
							1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility P			- :		an an an a' a' an a'				70.00
	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th						N		0	70.00 71.00
	recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, ente reporting period covers the begi or subsequent academic years of instructions) For cost reporting reporting period covers the begi teaching program in existence, e Inpatient Rehabilitation Facilit Is this facility an Inpatient Re subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th	lumn 2: Did this faci R 412.424 (d)(1)(iii) r 1, 2, or 3, in colu nning of the fourth y the new teaching prog periods beginning or nning of the sixth or nter 6 in column 3. ( y PPS habilitation Facility and "N" for no.	lity train (D)? Enter Jmn 3. (see year, enter gram in exis n or after C any subsec (see instruct (IRF), or	residents "Y" for ye instructio 4 in colur tence, en ictober 1, uuent acade tions) does it co	in a new tead es or "N" for ons) If this on n 3, or if th ter 5. (see 2012, if this emic year of t	ching no. cost he fifth s cost che new	N		0	75. 00 76. 00
	recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente 1, 2, or 3, in column 3. (see in of the fourth year, enter 4 in c teaching program in existence, e on or after October 1, 2012, if any subsequent academic year of instructions)	train residents in a r "Y" for yes or "N" structions) If this c olumn 3, or if the fi nter 5. (see instruct this cost reporting p	new teachir for no. Col cost reporti fth or subs tions) For c period cover	g program umn 3: If ng period equent aca ost report s the begi	in accordance column 2 is N covers the be ademic years of ting periods b nning of the	e with 42 (, enter eginning of the new beginning sixth or				
								1.0	0	
	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no.					g period? E	nter	N		80. 00 81. 00
	TEFRA Providers Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider (	excluded un				no.	N		85. 00 86. 00

Health Financial Systems RUSH MEMORIA	L HOSPI TAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		Period: From 01/01/2014	Worksheet S-2 Part I	2
			To 12/31/2014		
			V	XI X	
Title V and XIX Services			1.00	2.00	
90.00 Does this facility have title V and/or XIX inpatient hospita yes or "N" for no in the applicable column.			N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app	licable column.		N	N	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the application	able column.			N	92.00
93.00 Does this facility operate an ICF/MR facility for purposes ("Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.			N	N	94.00
<ul> <li>95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yest applicable column.</li> </ul>			0. 00 N	0.00 N	95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	plicable colum	n.	0.00	0.00	97.00
105.00 Does this hospital qualify as a Critical Access Hospital (C. 106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		nod of paymen	Y N		105.00 106.00
107.00 Column 1: If this facility qualifies as a CAH, is it eligit for I &R training programs? Enter "Y" for yes or "N" for m			Ν		107.00
instructions) If yes, the GME elimination would not be on W the program would be cost reimbursed. If yes complete Wkst.	kst. B, Pt. I,	col. 25 and			
this facility is a CAH, do I&Rs in an approved medical educ: CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or instructions)			e		
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee schee	dule? See 42	N		108.00
	Physi cal	Occupational		Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 Y	3.00 Y	4.00 N	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (4	10A Demo)for	1.00 N	110.00
			1.0	0 2.00 3.00	_
Miscellaneous Cost Reporting Information					115 00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider but 15 1 \$2200 1	. If column 2 i nt for long te	is "E", enter rm care (inclu	in column udes	0	115.00
Pub. 15-1, §2208. 1. 116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu			"N" for Y		116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i	f the policy	is 1		118.00
		Premiums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00 211,62	2.00	3.00	)118.01
		21170.	1.00	2.00	-
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scher			N	2.00	118. 02
and amounts contained therein. 119.00/D0 NOT USE THIS LINE		Jat Centera			119.00
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold			Ν	N	120.00
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment	ualifies for th	ne Outpatient			
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.			Y		121. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or yes and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en					126.00
in column 1 and termination date, if applicable, in column 1 127.00 If this is a Medicare certified heart transplant center, en	2.				127.00
in column 1 and termination date, if applicable, in column :					

SPITAL AND HUSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der	CCN: 151304		1/01/2014 2/31/2014		epared:
					1.00	2.00	-
8.00 If this is a Medicare certified li			ication date				128.0
in column 1 and termination date, 9.00 f this is a Medicare certified Lu			cation data	in			129.0
column 1 and termination date, if			cation date	111			129.0
0.00 If this is a Medicare certified pa	ancreas transplant cer	nter, enter the cer	ti fi cati on				130. 0
date in column 1 and termination of 1.00 of this is a Medicare certified in			ertification				131. 0
date in column 1 and termination of			ertification				131.0
2.00 If this is a Medicare certified is	slet transplant center	r, enter the certif	ication date				132. 0
in column 1 and termination date, 3.00 f this is a Medicare certified o			ication date				133. 0
in column 1 and termination date,							155.0
4.00 If this is an organ procurement or		ter the OPO number	in column 1				134. 0
and termination date, if applicabl All Providers	e, in column 2.						1
0.00 Are there any related organization	n or home office costs	s as defined in CMS	Pub. 15-1,		N		140. 0
chapter 10? Enter "Y" for yes or '				s			
are claimed, enter in column 2 the 1.00	<u>e home office chain nu</u>	umber. (see instruc 2.00	tions)		3.00		
If this facility is part of a chai	in organization, ente		ugh 143 the	name and		of the	
home office and enter the home of							-
1.00Name: 2.00Street:	Contractor's Nar PO Box:	ne:	Contrac	tor's Nu	mper:		141.0
3. 00 Ci ty:	State:		Zip Cod	e:			143.0
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4.00 Are provider based physicians' cos	sts included in Worksh	neet A?				1.00 Y	144. (
5.00 If costs for renal services are cl	aimed on Worksheet A,		costs for in	pati ent	servi ces	N	145. (
only? Enter "Y" for yes or "N" for	<sup>-</sup> no.						-
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<ul> <li>6. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7. 00 Was there a change in the statisti 8. 00 Was there a change in the order of 9. 00 Was there a change to the simplifin no.</li> <li>Does this facility contain a proviour charges? Enter "Y" for yes or "5. 00 Hospital</li> <li>6. 00 Subprovider - IPF 7. 00 Subprovider - IPF 7. 00 Subprovider - IRF 8. 00 SUBPROVIDER 9. 00 SNF 0. 00 HOME HEALTH AGENCY 1. 00 CMHC</li> <li>Multicampus</li> <li>5. 00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.</li> <li>6. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)</li> </ul>	gy changed from the pro- column 1. (See CMS F column 2. cal basis? Enter "Y" f allocation? Enter "Y ed cost finding metho ider that qualifies for "N" for no for each co "N" for no for each co ampus hospital that ha <u>Name</u> 0	Pub. 15-2, § 4020) for yes or "N" for (" for yes or "N" f pod? Enter "Y" for y Part A 1.00 or an exemption fro omponent for Part A N N N N N as one or more camp <u>County</u> 1.00	If yes, enterno. no. or no. es or "N" for Part B 2.00 m the applic and Part B. N N N N N N N N N N N N N	er T cation of (See 42 Cerent CE Cerent CE 3.00	N N N 3.00 F the Iowe 2 CFR §413 N N N N N N SAS?	Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N FTE/Campus 5.00	147. ( 148. ( 149. ( 155. ( 156. ( 157. ( 158. ( 157. ( 160. ( 161. ( 165. ( 165. ( 165. (
<ul> <li>6. 00 Has the cost allocation methodol og Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7. 00 Was there a change in the statisti 8. 00 Was there a change in the order of 9. 00 Was there a change to the simplifino.</li> <li>Does this facility contain a provior charges? Enter "Y" for yes or "5. 00 Hospital</li> <li>6. 00 Subprovider - IPF</li> <li>7. 00 Subprovider - IPF</li> <li>7. 00 Subprovider - IRF</li> <li>8. 00 SUBPROVIDER</li> <li>9. 00 SNF</li> <li>0. 00 HOME HEALTH AGENCY</li> <li>1. 00 CMHC</li> <li>Multicampus</li> <li>5. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in</li> </ul>	gy changed from the pr n column 1. (See CMS F column 2. cal basis? Enter "Y" f allocation? Enter "N ed cost finding metho ider that qualifies fo 'N" for no for each co 'N" for no for each co ampus hospital that ha <u>Name</u> 0 T) incentive in the Ar	Pub. 15-2, § 4020) for yes or "N" for (" for yes or "N" for y Part A 1.00 or an exemption from ponent for Part A N N N N N N N N N N N N N	If yes, enterno. no. or no. es or "N" for Part B 2.00 m the applic and Part B. N N N N N N N N N N N N N	ent Act	N N N 3.00 F the Iowe 2 CFR §413 N N N N N N SAS?	Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. ( 148. ( 149. ( 155. ( 156. ( 157. ( 158. ( 157. ( 158. ( 160. ( 161. ( 161. ( 165. ( 165. ( 165. (
<ul> <li>6. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in 7. 00 Was there a change in the statisti 8. 00 Was there a change in the order of 9. 00 Was there a change to the simplifin no.</li> <li>Does this facility contain a proviour charges? Enter "Y" for yes or " 5. 00 Hospital</li> <li>6. 00 Subprovider - IPF 7. 00 Subprovider - IPF 7. 00 SubPROVIDER</li> <li>9. 00 SNF</li> <li>0. 00 HOME HEALTH AGENCY</li> <li>1. 00 CMHC</li> <li>Multicampus</li> <li>5. 00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.</li> <li>6. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)</li> <li>Heal th Information Technology (HI</li> </ul>	gy changed from the pro- n column 1. (See CMS F column 2. cal basis? Enter "Y" f allocation? Enter "Y ed cost finding methe ider that qualifies for "N" for no for each co "N" for no for each co	Pub. 15-2, § 4020) for yes or "N" for (" for yes or "N" f pod? Enter "Y" for y Part A 1.00 or an exemption from pomponent for Part A N N N N N N N N N N N N N	If yes, enterno. no. or no. es or "N" for Part B 2.00 m the applic and Part B. N N N N N N N N N N N N N	ent Act for no.	N N N N SSAS? CBSA 4.00	Ti tl e XI X 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. ( 148. ( 149. ( 155. ( 155. ( 157. ( 157. ( 157. ( 157. ( 157. ( 157. ( 157. ( 157. ( 157. ( 156. ( 157. ( 160. ( 161. ( 161. ( 165. ( 165. ( 165. ( 165. ( 165. ( 166. (

Health Financial Systems	RUSH MEMORIAL HOS	SPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	FICATION DATA	Provider CCN: 151304	Period: From 01/01/2014	Worksheet S-2 Part I	2
					epared: 00 am
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	date and ending date	for the reporting	10/01/2012	09/30/2013	170.00
				1.00	
171.00 If line 167 is "Y", does this provider hav Medicare cost plans reported on Wkst. S-3, (see instructions)				N	171.00

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE Provi der		Period: From 01/01/2014 To 12/31/2014		
					5/29/2015 11:	: 00 ar
				Y/N 1.00	Date 2.00	+
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL MOSPITALS	ponses. Enter N for all NO re	esponses. Enter			
00	Provider Organization and Operation Has the provider changed ownership immediatel	y prior to the beginning of	the cost	N		1.
0	reporting period? If yes, enter the date of t					'.
			Y/N	Date	V/I	
0	Has the provider terminated participation in	the Medicare Dreaman? If	1.00 N	2.00	3.00	
00	yes, enter in column 2 the date of terminatic voluntary or "1" for involuntary.		N			2
00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or f relationships? (see instructions)	, chain home offices, drug d to the provider or its , or members of the board	N			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr	Audited, "C" for Compiled, enter date available in	Y	A		4.
0	Are the cost report total expenses and total	revenues different from	N			5
	those on the filed financial statements? If y	yes, submit reconciliation.		V /N	Lagal Open	
				Y/N 1.00	Legal Oper. 2.00	-
	Approved Educational Activities				2100	
0	Column 1: Are costs claimed for nursing scho the legal operator of the program?	<u> </u>	he provider is	N		6
0	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog cost reporting period? If yes, see instruction	grams approved and/or renewe	d during the	N N		8
0	Are costs claimed for Intern-Resident program	ns claimed on the current co	st report? If	N		9
00	yes, see instructions. Was an Intern-Resident program been initiated	d or renewed in the current	cost reporting	Ν		10.
00	period? If yes, see instructions. Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		proved	Ν		11.
	Treaching Frogram on worksheet A: IT yes, see				Y/N	
					1.00	
~~	Bad Debts		+!		N N	1 1 2
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad det period? If yes, submit copy.			st reporting	Y N	12
	If line 12 is yes, were patient deductibles a Bed Complement				N	14.
00	Did total beds available change from the pric	or cost reporting period? If	- <u>r</u>	r <u>uctions.</u> rt A	N Part B	15.
		Description	Y/N	Date	Y/N	
		0	1.00	2.00	3.00	
00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes,		Y	03/06/2015	Y	16
	Report used in columns 2 and 4 . (see instructions)					
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is		N		N	17.
00	yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional		Ν		N	18.
	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		N		N	19
00	made to PS&R Report data for corrections of					
00	other PS&R Report information? If yes, see instructions. If line 16 or 17 is yes, were adjustments		N		N	20

Heal th	Financial Systems	RUSH MEMORIA	AL HOSPI TAL		In Lie	u of Form CMS-	2552-10
				F	Period: From 01/01/2014	Worksheet S-2 Part II	
					0 12/31/2014		
				Par	rt A	Part B	
				Y/N	Date	Y/N	
	To         12/31/2014         Deter/Time Prepare by/29/2015 11:00           Part A provider's proords?         Part A part B         Part A part B           Iss the cost report prepared only using the provider's proords?         0         1.00         2.00         3.00         7           Iss the cost report prepared only using the provider's proords?         N         N         2         3.00         7           COMPLETED BY COST RELMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)         1.00         2.00         N         2           Capital Related Cost         N         2         1.00         2.00         N         2           Have assets been relifed for Medicare purposes? If yes, see instructions         N         2         2         N         2           Have assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N         2         2         1.00         2           Interest Expense         N         2         2         1.01         N         2           Ware lease for the requirements of second and/or bond funds (Debt Service Reserve Fund)         N         2         2           Intervetions         See instructions         N         2         2         1.00         2           Intervetions         See instructions </td <td></td>						
21.00	provider's records? If yes, see			N		N	21.00
						1.00	
		TALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)			-
22.00			, instructions			N	22.00
				sals made durir	a the cost		22.00
23.00		ation expense	uue to apprais		ig the cost	IN	23.00
24.00	Were new leases and/or amendments to existing	g leases entere	ed into during	this cost repo	orting period?	Ν	24.00
25.00		ed into during	the cost repor	rting period? I	fyes, see	Ν	25.00
26.00	, , , , , , , , , , , , , , , , , , ,	uired during th	ne cost reporti	ng period? If	yes, see	Ν	26.00
27.00		nged during the	e cost reportir	ng period?lfy	ves, submit	Ν	27.00
28.00		rs of credit er	ntered into dur	ing the cost r	reporting	N	28.00
29.00	Did the provider have a funded depreciation a	account and/or	bond funds (De	ebt Service Res	erve Fund)	Y	29.00
30.00				deht? If ves	SAA	N	30.00
00.00	5 1 1			debt. 11 yes,	300		00.00
31.00		rity without is	ssuance of new	debt? If yes,	see	Ν	31.00
	Purchased Services						
32.00				ed through cont	ractual	Ν	32.00
							0.0.00
33.00		sec. 2135.2 ap	biled pertainir	ig to competiti	ve blaaing? IT	IN	33.00
34.00		ty under an a	rangement with	n provider-base	d physicians?	Y	34.00
		5	5		1 5		
35.00				nts with the pr	ovi der-based	N	35.00
-	physicians during the cost reporting period?	lfyes, see in	nstructions.				
	Home Office Costs				1.00	2.00	
		eport?			N		36.00
	If line 36 is yes, has a home office cost sta	•	repared by the	home office?			37.00
38.00	If line 36 is yes , was the fiscal year end o				N		38.00
39.00	If line 36 is yes, did the provider render se				N		39.00
40.00	If line 36 is yes, did the provider render se	ervices to the	home office?	lfyes, see	N		40.00
			1.	00	2.	00	
		,					44.00
41.00	Enter the first name, last name and the title held by the cost report preparer in columns		MI CHAEL		ALESSANDRI NI		41.00
	respectively.	i, z, ailu s,					
42.00	Enter the employer/company name of the cost i	report	BLUE & CO., LL	_C			42.00
	preparer.	•					
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv		317-633-4705		MALESSANDRI NI @I	BLUEANDCO. COM	43.00

	Financial Systems	RUSH MEMORIAL			In Lieu	u of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 151304	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Pre 5/29/2015 11:	epared:
		Part B					
		Date					
		4.00					
	PS&R Data	00/0//0015					1 4 / 00
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)	03/06/2015					16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)						17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.						18.00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.						19.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:						20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.						21.00
		_	3. (	00			
	Cost Report Preparer Contact Information		5.1	00			
	Enter the first name, last name and the title held by the cost report preparer in columns ' respectively.		DNSULTANT				41.00
42.00	Enter the employer/company name of the cost r	report					42.00
43.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						43.00

IOSPI 1	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	RUSH MEMORIA			CCN: 151304	Pe	eri od:	u of Form C Worksheet		
							rom 01/01/2014	Part I Date/Time 5/29/2015	Pre	pared
								I/P Days /		
	Component	Worksheet A	No	of Beds	Bed Davs		CAH Hours	<u>Visits / Tr</u> Title V	ips	
	Component	Line Number	NO.	OI beus	Avai I abl e		CAR HOULS	ntie v		
		1.00		2.00	3.00		4.00	5.00		
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		25		25	31, 848. 00		0	1.
	8 exclude Swing Bed, Observation Bed and									
	Hospice days)(see instructions for col. 2									
	for the portion of LDP room available beds)									
. 00	HMO and other (see instructions)									2.
. 00	HMO I PF Subprovi der									3.
00	HMO I RF Subprovi der									4.
00	Hospital Adults & Peds. Swing Bed SNF								0	5.
00	Hospital Adults & Peds. Swing Bed NF			0.5		~ -	04 040 00		0	6.
00	Total Adults and Peds. (exclude observation			25	9, 1	25	31, 848. 00		0	7.
00	beds) (see instructions) INTENSIVE CARE UNIT									8.
00	CORONARY CARE UNIT									9.
0.00	BURN INTENSIVE CARE UNIT									10
. 00	SURGI CAL INTENSI VE CARE UNI T									11
2.00	OTHER SPECIAL CARE (SPECIFY)									12
3.00	NURSERY									13.
. 00	Total (see instructions)			25	9, 1	25	31, 848. 00		0	14
. 00	CAH visits			20	, , , ,	20	51, 040. 00		0	15
. 00	SUBPROVIDER - IPF								0	16
. 00	SUBPROVI DER – I RF									17
. 00	SUBPROVI DER									18
. 00	SKILLED NURSING FACILITY									19
. 00	NURSING FACILITY									20
. 00	OTHER LONG TERM CARE									21
. 00	HOME HEALTH AGENCY									22
. 00	AMBULATORY SURGICAL CENTER (D. P.)									23
. 00	HOSPICE									24
. 10	HOSPICE (non-distinct part)	30.00								24
. 00	CMHC - CMHC									25
. 00	RURAL HEALTH CLINIC									26
. 25	FEDERALLY QUALIFIED HEALTH CENTER									26
. 00	Total (sum of lines 14-26)			25						27
. 00	Observation Bed Days								0	28
. 00	Ambul ance Trips									29
. 00	Employee discount days (see instruction)									30
. 00	Employee discount days - IRF									31
2.00	Labor & delivery days (see instructions)			C		0				32
2. 01	Total ancillary labor & delivery room									32.
	outpatient days (see instructions)									
. 00	LTCH non-covered days				1					33

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provi der		Period: From 01/ To 12/	′01/2014 ′31/2014		epared:
		I/P Days	/ O/P Visits	/ Trips	Ful	I Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients		Interns idents	Employees On Payroll	
		6.00	7.00	8.00		00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	772	113		7			1.00
2.00	HMO and other (see instructions)	18	2					2.00
3.00	HMO IPF Subprovider	0	0					3.00
4.00	HMO IRF Subprovider	0	0					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	356	0	37	8			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	33	8			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 128	113	2, 04	.3			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 14.00	NURSERY	1 1 2 0	113	2.04	2	0.00	274.90	13.00
14.00	Total (see instructions) CAH visits	1, 128 0	0		0	0.00	274.90	15.00
16.00	SUBPROVIDER - IPF	0	0		0			16.00
17.00	SUBPROVIDER - IRF							17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY							22.00
23.00	AMBULATORY SURGICAL CENTER (D. P. )							23.00
24.00	HOSPICE							24.00
24.10	HOSPICE (non-distinct part)	o	0		0			24.10
25.00	CMHC - CMHC	-			-			25.00
26.00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26.25
27.00	Total (sum of lines 14-26)					0.00	274.90	27.00
28.00	Observation Bed Days		0	26	7			28.00
29.00	Ambul ance Trips	491						29.00
30.00	Employee discount days (see instruction)				0			30.00
31.00	Employee discount days - IRF				0			31.00
32.00	Labor & delivery days (see instructions)	0	0		0			32.00
32.01	Total ancillary labor & delivery room				0			32.01
	outpatient days (see instructions)							
33 00	LTCH non-covered days	0			1			33.00

HOSPI -	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provi der	CCN: 151304	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part I Date/Time Prep 5/29/2015 11:0	
		Full Time Equivalents		Di s	charges		
	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) HMO and other (see instructions)		0	2	6 1	412	1. 00 2. 00
3.00 4.00 5.00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF						3.00 4.00 5.00
6.00 7.00 8.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT						6.00 7.00 8.00
9.00 10.00 11.00 12.00	OTHER SPECIAL CARE (SPECIFY)						9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0. 00	0	2	35 24	412	13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00
23. 00 24. 00 24. 10 25. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction)	0. 00					23.00 24.00 25.00 26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.00

Heal th	Financial Systems	RUSH MEMORIAL HOS	PI TAL		In Li€	eu of Form CM	S-2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider C	CN: 151304	Peri od:	Worksheet S	
					From 01/01/2014		
					To 12/31/2014	Date/Time F 5/29/2015 1	
						572972015 1	1.00 all
						1.00	
	Uncompensated and indigent care cost compute	ation					
1.00	Cost to charge ratio (Worksheet C, Part I I		ded by line	e 202 columr	18)	0. 4270	84 1.00
	Medicaid (see instructions for each line)				· ·		
2.00	Net revenue from Medicaid					706, 7	68 2.00
3.00	Did you receive DSH or supplemental payments	s from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all			rom Medicaio	1?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supple	mental payments from	Medi cai d				0 5.00
6.00	Medicaid charges					3, 313, 9	
7.00	Medicaid cost (line 1 times line 6)					1, 415, 3	
8.00	Difference between net revenue and costs for	r Medicaid program (I	ine 7 minus	s sum of lir	nes 2 and 5; if	708, 5	69 8.00
	< zero then enter zero)		6				_
	State Children's Health Insurance Program (S	SCHIP) (see instructi	ons for eac	ch line)		1	
9.00	Net revenue from stand-alone SCHIP						0 9.00
10.00	5						0 10.00
11.00			(1)		: c +b		0 11.00
12.00	Difference between net revenue and costs for enter zero)	r stand-alone SCHIP (	line ii mir	nus Tine 9;	IT < Zero then		0 12.00
	Other state or local government indigent car	re program (see instr	suctions for	c each line)			_
13.00	Net revenue from state or local indigent cal						0 13.00
14.00	Charges for patients covered under state or						0 14.00
11.00	10)	rocar margent care					
15.00	State or local indigent care program cost (	line 1 times line 14)	1				0 15.00
16.00	Difference between net revenue and costs for			orogram (lir	ne 15 minus line		0 16.00
	13; if < zero then enter zero)		5	5 (			
	Uncompensated care (see instructions for eac	ch line)					
17.00		ome restricted to fun	nding charit	ty care			0 17.00
18.00	Government grants, appropriations or transfe					75, 8	
19.00	Total unreimbursed cost for Medicaid , SCHI	P and state and local	indigent o	care program	ns (sum of lines	708, 5	69 19.00
	8, 12 and 16)						_
				Uni nsured	Insured	Total (col.	1
			-	patients 1.00	patients 2.00	+ col. 2) 3.00	
20.00	Total initial obligation of patients approve	ed for charity care (	at full	636, 64			47 20.00
20.00	charges excluding non-reimbursable cost cen			030, 02	+/	030,0	47 20.00
21.00	Cost of initial obligation of patients appro			271, 90	02 0	271, 9	02 21.00
	times line 20)			,	-	, .	
22.00	Partial payment by patients approved for cha	arity care			0 0		0 22.00
23.00	Cost of charity care (line 21 minus line 22)	)		271, 90	02 0	271, 9	02 23.00
						1.00	
24.00	Does the amount in line 20 column 2 include			d a length o	of stay limit	N	24.00
	imposed on patients covered by Medicaid or (						
25.00				gram's lengt	h of stay limit		0 25.00
26.00		•				3, 561, 3	
27.00	Medicare bad debts for the entire hospital					348, 1	
28.00	Non-Medicare and non-reimbursable Medicare I				>	3, 213, 2	
29.00	Cost of non-Medicare and non-reimbursable M	•	ense (line '	1 times line	28)	1, 372, 3	
30.00	Cost of uncompensated care (line 23 column					1, 644, 2	
31.00	Total unreimbursed and uncompensated care co	ost (line 19 plus lin	ne 30)			2, 352, 7	89 31.00

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C				Period:	Worksheet A	
				rom 01/01/2014		
				Го 12/31/2014	Date/Time Pre 5/29/2015 11:	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
			+ col. 2)	ons (See A-6)		
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS	I I	1 000 110	1 000 11		1 000 110	1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	277 220	1, 932, 119				1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL	277, 320 2, 039, 055	2, 841, 925 2, 459, 275			3, 119, 252 4, 544, 292	4.00 5.00
7.00 00700 OPERATION OF PLANT	2, 039, 055	2, 459, 275 567, 334			4, 544, 292	5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE	228, 740	507, 554 0	/ ///			8.00
9. 00 00900 HOUSEKEEPI NG	244, 223	148, 333				9.00
10. 00 01000 DI ETARY	314, 923	239, 791	554, 714		138, 618	10.00
11. 00 01100 CAFETERIA	0	207777	(			
13. 00 01300 NURSI NG ADMI NI STRATI ON	95, 038	3, 019	98, 05		52, 095	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	48, 314	157, 564	205, 878		100, 088	14.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	303, 325	113, 030	416, 35	5 0	416, 355	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	755, 775	73, 052	828, 82	-4, 894	823, 933	30.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	585, 485	423, 517				
51.00 05100 RECOVERY ROOM	0	3, 869			38, 396	
53. 00 05300 ANESTHESI OLOGY	0	054 520	1 004 70	-	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	850, 189	954, 539	1, 804, 728	3 -1, 629	1, 803, 099	
55. 00 05500 RADI OLOGY-THERAPEUTI C 60. 00 06000 LABORATORY	607, 605	767, 280	1, 374, 88	5 -36	1, 374, 849	55.00 60.00
65. 00 06500 RESPI RATORY THERAPY	92, 671	6, 155			98, 821	65.00
66. 00 06600 PHYSI CAL THERAPY	231,074	86, 511	317, 58			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	170, 472	10, 898			181, 370	
68. 00 06800 SPEECH PATHOLOGY	21, 540	6,009			27, 549	
69. 00 06900 ELECTROCARDI OLOGY	170, 407	3,039				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(	0 0	0	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	14, 070	14, 070	137, 873	151, 943	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	101, 775	101, 77	5 0	101, 775	
73.00 07300 DRUGS CHARGED TO PATIENTS	408, 039	2, 369, 914	2, 777, 953	-460	2, 777, 493	73.00
OUTPATIENT SERVICE COST CENTERS	· · ·			-		
90. 00 09000 CLINIC	3, 796, 967	932, 421	4, 729, 388		4, 721, 401	90.00
91.00 09100 EMERGENCY	773, 310	1, 032, 489	1, 805, 799	-10, 920	1, 794, 879	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
	<b>F77</b> 007	(7.005	(45.01)	L E 707	(20.405	
95. 00 09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	577, 387	67, 825	645, 212	2 -5, 727	639, 485	95.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	12, 591, 859	15, 315, 753	27, 907, 612	2 201	27, 907, 813	118 00
NONREI MBURSABLE COST CENTERS	12, 371, 037	13, 313, 733	27, 707, 012	201	27, 707, 013	110.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	5		5 0	5	192.00
193. 00 19300 NONPAI D WORKERS	0	0				193.00
193. 01 19301 FOUNDATI ON	57, 210	365	57, 57		57, 575	
193. 02 19302 OCCUPATI ONAL MEDI CI NE	26, 286	1, 954	28, 240	0 0	28, 240	193. 02
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	(	-		194.00
200.00   TOTAL (SUM OF LINES 118-199)	12, 675, 355	15, 318, 077	27, 993, 432	2 0	27, 993, 432	200. 00

Health Fi	nancial Systems	RUSH MEMORIA	L HOSPI TAL		In Lieu of	f Form CMS-2552-10
	FICATION AND ADJUSTMENTS OF TRIAL BALANCE OF			- CCN: 151304		rksheet A
RECERCONT		ENTENDED	11001 dei		From 01/01/2014	
					To 12/31/2014 Da	te/Time Prepared:
	Cost Center Description	Adjustments	Net Expenses		5/	29/2015 11:00 am
	cost center bescription		For Allocatio			
		6.00	7.00			
GE	NERAL SERVICE COST CENTERS	0.00	7.00	_		
	100 NEW CAP REL COSTS-BLDG & FIXT	-153, 135	1, 778, 98	4		1.00
	400 EMPLOYEE BENEFITS DEPARTMENT	-1, 299				4.00
	500 ADMINI STRATI VE & GENERAL	-1, 702, 770				5.00
	700 OPERATI ON OF PLANT	-287	797, 36			7.00
	800 LAUNDRY & LINEN SERVICE	-207	56, 78			8.00
	1900 HOUSEKEEPING	-140				9.00
	000 DI ETARY	-2, 387	136, 23			10.00
	100 CAFETERI A	-97, 616				11.00
	300 NURSI NG ADMI NI STRATI ON	-246				13.00
	400 CENTRAL SERVICES & SUPPLY	-632				14.00
	600 MEDI CAL RECORDS & LI BRARY	-5, 903	410, 45	2		16.00
	PATIENT ROUTINE SERVICE COST CENTERS			-		
	000 ADULTS & PEDIATRICS	-1, 701	822, 23	2		30.00
	CILLARY SERVICE COST CENTERS					
	OOO OPERATING ROOM	-431, 906				50.00
	100 RECOVERY ROOM	0	38, 39			51.00
	300 ANESTHESI OLOGY	0		0		53.00
	400 RADI OLOGY-DI AGNOSTI C	-586, 693		1		54.00
	500 RADI OLOGY-THERAPEUTI C	0		0		55.00
	000 LABORATORY	-460	1, 374, 38	9		60.00
65.00 06	500 RESPI RATORY THERAPY	-2, 160	96, 66	1		65.00
66.00 06	600 PHYSI CAL THERAPY	-10, 094	307, 32	3		66.00
67.00 06	700 OCCUPATI ONAL THERAPY	0	181, 37	0		67.00
68.00 06	800 SPEECH PATHOLOGY	-61	27, 48	8		68.00
69.00 06	900 ELECTROCARDI OLOGY	-28	173, 28	9		69.00
70.00 07	000 ELECTROENCEPHALOGRAPHY	0		o		70.00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-444	151, 49	9		71.00
72.00 07	200 IMPL. DEV. CHARGED TO PATIENT	0	101, 77			72.00
	300 DRUGS CHARGED TO PATIENTS	-4, 334				73.00
	TPATIENT SERVICE COST CENTERS	.,	_,,.	-		
		-2, 672, 748	2,048,65	3		90, 00
	100 EMERGENCY	-301	1, 794, 57			91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	001	1,771,07			92.00
	HER REIMBURSABLE COST CENTERS		I			72.00
	500 AMBULANCE SERVICES	0	639, 48	5		95.00
	ECIAL PURPOSE COST CENTERS		007,10	0		
118.00	SUBTOTALS (SUM OF LINES 1-117)	-5, 675, 345	22, 232, 46	8		118.00
	NREIMBURSABLE COST CENTERS	0/0/0/0/0	22,202,10	<u> </u>		
192.0019	200 PHYSI CLANS' PRI VATE OFFI CES	0		5		192.00
	300 NONPAI D WORKERS	0				193.00
	301 FOUNDATI ON	0				193.01
	302 OCCUPATI ONAL MEDI CI NE	0	28, 24			193.02
	950 OTHER NONREIMBURSABLE COST CENTERS	0		o		194.00
200.00	TOTAL (SUM OF LINES 118-199)	-5, 675, 345				200.00
			, , , , , , , , , , , , , , , , , , , ,	1		1==== 30

Health Financial Systems		RUSH MEMORIAL	HOSPI TAI		Inlie	u of Form CMS-255	52-10
RECLASSI FI CATI ONS				CCN: 151304	Period: From 01/01/2014 To 12/31/2014	Worksheet A-6 Date/Time Prepar 5/29/2015 11:00	red:
	Increases						
Cost Center	Line #	Salary	Other				
2.00	3.00	4.00	5.00				
A - LAUNDRY AND LINEN		· · · ·					
1.00 LAUNDRY & LINEN SERVICE	8.00	0	56, 788				1.00
		— — — o	56, 788				
B - DIETARY/ CAFETERIA	I	-1					
1.00 CAFETERIA	11.00	223, 195	192, 855				1.00
		223, 195	192, 855				
C - MED SUPPLY RECLASS		2207170	172,000				
1.00 MEDICAL SUPPLIES CHARGED TO	71.00	0	137, 873				1.00
PATIENTS	71.00	Ŭ	137, 073				1.00
2.00	0,00	0	0				2.00
3.00	0.00	o	0				3.00
4.00	0.00	0	0				4.00
5.00	0.00	0	0				5.00
6.00	0.00	0	0				6.00
		-	0				
7.00	0.00	0	0				7.00
8.00	0.00	0	0				8.00
9.00	0.00	0	0				9.00
10.00	0.00	0	0				0.00
11.00	0.00	0	0				1.00
12.00	0.00	0	0				2.00
13.00	0.00	0	0				3.00
14.00	0.00	0	0				4.00
15.00	0.00	0	0			1	15.00
0		0	137, 873				
D - AMBULANCE RECLASS							
1.00 OPERATION OF PLANT	7.00	1, 575	0				1.00
2.00 ADULTS & PEDIATRICS	30.00	590	0				2.00
3. 00 RADI OLOGY-DI AGNOSTI C	54.00	109	0				3.00
4.00 LABORATORY	60.00	20	0				4.00
5.00 EMERGENCY	91.00	1, 946	0				5.00
6.00 EMPLOYEE BENEFITS DEPARTMENT	4.00	102	0				6.00
0		4, 342	ō				
E - SALARY RECLASS		· · ·					
1.00 RECOVERY ROOM	51.00	35, 990	0				1.00
2.00 ADMINISTRATIVE & GENERAL	5.00	45, 962	0				2.00
		81,952	ō				
500.00 Grand Total: Increases		309, 489	387, 516			50	00.00

	Financial Systems		RUSH MEMORIAL			In Lie	u of Form CMS-2552-
RECLAS	SI FI CATI ONS			Provi der	CCN: 151304	Period: From 01/01/2014 To 12/31/2014	Worksheet A-6 Date/Time Prepared 5/29/2015 11:00 am
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	F	
	6.00	7.00	8.00	9.00	10.00		
	A - LAUNDRY AND LINEN						
1.00	HOUSEKEEPING	9.00	0	5 <u>6, 7</u> 88		0	1.0
	0		0	56, 788			
	B - DIETARY/ CAFETERIA						
1.00	DI ETARY	10.00	223, 195	192,855		0	1.0
	0		223, 195	192, 855			
	C - MED SUPPLY RECLASS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	95		0	1.0
2.00	DI ETARY	10.00	0	46		0	2.0
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	105, 790		0	3.0
4.00	ADULTS & PEDIATRICS	30.00	0	5, 484		0	4.0
5.00	RECOVERY ROOM	51.00	0	1, 463		0	5.0
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 738		0	6.0
7.00	LABORATORY	60.00	0	56		0	7.0
8.00	RESPI RATORY THERAPY	65.00	0	5		0	8.0
9.00	PHYSI CAL THERAPY	66.00	0	168		0	9.0
10.00	ELECTROCARDI OLOGY	69.00	0	129		0	10.0
11.00	DRUGS CHARGED TO PATIENTS	73.00	0	460		0	11.0
12.00	CLINIC	90.00	0	7, 987		0	12.0
13.00	EMERGENCY	91.00	0	12, 866		0	13.0
14.00	AMBULANCE SERVICES	95.00	0	1, 385		0	14.0
15.00	NONPAID WORKERS	193.00	0	201		0	15.0
				137, 873		-	
	D - AMBULANCE RECLASS			· · ·			
1.00	AMBULANCE SERVICES	95.00	4, 342	0		0	1.0
2.00		0.00	0	0		0	2.0
3.00		0,00	0	0		0	3.0
4.00		0.00	0	0		0	4.0
5.00		0.00	0	0		0	5. C
6.00		0.00	0	0		0	6.0
			4, 342			-	
	E - SALARY RECLASS		.,				
1.00	OPERATING ROOM	50.00	35, 990	0		0	1.0
2.00	NURSI NG ADMI NI STRATI ON	13.00	45, 962	0		0	2.0
			81, 952	0	<u> </u>	1	2.0
	Grand Total: Decreases		309, 489	387, 516			500. C

Health Financial Systems	RUSH MEMORIA				eu of Form CMS-2	
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151304	Peri od:	Worksheet A-7	
				From 01/01/2014 To 12/31/2014		narod
				10 12/31/2014	5/29/2015 11:0	
			Acqui si ti on	S		
	Begi nni ng	Purchases	Donati on	Total	Disposals and	
	Bal ances				Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CA	PITAL ASSET BALANCES		•			
1.00 Land	188, 708	0		0 0	0	1.00
2.00 Land Improvements	318, 434	7, 573		0 7,573	0	2.00
3.00 Buildings and Fixtures	13, 590, 488	2,069,055		0 2, 069, 055	0	3.00
4.00 Building Improvements	950, 871	0		0 0	949, 914	4.00
5.00 Fixed Equipment	813, 702	9, 756		0 9, 756	0	5.00
6.00 Movable Equipment	10, 900, 339	2, 926, 874		0 2, 926, 874	355, 334	6.00
7.00 HIT designated Assets	0	0		0 0	0	7.00
8.00 Subtotal (sum of lines 1-7)	26, 762, 542	5, 013, 258		0 5, 013, 258	1, 305, 248	8.00
9.00 Reconciling Items	0	0		0 0	0	9.00
10.00 Total (line 8 minus line 9)	26, 762, 542	5, 013, 258		0 5, 013, 258	1, 305, 248	10.00
	Endi ng Bal ance	Fully				
	_	Depreciated				
		Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CA						
1.00 Land	188, 708	0				1.00
2.00 Land Improvements	326, 007	0				2.00
3.00 Buildings and Fixtures	15, 659, 543	0				3.00
4.00 Building Improvements	957	0				4.00
5.00 Fixed Equipment	823, 458	0				5.00
6.00 Movable Equipment	13, 471, 879	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	30, 470, 552	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	30, 470, 552	0				10.00

Heal th	Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period:	Worksheet A-7	
					From 01/01/2014 To 12/31/2014		
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 366, 722	0	5, 45	4 559, 943	0	1.00
3.00	Total (sum of lines 1-2)	1, 366, 722	0	5, 45	4 559, 943	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	1, 932, 119				1.00
3.00	Total (sum of lines 1-2)	0	1, 932, 119				3.00

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014	Worksheet A-7 Part III	
				To 12/31/2014		
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
		Leases	(col . 1 - col 2)			
	1,00	2.00	3.00	4,00	5,00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 1.000000		1.00
3.00 Total (sum of lines 1-2)	0	0		0 1.000000		3.00
	ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				0 4 0 4 4 70	0	1 00
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	-		0 1, 264, 678		1.00
3.00 Total (sum of lines 1-2)	0	0	I JMMARY OF CAPI	0 1, 264, 678	0	3.00
		SL				
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
	11.00	12.00	13.00	instructions)	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 NEW CAP REL COSTS-BLDG & FIXT	-45, 637	559, 943			1 770 004	1 00
3.00 Total (sum of lines 1-2)	-45,637 -45,637			0 0 0 0		1.00 3.00
5.00   TOLAT (SUM OF TIMES 1-2)	-40,637	559,943	I	0	1, 778, 984	3.00

	Financial Systems MENTS TO EXPENSES		RUSH MEMORIA		In Lie Period:	u of Form CMS-2 Worksheet A-8	
105001				F	rom 01/01/2014 o 12/31/2014		pared:
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - NEW CAP	1.00	2.00 C	3.00 NEW CAP REL COSTS-BLDG &	4.00	5.00 0	1.00
	REL COSTS-BLDG & FLXT (chapter 2)			FIXT			
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			*** Cost Center Deleted ***	2.00		
3.00 4.00	Investment income - other (chapter 2) Trade, quantity, and time		c		0.00		
4.00 5.00	di scounts (chapter 8) Refunds and rebates of		C		0.00		
6.00	expenses (chapter 8) Rental of provider space by		C		0.00		
7.00	suppliers (chapter 8) Telephone services (pay		C		0.00		
	stations excluded) (chapter 21)						
8.00	Television and radio service (chapter 21)		C		0.00	0	8.00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	C -3, 692, 184		0.00	0	
11.00	adjustment Sale of scrap, waste, etc.		C		0.00	0	11.00
12.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	C			0	12.00
13. 00 14. 00	Laundry and Linen service Cafeteria-employees and guests		C		0.00		
15.00	Rental of quarters to employee and others		C		0.00		
16.00	Sale of medical and surgical supplies to other than patients		C		0.00	0	16.00
17.00	Sale of drugs to other than patients		C		0.00	0	17.00
18.00	Sale of medical records and abstracts		C		0.00	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)		C		0.00	0	19.00
20. 00 21. 00	Vending machines Income from imposition of interest, finance or penalty		C C		0. 00 0. 00		
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	C	RESPI RATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	C	PHYSI CAL THERAPY	66.00		24.00
25. 00	Utilization review - physicians' compensation (chapter 21)		C	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			*** Cost Center Deleted ***	2.00		
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		C	*** Cost Center Deleted ***	19.00 0.00	0	
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for	А	-98, 044	NEW CAP REL COSTS-BLDG &	1.00	9	32.00
33.00	Depreciation and Interest CAFETERIA	В	-95, 640	FI XT CAFETERI A	11.00	0	33.00

	Financial Systems		RUSH MEMORIA			eu of Form CMS-	
DJUSI	MENTS TO EXPENSES			Provider CCN: 151304	Period: From 01/01/2014	Worksheet A-8	
					To 12/31/2014		
				Expense Classification o	n Worksheet A	0,2,,2010 11.	
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
4.00	JAIL MEALS	В		CAFETERI A	11.00		
5.00	VENDING MACHINES	В		ADMI NI STRATI VE & GENERAL	5.00		
7.00	SALE OF SUPPLIES	В		MEDICAL SUPPLIES CHARGED TO	71.00	0	37.
				PATI ENTS	5.00		
3.00	PHYSICIAN APPLICATION FEES	В		ADMI NI STRATI VE & GENERAL	5.00		
9.00	NSF FEES	В		EMPLOYEE BENEFITS DEPARTMEN		-	
). 00	MEDICAL RECORDS TRANSCRIPTION FEES	В	-5, 903	MEDICAL RECORDS & LIBRARY	16.00	0	40
. 00	COPI ER FEES	В	-15 761	ADMI NI STRATI VE & GENERAL	5.00	0	41
2.00	ATHLETIC TRAINER - SCHOOL REV	В		ADMI NI STRATI VE & GENERAL	5.00		
2. 01	WELLNESS PROGRAM	В		EMPLOYEE BENEFITS DEPARTMEN			
5.00	SALE OF SCRAP	B		CENTRAL SERVICES & SUPPLY	14.00		
5. 02	MISC. INCOME	В		EMPLOYEE BENEFITS DEPARTMEN			
5. 03	MISC. INCOME	В		ADMI NI STRATI VE & GENERAL	5.00		
5. 04	MISC. INCOME	В	-550	DI ETARY	10.00	0	45
5. 05	INTEREST INCOME	В		NEW CAP REL COSTS-BLDG &	1.00	11	45
5. 06	TELEPHONE SALARY	А		FIXT ADMINISTRATIVE & GENERAL	5.00	0	45
5.07	TELEPHONE OTHER	A		ADMI NI STRATI VE & GENERAL	5.00		
5. 08	TELEPHONE BENEFITS	A		ADMI NI STRATI VE & GENERAL	5.00		
5.09	ADVERTI SI NG	A		ADMI NI STRATI VE & GENERAL	5.00		
5. 10	I HA & AHA LOBBYI NG	A		ADMI NI STRATI VE & GENERAL	5.00		
5. 11	REBATES	В		NEW CAP REL COSTS-BLDG &	1.00		
				FIXT			
5. 12	REBATES	В		ADMI NI STRATI VE & GENERAL	5.00		
5. 13	REBATES	В		OPERATION OF PLANT	7.00		
. 14	REBATES	В		HOUSEKEEPI NG	9.00	-	
5. 15	REBATES	В		DI ETARY	10.00		
5. 16	REBATES	В		NURSING ADMINISTRATION	13.00		
5.17	REBATES	В		ADULTS & PEDIATRICS	30.00		
5. 18 5. 19	REBATES	B B		OPERATING ROOM	50.00	-	
5. 20	REBATES REBATES	В		RADI OLOGY-DI AGNOSTI C LABORATORY	54.00 60.00		
5.20 5.21	REBATES	В		PHYSICAL THERAPY	66.00		
5. 23	REBATES	В		SPEECH PATHOLOGY	68.00		
5. 23	REBATES	В		ELECTROCARDI OLOGY	69.00		
5. 26	REBATES	В		DRUGS CHARGED TO PATIENTS	73.00		
5. 27	REBATES	B		CLINIC	90.00		
. 27	REBATES	B		EMERGENCY	90.00		
5. 29	HAF EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	-	
b. 00	SPONSORSHI PS	A		ADMI NI STRATI VE & GENERAL	5.00		
5. 01	PHYSI CI AN RECRUI TMENTS	A		ADMI NI STRATI VE & GENERAL	5.00		
5. 02	MASSAGE REVENUE	В		PHYSICAL THERAPY	66.00		
D. 00	TOTAL (sum of lines 1 thru 49)		-5, 675, 345			ĺ	50
	(Transfer to Worksheet A,						
	column 6, line 200.)						1

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Syste	ems	RUSH MEMORI	AL HOSPI TAL		In Li	eu of Form CMS-	2552-10
	R BASED PHYSIC					Peri od:	Worksheet A-8	
						From 01/01/2014 To 12/31/2014		anarod.
						10 12/31/2014	5/29/2015 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	465, 944	431, 004	34, 94	0 0	0	1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	611, 585	586, 585	25,00	0 0	0	2.00
3.00	60.00	LABORATORY	36, 000	C	36,00	0 0	0	3.00
4.00	90.00	CLINIC	3, 243, 083	2, 672, 435	570, 64	3 0	0	4.00
5.00	91.00	EMERGENCY	962, 866	C	962, 86	5 0	0	5.00
6.00	65.00	RESPI RATORY THERAPY	2, 160	2, 160	) (	0 0	0	6.00
7.00	0.00		0	C	) (	o l	0	7.00
8.00	0.00		0	C	) (	o l	0	8.00
9.00	0.00		0	c	) (	o l	0	9.00
10.00	0, 00		0	C		0 0	0	10.00
200.00			5, 321, 638	3, 692, 184	1, 629, 45	4	0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er		Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0	C	)	0 0	0	1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	0			0 0	0	2.00
3.00	60.00	LABORATORY	0	C	) (	o l	0	3.00
4.00	90.00	CLINIC	0	C	) (	o l	0	4.00
5.00	91.00	EMERGENCY	0	C	) (	o l	0	5.00
6.00	65.00	RESPI RATORY THERAPY	0	c		o l	0	6,00
7.00	0.00		0	c		o l	0	7.00
8.00	0.00		0	c		o l	0	8.00
9.00	0, 00		0	C		0 0	0	9,00
10.00	0.00		0	C		0 0	0	10.00
200.00			0				0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	_	
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	50.00	OPERATING ROOM	0	C	) (	431,004		1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	0			586, 585		2.00
3.00	60.00	LABORATORY	0	C	) (	0 0		3.00
4.00	90.00	CLINIC	0	C	) (	2, 672, 435		4.00
5.00	91.00	EMERGENCY	0	C	) (	0 0		5.00
6.00	65.00	RESPI RATORY THERAPY	0	C	) (	2, 160		6.00
7.00	0.00		0	C	) (	0 0		7.00
8.00	0.00		0			0 0		8.00
9.00	0.00		0					9.00
10.00	0.00		0					10.00
200.00	5100		0			3, 692, 184		200.00
	•	1		-	1			

	IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	RUSH MEMORI AI FURNI SHED BY		CCN: 151304	Period: From 01/01/2014 To 12/31/2014 Occupational Therapy	u of Form CMS-2 Worksheet A-8- Parts I-VI Date/Time Prep 5/29/2015 11:0 Cost	-3 pared:			
					i inerapy	1.00				
	PART I – GENERAL INFORMATION					1.00				
1.00	Total number of weeks worked (excluding aides	s) (see instruc	ti ons)			14	1.00			
2.00 3.00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis	or or theranis	t was on provi	dar sita (sa	e instructions)	210 33				
4.00	Number of unduplicated days in which therapy					0				
	nor therapist was on provider site (see inst	,								
5.00 6.00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera assistant and on which supervisor and/or the	apy assistants	(include only	visits made		0 0	5.00 6.00			
	instructions)	nstructions)								
7.00	Standard travel expense rate					0.00				
8.00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8.00			
		1.00	2.00	<u> </u>	4.00	5.00				
9.00	Total hours worked	0. 00	191.25	0.		0.00				
10.00 11.00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0. 00 36. 27	72. 54 36. 27	0. 0.		0.00				
11.00	one-half of column 2, line 10; column 3,	30.27	30.27	0.	00		11.00			
	one-half of column 3, line 10)									
12.00	Number of travel hours (provider site)	0	37		0		12.00			
12.01 13.00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12.01 13.00			
13.01	Number of miles driven (offsite)	0	0		0		13.01			
						1.00				
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00				
14.00	Supervisors (column 1, line 9 times column 1,	line 10)				0	14.00			
15.00	Therapists (column 2, line 9 times column 2,					13, 873				
16.00 17.00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 and		ratory thorany	or lines 14	16 for all	0 13, 873				
17.00	others)	iu is ioi respi	ratory therapy	UTTILES 14		13, 073	17.00			
18.00	Aides (column 4, line 9 times column 4, line					0				
19.00	Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17–19 fo		thorony or lin	ap 17 and 10	for all others)	0	19.00			
20. 00	If the sum of columns 1 and 2 for respiratory					13, 873 10 ogy or	20.00			
	occupational therapy, line 9, is greater than	n line 2, make i								
21.00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra		divided by su	m of columns	1 and 2 line 0	72.54	21.00			
21.00	for respiratory therapy or columns 1 thru 3,					72.54	21.00			
22.00	Weighted allowance excluding aides and trained	ees (line 2 tim	es line 21)			15, 233				
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	VANCE AND TRAVE				15, 233	23.00			
	Standard Travel Allowance	ANCE AND TRAVEL	E EXI ENSE COMIN		SVIDER STIL		-			
~ . ~ ~	Therapists (line 3 times column 2, line 11)									
24.00	Assistants (line 4 times column 3 line 11)					1, 197				
25.00										
25. 00 26. 00	Subtotal (line 24 for respiratory therapy or				3 and 4 for all	0 1, 197	25.00 26.00			
25. 00 26. 00 27. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)	for respirator	y therapy or s	um of lines		0 1, 197 0	25. 00 26. 00 27. 00			
25. 00 26. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard	for respirator	y therapy or s	um of lines		0 1, 197	25. 00 26. 00 27. 00			
25. 00 26. 00 27. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)	for respirator	y therapy or s	um of lines		0 1, 197 0	25. 00 26. 00 27. 00			
25.00 26.00 27.00 28.00 29.00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of	for respirator travel expense Expense of columns 1 and	y therapy or s at the provid	um of lines		0 1, 197 0 1, 197 2, 684	25. 00 26. 00 27. 00 28. 00 29. 00			
25.00 26.00 27.00 28.00 29.00 30.00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,	for respirator travel expense Expense of columns 1 and line 12)	y therapy or s at the provid d 2, line 12 )	um of lines er site (sum		0 1, 197 0 1, 197 2, 684 0	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00			
25.00 26.00 27.00 28.00 29.00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 2	y therapy or s at the provid d 2, line 12 ) 9 and 30 for a	um of lines er site (sum	of lines 26 and	0 1, 197 0 1, 197 2, 684	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00			
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 2 s 1 and 2, line	y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir	um of lines er site (sum	of lines 26 and	0 1, 197 0 1, 197 2, 684 0 2, 684 0 2, 684 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00			
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line	y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28)	um of lines er site (sum unders) atory therap	of lines 26 and	0 1, 197 0 1, 197 2, 684 0 2, 684 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00			
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	for respirator: travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum	y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an	um of lines er site (sum Il others) atory therap d 31)	of lines 26 and	0 1, 197 0 1, 197 2, 684 0 2, 684 0 2, 684 0	26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00			
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/	for respirator: travel expense <u>Expense</u> of columns 1 an- line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	um of lines er site (sum II others) atory therap d 31) d 32)	of lines 26 and	0 1, 197 0 1, 197 2, 684 0 2, 684 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00			
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense	for respirator: travel expense <u>Expense</u> of columns 1 an- line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	um of lines er site (sum II others) atory therap d 31) d 32)	of lines 26 and	0 1, 197 0 1, 197 2, 684 0 2, 684 0 2, 684 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00			
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWF Standard Travel Expense Therapists (line 5 times column 2, line 11)	for respirator: travel expense <u>Expense</u> of columns 1 an- line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	um of lines er site (sum II others) atory therap d 31) d 32)	of lines 26 and	0 1, 197 0 1, 197 2, 684 0 2, 684 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00			
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense	for respirator: travel expense <u>Expense</u> of columns 1 an- line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	um of lines er site (sum II others) atory therap d 31) d 32)	of lines 26 and	0 1, 197 0 1, 197 2, 684 0 2, 684 0 2, 684 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00			
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 36 and 37) Standard travel expense (line 7 times the sum	for respirator: travel expense <u>Expense</u> of columns 1 an- line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL	y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	um of lines er site (sum II others) atory therap d 31) d 32)	of lines 26 and	0 1, 197 0 1, 197 2, 684 0 2, 684 0 2, 684 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00			
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel	for respirator: travel expense Df columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL m of lines 5 and Expense	y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6)	um of lines er site (sum II others) atory therap d 31) d 32)	of lines 26 and	0 1, 197 0 1, 197 2, 684 0 2, 684 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00			
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 36 and 37) Standard travel expense (line 7 times the sum	for respirator: travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL m of lines 5 and Expense	y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6)	um of lines er site (sum II others) atory therap d 31) d 32)	of lines 26 and	0 1, 197 0 1, 197 2, 684 0 2, 684 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00			
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	for respirator: travel expense Expense of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (sum expense (sum expense (sum NCE AND TRAVEL n of lines 5 and Expense 1 times column n 3, line 10)	y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir. 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10)	um of lines er site (sum II others) atory therap d 31) d 32)	of lines 26 and	0 1, 197 0 1, 197 2, 684 0 2, 684 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00			
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	for respirator: travel expense Expense of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL m of lines 5 and Expense D1 times column n 3, line 10) m of columns 1-	y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	um of lines er site (sum ll others) atory therap d 31) d 32) TATION - SER	of lines 26 and y or sum of <u>VICES OUTSIDE PRO</u>	0 1, 197 0 1, 197 2, 684 0 2, 684 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00			
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	for respirator: travel expense Expense of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL m of lines 5 and Expense D1 times column n 3, line 10) m of columns 1-	y therapy or s at the provid d 2, line 12 ) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	um of lines er site (sum ll others) atory therap d 31) d 32) TATION - SER	of lines 26 and y or sum of <u>VICES OUTSIDE PRO</u>	0 1, 197 0 1, 197 2, 684 0 2, 684 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00			

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	RUSH MEMORI AI			Period: From 01/01/2014 Fo 12/31/2014		-3 pared:
					Occupati onal Therapy	Cost	
						1.00	
45.00	Optional travel allowance and standard travel	expense (sum	of lines 39 an	d 42 - see ins	structions)	0	45.00
46.00	Optional travel allowance and optional travel		of lines 42 an			0	46.00
		Therapists 1.00	Assistants	Ai des 3.00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
8. 00	Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.00
9.00	Total overtime (including base and overtime	0.00	0.00	0.0	0.00		49.00
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT			<u> </u>			
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.00	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.00	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE					I	
2.00	Adjusted hourly salary equivalency amount (see instructions)	72. 54	0.00				52.00
3. 00	Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.00
4. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.00
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0		0 0	0	56.00
	Tor an others.)	I		1		1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	AD JUSTMENT			1.00	
7.00			100001112111			15, 233	57.00
2.00	Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62)	•		)		0 0 0 0 15, 233	59.00 60.00 61.00 62.00
5.00	Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	- if negative				11, 570 0	65.00
00. 01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION				others	0	100. 00 100. 01 100. 02
01. 01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31				others	2, 684	101. 00 101. 01 101. 02
	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line 13 for all others				nns 1-3, line		102. 00 102. 01
02.02	Line 35 = sum of lines 31 and 32					2, 684	102. 02

51311	WABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151304	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8 Parts I-VI Date/Time Pre 5/29/2015 11:	pared:
					Speech Pathology		
						1.00	
	PART I - GENERAL INFORMATION						
. 00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instruc	tions)			7 105	1.0 2.0
. 00	Number of unduplicated days in which supervis	sor or therapis	t was on provi	der site (se	e instructions)	105	3.0
. 00	Number of unduplicated days in which therapy					0	
00	nor therapist was on provider site (see instr			- + + :		0	
. 00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera				hy therany	0	5.0 6.0
. 00	assistant and on which supervisor and/or ther					Ū	
	instructions)						
. 00 . 00	Standard travel expense rate Optional travel expense rate per mile					0.00	
. 00	optional traver expense rate per mine	Supervi sors	Therapi sts	Assi stants		Trai nees	0.0
. 00	Total hours worked	1.00	2.00 75.50	3.00	4.00 00 0.00	5.00	9.0
0.00	AHSEA (see instructions)	0.00	69.73		00 0.00		
1.00	Standard travel allowance (columns 1 and 2,	34. 87	34.87	0.	00		11.0
	one-half of column 2, line 10; column 3,						
2.00	one-half of column 3, line 10) Number of travel hours (provider site)	0	1		0		12.0
2. 01	Number of travel hours (offsite)	0	0		0		12.0
3.00 3.01	Number of miles driven (provider site)	0	0		0		13.0
3.01	Number of miles driven (offsite)	U0	U		0		13. C
						1.00	
4.00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1,	line 10)				0	14.0
5.00	Therapists (column 2, line 9 times column 2,					5, 265	
6. 00	Assistants (column 3, line 9 times column 3,					0	16. (
7.00	Subtotal allowance amount (sum of lines 14 ar	nd 15 for respi	ratory therapy	or lines 14	-16 for all	5, 265	17. (
8.00	others) Aides (column 4, line 9 times column 4, line	10)				0	18.0
9.00	Trainees (column 5, line 9 times column 5, li	ne 10)				0	19. (
0.00	Total allowance amount (sum of lines 17-19 for					5, 265	20.0
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete	lines 21-23.					
1.00	Weighted average rate excluding aides and tra	pinoos (lino 17					
1.00	) Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						
2. 00		line 9 for all	others)	m of columns	1 and 2, line 9	69. 74 7, 323	
	Weighted allowance excluding aides and traine Total salary equivalency (see instructions)	line 9 for all ees (line 2 tim	others) es line 21)			69.74 7,323 7,323	22. (
2. 00	Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	line 9 for all ees (line 2 tim	others) es line 21)			7, 323	22. (
2. 00 3. 00	Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	line 9 for all ees (line 2 tim	others) es line 21)			7, 323 7, 323	22. ( 23. (
2. 00 3. 00	Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	line 9 for all ees (line 2 tim	others) es line 21)			7, 323 7, 323	22. ( 23. ( 24. (
2. 00 3. 00 4. 00 5. 00 6. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2	others) es line 21) <u>EXPENSE COMP</u> 4 and 25 for a	UTATION - PR	OVI DER SI TE	7, 323 7, 323 384 0 384	22. ( 23. ( 24. ( 25. ( 26. (
2.00 3.00 4.00 5.00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3	line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2	others) es line 21) <u>EXPENSE COMP</u> 4 and 25 for a	UTATION - PR	OVI DER SI TE	7, 323 7, 323 384 0	22. ( 23. ( 24. ( 25. ( 26. (
2. 00 3. 00 4. 00 5. 00 6. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard	line 9 for all ees (line 2 tim AANCE AND TRAVE sum of lines 2 for respirator	others) es line 21) <u>EXPENSE COMP</u> 4 and 25 for a y therapy or su	<u>UTATION - PR</u> Il others) um of lines	OVIDER SITE 3 and 4 for all	7, 323 7, 323 384 0 384	22. ( 23. ( 24. ( 25. ( 26. ( 27. (
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27)	line 9 for all ees (line 2 tim MANCE AND TRAVE sum of lines 2 for respirator travel expense	others) es line 21) <u>EXPENSE COMP</u> 4 and 25 for a y therapy or su	<u>UTATION - PR</u> Il others) um of lines	OVIDER SITE 3 and 4 for all	7, 323 7, 323 384 0 384 0	22. ( 23. ( 24. ( 25. ( 26. ( 27. (
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard	line 9 for all ees (line 2 tim ANCE AND TRAVE sum of lines 2 for respirator travel expense Expense	others) es line 21) _ EXPENSE COMPU 4 and 25 for a y therapy or su at the provide	<u>UTATION - PR</u> Il others) um of lines	OVIDER SITE 3 and 4 for all	7, 323 7, 323 384 0 384 0	22. ( 23. ( 24. ( 25. ( 26. ( 27. ( 28. (
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,	line 9 for all ees (line 2 tim ANCE AND TRAVE) sum of lines 2 for respirator travel expense <u>Expense</u> of columns 1 an line 12)	others) es line 21) <u>EXPENSE COMP</u> 4 and 25 for a y therapy or su at the provide d 2, line 12 )	UTATION - PR II others) um of lines er site (sum	OVIDER SITE 3 and 4 for all	7, 323 7, 323 384 0 384 0 384 0 384 0 384	22. 23. 24. 25. 26. 27. 28. 29. 30.
<ol> <li>2.00</li> <li>3.00</li> <li>4.00</li> <li>5.00</li> <li>6.00</li> <li>7.00</li> <li>8.00</li> <li>9.00</li> <li>0.00</li> <li>1.00</li> </ol>	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	line 9 for all ees (line 2 tim ANCE AND TRAVE sum of lines 2 for respirator travel expense <u>Expense</u> of columns 1 an line 12) sum of lines 2	others) es line 21) <u>EXPENSE COMP</u> 4 and 25 for a y therapy or su at the provide d 2, line 12 ) 9 and 30 for a	UTATION - PR II others) um of lines er site (sum II others)	OVIDER SITE 3 and 4 for all of lines 26 and	7, 323 7, 323 384 0 384 0 384 0 384 0 384	22. ( 23. ( 25. ( 25. ( 27. ( 28. ( 29. ( 30. ( 31. (
<ol> <li>2.00</li> <li>3.00</li> <li>4.00</li> <li>5.00</li> <li>6.00</li> <li>7.00</li> <li>8.00</li> <li>9.00</li> <li>0.00</li> </ol>	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,	line 9 for all ees (line 2 tim ANCE AND TRAVE sum of lines 2 for respirator travel expense <u>Expense</u> of columns 1 an line 12) sum of lines 2	others) es line 21) <u>EXPENSE COMP</u> 4 and 25 for a y therapy or su at the provide d 2, line 12 ) 9 and 30 for a	UTATION - PR II others) um of lines er site (sum II others)	OVIDER SITE 3 and 4 for all of lines 26 and	7, 323 7, 323 384 0 384 0 384 0 384 0 384	22. ( 23. ( 25. ( 25. ( 26. ( 27. ( 28. ( 30. ( 31. (
<ol> <li>2. 00</li> <li>3. 00</li> <li>4. 00</li> <li>5. 00</li> <li>6. 00</li> <li>7. 00</li> <li>8. 00</li> <li>9. 00</li> <li>0. 00</li> <li>1. 00</li> <li>2. 00</li> <li>3. 00</li> </ol>	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel	line 9 for all ees (line 2 tim ANCE AND TRAVE for respirator travel expense Expense of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (line	others) es line 21) <u>EXPENSE COMPU</u> 4 and 25 for a y therapy or su at the provide d 2, line 12 ) 9 and 30 for a 13 for respire 28)	UTATION - PR II others) um of lines er site (sum li others) atory therap	OVIDER SITE 3 and 4 for all of lines 26 and	7, 323 7, 323 384 0 384 0 384 0 384 0 384 0 0 384 0 0 0 0 0	22. ( 23. ( 25. ( 25. ( 27. ( 28. ( 30. ( 31. ( 32. ( 33. ( 33. (
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REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	RUSH MEMORIAL		CCN: 151304	In Lie Period: From 01/01/2014	u of Form CMS-2 Worksheet A-8 Parts I-VI	
001310	E SUPPLIERS				To 12/31/2014		
					Speech Pathology		
						1.00	
46.00	Optional travel allowance and optional travel	expense (sum o	flines 42 an	nd 43 - see ir	nstructions)	0	46.00
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION Overtime hours worked during reporting	0.00	0.00			0.00	47.00
47.00	period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each	0. 00	0.00	0.0	00 0.00	0.00	47.00
48.00	column of line 56) Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48. OC
	Overtime rate (see instructions) Total overtime (including base and overtime	0.00	0.00	1			48.00 49.00
+ 7. 00	CALCULATION OF LIMIT	0.00	0.00	0.0	0.00		47.00
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0.00	0.00	50. OC
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.0	0.00	0.00	51.00
52.00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount (see instructions)	69. 73	0.00	0.0	0.00		52.00
53.00	Overtime cost limitation (line 51 times line 52)	о	0		0 0		53.00
54.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
55.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	Ο	0		0 0		55.OC
56.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3	0	0		0 0	0	56.00
	for all others.)						
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST A	AD ILISTMENT			1.00	
	Salary equivalency amount (from line 23)	ND EXCESS COST /	AD505TWENT			7, 323	57.00
	Travel allowance and expense - provider site	(from lines 33,	34, or 35))			0	58.00
	Travel allowance and expense - Offsite servic	es (from lines 4	44, 45, or 46	)		0	59.00
	Overtime allowance (from column 5, line 56)					0	60.00
	Equipment cost (see instructions)					0	61.00
	Supplies (see instructions)					0	62.00
	Total allowance (sum of lines 57-62)					7, 323	
5.00	Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION		enter zero)			5, 650 0	
	Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	ll others		384	100. 00
	Line 27 = line 7 times line 3 for respiratory				others		100.01
00.01	Line 33 = line 28 = sum of lines 26 and 27						100. 02
00. 02	LINE 34 CALCULATION		6.1.1	nd 1 for all	others	0	101.00
00. 02 01. 00	Line 27 = line 7 times line 3 for respiratory						
100. 02 101. 00 101. 01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31						101. 01 101. 02
00. 02 01. 00 01. 01 01. 02 02. 00	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or	sum of lines 29 sum of lines 29	and 30 for a and 30 for a	III others		70	

COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151304	Peri od:	Worksheet B	
					From 01/01/2014	Part I	
					To 12/31/2014	Date/Time Pre 5/29/2015 11:	pared: 00 am
			CAPI TAL				[
			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)					
		0	1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS		1.00	1.00		0.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	1, 778, 984	1, 778, 984				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 117, 953	13, 676	3, 131, 62	29		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 841, 522	283, 763	526, 66	3, 651, 946	3, 651, 946	5.00
7.00	00700 OPERATION OF PLANT	797, 362	154, 869	58, 17	76 1, 010, 407	197, 679	7.00
3.00	00800 LAUNDRY & LINEN SERVICE	56, 788	6, 078		0 62, 866	12, 299	8.00
9.00	00900 HOUSEKEEPI NG	335, 628	29, 651	61, 68	426, 968	83, 533	9.00
0.00	01000 DI ETARY	136, 231	57, 147	23, 17	216, 548	42, 366	10.00
1.00	01100 CAFETERI A	318, 434	18, 994	56, 37	7 393, 805	77, 045	11.0
13.00	01300 NURSI NG ADMI NI STRATI ON	51, 849		12, 39			13.00
4.00	01400 CENTRAL SERVICES & SUPPLY	99, 456					
6.00	01600 MEDICAL RECORDS & LIBRARY	410, 452	29, 323	76, 6	8 516, 393	101, 029	16.0
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		107.050	101.01		000.450	
30.00	03000 ADULTS & PEDI ATRI CS	822, 232	127, 353	191, 05	1, 140, 638	223, 158	30.0
50.00	ANCI LLARY SERVI CE COST CENTERS	541, 106	111, 460	138, 79	791, 365	154, 825	50.00
51.00	05100 RECOVERY ROOM	38, 396					50.00
3.00	05300 ANESTHESI OLOGY	0			0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 216, 406	-				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 210, 400	100,770	214,7	0 1, 300, 930	0	55.0
0.00	06000 LABORATORY	1, 374, 389	42, 732	153, 48	0		60.00
5.00	06500 RESPI RATORY THERAPY	96, 661	2, 690				65.0
6.00	06600 PHYSI CAL THERAPY	307, 323					66.0
57.00	06700 OCCUPATI ONAL THERAPY	181, 370					
8.00	06800 SPEECH PATHOLOGY	27, 488					
9.00	06900 ELECTROCARDI OLOGY	173, 289					69.0
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.0
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	151, 499			0 151, 499		71.0
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	101, 775			0 101, 775		72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 773, 159		103, 06		564, 144	73.0
	OUTPATIENT SERVICE COST CENTERS		·				1
90.00	09000 CLI NI C	2,048,653	451, 794	959, 08	3, 459, 530	676, 839	90.00
91.00	09100 EMERGENCY	1, 794, 578	79, 221	195, 82	2, 069, 623	404, 907	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVI CES	639, 485	26, 284	144, 74	810, 516	158, 572	95.00
	SPECIAL PURPOSE COST CENTERS	1		1			
18.00		22, 232, 468	1, 770, 647	3, 110, 53	22, 203, 040	3, 629, 398	118.00
	NONREI MBURSABLE COST CENTERS	1		1	- 1		
	19200 PHYSI CLANS' PRI VATE OFFI CES	5	0		0 5		192.00
	19300 NONPAID WORKERS	-201	0		0 -201		193. 00
	19301 FOUNDATI ON	57, 575					
	19302 OCCUPATIONAL MEDICINE	28, 240	3, 183	6, 64			193. 0
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.0
200.00					0		200.00
201.00 202.00			0		0 0		201.00
	TOTAL (sum lines 118-201)	22, 318, 087	1, 778, 984	3, 131, 62	29 22, 318, 087	3, 651, 946	1202 0

Heal th	n Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151304	Period:	Worksheet B	
					From 01/01/2014 To 12/31/2014	Part I Date/Time Pre	nared
					10 12/31/2014	5/29/2015 11:	
	Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI N	G DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS		[				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1 000 00/					5.00
7.00	00700 OPERATION OF PLANT	1, 208, 086					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	5, 535					8.00
9.00	00900 HOUSEKEEPI NG	27,001	5,66				9.00
10.00	01000 DI ETARY	52,038				101.100	10.00
11.00	01100 CAFETERIA	17, 296		7,9		496, 138	
13.00	01300 NURSI NG ADMI NI STRATI ON	11, 500		5,3		2, 603	
14.00	01400 CENTRAL SERVICES & SUPPLY	36, 967		0 17,0		5, 206	
16.00	01600 MEDICAL RECORDS & LIBRARY	26, 702	(	0 12, 3	38 0	31, 757	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	115, 969	52, 61	9 53, 5	84 337, 319	56, 486	30.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	101, 497	5, 28				
51.00	05100 RECOVERY ROOM	11, 743		5,4			
53.00	05300 ANESTHESI OLOGY	0		C	0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	141, 848				45, 553	
55.00	05500 RADI OLOGY - THERAPEUTI C	0			0 0	0	
60.00	06000 LABORATORY	38, 912		0 17,9		41, 388	
65.00	06500 RESPI RATORY THERAPY	2, 450				5, 206	
66.00	06600 PHYSI CAL THERAPY	71, 485				13, 796	
67.00	06700 OCCUPATI ONAL THERAPY	15, 576	73			7, 288	
68.00	06800 SPEECH PATHOLOGY	2, 319				521	
69.00	06900 ELECTROCARDI OLOGY	7, 517		3,4		8, 330	
70.00	07000 ELECTROENCEPHALOGRAPHY	0		C	0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		C	0 0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0		C	0 0		
73.00		6, 657	(	3,0	76 0	15, 098	73.00
	OUTPATIENT SERVICE COST CENTERS	1					
90.00	09000 CLI NI C	411, 409		0 190, 0			
91.00	09100 EMERGENCY	72, 140	8, 36	9 33, 3	32 0	45, 032	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS			1			_
95.00		23, 934	(	0 11,0	59 0	51, 540	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		1, 200, 495	80, 70	539,6	58 337, 319	490, 672	118.00
	NONREI MBURSABLE COST CENTERS						
	D 19200 PHYSI CLANS' PRI VATE OFFI CES	0		C	0 0		192.00
	D 19300 NONPAI D WORKERS	0		C	0 0		193.00
	1 19301 FOUNDATI ON	4, 693		2, 1			193. 01
	2 19302 OCCUPATI ONAL MEDI CI NE	2, 898	(	0 1,3	39 0		193. 02
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	(	C	0 0	0	194.00
200.00							200.00
201.00		0	(	C	0 0		201.00
202.00	D TOTAL (sum lines 118-201)	1, 208, 086	80, 700	543, 1	66 337, 319	496, 138	202.00

Health Financial Systems	RUSH MEMORIAL	- HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151304	Peri od:	Worksheet B	
				From 01/01/2014 To 12/31/2014	Part I	narod
				10 12/31/2014	Date/Time Prep 5/29/2015 11:0	pareu. 00 am
Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	Subtotal	Intern &	
	ADMI NI STRATI ON	SERVICES &	RECORDS &		Residents Cost	
		SUPPLY	LI BRARY		& Post	
					Stepdown	
					Adjustments	
	13.00	14.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS	1			1		1 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 8.00 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
						9.00
10. 00  01000  DI ETARY 11. 00  01100  CAFETERI A						10.00 11.00
	111 220					
13.00 01300 NURSING ADMINISTRATION	111, 330	241 200				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	241, 298	(00.15	-		14.00
16. 00 01600 MEDI CAL_RECORDS & LI BRARY	0	936	689, 15	5		16.00
30. 00 03000 ADULTS & PEDIATRICS	33, 838	10, 384	296, 10	2, 320, 098	0	30.00
ANCI LLARY SERVICE COST CENTERS	33,030	10, 364	290, 10	2, 320, 090		30.00
50. 00 05000 OPERATING ROOM	13.375	27, 629	65, 11	9 1, 230, 978	0	50.00
51. 00 05100 RECOVERY ROOM	1, 609	1, 035		0 94, 613	0	51.00
53. 00 05300 ANESTHESI OLOGY	1,009	1,035		0 94,013	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	9, 679	78, 84	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	3,073	70,04	0 2, 242, 313	0	55.00
60. 00 06000 LABORATORY	0	99, 321		0 2, 075, 480	0	60.00
65. 00 06500 RESPIRATORY THERAPY	3, 058	920	1, 46		0	65.00
66. 00 06600 PHYSI CAL THERAPY	3,030	1, 102	1,40	0 652, 098	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 102		0 319, 595	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	432		0 46, 789	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	432		0 287, 847	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 207, 047	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	28, 305		0 209, 444	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	20, 303		0 148, 826	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1,659	2, 277		0 3, 476, 448	0	73.00
OUTPATIENT SERVICE COST CENTERS	1,007	2,277	<u> </u>	0, 170, 110		70.00
90. 00 09000 CLINIC	0	13, 214		0 4, 884, 360	0	90.00
91. 00 09100 EMERGENCY	27, 158	14, 039	247, 62		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		,	,	_, ,	0	
OTHER REIMBURSABLE COST CENTERS			I			
95. 00 09500 AMBULANCE SERVICES	30, 633	4, 563		0 1, 090, 817	0	95.00
SPECIAL PURPOSE COST CENTERS				· · · · · · · · · · · · · · · · · · ·		
118.00 SUBTOTALS (SUM OF LINES 1-117)	111, 330	240, 988	689, 15	5 22, 163, 617	0	118.00
NONREI MBURSABLE COST CENTERS	· · · · · ·					
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 6	0	192.00
193. 00 19300 NONPALD WORKERS	0	0		0 -201	0	193.00
193. 01 19301 FOUNDATI ON	0	83		0 104, 691	0	193. 01
193. 02 19302 OCCUPATI ONAL MEDI CI NE	0	227		0 49, 974	0	193. 02
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.00
200.00 Cross Foot Adjustments				0	0	200. 00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	111, 330	241, 298	689, 15	5 22, 318, 087	0	202.00
					-	

Health Financial Systems	RUSH MEMORIAL H		of Form CMS-2552-1
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 151304	Vorksheet B
			Part I Date/Time Prepared:
			5/29/2015 11:00 am
Cost Center Description	Total		
	26.00		
GENERAL SERVICE COST CENTERS			
I. 00 00100 NEW CAP REL COSTS-BLDG & FIXT			1.0
I. 00 00400 EMPLOYEE BENEFITS DEPARTMENT			4.0
0.00 00500 ADMINI STRATI VE & GENERAL			5.0
7.00 00700 OPERATION OF PLANT			7.0
8. 00 00800 LAUNDRY & LINEN SERVICE			8.0
0.00 00900 HOUSEKEEPING			9.0
0. 00 01000 DI ETARY			10.0
1.00 01100 CAFETERIA			11.0
13.00 01300 NURSING ADMINISTRATION			13.0
4.00 01400 CENTRAL SERVICES & SUPPLY			14.0
6.00 01600 MEDICAL RECORDS & LIBRARY			16. 0
INPATIENT ROUTINE SERVICE COST CENTERS	2 220 000		
30. 00 03000 ADULTS & PEDIATRICS	2, 320, 098		30.0
	1 220 070		FO 0
0. 00 05000 OPERATING ROOM	1, 230, 978		50.0
1.00 05100 RECOVERY ROOM	94, 613		51.0
3. 00 05300 ANESTHESI OLOGY	0		53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 242, 313		54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	0		55.0
0.00 06000 LABORATORY	2,075,480		60.0
5. 00 06500 RESPI RATORY THERAPY	161, 682		65.0
6. 00 06600 PHYSI CAL THERAPY	652, 098		66.0
57.00 06700 OCCUPATI ONAL THERAPY	319, 595		67.0
8.00 06800 SPEECH PATHOLOGY	46, 789		68.0
9.00 06900 ELECTROCARDI OLOGY	287, 847		69.0
0.00 07000 ELECTROENCEPHALOGRAPHY	0		70.0
1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	209, 444		71.0
2.00 07200 I MPL. DEV. CHARGED TO PATIENT	148, 826		72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 476, 448		73.0
OUTPATIENT SERVICE COST CENTERS	1		
0.00 09000 CLINIC	4, 884, 360		90.0
1.00 09100 EMERGENCY	2, 922, 229		91.0
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			92.0
OTHER REIMBURSABLE COST CENTERS	·		
25. 00 09500 AMBULANCE SERVICES	1, 090, 817		95.0
SPECIAL PURPOSE COST CENTERS			
18.00 SUBTOTALS (SUM OF LINES 1-117)	22, 163, 617		118. 0
NONREI MBURSABLE COST CENTERS			100.0
92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	6		192.0
93. 00 19300 NONPALD WORKERS	-201		193.0
93. 01 19301 FOUNDATI ON	104, 691		193.0
93. 02 19302 OCCUPATIONAL MEDICINE	49, 974		193. 0
94.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0		194. 0
200.00 Cross Foot Adjustments	0		200. 0
201.00 Negative Cost Centers	0		201.0
202.00   TOTAL (sum lines 118-201)	22, 318, 087		202. 0

Heal th	Financial Systems	RUSH MEMORIA	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS			CCN: 151304	Period: From 01/01/2014 To 12/31/2014		pared:
		1				5/29/2015 11:	00 am
			CAPI TAL				
	Cost Center Description	Directly Assigned New Capital	RELATED COSTS NEW BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
		Related Costs					
		0	1.00	2A	4.00	5.00	
1 00	GENERAL SERVICE COST CENTERS			1		I	1 1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		10 (7)	10.0	10 171		1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	0				286, 063	
7.00	00700 OPERATION OF PLANT	0				15, 484	
8.00	00800 LAUNDRY & LINEN SERVICE	0	-,			963	
9.00	00900 HOUSEKEEPI NG	0	27,001			6, 543	
10.00	01000 DI ETARY	0	01111			3, 319	1
11.00	01100 CAFETERI A	0				6, 035	
13.00	01300 NURSI NG ADMI NI STRATI ON	0				1, 178	
14.00	01400 CENTRAL SERVICES & SUPPLY	0				2, 333	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	29, 323	29, 32	23 335	7, 914	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30.00	03000 ADULTS & PEDIATRICS	0	127, 353	127, 35	53 834	17, 480	30.00
	ANCI LLARY SERVICE COST CENTERS	1		1	- 1		
50.00	05000 OPERATING ROOM	0	111, 460	111, 40	606	12, 128	50.00
51.00	05100 RECOVERY ROOM	0	12, 896	12, 89	96 40	925	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	155, 773	155, 7	73 938	24, 320	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
60.00	06000 LABORATORY	0	42, 732	42, 73	32 670	24, 069	60.00
65.00	06500 RESPI RATORY THERAPY	0	2, 690	2, 69	90 102	1, 881	65.00
66.00	06600 PHYSI CAL THERAPY	0	78, 502	78, 50	255 255	6, 807	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	17, 105	17, 10	05 188	3, 702	67.00
68.00	06800 SPEECH PATHOLOGY	0	2, 546	2, 54	16 24	544	68.00
69.00	06900 ELECTROCARDI OLOGY	0	8, 255	8, 25	55 188	3, 442	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	2, 322	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	1, 560	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7, 310	7, 3	450	44, 190	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	451, 794	451, 79	4, 190	53, 020	90.00
91.00	09100 EMERGENCY	0	79, 221	79, 22	21 855	31, 717	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0	26, 284	26, 28	34 632	12, 421	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		0	1, 770, 647	1, 770, 64	13, 584	284, 297	1118.00
	NONREI MBURSABLE COST CENTERS	·					
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
	19300 NONPALD WORKERS	0	0		0 0	0	193.00
	19301 FOUNDATI ON	0	5, 154	5, 15	54 63		193.01
	19302 OCCUPATIONAL MEDICINE	0					193.02
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0,.00	0,10	0 0		194.00
200.00		1	l		0		200.00
200.00	· · · · · · · · · · · · · · · · · · ·		0		0 0	n –	201.00
201.00	5	0	1, 778, 984	1, 778, 98	34 13, 676		1
202.00			1 ., , , 0, ,04	.,,,,,,,,	10,070	1 200,000	

Heal th	Financial Systems	RUSH MEMORIA	I HOSPI TAI		Inlie	u of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS			CCN: 151304	Peri od:	Worksheet B	
					From 01/01/2014	Part II	
					To 12/31/2014	Date/Time Pre	pared:
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPIN	G DI ETARY	5/29/2015 11: CAFETERI A	00 am
	cost center bescription	PLANT	LINEN SERVICE		G DIETART	CAFETERIA	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	170, 607					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	782	7, 823	3			8.00
9.00	00900 HOUSEKEEPI NG	3, 813	549	9 40, 8	25		9.00
10.00	01000 DI ETARY	7,349	225	5 1,8	07 69, 948		10.00
11.00	01100 CAFETERI A	2, 443	(	6	01 0	28, 319	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 624	(	) 3	99 0	149	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	5, 221	(	1,2	84 0	297	14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	3, 771	(	9	27 0	1, 813	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	16, 377	5, 101	1 4, 0	27 69, 948	3, 224	30.00
	ANCI LLARY SERVI CE COST CENTERS			1			-
50.00	05000 OPERATI NG ROOM	14, 333				1, 426	50.00
51.00	05100 RECOVERY ROOM	1, 658			08 0	149	51.00
53.00	05300 ANESTHESI OLOGY	0		D	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	20, 032	331			2, 600	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	(		0 0	0	55.00
60.00	06000 LABORATORY	5, 495				2, 362	60.00
65.00	06500 RESPI RATORY THERAPY	346	66		85 0	297	65.00
66.00	06600 PHYSI CAL THERAPY	10, 095	154			787	66.00
67.00	06700 OCCUPATI ONAL THERAPY	2,200	71	1	41 0	416	•
68.00	06800 SPEECH PATHOLOGY	327			81 0	30	68.00
69.00	06900 ELECTROCARDI OLOGY	1,062	-		61 0	475	
70.00	07000 ELECTROENCEPHALOGRAPHY	0		-	0 0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	(		0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0			0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	940	(	2	31 0	862	73.00
00.00	OUTPATIENT SERVICE COST CENTERS	F0.000		14.0	00 0	7 (00	00.00
90.00	09000 CLINIC	58,099				7,608	•
91.00	09100 EMERGENCY	10, 188	811	2,5	05 0	2, 570	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
05 00		2 200	(		31 0	2.042	
95.00	09500 AMBULANCE SERVICES	3, 380	(	8	31 0	2, 942	95.00
110.00	SPECIAL PURPOSE COST CENTERS	1/0 525	7.00	10.5	(1) (0.040	20.007	110 00
118.00	SUBTOTALS (SUM OF LINES 1-117)           NONREIMBURSABLE COST CENTERS	169, 535	7, 823	3 40, 5	61 69, 948	28,007	118.00
102 00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	(		0 0	0	192.00
	19300 NONPALD WORKERS	0			0 0		192.00
	19301 FOUNDATION	663	-		63 0		193.00
	19302 OCCUPATIONAL MEDICINE	409	(		01 0		193.01
	07950 OTHER NONREIMBURSABLE COST CENTERS	409		, i			193.02
200.00		0		1		0	200.00
200.00		0	ſ		0	Λ	200.00
201.00		170, 607	7, 823	40,8	25 69, 948		201.00
202.00			., 020	1 10,0		20,017	

Heal th	Financial Systems	RUSH MEMORIAL	- HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS			CCN: 151304	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Pre	pared:
						5/29/2015 11:	00 am
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	Subtotal	Intern &	
		ADMI NI STRATI ON	SERVICES & SUPPLY	RECORDS & LI BRARY		Residents Cost & Post	
			SUPPLY	LIBRARY		Stepdown	
						Adj ustments	
		13.00	14.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	10.00	21.00	20.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	16, 033					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	49, 784				14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	193	44, 27	6		16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1					
30.00	03000 ADULTS & PEDI ATRI CS	4, 873	2, 142	19, 02	24 270, 383	0	30.00
	ANCI LLARY SERVICE COST CENTERS					-	
50.00	05000 OPERATING ROOM	1, 926	5, 700	4, 18		0	
51.00	05100 RECOVERY ROOM	232	214		0 16, 522	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 997	5, 06		0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	20,401		0 0 0 97, 170	0	
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	440	20, 491 190		0 97, 170 94 6, 191	0	60.00 65.00
66.00	06600 PHYSI CAL THERAPY	440	227	-	0 99, 310	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	3		0 24, 226	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	89		0 3, 644	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 13,683	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	5, 840		0 8, 162	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	5, 599		0 7, 159	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	239	470		0 54, 692	0	•
	OUTPATIENT SERVICE COST CENTERS			•			1
90.00	09000 CLI NI C	0	2, 726	1	0 591, 725	0	90.00
91.00	09100 EMERGENCY	3, 911	2, 897	15, 90	)9 150, 584	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	4, 412	942		0 51, 844	0	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		16, 033	49, 720	44, 27	76 1, 767, 077	0	118.00
400.00	NONREI MBURSABLE COST CENTERS						100.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	19300 NONPALD WORKERS	0	0		0 0		193.00
		0	17		0 7,555 0 4,352		193.01
	19302 OCCUPATIONAL MEDICINE 07950 OTHER NONREIMBURSABLE COST CENTERS	0	47		0 4, 352 0 0		193.02 194.00
200.00		0	0		0 0		200.00
200.00	· · · · · · · · · · · · · · · · · · ·	0	Ω		0 0		200.00
201.00	5	16,033	49, 784	44, 27	76 1, 778, 984		201.00
202.00		,	, /01	, 2,	-, ., ., ., ., ., ., .,	Ŭ	

ALLOCAT	Financial Systems TON OF CAPITAL RELATED COSTS	RUSH MEMORIAL	Provider CCN: 151304	In Lieu Period:	Worksheet B
				From 01/01/2014 To 12/31/2014	Part II Date/Time Prepare 5/29/2015 11:00 a
	Cost Center Description	Total			572972015 11:00 a
	•	26.00			
¢	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.
5.00	00500 ADMINISTRATIVE & GENERAL				5.
.00	00700 OPERATION OF PLANT				7.
3.00	00800 LAUNDRY & LINEN SERVICE				8.
. 00	00900 HOUSEKEEPI NG				9.
0.00	01000 DI ETARY				10.
1.00	01100 CAFETERI A				11.
3.00	01300 NURSING ADMINISTRATION				13.
4.00	01400 CENTRAL SERVICES & SUPPLY				14.
6.00	01600 MEDI CAL RECORDS & LI BRARY				16.
1	INPATIENT ROUTINE SERVICE COST CENTERS				
0. 00	03000 ADULTS & PEDIATRICS	270, 383			30.
	ANCILLARY SERVICE COST CENTERS				
0.00	05000 OPERATING ROOM	155, 800			50.
1.00	05100 RECOVERY ROOM	16, 522			51.
3.00	05300 ANESTHESI OLOGY	0			53.
4.00	05400 RADI OLOGY-DI AGNOSTI C	215, 982			54.
5.00	05500 RADI OLOGY-THERAPEUTI C	0			55.
60.00	06000 LABORATORY	97, 170			60.
55.00	06500 RESPI RATORY THERAPY	6, 191			65.
6.00	06600 PHYSI CAL THERAPY	99, 310			66.
57.00	06700 OCCUPATI ONAL THERAPY	24, 226			67.
68.00	06800 SPEECH PATHOLOGY	3, 644			68.
69.00	06900 ELECTROCARDI OLOGY	13, 683			69.
0.00	07000 ELECTROENCEPHALOGRAPHY	0			70.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 162			71.
2.00	07200 IMPL. DEV. CHARGED TO PATIENT	7, 159			72.
	07300 DRUGS CHARGED TO PATIENTS	54, 692			73.
	DUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	591, 725			90.
1.00	09100 EMERGENCY	150, 584			91.
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.
(	OTHER REIMBURSABLE COST CENTERS				
5.00	09500 AMBULANCE SERVI CES	51, 844			95.
4	SPECIAL PURPOSE COST CENTERS				
18.00	SUBTOTALS (SUM OF LINES 1-117)	1, 767, 077			118.
Ī	VONREIMBURSABLE COST CENTERS				
92.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.
	19300 NONPALD WORKERS	0			193.
	19301 FOUNDATI ON	7, 555			193.
	19302 OCCUPATI ONAL MEDI CI NE	4, 352			193.
	07950 OTHER NONREIMBURSABLE COST CENTERS	0			194.
00.00	Cross Foot Adjustments	0			200.
201.00	Negative Cost Centers	0			201.
202.00	TOTAL (sum lines 118-201)	1, 778, 984			201.

COST         ALLOCATION         STATISTICAL BASIS         Provider         ODE         Provider         ODE         Provider         Provider <t< th=""><th>Heal th</th><th>Financial Systems</th><th>RUSH MEMORIAL</th><th>- HOSPI TAL</th><th></th><th>In Lie</th><th>eu of Form CMS-:</th><th>2552-10</th></t<>	Heal th	Financial Systems	RUSH MEMORIAL	- HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
To         12/31/2014         Detert The Prepared           Cost Center Description         Net Attach Costs         Entrover Benefits         Benefits         Entrover Benefits         Costs Center Costs         OPERATION Prepared           1:00         Cost Center Description         Net Attach Costs         Bit Attach Costs         State Costs         Costs Center Costs         Prepared         Prepared <td< td=""><td></td><td></td><td></td><td></td><td></td><td>Period:</td><td></td><td></td></td<>						Period:		
Contract         Exercise							Dato/Timo Pro	narod
Desk Center Description         BELATED COST SIL SUBJECT & FEINT SIL SUBJECT & FEINT SIL SUBJECT & FEINT SIL SUBJECT & SALART (S)         Explore the ENERTIS SIL SUBJECT & SALART (S)         Explore the SUBJECT & SALART (S)         Explore the SUBJECT & SALART (S)         OPERATION OF SUBJECT & SALART (S)         OPERATION OF SUBJECT & SUBJECT & S						10 12/31/2014		
Lost Center Description         New FLDS a FLXT (SOUARE FFFT)         Def VENET TS DEPARTINENT         Reconcil List on XOUNIN ISTRATIVE (SOUARE FFFT)         OPERATION OF A (SOUARE SOUARE FFFT)           0         0         64.00         64.00         64.00         64.00         64.00           1.00         00100 [NB CAP REL COST-BLDS & FLXT 000400 [PARTINO F PLAN 5.00         0.00         64.00         64.00         64.00         1.00           0.00         00400 [PARTINO F PLAN 5.00         0.00 [PARTINO F PLAN 5.00								
FIXT         BENEFITS         Control         Control         Control           0         00000         00000         0         5A         5.00         7.00           1         00         00000         00000         5A         5.00         7.00           1         00         00000								
EVEN PLAN         COLMARE FLET)         COLMARE FLET)         CACUMA (CR0SS SALARIES)         CACUMA (CR0SS SALARIES)         CACUMA (CR0SS SALARIES)         CACUMA (CR0SS SALARIES)           1         00         0.00         1.00         4.00         5.00         7.00           1         00         0.00         0.00         7.00         7.00         4.00           1         00         0.00		Cost Center Description			Reconciliatio			
FLET)         G(9005         COST)         FLET)           1.00         1.00         4.00         SA         5.00         7.00           1.00         0.0000         DUPCORT SELEC AS REL CAST SELEC A FIXT         86.632         1.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
SALARY ES         -         -           BENEMAL SERVICE COST CENTERS         -								
CENERAL SERVICE COST CENTERS			,				· · · ·	
1.00         00100 NEW CAP REL COSTS-BLOG & FLYT         86, 635         1.00           0.00         00500 DENOYCE BERETIS DEPARTMENT         66,6 32         1.00           0.00         00500 DERATION OF LEANT         13, 819         2.085, 017         -3, 651, 944         18, 666, 342         5.00           0.00         00500 DERATION OF LEANT         7, 542         230, 315         0         1, 101, 407         44, 000           0.00         00500 DERATION OF LEANT         7, 542         230, 315         0         1, 666, 342         6.00           0.00         00500 DERATION STRATIVE & GENERAL         13, 300         0, 216, 544         2, 783         0, 1020         11, 00         110, 00         10, 00         10, 644         2, 783         0, 103, 200         11, 00         13, 00         13, 00         13, 00         13, 00         13, 00         14, 00			1.00	4.00	5A	5.00	7.00	
4. 00         00400 [EMPLOVER ERNETTS IDPARTMENT         666         12. 397, 933         -3. 651, 946         4. 00           0.00         00700 [DPEANTION OF PLANT         7. 542         230, 315         0         18. 666, 342         5. 00           0.00         00700 [DPEANTION OF PLANT         7. 542         230, 315         0         6. 00         7. 00         6. 00         7. 00         6. 00         7. 00	1 00		04 425		1	1		1 00
5. 00         00500 ADM.INISTRATIVE & GENERAL.         13, 819         2, 085, 017         -3, 651, 946         18, 666, 342         5. 00           0. 00         006800 LAUMORY & LINEN SERVICE         296         0         0.001, 00         64, 608         296         8. 00           0. 00         01000 DIETARY         2, 783         91, 728         0         26, 548         2, 783         10. 00           11.00         01100 CIENTRAL SERVICES & SUPPLY         1, 977         48, 314         0         26, 648         1, 444           11.00         01100 CIENTRAL SERVICE SS & SUPPLY         1, 977         48, 314         0         16, 00         16, 648         1, 429         30, 30         60         14, 429         16, 00         16, 00         16, 00         16, 00         16, 00         16, 00         16, 00         16, 00         16, 00         140, 638         6, 202         756, 365         0         1, 140, 638         6, 202         30, 00           0         0.00 OFFEATINE ROUTE COST CENTERS         6, 202         756, 365         0         1, 140, 638         6, 202         30, 00         30, 00         30, 00         30, 00         30, 00         30, 00         30, 00         30, 00         30, 00         30, 00         30, 00         <				10 207 022				
7. 00         00700 0FEARTION OF PLANT         7, 542         230, 315         0         1, 101, 407         64, 608         7, 60           8. 00         00800 LAUNDRY & LINEN SERVICE         296         0         0, 28, 86         296         8, 00           9. 00         00100 CAFETERIA         2, 783         91, 728         0         426, 548         2, 783         10, 728           13. 00         01100 CAFETERIA         925         223, 195         0         39, 805         925         11, 00           14. 00         01400 CENTRAL SERVICES & SUPPLY         1, 977         46, 314         0         152, 256         1, 977         14, 00           14. 00         01400 CENTRAL SERVICE COST CENTERS         -         <					1	6 18 666 342		
8. 00         000000         LANDARY & LINEN SERVICE         296         0         0         0. 00         0. 00000         0. 00000         0. 00000         0. 00000         0. 00000         0. 00000         0. 00000         0. 00000         0. 000000         0. 000000         0. 00000000000000000000000000000000000							64,608	
9. 00         000000 HOLSEKEPING         1,444         244,223         0         2426,968         1,444         9.00           11. 00         01100 CAFETERIA         2783         91,728         0         216,548         2,783         10.00           11. 00         01100 CAFETERIA         2765         223,195         0         373,805         925         11.00           11. 00         01100 CENTERIA         SKIPL         1,977         14.00         152,256         1,977         14.00           11. 00         01400 CENTRAL SERVICE OST CENTERS         -         -         -         280         0         30.00           00         03000 OPERATIR (S. ROM         6,202         756,365         0         1,140,638         6,202         30.00           00         0500 RECOVERY NOM         628         50,990         0         60.383         628         51.00           51.00         05100 RECOVERY NOM         628         50,990         0         1,576,352         0         1,576,354         50.00           53.00         05500 RESPIRATORY THERAPY         2,081         607,625         0         1,576,354         50.00         55.00         55.00         55.00         55.00         55.00								
11 0.0 01100 (AFTERIA       925       223, 195       0       393, 805       925       11.00         13 00 01300 (URSIN GANN INSTRATION)       615       49, 076       0       76, 874       615       13.00         14 0.0 01400 (ENTRAL SERVICES & SUPPLY       1, 977       48, 314       0       152, 256       1, 977       14.00         10 0100 (DIEDICAL RECORDS & LIBRARY       1, 428       303, 325       0       11.40, 638       6, 202       30.00         00 03000 (DPERATINE ROOM       5, 428       549, 495       0       791, 365       5, 428       50.00         51.00 05100 (PERATINE ROOM       5, 428       36, 990       0       60.383       6282       51.00         53.00 05300 (RASTINES) IOLOGY       0       0       0       0       0       0       55.00         54.00 06.000 (RASTINES) IOLOGY       0       0       0       0       0       0       0       55.00         55.00 06.000 (RASTINES) IOLOGY       0       0       0       0       0       0       0       0       55.00       0       55.00       0       55.00       0       0       0       0       0       0       0       0       0       0       0       0	9.00			244, 223				9.00
13.00       U1300       ULBRING ADMINISTRATION       615       49.076       0       76.874       615       13.00         14.00       01400       VERY CES & SUPPLY       1,977       48.314       0       152.256       1.977       14.00         11.00       COLOR AL, RECORDS & LIBRARY       1.428       303.325       0       516.393       1.420       16.00         INPATE INT ROUTINE SERVICE COST CENTERS	10.00	01000 DI ETARY	2, 783	91, 728		0 216, 548	2, 783	10.00
14.0.0       01400       CENTRAL SERVICES & SUPPLY       1,977       48.314       0       152,256       1,977       14.00         10.00       DIOD VEDICAL RECORS & LIBRARY       1,428       303.325       0       51.393       1.428       16.00         10.00       DIOD OD VEDICAL RECORS & LIBRARY       1,428       303.325       0       0       30.00         0.00       DOOD OPERATINC SERVICE COST CENTERS       -       -       -       -       -       -       30.00         0.00       DOOD OPERATINC ROOM       5,428       56,90       0       60.383       6.282       51.00       -       0	11.00		925					11.00
16.00         01600 MEDICAL RECORDS & LIBRARY         1,428         303,325         0         516,393         1,428         16.00           10010         02000 ADULTS & PEDIATRICS         6,202         756,305         0         1,140,638         6,202         30.00           ANCILLARY SERVICE COST CENTERS         5.428         5.494         0         791,365         5,428         5.00         6.0333         628         51.00         510,00         510,00         510,00         510,00         510,00         510,00         510,00         510,00         510,00         53,00         628         51,00         53,00         60,00         60,00         60,00         53,00         60,00         60,00         60,00         60,00         53,00         60,00					1			
INPATI ENT NOUTINE SERVICE COST CENTERS								
30. 00         O3000[ADULTS & PEDIATINC S         6, 202         756, 365         0         1, 140, 638         6, 202         30. 00           ANCILLARY SERVICE COST CENTERS         5         428         549, 495         0         791, 365         5, 428         50. 00         60, 383         628         51. 00         51.00         60, 383         628         51. 00         50. 00         50. 00         60, 383         628         51. 00         53. 00         53. 00         53. 00         53. 00         53. 00         53. 00         53. 00         53. 00         53. 00         53. 00         53. 00         53. 00         55. 00         60. 00	16.00		1, 428	303, 325		0 516, 393	1, 428	16.00
ANCI LLARY SERVICE COST CENTERS	20.00		6 202	756 265	1	0 1 140 629	6 202	20.00
50.00         050000         0FERATING ROOM         5,428         54,4945         0         791,365         5,428         50.00           51.00         05000 REDUELPR ROM         628         35,990         0         60.033         628         51.00           54.00         05300 ANDILOGY-DI ACNOSTIC         7,586         850,298         0         1,586,958         7,586         54.00           55.00         05500 RADI OLOGY-THERAPEUTIC         0         0         0         1,570,603         2,081         60.70         67.00         65.00         65.00         66.00         65.00         66.00         65.00         66.00         66.00         66.00         66.00         66.00         66.00         64.00         62.2759         131         65.00         66.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60	30.00		0, 202	700, 300		0 1, 140, 036	0, 202	30.00
51:00       DS100       RECOVERY ROOM       6.28       35,90       0       6.0,383       628       51.00         53:00       DS300       ANSTHESILOLGY       0       0       0       0       0       0       53.00         54:00       DS300       ANSTHESILOLGY       0       0       0       0       55.00         0       DS500       RADIOLOGY-DIAGNESTIC       7, 586       850, 298       0       1, 570, 603       2, 081       60.00         66:00       D66000       HABORATORY       131       92, 671       0       122, 759       131       65.00         66:00       D66000       PHYSICAL THERAPY       3, 823       610.00       444, 193       33, 823       66.00       66.00       660.00       60.00       0       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00       70.00	50 00		5 428	549 495		0 791 365	5 428	50 00
53.00       05300       ARSTHEST LOLOGY       0       0       0       0       53.00       53.00         54.00       05400       RADIOLOGY-THERAPEUTIC       7,586       850,298       0       1,566,958       7,586       54.00         55.00       05500       RADIOLOGY-THERAPEUTIC       0       0       0       1,570,603       2,081       60.00         66.00       06000       RESPI RATORY THERAPY       3,823       231,074       0       1444,193       3,823       66.00         67.00       0700 OCLIPATIONAL THERAPY       833       170,472       0       241,535       683,67.00         68.00       068000       SPECH PATHOLOGY       124       21,540       0       35,475       124       68.00         00       0000       CELCTROENCEPHALOGRAPHY       0       0       0       0       70.00         71.00       07100       DITAL       CHARGED TO PATIENTS       0       0       0       151,499       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       356       400.03       3459,530       22.002       3,769,697       0       3,459,530       22.002       91.00       92.00       92.00       92.00					1			
55.00         OBSON         RADIOLOGY-THERAPEUTIC         O <tho< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tho<>								
60.00         06000         LABORATORY         2,081         607,625         0         1,570,603         2,081         60.00           65.00         06500         RESPIRATORY THERAPY         131         92,671         0         122,759         131         65.00           66.00         06600         PHYSICAL THERAPY         3,823         231,074         0         444,193         3,823         66.00           67.00         06700         CCUPATI ONAL THERAPY         3,823         421,540         0         35,475         124         68.00           68.00         06800         PEECH PATHOLOGY         124         21,540         0         36,475         124         68.00           69.00         070.00         07000         LECTROCARDIOLOGY         402         170,407         0         224,588         402         69.00           71.00         07100         INPL. DEV. CHARGED TO PATIENTS         0         0         0         101,775         0         72.00           73.00         07300         INPL. DEV. CHARGED TO PATIENT         3,858         775,256         0         2,069,623         3,858         91.00           90.00         09100         EMERGENCY         3,858         775,256<	54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 586	850, 298		0 1, 586, 958	7, 586	54.00
65.00         06500         RESPIRATORY THERAPY         131         92,671         0         122,759         131         65.00           66.00         06600         PHYSICAL THERAPY         3,823         231,074         0         444,193         3,823         66.00           67.00         06700         OCCUPATIONAL THERAPY         833         170,472         0         241,535         68.30         66.00           68.00         DEECT PATHOLOGY         124         21,540         0         35,475         124         68.00           69.00         66000         ELECTROEACRDI OLOGY         122         170,407         0         224,588         402.26         69.00           70.00         7000         ELECTROEACPHALOGRAPHY         0         0         0         151,499         71.00           71.00         7000         DEVECKARDED TO PATIENTS         0         0         101,775         72.00           73.00         073000         DEVECKARGED TO PATIENTS         356         408,039         2.089,537         356           90.00         OSESERVATION BEDS (NON-DISTINCT PART)         3,858         775.256         0         2.069,623         3,858         91.00           92.00         OSESER	55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
66.00       06600       PHYSI CAL THERAPY       3,823       231,074       0       444,193       3,823       66.00         67.00       06700       0CCUPATI ONAL THERAPY       833       170,472       0       241,535       833       67.00         68.00       06800       SPEECH PATHOLOGY       124       21,540       0       35,475       124       68.00         69.00       06800       SPEECH PATHOLOGY       402       170,407       0       224,588       402       69.00         70.00       07000       ELCTROCARDI OLOGY       402       170,407       0       224,588       402       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       0       0       71.00       71.00         73.00       07300       DRUS CHARGED TO PATIENTS       356       408,039       0       2,883,537       356       72.00       73.00         00.00       90000       CLINIC       22,002       3.796,677       0       3.459,530       22.002       9.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.06       92.049,63<	60.00		2, 081			0 1, 570, 603	2, 081	•
67.00       06700       OCCUPATIONAL THERAPY       833       170,472       0       241,535       833       67.00         68.00       06800       SPECH PATHOLOGY       124       21,540       0       35,475       124       68.00         69.00       06900       ELECTROCARDIOLOGY       402       170,407       0       224,588       402       69.00         70.00       07000       ELECTROCARDIOLOGY       0       0       0       0       0       0       70.00       0       70.00       0       0       0       70.00       0       70.00       70.00       0       71.00       70.00       <						.22,707		
68.00         06800         SPECH         PATHOLOGY         124         21,540         0         35,475         124         68.00           69.00         06900         ELECTROCARDIOLOGY         402         170,407         0         224,588         402         69.00           70.00         07000         ELECTROCARDIOLOGY         0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
69.00         06900         ELECTROCARDIQLOGY         402         170,407         0         224,588         402         69.00           70.00         07000         ELECTROENCEPHALOGRAPHY         0								1
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0         0         0         70.00         70.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0         0         0         151,499         0         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         356         408,039         0         2,883,537         356         73.00           001PATIENT SERVICE COST CENTERS         0         0         3,796,967         0         3,459,530         22,002         90.00           90.00         09000         CLINIC         22,002         3,796,967         0         3,459,530         22,002         90.00           90.00         09000         CLINIC         3,858         775,256         0         2,069,623         3,858         91.00           91.00         09500         AMBULANCE SERVI CES         1,280         573,045         810,516         1,280         92.00           95.00         MBURSABLE COST CENTERS         9         0         0         0         0         91.00         91.00         91.00         91.00         91.00         91.00         91.00         91.00         91.00								
71. 00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       0       0       151,499       0       71. 00         72. 00       07200       IMPL. DEV. CHARGED TO PATIENT       356       408,039       0       2,883,537       356       73. 00         73. 00       O7300       RUGS CHARGED TO PATIENTS       356       408,039       0       2,883,537       356       73. 00         90. 00       O9000       CLINIC       22,002       3,796,967       0       3,459,530       22,002       91. 00         91. 00       9000       DERGENCY       3,858       775,256       0       2,069,623       3,859       91. 00         92. 00       09200       0BSERVATION BEDS (NON-DISTINCT PART)       356       0       810,516       1,280       92. 00         95. 00       O9500       MBULANCE SERVICES       1,280       573,045       0       810,516       1,280       95. 00         95. 00       SPECIAL PURPOSE COST CENTERS       1,280       573,045       0       0       0       193.01       193.01       193.01       193.01       193.01       193.01       193.01       193.01       193.01       193.01       193.01       193.01       193.01       193.01				-				
72.00         07200         IMPL.         DEV.         CHARGED TO PATIENT         0         0         0         101,775         0         72.00           73.00         DRUGS CHARGED TO PATIENTS         356         408,039         0         2,883,537         356         73.00           90.00         OPODO CLINIC         22,002         3,796,967         0         3,459,530         22,002         90.00           91.00         P9100         EMERGENCY         3,858         775,256         0         2,069,623         3,858         91.00           92.00         09200         DESENVATION BEDS (NON-DI STINCT PART)         3,858         775,256         0         2,069,623         3,858         91.00         92.00           95.00         OP500 AMBULANCE SERVICES         1,280         573,045         0         810,516         1,280         95.00           95.00         OP500 CLINES         1,280         573,045         0         810,516         1,280         95.00           95.00         OP500 CLINES         1,280         573,045         0         810,516         1,280         95.00           91.001         SPECIAL PURPOSE COST CENTERS         1         18,051,946         18,551,946         18,551,946 <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>			-					
73.00         OT300         DRUGS CHARGED TO PATIENTS         356         408,039         0         2,883,537         356         73.00           0UTPATIENT SERVICE COST CENTERS			-	0				
OUTPATI ENT SERVICE COST CENTERS           90. 00         OPOCOC CLINIC         22,002         3,796,967         0         3,459,530         22,002         90.00           91. 00         OPOCOC CLINIC         23,858         775,256         0         2,069,623         3,858         92.00           92. 00         OPSCOLO (BSERVATI ON BEDS (NON-DI STINCT PART)         3,858         775,256         0         2,069,623         3,858         92.00           00 OPSCOL AMBULANCE SERVICES         1,280         573,045         0         810,516         1,280         95.00           SPECIAL PURPOSE COST CENTERS         95.00         SUBTOTALS (SUM OF LINES 1-117)         86,229         12,314,437         -3,651,946         18,551,094         64,202         118.00           118.00         SUBTOTALS (SUM OF LINES 1-117)         86,229         12,314,437         -3,651,946         18,551,094         64,202           192.00         PHYOSE COST CENTERS         0         0         0         0         192.00           192.00         PHYOSE COST CENTERS         0         0         0         0         193.01           193.01         FOUNDATION         251         57,210         0         77,180         251         93.02				408, 039				
91.00       09100       EMERGENCY       3,858       775,256       0       2,069,623       3,858       91.00       92.00         92.00       09200       ODSERVATION BEDS (NON-DISTINCT PART)       0       810,516       1,280       92.00         95.00       OP500       AMBULANCE SERVICES       1,280       573,045       0       810,516       1,280       95.00         SPECIAL PURPOSE COST CENTERS       118.00       SUBTOTALS (SUM OF LINES 1-117)       86,229       12,314,437       -3,651,946       18,551,094       64,202       118.00         118.00       SUBTOTALS (SUM OF LINES 1-117)       86,229       12,314,437       -3,651,946       18,551,094       64,202       118.00         192.00       19200       PHYSI CLANS' PRI VATE OFFICES       0       0       0       192.00       193.00       019300       NONPAID WORKERS       0       0       0       193.00       019300       NONPAID WORKERS       0       0       0       193.00       00       0       0       193.00       193.01       193.02       193.02       00       0       0       0       193.02       193.02       0CUPATI ONAL MEDI CINE       155       26,286       0       38,063       155       193.02       200.00				· · · · · · · · · · · · · · · · · · ·				1
92.00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART)       92.00         0THER       REI MBURSABLE       COST CENTERS       95.00       810.516       1.280       95.00         95.00       09500       AMBULANCE       SERVICES       1.280       573.045       0       810.516       1.280         95.01       JURDONALE       SUBTOTALS       SUBTOTALS       SUBTOTALS       SUBTOTALS       118.00       118.00       118.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       193.01       0       0       0       0       192.00       192.00       193.00       193.01       0       0       193.01       0       193.01       0       193.01       0       193.01       0       193.02       193.02       0       0       0       0       0       0       193.02       193.02       0       0       0       0       193.02       193.02       0       0       0       0       193.02       193.02       0       0       0       0       0       0	90.00	09000 CLI NI C	22, 002	3, 796, 967		0 3, 459, 530	22, 002	90.00
OTHER         REI MBURSABLE         COST         CENTERS         95.00         95.00         810,516         1,280         573,045         0         810,516         1,280         95.00         95.00         95.00         95.00         810,516         1,280         95.00 <td></td> <td></td> <td>3, 858</td> <td>775, 256</td> <td>,</td> <td>0 2, 069, 623</td> <td>3, 858</td> <td></td>			3, 858	775, 256	,	0 2, 069, 623	3, 858	
95.00       09500       AMBULANCE SERVICES       1,280       573,045       0       810,516       1,280       95.00         SPECIAL PURPOSE COST CENTERS         118.00         SUBTOTALS (SUM OF LINES 1-117)       86,229       12,314,437       -3,651,946       18,551,094       64,202       118.00         NONREI MBURSABLE COST CENTERS         118.00       0       0       0       0       0       192.00       19200       PHYSI CLANS' PRI VATE OFFICES       0       0       0       192.00       193.00       19300       NONPAI D WORKERS       0       0       0       193.00       19300       NONPAI D WORKERS       0       0       0       193.00       19302       OCCUPATI ONAL MEDI CI NE       155       26,286       0       38,063       155       193.02       193.02         193.02       19302       OCCUPATI ONAL MEDI CI NE       155       26,286       0       38,063       155       193.02       193.02       194.00       00       0       194.00       200.00       200.00       200.00       200.00       200.00       200.00       201.00       201.00       202.00       0       0       0       194.00       202.00	92.00							92.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1-117)         86,229         12,314,437         -3,651,946         18,551,094         64,202         118.00           NONREI MBURSABLE COST CENTERS         0         0         0         5         0         192.00           192.00         19300         NONREI MBURSABLE COST CENTERS         0         0         201         0         192.00           193.01         19301         FOUNDATI ON         251         57,210         0         77,180         251         193.01           193.02         19302         OCCUPATI ONAL MEDI CINE         155         26,286         0         38,063         155         193.02           194.00         07950         OTHER NONREI MBURSABLE COST CENTERS         0         0         0         0         194.00           200.00         Cross Foot Adj ustments         0         0         0         0         0         0         0         194.00           202.00         Cost to be al located (per Wkst. B, Part I)         20.534241         0.252593         0.195643         18.698706         203.00           203.00         Unit cost multiplier (Wkst. B, Part I)         20.534241         0.252593         0.195643	05 00		1 200	E72 04E		0 910 514	1 290	05 00
SUBTOTALS (SUM OF LINES 1-117)         86,229         12,314,437         -3,651,946         18,551,094         64,202         118.00           NONREI MBURSABLE COST CENTERS         0         0         0         5         0         192.00           192.00         19200         PHYSI CLANS' PRI VATE OFFICES         0         0         0         0         192.00           193.00         19300         NONPAID         WORKERS         0         0         0         193.00         193.00           193.01         19300         NONPAID WORKERS         0         0         77,180         251         193.01           193.02         OCCUPATI ONAL MEDI CINE         155         26,286         0         38,063         155         193.02           194.00         O7950         OTHER NONREI MBURSABLE COST CENTERS         0         0         0         0         194.00           200.00         Cross Foot Adj ustments         200.00         200.00         200.00         200.00         200.00         201.00         201.00         202.00         201.00         201.00         202.00         201.00         202.00         202.00         202.00         203.00         205.00         205.00         205.00         205.00	95.00		1,200	575,045		0 010, 510	1,200	95.00
NONREI MBURSABLE COST CENTERS           192.00         19200         PHYSI CLANS' PRI VATE OFFICES         0         0         5         0         192.00           193.00         19300         NONPAID         WORKERS         0         0         201         0         0         193.00           193.01         19301         FOUNDATI ON         251         57,210         0         77,180         251         193.02           193.02         19302         OCCUPATI ONAL MEDI CINE         155         26,286         0         38,063         155         193.02           194.00         007950         OTHER NONREI MBURSABLE COST CENTERS         0         0         0         0         194.00           200.00         Cross Foot Adj ustments         0         0         0         0         194.00           201.00         Negative Cost Centers         0         0         0         0         194.00           202.00         Cost to be allocated (per Wkst. B, Part I)         20.534241         0.252593         3,651,946         1,208,086         202.00           203.00         Unit cost multiplier (Wkst. B, Part I)         20.534241         0.252593         0.195643         18.698706         203.00	118 00		86 229	12 314 437	-3 651 94	6 18 551 094	64 202	118 00
192.00       19200       PHYSICIANS' PRIVATE OFFICES       0       0       5       0       192.00         193.00       19300       NONPAID       WORKERS       0       0       201       0       0       193.00         193.01       19301       FOUNDATION       251       57,210       0       77,180       251       193.01         193.02       19302       OCCUPATIONAL MEDICINE       155       26,286       0       38,063       155       194.00         194.00       07950       OTHER NONELIMBURSABLE COST CENTERS       0       0       0       0       0       0       0       0       0       0       193.02       200.00       0			,	/ /				
193.01       FOUNDATION       251       57, 210       0       77, 180       251       193.01         193.02       19302       OCCUPATIONAL MEDICINE       155       26, 286       0       38, 063       155       193.02         194.00       07950       OTHER NONREIMBURSABLE COST CENTERS       0       0       0       0       194.00         200.00       Cross Foot Adjustments       0       0       0       0       200.00       200.00       200.00       200.00       200.00       201.00       201.00       202.00       201.00       202.00       <	192.00		0	0		0 5	0	192.00
193.02       19302       OCCUPATIONAL MEDICINE       155       26,286       0       38,063       155       193.02         194.00       07950       OTHER NONREIMBURSABLE COST CENTERS       0       0       0       0       194.00         200.00       Cross Foot Adjustments       0       0       0       0       200.00       200.00       200.00       200.00       200.00       200.00       200.00       200.00       201.00       201.00       202.00       201.00       202.00       201.00       202.00       201.00       202.00	193.00	19300 NONPAID WORKERS	0	0	20	1 0	0	193.00
194.00       07950       OTHER NONREIMBURSABLE COST CENTERS       0       0       0       194.00         200.00       Cross Foot Adjustments       201.00       Negative Cost Centers       201.00	193.01	19301 FOUNDATI ON	251	57, 210				193. 01
200.00       Cross Foot Adjustments       200.00       200.00         201.00       Negative Cost Centers       201.00       201.00         202.00       Cost to be allocated (per Wkst. B, Part I)       1,778,984       3,131,629       3,651,946       1,208,086       202.00         203.00       Unit cost multiplier (Wkst. B, Part I)       20.534241       0.252593       0.195643       18.698706       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       20.534241       0.252593       0.195643       18.698706       203.00         205.00       Unit cost multiplier (Wkst. B, Part I)       20.001103       0.015325       2.640648       205.00			155	26, 286		0 38, 063		
201.00       Negative Cost Centers       201.00         202.00       Cost to be allocated (per Wkst. B, Part I)       1,778,984       3,131,629       3,651,946       1,208,086       202.00         203.00       Unit cost multiplier (Wkst. B, Part I)       20.534241       0.252593       0.195643       18.698706       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       20.534241       0.252593       0.195643       18.698706       203.00         205.00       Unit cost multiplier (Wkst. B, Part       0.001103       0.015325       2.640648       205.00			0	0		0 0	0	
202.00       Cost to be allocated (per Wkst. B, Part I)       1,778,984       3,131,629       3,651,946       1,208,086       202.00         203.00       Unit cost multiplier (Wkst. B, Part I)       20.534241       0.252593       0.195643       18.698706       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       20.534241       0.252593       0.195643       18.698706       203.00         205.00       Unit cost multiplier (Wkst. B, Part       0.001103       0.015325       2.640648       205.00								
203.00       Part I)       20.534241       0.252593       0.195643       18.698706       203.00         204.00       Cost to be allocated (per Wkst. B, Part I)       20.534241       0.252593       0.195643       18.698706       203.00         205.00       Unit cost multiplier (Wkst. B, Part I)       0.001103       0.015325       2.640648       205.00			1 770 000	0 404 400		0 / 54 . 6 . /	1 000 007	
203.00         Unit cost multiplier (Wkst. B, Part I)         20.534241         0.252593         0.195643         18.698706         203.00           204.00         Cost to be allocated (per Wkst. B, Part I)         20.534241         0.252593         0.195643         18.698706         203.00           205.00         Unit cost multiplier (Wkst. B, Part         0.001103         0.015325         2.640648         205.00	202.00		1, 778, 984	3, 131, 629		3, 651, 946	1, 208, 086	202.00
204.00         Cost to be allocated (per Wkst. B, Part II)         13,676         286,063         170,607         204.00           205.00         Unit cost multiplier (Wkst. B, Part         0.001103         0.015325         2.640648         205.00	203 00		20 52/2/1	0 252502		0 105642	18 609706	203 00
Part II)            205.00         Unit cost multiplier (Wkst. B, Part         0.001103         0.015325         2.640648         205.00			20. 004241					
205.00         Unit cost multiplier (Wkst. B, Part         0.001103         0.015325         2.640648         205.00	207.00			15, 570		200, 003	1,0,007	
	205.00			0. 001103		0. 015325	2. 640648	205.00

Health Financial Systems	RUSH MEMORIA			Inlie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			CCN: 151304 F	Period:	Worksheet B-1	
				rom 01/01/2014		
			1	o 12/31/2014	Date/Time Pre 5/29/2015 11:	
Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG	
	LINEN SERVICE	(SQUARE	(MEALS	(FTE'S)	ADMI NI STRATI ON	
	(POUNDS OF	FEET)	SERVED)			
	LAUNDRY)				(DI RECT	
			10.00	44.00	NRSING HRS)	
GENERAL SERVICE COST CENTERS	8.00	9.00	10.00	11.00	13.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	1	1				1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					1	4.00
5.00 00500 ADMI NI STRATI VE & GENERAL					1	5.00
7. 00 00700 OPERATION OF PLANT					1	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	28, 495				1	8.00
9. 00 00900 HOUSEKEEPI NG	2,000				1	9.00
10. 00 01000 DI ETARY	820	2, 783	100	)	1	10.00
11. 00 01100 CAFETERI A	0	925	0	1, 906	1	11.00
13.00 01300 NURSING ADMINISTRATION	0	615	c	10	148, 349	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	1, 977	0	20	0	14.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1, 428	0	122	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 03000 ADULTS & PEDI ATRI CS	18, 580	6, 202	100	217	45, 088	30.00
ANCI LLARY SERVI CE COST CENTERS	1.0/5	<b>F</b> 400			17.000	50.00
50. 00 05000 OPERATING ROOM	1, 865				17, 823	50.00
51.00 05100 RECOVERY ROOM	0	628 0			2, 144	51.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		-	-	0	53.00 54.00
55. 00 05500 RADI OLOGY - DI AGNOSTI C	1,205	7, 586		0 175 0 0	0	54.00
60. 00 06000 LABORATORY	0	2, 081	-	-	0	60.00
65. 00 06500 RESPI RATORY THERAPY	240				4,075	65.00
66. 00 06600 PHYSI CAL THERAPY	561			53	4,075	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	258				0	67.00
68. 00 06800 SPEECH PATHOLOGY	11				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	402		32	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	( c	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	356	0	58	2, 211	73.00
OUTPATIENT SERVICE COST CENTERS	1	1	1			
90. 00 09000 CLINIC	0				0	90.00
91.00 09100 EMERGENCY	2, 955	3, 858	0	173	36, 189	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
	0	1 200		100	40.010	
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	1, 280	(	198	40, 819	95.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	28, 495	62, 462	100	1, 885	148, 349	118 00
NONREI MBURSABLE COST CENTERS	20,473	02,402	100	1,005	140, 347	110.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	0	192.00
193. 00 19300 NONPAI D WORKERS	0					193.00
193. 01 19301 FOUNDATI ON	0	251		21		193.01
193. 02 19302 OCCUPATI ONAL MEDI CI NE	0	155		0		193.02
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0		194.00
200.00 Cross Foot Adjustments					-	200.00
201.00 Negative Cost Centers					1	201.00
202.00 Cost to be allocated (per Wkst. B,	80, 700	543, 166	337, 319	496, 138	111, 330	
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	2.832076				0. 750460	
204.00 Cost to be allocated (per Wkst. B,	7,823	40, 825	69, 948	8 28, 319	16, 033	204.00
Part II)	0.0715			44.0570-	0.1000-	005 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 274539	0. 649376	699.480000	14. 857817	0. 108076	205.00
11)	I	I	I	I I		I

Heal th	Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lieu	u of Form CMS-2552	2-10
	LLOCATION - STATISTICAL BASIS		Provi der	CCN: 151304	Peri od:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014	Data /Tima Dropary	od
					10 12/31/2014	Date/Time Prepare 5/29/2015 11:00 a	
	Cost Center Description	CENTRAL	MEDI CAL				
	·	SERVICES &	RECORDS &				
		SUPPLY	LI BRARY				
		(COSTED	(TIME				
		REQUIS.)	SPENT)	-			
		14.00	16.00				
	GENERAL SERVICE COST CENTERS	I I		1			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00							7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						3.00 9.00
9.00	01000 DI ETARY						). 00
11.00	01100 CAFETERI A						1.00
13.00	01300 NURSI NG ADMI NI STRATI ON						3.00
14.00	01400 CENTRAL SERVICES & SUPPLY	901, 861					4.00
16.00	01600 MEDICAL RECORDS & LIBRARY	3, 497	94, 400				f. 00 5. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	5,477	74, 400	/		10.	). 00
30.00	03000 ADULTS & PEDI ATRI CS	38, 809	40, 560			30	0. 00
50.00	ANCI LLARY SERVICE COST CENTERS	30,007	40, 300	/			/. 00
50, 00	05000 OPERATING ROOM	103, 264	8, 920			50	0. 00
51.00	05100 RECOVERY ROOM	3, 869	0, 720	•			1.00
53.00	05300 ANESTHESI OLOGY	0,007	C	1			3.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	36, 176	10, 800	1			4.00
55.00	05500 RADI OLOGY-THERAPEUTI C	00,170	10, 000 C	1			5.00
60.00	06000 LABORATORY	371, 220	C	1			0.00
65.00	06500 RESPIRATORY THERAPY	3, 437	200	1			5.00
66.00	06600 PHYSI CAL THERAPY	4, 120	200	•			5.00
67.00	06700 OCCUPATI ONAL THERAPY	49	C	•			7.00
68.00	06800 SPEECH PATHOLOGY	1, 616	C				3.00
69.00	06900 ELECTROCARDI OLOGY	0	C				9.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C			70	0. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	105, 790	C			71	1.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	101, 433	C			72	2.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 509	C			73	3.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	49, 386	C			90	0. 00
91.00	09100 EMERGENCY	52, 472	33, 920			91	1.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92	2.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	17, 056	C	)		95	5.00
	SPECIAL PURPOSE COST CENTERS						
118.00		900, 703	94, 400			118	3. 00
	NONREI MBURSABLE COST CENTERS						
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	C				2.00
	19300 NONPAI D WORKERS	0	C				3.00
	19301 FOUNDATI ON	311	C				3. 01
	19302 OCCUPATIONAL MEDICINE	847	C	1			3. 02
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	C				4.00
200.00	, , , , , , , , , , , , , , , , , , ,						0. 00
201.00							1.00
202.00		241, 298	689, 155			202	2.00
	Part I)						
203.00		0. 267556	7. 300371	•			3.00
204.00		49, 784	44, 276			204	4.00
205 65	Part II)	0.055000	0 4/000				
205.00	Unit cost multiplier (Wkst. B, Part	0. 055201	0. 469025			205	5.00

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151304	Period: From 01/01/2014	Worksheet C Part I	
				To 12/31/2014	Date/Time Pre 5/29/2015 11:	pared: 00 am
		Ti tl	e XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)	0.00	0.00	4.00		
UNDATE ENT. DOUTENE, CEDVILOE, COOT, CENTERO	1.00	2.00	3.00	4.00	5.00	
30.00 O3000 ADULTS & PEDIATRICS	2, 320, 098		2, 320, 0	20 0	0	30.00
ANCI LLARY SERVICE COST CENTERS	2, 320, 098		2, 320, 0	98 0	0	30.00
50. 00 05000 OPERATI NG ROOM	1, 230, 978		1, 230, 9	78 0	0	50.00
51. 00 05100 RECOVERY ROOM	94, 613		94, 6		0	51.00
53. 00 05300 ANESTHESI OLOGY	0,019		74,0	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 242, 313		2, 242, 3	13 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		2,2.2,0	0 0	0	55.00
60. 00 06000 LABORATORY	2,075,480		2, 075, 4	80 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	161, 682		161, 6		0	65.00
66. 00 06600 PHYSI CAL THERAPY	652, 098	0	652, 0	98 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	319, 595	0	319, 5	95 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	46, 789	0	46, 7	89 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	287, 847		287, 8	47 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	209, 444		209, 4		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	148, 826		148, 8		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 476, 448		3, 476, 4	48 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	4, 884, 360		4, 884, 3		0	
91.00 09100 EMERGENCY	2, 922, 229		2, 922, 2		0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	308, 222		308, 2	22	0	92.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	1, 090, 817		1, 090, 8	17 0	0	95.00
200.00 Subtotal (see instructions)	22, 471, 839				-	95.00 200.00
201.00 Less Observation Beds	308, 222		308, 2			200.00
202.00 Total (see instructions)	22, 163, 617					201.00
	22,100,017	0	1 22,100,0	.,, 0	0	202.00

Health Financial Systems	RUSH MEMORIAL	- HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES				Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/29/2015 11:	
		Ti tl	e XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				-		
30. 00 03000 ADULTS & PEDI ATRI CS	1, 650, 862		1, 650, 86	2		30.00
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	197, 003	2, 700, 092			0.000000	50.00
51.00 05100 RECOVERY ROOM	33, 220	614, 197			0.00000	51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0. 000000	0.00000	1
54.00 05400 RADI OLOGY-DI AGNOSTI C	671, 555	13, 905, 034			0.00000	
55.00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0. 000000		
60. 00 06000 LABORATORY	762, 734	8, 616, 158				
65. 00 06500 RESPI RATORY THERAPY	179, 266	200, 520				
66. 00 06600 PHYSI CAL THERAPY	187, 706	1, 071, 000				
67.00 06700 OCCUPATI ONAL THERAPY	142, 116	350, 985				
68.00 06800 SPEECH PATHOLOGY	25, 968	47,620				
69. 00 06900 ELECTROCARDI OLOGY	222, 479	1, 909, 658	2, 132, 13			
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0. 000000		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	163, 875	2, 034, 371				
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	56, 431	217, 440	273, 87			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 038, 632	5, 901, 502	6, 940, 13	4 0. 500919	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	61, 997	2, 592, 476				90.00
91.00 09100 EMERGENCY	84, 804	4, 611, 714			0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	711, 938	711, 93	8 0. 432934	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS			-			
95. 00 09500 AMBULANCE SERVICES	0	931, 816	931, 81	6 1.170636	0.000000	95.00
200.00 Subtotal (see instructions)	5, 478, 648	46, 416, 521	51, 895, 16	9		200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	5, 478, 648	46, 416, 521	51, 895, 16	9		202.00

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151304	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/29/2015 11:	
		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
ANCI LLARY SERVI CE COST CENTERS					_
50.00 05000 OPERATING ROOM	0. 000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000				55.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				90.00
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0.000000				95.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151304	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/29/2015 11:0	pared: 00 am
		Tit	le XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 320, 098		2, 320, 0	98 0	2, 320, 098	30.00
ANCI LLARY SERVI CE COST CENTERS	4 000 070	1	1 000 0		1 000 070	50.00
50. 00 05000 OPERATING ROOM	1, 230, 978		1, 230, 9		1, 230, 978	
51.00 05100 RECOVERY ROOM 53.00 05300 ANESTHESI OLOGY	94, 613		94, 6		94, 613	51.00 53.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	U U		2 242 2	0	0	
55. 00 05500 RADIOLOGY-DIAGNOSTIC	2, 242, 313		2, 242, 3	0	2, 242, 313 0	54.00 55.00
60. 00 06000 LABORATORY	2,075,480		2, 075, 4		2, 075, 480	
65. 00 06500 RESPI RATORY THERAPY	161, 682		161, 6		2, 075, 480	65.00
66. 00 06600 PHYSI CAL THERAPY	652,098		652, 0		652, 098	
67. 00 06700 OCCUPATI ONAL THERAPY	319, 595		319, 5		319, 595	67.00
68. 00 06800 SPEECH PATHOLOGY	46, 789		46, 7		46, 789	68.00
69. 00 06900 ELECTROCARDI OLOGY	287, 847	0	287, 8		287, 847	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		207,0	0 0	207,017	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	209, 444		209, 4	-	209, 444	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	148, 826		148, 8		148, 826	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 476, 448		3, 476, 4		3, 476, 448	
OUTPATIENT SERVICE COST CENTERS		I				
90. 00 09000 CLI NI C	4, 884, 360		4, 884, 3	60 0	4, 884, 360	90.00
91.00 09100 EMERGENCY	2, 922, 229		2, 922, 2	29 0	2, 922, 229	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	308, 222		308, 22	22	308, 222	92.00
OTHER REIMBURSABLE COST CENTERS		·				
95. 00 09500 AMBULANCE SERVI CES	1, 090, 817		1, 090, 8	17 0	1, 090, 817	95.00
200.00 Subtotal (see instructions)	22, 471, 839					
201.00 Less Observation Beds	308, 222		308, 22		308, 222	
202.00 Total (see instructions)	22, 163, 617	0	22, 163, 6	17 0	22, 163, 617	202.00

Health Financial Systems	RUSH MEMORIAL	- HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES				Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/29/2015 11:	
		Ti t	le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				-		
30. 00 03000 ADULTS & PEDI ATRI CS	1, 650, 862		1, 650, 86	2		30.00
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	197, 003	2, 700, 092			0.000000	50.00
51.00 05100 RECOVERY ROOM	33, 220	614, 197			0.00000	51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0. 000000	0.00000	1
54.00 05400 RADI OLOGY-DI AGNOSTI C	671, 555	13, 905, 034			0.00000	
55.00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0.000000		
60. 00 06000 LABORATORY	762, 734	8, 616, 158				
65. 00 06500 RESPI RATORY THERAPY	179, 266	200, 520				
66. 00 06600 PHYSI CAL THERAPY	187, 706	1, 071, 000				
67.00 06700 OCCUPATI ONAL THERAPY	142, 116	350, 985				
68.00 06800 SPEECH PATHOLOGY	25, 968	47,620				
69. 00 06900 ELECTROCARDI OLOGY	222, 479	1, 909, 658	2, 132, 13			
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0. 000000		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	163, 875	2, 034, 371				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	56, 431	217, 440	273, 87			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 038, 632	5, 901, 502	6, 940, 13	4 0. 500919	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	61, 997	2, 592, 476				90.00
91.00 09100 EMERGENCY	84, 804	4, 611, 714	4, 696, 51		0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	711, 938	711, 93	8 0. 432934	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS			-			
95. 00 09500 AMBULANCE SERVICES	0	931, 816	931, 81	6 1.170636	0.000000	95.00
200.00 Subtotal (see instructions)	5, 478, 648	46, 416, 521	51, 895, 16	9		200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	5, 478, 648	46, 416, 521	51, 895, 16	9		202.00

Heal th	Financial Systems	RUSH MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151304	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pro 5/29/2015 11:	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	NPATIENT ROUTINE SERVICE COST CENTERS					_
	D3000 ADULTS & PEDIATRICS					30.00
	ANCILLARY SERVICE COST CENTERS					_
	D5000 OPERATI NG ROOM	0. 000000				50.00
	D5100 RECOVERY ROOM	0. 000000				51.00
	D5300 ANESTHESI OLOGY	0. 000000				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
	D6000 LABORATORY	0. 000000				60.00
	06500 RESPI RATORY THERAPY	0. 000000				65.00
	D6600 PHYSI CAL THERAPY	0. 000000				66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
	D6800 SPEECH PATHOLOGY	0. 000000				68.00
	D6900 ELECTROCARDI OLOGY	0. 000000				69.00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
-	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	DUTPATIENT SERVICE COST CENTERS	1 1				-
	09000 CLI NI C	0. 000000				90.00
	D9100 EMERGENCY	0. 000000				91.00
-	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00
	OTHER REIMBURSABLE COST CENTERS	TT				
	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	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	NL COSTS			Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre 5/29/2015 11:	
			e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	1	1			
50. 00 05000 OPERATI NG ROOM	155, 800					50.00
51.00 05100 RECOVERY ROOM	16, 522				169	51.00
53. 00 05300 ANESTHESI OLOGY	0		0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	215, 982	14, 576, 589			3, 300	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0.00000		0	55.00
60. 00 06000 LABORATORY	97, 170				3, 504	60.00
65. 00 06500 RESPI RATORY THERAPY	6, 191					65.00
66. 00 06600 PHYSI CAL THERAPY	99, 310	1, 258, 706				66.00
67.00 06700 OCCUPATI ONAL THERAPY	24, 226	493, 101			1, 959	67.00
68.00 06800 SPEECH PATHOLOGY	3,644					68.00
69. 00 06900 ELECTROCARDI OLOGY	13, 683	2, 132, 137	0. 00641	8 118, 160	758	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 162	2, 198, 246	0.00371	3 55, 373	206	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	7, 159	273, 871	0. 02614	52, 503	1, 372	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	54, 692	6, 940, 134	0. 00788	385, 227	3, 036	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	591, 725	2, 654, 473	0. 22291	6 0	0	90.00
91.00 09100 EMERGENCY	150, 584	4, 696, 518	0. 03206	3, 650	117	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	45, 290	711, 938	0. 06361	5 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00   Total (lines 50-199)	1, 490, 140	49, 312, 491		1, 440, 013	24, 288	200. 00

Health Financial Systems	RUSH MEMORIAL	- HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provi der	CCN: 151304	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
		Ti +1	e XVIII	Hospi tal	5/29/2015 11: Cost	<u>oo am</u>
Cost Center Description	Non Physician				Total Cost	
cost center bescription	Anesthetist	an string school		Medi cal	(sum of col 1	
	Cost			Educati on Cost		
	0001				4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0	)	0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	)	0 0	0	51.00
53.00 05300 ANESTHESI OLOGY	0	0	)	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0	)	0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	)	0 0	0	55.00
60. 00 06000 LABORATORY	0	0	)	0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	)	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	)	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	)	0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00   Total (lines 50-199)	0	0		0 0	0	200. 00

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2014 To 12/31/2014		parod
				10 12/31/2014	5/29/2015 11:0	
			e XVIII	Hospi tal	Cost	
Cost Center Description	Total	Total Charges			Inpati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	-	1	-1		
50.00 05000 OPERATING ROOM	0	2, 897, 095	0. 00000			
51.00 05100 RECOVERY ROOM	0	647, 417				51.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	14, 576, 589	0.00000	0.000000	222, 722	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000	0.000000	0	55.00
60. 00 06000 LABORATORY	0	9, 378, 892	0.00000	0.000000	338, 191	60.00
65. 00 06500 RESPI RATORY THERAPY	0	379, 786	0.00000	0.000000	90, 386	65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 258, 706	0. 00000	0.000000	62, 866	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	493, 101	0. 00000	0.000000	39, 864	67.00
68.00 06800 SPEECH PATHOLOGY	0	73, 588	0. 00000	0.000000	7, 516	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 132, 137	0. 00000	0.000000	118, 160	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0.000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 198, 246	0. 00000	0.000000	55, 373	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	273, 871	0. 00000	0. 000000	52, 503	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	6, 940, 134	0. 00000	0. 000000	385, 227	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	2, 654, 473	0.00000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	4, 696, 518	0. 00000	0. 000000	3, 650	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	711, 938	0. 00000	0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS		·	·			
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	49, 312, 491			1, 440, 013	200. 00

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der	CCN: 151304	Period: From 01/01/2014	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2014		pared:
					5/29/2015 11:	<u>00 am</u>
			e XVIII	Hospi tal	Cost	
Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col.	9		
	x col. 10) 11.00	12.00	x col. 12) 13.00	_		
ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	13.00			
50. 00 05000 OPERATING ROOM	0	0		0		50.00
51. 00 05100 RECOVERY ROOM	0	0		0		51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0		55.00
60, 00 06000 LABORATORY	0	C	)	0		60,00
65. 00 06500 RESPI RATORY THERAPY	0	C	)	0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C	)	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	C	)	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	)	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	)	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C	)	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0		90.00
91.00 09100 EMERGENCY	0	0		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00   Total (lines 50-199)	0	0	1	0		200. 00

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
					5/29/2015 11:	00 am
		Titl	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0, 424901	0	961, 16	3 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 146139				0	
53. 00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 153830			0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000		, , , , , , , , , , , , , , , , , , ,	0 0	0	
60. 00 06000 LABORATORY	0. 221293		3, 191, 21	0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 425719		57, 91		0	
66. 00 06600 PHYSI CAL THERAPY	0. 518070		356, 31		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 648133		103, 61		0	
68. 00 06800 SPEECH PATHOLOGY	0. 635824		6, 86		0	
69. 00 06900 ELECTROCARDI OLOGY	0. 135004		926, 90		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	•
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 095278		375, 86		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 543416				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 500919				0	
OUTPATIENT SERVICE COST CENTERS		-				
90. 00 09000 CLINIC	1.840049	0	314, 93	5 5, 333	0	90.00
91.00 09100 EMERGENCY	0. 622212	0	954, 37		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 432934	0	307, 09	2 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	1. 170636			0		95.00
200.00 Subtotal (see instructions)		0	15, 093, 55	7 14, 273	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)		0	15, 093, 55	7 14, 273	0	202.00

Health Financial Systems	RUSH MEMORIA	AL HOSPITAL		In Lieu of Form CMS-2552		
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 151304	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prep 5/29/2015 11:0	
		Ti tl	e XVIII	Hospi tal	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	400.000					
50. 00 05000 0PERATING ROOM	408, 399					50.00 51.00
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	21, 580	0				51.00 53.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	(07.001	0				53.00 54.00
	687, 991					54.00 55.00
	0	-				
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	706, 194					60. 00 65. 00
	24,657					
	184, 597					66.00 67.00
67. 00 06700 OCCUPATI ONAL THERAPY	67, 159					
68. 00 06800 SPEECH PATHOLOGY	4, 365					68.00
69. 00 06900 ELECTROCARDI OLOGY	125, 136					69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	-				70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	35, 811					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	27,930					72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS	1, 435, 538	4, 478				73.00
90. 00 09000 CLINIC	579, 496	9, 813				90.00
90. 00 109000 CET NTC 91. 00 109100 EMERGENCY	593, 825					90.00 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	132, 951					91.00 92.00
072.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	132,951	0	I			72.00
95. 00 09500 AMBULANCE SERVICES	0	1				95.00
200.00 Subtotal (see instructions)	5, 035, 629	14, 291				200.00
201.00 Less PBP Clinic Lab. Services-Program	5,035,027	14, 271				200.00
Only Charges					ľ	201.00
202.00 Net Charges (line 200 +/- line 201)	5, 035, 629	14, 291				202.00

Health Financial Systems	RUSH MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provi der	CCN: 151304	Peri od:	Worksheet D	
		Component		From 01/01/2014 To 12/31/2014	Part V Date/Time Pre	narad
		Component	L CCN. 152504	10 12/31/2014	5/29/2015 11:	
		Titl	e XVIII	Swing Beds - SNF		<u></u>
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 424901			0 0	0	
51.00 05100 RECOVERY ROOM	0. 146139			0 0	0	51.00
53.00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 153830			0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			0 0	0	55.00
60. 00 06000 LABORATORY	0. 221293			0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 425719			0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 518070			0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 648133	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 635824			0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 135004	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 095278			0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 543416			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 500919	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS		-	1	- 1		
90. 00 09000 CLI NI C	1. 840049			0 0	0	90.00
91. 00 09100 EMERGENCY	0. 622212			0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 432934	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		1	-			
95. 00 09500 AMBULANCE SERVICES	1. 170636			0		95.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program	1			0 0		201.00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)		0	1	0 0	0	202.00

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 151304 t CCN: 15Z304	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepared: 5/29/2015 11:00 am
		Ti tl	e XVIII	Swing Beds - SNF	Cost
	Cos	sts			
Cost Center Description	Cost Reimbursed	Cost Reimbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coins.	Ded. & Coins.			
	(see inst.)	(see inst.)			
	6.00	7.00	1		
ANCI LLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0	C	)		50.00
51.00 05100 RECOVERY ROOM	0	0			51.00
53. 00 05300 ANESTHESI OLOGY	0	C			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	c c			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	c c			55.00
60. 00 06000 LABORATORY	0	C			60.00
65. 00 06500 RESPI RATORY THERAPY	0	C			65.00
66. 00 06600 PHYSI CAL THERAPY	0	l a			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	c			67.00
68.00 06800 SPEECH PATHOLOGY	0	c			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	c			69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	c			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	c			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0	0	)		90.00
91.00 09100 EMERGENCY	0	0			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			92.00
OTHER REI MBURSABLE COST CENTERS	·	•			
95. 00 09500 AMBULANCE SERVICES	0				95.00
200.00 Subtotal (see instructions)	0	0			200.00
201.00 Less PBP Clinic Lab. Services-Program	0				201.00
Only Charges					
202.00 Net Charges (line 200 +/- line 201)	0	c			202.00

	FINANCIAL SYSTEMS RUSH MEMORIAL HC	Provider CCN: 151304	Period: From 01/01/2014	u of Form CMS-2 Worksheet D-1	
			To 12/31/2014	Date/Time Prep 5/29/2015 11:0	
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	avaluding nauharn)		2,210	   1.
. 00	Inpatient days (including private room days, excluding swing-bed days,			2, 310 1, 594	2.
00	Private room days (excluding swing-bed and observation bed days	s). If you have only pr	ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	d days)		1, 327	4
00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	378	5
00	reporting period Total swing-bed SNF type inpatient days (including private room	m davs) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	5.7			
00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	338	7
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing_bed_and	772	9
00	newborn days)		Swirig bed and	112	ĺ
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi		oom days)	356	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	ly (including private r	oom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, end Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
. 00	through December 31 of the cost reporting period		<u> </u>		
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			0	13
. 00	Medically necessary private room days applicable to the Program			0	14
. 00	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to services	s through December 31 o	f the cost		17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services reporting period	s after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	129. 14	19
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	he cost	0.00	20
. 00	Total general inpatient routine service cost (see instructions)			2, 320, 098	
. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	r 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	31 of the cost reportin	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	43, 649	24
	7 x line 19) Swing-bed cost applicable to NF type services after December 31	1 of the cost reporting	period (line 8	0	25
. 00					
	x line 20) Total swing-bed cost (see instructions)			480 008	26
. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	line 21 minus line 26)		480, 008 1, 840, 090	
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ł	arges)	1, 840, 090	27
. 00 . 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ł	arges)		27 28
. 00 . 00 . 00 . 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I <u>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</u> General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	and observation bed ch	arges)	1, 840, 090 0 0 0	27 28 29 30
. 00 . 00 . 00 . 00 . 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	and observation bed ch	arges)	1, 840, 090 0 0 0.000000	27 28 29 30 31
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I <u>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</u> General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)	and observation bed ch	arges)	1, 840, 090 0 0 0	27 28 29 30 31 32
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)	and observation bed ch line 28)		1, 840, 090 0 0 0 0. 000000 0. 00	27 28 29 30 31 32 33
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge differential (line 32 minu Average per diem private room cost differential (line 34 x line	and observation bed ch line 28) us line 33)(see instruc		1, 840, 090 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00	27 28 29 30 31 32 33 34 35
<ul> <li>a. 00</li> <li>b. 00</li> <li>c. 00</li> </ul>	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 34 × line Private room cost differential adjustment (line 3 × line 35)	and observation bed ch line 28) us line 33)(see instruc e 31)	tions)	1, 840, 090 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	27 28 29 30 31 32 33 34 35 36
<ul> <li>a. 00</li> <li>b. 00</li> <li>c. 00</li> </ul>	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost ar 27 minus line 36)	and observation bed ch line 28) us line 33)(see instruc e 31)	tions)	1, 840, 090 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00	27 28 29 30 31 32 33 34 35 36
0.00         1.00         2.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 × line Private room cost differential adjustment (line 3 × line 35) General inpatient routine service cost net of swing-bed cost ar 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	and observation bed ch line 28) us line 33)(see instruc e 31) nd private room cost di	tions)	1, 840, 090 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	27 28 29 30 31 32 33 34 35 36
a.       00         7.       00         3.       00         b.       00         b.       00         c.       00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room cost differential (line 32 minu Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost ar 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	and observation bed ch line 28) us line 33)(see instruc e 31) nd private room cost di	tions)	1, 840, 090 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0 1, 840, 090	277 28 29 30 31 32 33 34 35 36 37
5. 00 7. 00 3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00 7. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 × line Private room cost differential adjustment (line 3 × line 35) General inpatient routine service cost net of swing-bed cost ar 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	and observation bed ch line 28) us line 33)(see instruc e 31) nd private room cost di STMENTS instructions)	tions)	1, 840, 090 0 0 0. 000000 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	277 28 29 30 31 32 33 34 35 36 37 36 37

MPUT	ATION OF INPATIENT OPERATING COST		Provi de	er CCN: 151304	Period: From 01/01/2014		
					To 12/31/2014	Date/Time Pre 5/29/2015 11:	
	Cost Center Description	Total	Ti Total	tle XVIII Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost				(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.
00	INTENSIVE CARE UNIT		1				43
00	CORONARY CARE UNI T						44
00	BURN INTENSIVE CARE UNIT						45
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46
00	Cost Center Description						47
						1.00	
	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			ions)		480, 922 1, 372, 111	
00	PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instruct	1005)		1, 372, 111	49
00	Pass through costs applicable to Program inpa	atient routine	services (fr	om Wkst. D, su	m of Parts I and	C	50
~~	III)			from What D			1
. 00	Pass through costs applicable to Program inpa and IV)	atlent ancillar	ry services (	TFOM WKST. D,	sum of Parts II	C	51
. 00	Total Program excludable cost (sum of lines !	50 and 51)				c c	52
. 00	Total Program inpatient operating cost exclud		elated, non-p	hysician anest	hetist, and	0	53
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					
. 00	Program discharges					0	54
00	Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					0	
00	Difference between adjusted inpatient operati	ing cost and ta	arget amount	(line 56 minus	line 53)		
8.00  Bonus payment (see instructions) 9.00  Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the							) 58
	market basket	oor tring porrou	ondring 1770,	updatou and o			
. 00	Lesser of lines 53/54 or 55 from prior year of					0.00	
. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					C	61
	amount (line 56), otherwise enter zero (see i		13 (11103 54	x 00), 01 1% 0	i the target		
	Relief payment (see instructions)					0	
. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	) 63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of t	he cost report	ing period (See	410, 963	64
	instructions)(title XVIII only)	Ū.			0		
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reportin	g period (See	0	) 65
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVI	II onlv). For	410, 963	66
	CAH (see instructions)				•		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	n December 31	of the cost r	eporting period	0	67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after [	ecember 31 c	f the cost ren	orting period	0	68
. 00	(line 13 x line 20)				or tring period		
. 00	Total title V or XIX swing-bed NF inpatient		•	,		C	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70
. 00	Adjusted general inpatient routine service of						71
. 00	Program routine service cost (line 9 x line			,			72
. 00	Medically necessary private room cost applica						73
. 00 . 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient i				Part II column		74
. 00	26, line 45)	Satine service		NOT KOHEEL D,	art II, corunn		'
. 00	Per diem capital-related costs (line 75 ÷ li						76
. 00	Program capital -related costs (line 9 x line	,					77
00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess	,	provider reco	rds)			78
00	Total Program routine service costs for compa	• •		· .	nus line 79)		80
00	Inpatient routine service cost per diem limi	tati on			-		81
00	Inpatient routine service cost limitation (li						82
. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see ins		15)				83
. 00	Utilization review - physician compensation		ons)				85
. 00	Total Program inpatient operating costs (sum	of lines 83 th					86
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0/7	1 07
00	LILLAL DUSELVATION DED DAVS (SEE EDSTELICTIONS)	,				267	'  87
. 00 . 00	Adjusted general inpatient routine cost per o		÷line 2)			1, 154. 39	88

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lieu of Form CMS-2552-			
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1		
				To 12/31/2014	Date/Time Pre 5/29/2015 11:	pared: 00 am	
	Title XVIII				Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST						
90.00 Capital-related cost	270, 383	1, 840, 090	0. 14694	308, 222	45, 290	90.00	
91.00 Nursing School cost	0	1, 840, 090	0.00000	308, 222	0	91.00	
92.00 Allied health cost	0	1, 840, 090	0.00000	308, 222	0	92.00	
93.00 All other Medical Education	0	1, 840, 090	0.00000	308, 222	0	93.00	

	Financial Systems RUSH MEMORIAL HOST	Provider CCN: 151304	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2014 To 12/31/2014	Date/Time Prep 5/29/2015 11:0	
		Title XIX	Hospi tal	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed days,			2, 310 1, 594	1
00 00	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days)		ivate room days	1, 594	
00	do not complete this line.	. If you have only pr	vare room aays,	0	
00	Semi-private room days (excluding swing-bed and observation bed			1, 327	4
00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private room	davs) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private room d	ays) through December	31 of the cost	338	7
00	reporting period Total swing-bed NF type inpatient days (including private room d	ave) after December 2	1 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	ays) arter becember 3	I OI LINE COST	0	
00	Total inpatient days including private room days applicable to t	he Program (excluding	swing-bed and	113	ģ
	newborn days)	(including at 1	a am day := )		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instructio		oom days)	0	10
. 00	5		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, ente	r 0 on this line)	5		
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX o through December 31 of the cost reporting period	nly (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX o	nlv (including privat	e room davs)	0	13
	after December 31 of the cost reporting period (if calendar year	, enter 0 on this lin	e)	-	
	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15 16
. 00	SWING BED ADJUSTMENT		I	0	
. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost		17
	reporting period	- Et a Daramban 21 - E	***		1
5. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	arter December 31 01	the cost		18
9. 00	Medicaid rate for swing-bed NF services applicable to services t	hrough December 31 of	the cost	0.00	19
	reporting period	6t	<b>-</b>	0.00	
0.00	Medicaid rate for swing-bed NF services applicable to services a reporting period	The December 31 01 t	ne cost	0.00	20
. 00	Total general inpatient routine service cost (see instructions)			2, 320, 098	21
2.00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22
	5 x line 17) Swing-bed cost applicable to SNF type services after December 31	of the cost reporting	a ported (line (	0	23
8. 00	x line 18)	of the cost reporting	y period (inte o	0	23
1.00	Swing-bed cost applicable to NF type services through December 3	1 of the cost reporti	ng period (line	0	24
. 00	7 x line 19)	of the cost reporting	pariod (line 9	0	25
5.00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (inte o	0	20
5.00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost (li	ne 21 minus line 26)		2, 320, 098	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed a	nd obsorvation bod ch	argos)	0	28
	Private room charges (excluding swing-bed charges)		ai ges)	0	
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 ÷ l	ine 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus	line 33)(see instruc	tions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x line			0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	5	private room cost di	fferential (line	2, 320, 098	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
8.00	Adjusted general inpatient routine service cost per diem (see in			1, 455. 52	
	Program general inpatient routine service cost (line 9 x line 38	)		164, 474	39
	Medically necessary private room cost applicable to the Program			0	

MPUT.	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 151304	Period: From 01/01/2014	Worksheet D-1	1
					To 12/31/2014		
				tle XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00	NURSERY (title V & XIX only)						42
00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43
	CORONARY CARE UNIT						43
	BURN INTENSIVE CARE UNIT						45
	SURGI CAL INTENSI VE CARE UNI T						46
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1 00	-
00	Program inpatient ancillary service cost (Wks	st D_3 col 3	line 200)	-		1.00 100,798	3 48
	Total Program inpatient costs (sum of lines 4			ons)		265, 272	
	PASS THROUGH COST ADJUSTMENTS	······································					
00	Pass through costs applicable to Program inpa	atient routine	services (fro	n Wkst. D, sur	m of Parts I and	C	50
~~							
00	Pass through costs applicable to Program inpa and IV)	atient anciiiar	ry services (T	rom WKST. D, S	sum of Parts II	C	) 51
00	Total Program excludable cost (sum of lines !	50 and 51)				C	52
00	Total Program inpatient operating cost exclud		ated, non-ph	ysician anestl	netist, and	C	
	medical education costs (line 49 minus line !	52)	•				
~ ~	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0. 00	
	Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operati	ng cost and ta	arget amount (	line 56 minus	line 53)	C	
00							
~~	market basket					0.00	
00 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0. 00 C	
00	which operating costs (line 53) are less than						
	amount (line 56), otherwise enter zero (see i				<u>J</u>		
	Relief payment (see instructions)					C	
00	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			C	) 63
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos:	ts through Dece	mber 31 of th	e cost reporti	ing period (See	C	64
00	instructions) (title XVIII only)	to through bood		o ocor i opoi i	ing poirted (eee		
00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reporting	g period (See	C	) 65
~~	instructions)(title XVIII only)		<i></i>				
00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line	64 plus line	55)(title XVI	II ONLY). FOR	C	66
00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31	of the cost re	eporting period	C	67
	(line 12 x line 19)					-	
00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	C	68
00	(line 13 x line 20)			- (0)			
00	Total title V or XIX swing-bed NF inpatient N PART III - SKILLED NURSING FACILITY, OTHER NU			,		U	) 69
00	Skilled nursing facility/other nursing facili						70
	Adjusted general inpatient routine service co						71
	Program routine service cost (line 9 x line						72
	Medically necessary private room cost applica						73
00 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient i	•			Part II column		74
00	26, line 45)	Satine service		NOTROLET D, I	artir, corumn		'
00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76
	Program capital-related costs (line 9 x line						77
	Inpatient routine service cost (line 74 minus	,		-1 - 2			78
	Aggregate charges to beneficiaries for excess	• •		· · · · · · · · · · · · · · · · · · ·	ous line 70)		80
	Total Program routine service costs for compa Inpatient routine service cost per diem limi		Jost i i mi tati O		105 I I I E /7)		81
	Inpatient routine service cost per drem rim		)				82
	Reasonable inpatient routine service costs (						83
	Program inpatient ancillary services (see in						84
	Utilization review - physician compensation						85
00	Total Program inpatient operating costs (sum		irougn 85)				86
00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					267	7 87
55			1:00 2)			1, 455. 52	
00	Adjusted general inpatient routine cost per o	alem (IIne ∠/÷	· i i ne z)			1,400.02	

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lieu of Form CMS-2552-1			
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1		
				To 12/31/2014	Date/Time Pre 5/29/2015 11:		
		Tit	le XIX	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST						
90.00 Capital-related cost	270, 383	2, 320, 098	0. 11653	9 388, 624	45, 290	90.00	
91.00 Nursing School cost	0	2, 320, 098	0.00000	0 388, 624	0	91.00	
92.00 Allied health cost	0	2, 320, 098	0.00000	0 388, 624	0	92.00	
93.00 All other Medical Education	0	2, 320, 098	0.00000			93.00	

Health Financial Systems	RUSH MEMORIAL HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151304	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Pre	pared:
	T: +1	e XVIII	Hospi tal	5/29/2015 11: Cost	<u>00 am</u>
Cost Center Description	11 11	Ratio of Cos		Inpati ent	
cost center bescription		To Charges	Program	Program Costs	
		10 charges		$(col. 1 \times col.$	
			onar ges	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			975, 183		30.00
ANCI LLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 42490		24, 193	
51.00 05100 RECOVERY ROOM		0. 14613		967	
53. 00 05300 ANESTHESI OLOGY		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 15383		34, 261	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000		0	
60. 00 06000 LABORATORY		0. 22120		74, 839	•
65. 00 06500 RESPI RATORY THERAPY		0. 4257		38, 479	
66. 00 06600 PHYSI CAL THERAPY		0. 5180			
67.00 06700 OCCUPATI ONAL THERAPY		0. 64813		25, 837	•
68.00 06800 SPEECH PATHOLOGY		0. 63582			
69. 00 06900 ELECTROCARDI OLOGY		0. 13500		15, 952	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0952		5, 276	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 5434		28, 531	•
73.00 07300 DRUGS CHARGED TO PATIENTS		0.5009	385, 227	192, 968	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		1.84004		0	
91.00 09100 EMERGENCY		0. 6222		2, 271	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 43293	34 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		1			
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50-94 and 96-98)			1, 440, 013	480, 922	
201.00 Less PBP Clinic Laboratory Services-Progr	am only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)		1	1, 440, 013		202.00

Health Financial Systems RUSH	MEMORIAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Period:	Worksheet D-3	
	Component		From 01/01/2014 To 12/31/2014	Date/Time Pre	narod
	component	CCN. 152504	10 12/31/2014	5/29/2015 11:	
	Title	e XVIII -	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			0		20.00
30. 00 03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS			0		30.00
50. 00 05000 OPERATING ROOM		0. 42490	1 0	0	50.00
51. 00 05100 RECOVERY ROOM		0. 14613		0	51.00
53. 00 05300 ANESTHESI OLOGY		0. 00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 15383			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 00000		0	55.00
60. 00 06000 LABORATORY		0. 22129			60.00
65. 00 06500 RESPIRATORY THERAPY		0. 42571			
66. 00 06600 PHYSI CAL THERAPY		0. 51807			66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 64813	3 56, 228	36, 443	67.00
68.00 06800 SPEECH PATHOLOGY		0. 63582	4 6, 843	4, 351	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 13500	4 13, 337	1, 801	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000	0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.09527	8 143	14	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 54341		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 50091	9 79, 874	40, 010	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		1.84004		0	90.00
91.00 09100 EMERGENCY		0. 62221		0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 43293	4 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					05 00
95.00 09500 AMBULANCE SERVICES 200.00 Total (sum of lines 50-94 and 96-98)			200,004	120 700	95.00
	V charges (Line (1)		309, 094	139, 708	200.00
201.00Less PBP Clinic Laboratory Services-Program onl202.00Net Charges (line 200 minus line 201)	y charges (The 61)		309, 094		201.00
202.00 [INEL CIALGES (TITLE 200 IIITIUS TITLE 201)	I		309, 094	l	202.00

Health Financial Systems RUSH MEMORIAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provid	er CCN: 151304	Period: From 01/01/2014 To 12/31/2014	Worksheet D-3 Date/Time Pre 5/29/2015 11:0	pared:
	Title XIX	Hospi tal	Cost	
Cost Center Description	Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		146, 637		30.00
ANCI LLARY SERVI CE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 4249			50.00
51.00 05100 RECOVERY ROOM	0. 1461			51.00
53. 00 05300 ANESTHESI OLOGY	0.0000		-	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 1538			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.0000		-	55.00
60. 00 06000 LABORATORY	0. 2212			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 4257			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 5180			
67.00 06700 OCCUPATI ONAL THERAPY	0. 6481			
68.00 06800 SPEECH PATHOLOGY	0. 6358		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 1350		524	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.0000		0	70.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0.0952		564	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 5434		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 5009	19 63, 492	31, 804	73.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	1.8400			90.00
91. 00 09100 EMERGENCY	0. 6222		16, 886	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 4329	34 0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVI CES				95.00
200.00 Total (sum of lines 50-94 and 96-98)		324, 015		
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 6'	)	0		201.00
202.00 Net Charges (line 200 minus line 201)	I	324, 015		202.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151304	Period: From 01/01/2014 To 12/31/2014		
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
00	Medical and other services (see instructions)			5, 049, 920	1.0
00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	2.
00 00	PPS payments Outlier payment (see instructions)			0	3. 4.
00	Enter the hospital specific payment to cost ratio (see instruct	tions)		0.000	
00	Line 2 times line 5			0	
00	Sum of line 3 plus line 4 divided by line 6			0.00	
00	Transitional corridor payment (see instructions)	/ I 10 I' 000		0	-
00	Ancillary service other pass through costs from Wkst. D, Pt. IN Organ acquisitions	7, COL. 13, LINE 200		0	9. 10.
	Total cost (sum of lines 1 and 10) (see instructions)			5, 049, 920	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
	Ancillary service charges	- 4)		0	12. 13.
	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co Total reasonable charges (sum of lines 12 and 13)	JI. 4)		0	
. 00	Customary charges				
	Aggregate amount actually collected from patients liable for pa			0	15.
. 00	Amounts that would have been realized from patients liable for	1 5	n a chargebasis	0	16.
. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	)		0.000000	17
	Total customary charges (see instructions)			0.000000	18.
	Excess of customary charges over reasonable cost (complete only	yifline 18 exceeds li	ne 11) (see	0	
	instructions)			_	
. 00	Excess of reasonable cost over customary charges (complete only	y if line 11 exceeds li	ne 18) (see	0	20.
. 00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		5, 100, 419	21
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	
. 00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.
. 00	Deductibles and coinsurance (for CAH, see instructions)			49, 179	25.
. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		2, 361, 704	
. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23} (for	2, 689, 536	27.
00	CAH, see instructions)	Page (50)		0	20
	Direct graduate medical education payments (from Wkst. E-4, lir ESRD direct medical education costs (from Wkst. E-4, line 36)	le 50)		0	
	Subtotal (sum of lines 27 through 29)			2, 689, 536	
. 00	Primary payer payments			438	31.
. 00	Subtotal (line 30 minus line 31)	-0)		2, 689, 098	32.
00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	-5)		0	33.
	Allowable bad debts (see instructions)			431, 054	
	Adjusted reimbursable bad debts (see instructions)			327, 601	
	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		333, 470	
	Subtotal (see instructions)			3, 016, 699	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions)	)		0	
	Partial or full credits received from manufacturers for replace		tions)	0	39.
. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
	Subtotal (see instructions) Sequestration adjustment (see instructions)			3, 016, 699 60, 334	
	Interim payments			2, 818, 550	
	Tentative settlement (for contractors use only)			2,010,000	
. 00	Balance due provider/program (see instructions)			137, 815	43.
. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2,	chapter 1,	0	44.
	§115.2 TO BE COMPLETED BY CONTRACTOR				
. 00	Original outlier amount (see instructions)			0	90.
	Outlier reconciliation adjustment amount (see instructions)			0	
00	The rate used to calculate the Time Value of Money			0.00	92.
. 00	Time Value of Money (see instructions)			0	93.

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 151304	Period: From 01/01/201 To 12/31/201		pare
		Ti tl	e XVIII	Hospi tal	Cost	00 a
		Inpatien			art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		952, 7		2, 818, 550	1.
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,			0	0	2.
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	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					
01	ADJUSTMENTS TO PROVIDER	08/01/2014	81, 8		0	
)2				0	0	
)3 )4				0	0	
)4 )5				0	0	
55	Provider to Program			0	0	1 3
50	ADJUSTMENTS TO PROGRAM			0	0	1 3
51				0	0	
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		81, 8	00	0	3
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 034, 5	89	2, 818, 550	4
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					1 5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
)1	TENTATI VE TO PROVI DER			0	0	
)2				0	0	
)3	Dravidar to Dragram			0	0	5
50	Provider to Program TENTATIVE TO PROGRAM			0	0	1 5
50 51				0	0	
52				0	0	
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		150, 6	60	137, 815	
)2	SETTLEMENT TO PROGRAM			0	0	-
00	Total Medicare program liability (see instructions)		1, 185, 2		2, 956, 365	7
				Contractor Number	NPR Date	
			)	1. 00	(Mo/Day/Yr) 2.00	
			,	1.00	2.00	1

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		F	Period: From 01/01/2014 Fo 12/31/2014		
		component			5/29/2015 11:	00 am
				wing Beds - SNF		1
		Inpatien	it Part A	Par	rt 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		445, 484	1	0	
2.00	Interim payments payable on individual bills, either		(	D	0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	08/01/2014	36, 800		0	3.01
3.02		00/01/2011			0	
3.03				D	0	3. 03
3.04				D	0	
3.05			(		0	3.05
2 50	Provider to Program	T			0	2 50
3.50 3.51	ADJUSTMENTS TO PROGRAM				0	
3.52					0	
3.53					0	
3.54				D	0	3.54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		36, 800	D	0	3.99
4.00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		482, 284	1	0	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		402, 204	+	0	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
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					
5.01	TENTATI VE TO PROVI DER		(	ן 🛛	0	5.01
5.02				D	0	
5.03			(	)	0	5.03
5.50	Provider to Program TENTATIVE TO PROGRAM				0	5.50
5.50	IENTATIVE TO PROGRAM				0	
5.52					0	
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			D	0	5.99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		55, 322		0	6.01
6.01	SETTLEMENT TO PROVIDER		00, 322		0	
7.00	Total Medicare program liability (see instructions)		537, 606	,	0	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	00	1.00	2.00	8.00

Heal th	Financial Systems RUSH	MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151304	Period:	Worksheet E-1	
			From 01/01/2014 To 12/31/2014		arad
			10 12/31/2014	5/29/2015 11:0	
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST	REPORTS			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND C.	ALCULATION			
1.00	Total hospital discharges as defined in AARA §4102	from Wkst. S-3, Pt. I col. 15 line	14	412	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of	lines 1, 8-12		772	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. li	ne 2		18	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of	lines 1, 8-12		1, 327	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 I	ine 200		51, 895, 169	5.00
6.00	Total hospital charity care charges from Wkst. S-10	, col. 3 line 20		636, 647	6.00
7.00	CAH only - The reasonable cost incurred for the pur	chase of certified HIT technology	Wkst. S-2, Pt. I	0	7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instr	ructions)		0	8.00
9.00	Sequestration adjustment amount (see instructions)			0	9.00
10.00	Calculation of the HIT incentive payment after sequ	estration (see instructions)		0	10.00
	I NPATI ENT HOSPI TAL SERVICES UNDER PPS & CAH				
	Initial/interim HIT payment adjustment (see instruc	tions)		0	30.00
	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus lin	e 30 and line 31) (see instruction	s)	0	32.00

	Financial Systems	RUSH MEMORIAL HO			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING B	BEDS	Provider CCN: 151304	Peri od:	Worksheet E-2	
			Component CCN: 15Z304	From 01/01/2014 To 12/31/2014	Date/Time Pre	narod
				10 12/31/2014	5/29/2015 11:	
			Title XVIII	Swing Beds - SNF		
				Part A	Part B	
				1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF			415, 073	0	
2.00	Inpatient routine services - swing bed-NF (					2.00
3.00	Ancillary services (from Wkst. D-3, col. 3,			141, 105	0	3.00
	Part V, cols. 6 and 7, line 202 for Pt. B)					
4.00	Per diem cost for interns and residents not	in approved teachin	g program (see		0.00	4.00
	instructions)				_	
5.00	Program days			356	0	
6.00	Interns and residents not in approved teach				0	
7.00	Utilization review - physician compensation		od only	0	_	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lin	ies 6 and 7)		556, 178	0	
9.00	Primary payer payments (see instructions)			0	0	
10.00	Subtotal (line 8 minus line 9)			556, 178	0	
11.00	Deductibles billed to program patients (exc professional services)	lude amounts applica	ble to physician	0	0	11.00
12.00	Subtotal (line 10 minus line 11)			556, 178	0	12.00
13.00	Coinsurance billed to program patients (fro	m provider records)	(exclude coinsurance	7,600	0	
	for physician professional services)		(	.,	-	
14.00	80% of Part B costs (line 12 x 80%)				0	14.00
15.00	Subtotal (enter the lesser of line 12 minus	line 13, or line 14	)	548, 578	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI	FY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustmen	t (see instructions)		0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT			0		16.55
17.00	Allowable bad debts (see instructions)			0	0	17.00
17.01	Adjusted reimbursable bad debts (see instru			0	0	
18.00	Allowable bad debts for dual eligible benef	ïciaries (see instru	ctions)	0	0	18.00
19.00	Total (see instructions)			548, 578	0	19.00
19.01	Sequestration adjustment (see instructions)			10, 972	0	
20.00	Interim payments			482, 284	0	20.00
21.00	Tentative settlement (for contractor use on			0	0	21.00
22.00	Balance due provider/program (line 19 minus			55, 322	0	
23.00	Protested amounts (nonallowable cost report	items) in accordanc	e with CMS Pub. 15-2,	0	0	23.00
	§115. 2					

	Financial Systems RUSH MEMORI ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151304	Peri od:	u of Form CMS-2 Worksheet E-3	
ALCUL	ATTON OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151304	From 01/01/2014	Part V	
			To 12/31/2014	Date/Time Pre	pared
				5/29/2015 11:	<u>00 am</u>
		Title XVIII	Hospi tal	Cost	-
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDIO	CARE PART A SERVICES - COST	REIMBURSEMENT	1.00	
1.00	Inpatient services			1, 372, 111	1 1.0
2.00	Nursing and Allied Health Managed Care payment (see instru	uctions)		0	
8.00	Organ acqui si ti on			0	3.1
4.00	Subtotal (sum of lines 1 through 3)			1, 372, 111	4.0
5.00	Primary payer payments			0	5.0
5.00	Total cost (line 4 less line 5). For CAH (see instruction:	s)		1, 385, 832	6. (
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
7.00	Routine service charges			0	
3.00	Ancillary service charges			0	
9.00	Organ acquisition charges, net of revenue			0	
0.00	Total reasonable charges			0	10.
1 00	Customary charges Aggregate amount actually collected from patients liable	for normant for convision on	a charge bacile	0	111.
1.00	Amounts that would have been realized from patients liable			0	
2.00	had such payment been made in accordance with 42 CFR 413.		n a charge basis	0	12.
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	13(e)		0,000000	13
4.00	Total customary charges (see instructions)			0.000000	
5.00	Excess of customary charges over reasonable cost (complete	e only if line 14 exceeds li	ne 6) (see	0	
	instructions)			-	
6.00	Excess of reasonable cost over customary charges (complete	e only if line 6 exceeds lin	e 14) (see	0	16.
	instructions)				
7.00	Cost of physicians' services in a teaching hospital (see	instructions)		0	17.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
8.00	Direct graduate medical education payments (from Workshee	t E-4, line 49)		0	
9.00	Cost of covered services (sum of lines 6, 17 and 18)			1, 385, 832	
20.00	Deductibles (exclude professional component)			196, 928	
1.00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21)			1, 188, 904	
3.00	Coinsurance Subtotal (line 22 minus line 23)			0 1, 188, 904	
4.00 5.00	Allowable bad debts (exclude bad debts for professional s	anvious) (cas instructions)		27,018	
.5.00 .6.00	Adjusted reimbursable bad debts (see instructions)	ervices) (see filstructions)		20, 534	
27.00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		1, 117	
8.00	Subtotal (sum of lines 24 and 25, or line 26)			1, 209, 438	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			1, 207, 430	
9.50	Pioneer ACO demonstration payment adjustment (see instruc	tions)		0	
9.99	Recovery of Accel erated Depreciation			0	
0.00	Subtotal (see instructions)			1, 209, 438	
0.01	Sequestration adjustment (see instructions)			24, 189	
	Interim payments			1,034,589	
2.00	Tentative settlement (for contractor use only)			0	
	Balance due provider/program (line 30 minus lines 30.01,	31, and 32)		150, 660	33.
33.00			chapter 1,		34.

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151304	Peri od:	Worksheet E-3	2552-10
			From 01/01/2014 To 12/31/2014	Part VII Date/Time Pre 5/29/2015 11:	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	ES FOR TITLES V OR X	I X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		265, 272	0	1.00
2.00 3.00	Medical and other services Organ acquisition (certified transplant centers only)		0	0	2.00 3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		265, 272	0	
5.00	Inpatient primary payer payments		0	0	5.00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		265, 272	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		146, 637	0	8.00
9.00 10.00	Ancillary service charges		324, 015 0	0	9.00 10.00
11.00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		470, 652	0	12.00
12.00	CUSTOMARY CHARGES		170,002		12.00
13.00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	13.00
14.00	basis Amounts that would have been realized from patients liable for pa	vment for services o	n 0	0	14.00
14.00	a charge basis had such payment been made in accordance with 42 C			0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.00000	15.00
	Total customary charges (see instructions)		470, 652	0	
17.00	Excess of customary charges over reasonable cost (complete only i	fline 16 exceeds	205, 380	0	17.00
10.00	line 4) (see instructions)			0	10.00
18.00	Excess of reasonable cost over customary charges (complete only i 16) (see instructions)	r line 4 exceeds lin	e u	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruct	ions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		265, 272	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	pleted for PPS provi			
22.00	Other than outlier payments		0	0	22.00
	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	
27.00 28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		265, 272	0	1
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		200,272		27.00
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		265, 272	0	31.00
32.00	Deducti bl es		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	1
35.00	Utilization review	<b>`</b>	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33	)	265, 272	0	
37.00 38.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37)		265, 272	0	
39.00	Direct graduate medical education payments (from Wkst. E-4)		205, 272	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		265, 272	0	
41.00	Interim payments		254, 628	0	
42.00	Balance due provider/program (line 40 minus line 41)		10, 644	0	1
43.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	
	chapter 1, §115.2				

	E SHEET (If you are nonproprietary and do not maintain		CCN: 151304	Period: From 01/01/2014	Worksheet G	
ina-t <u>i</u>	ype accounting records, complete the General Fund column onl	y)		To 12/31/2014	Date/Time Pre	
		General Fund	Speci fi c	Endowment Fund	5/29/2015 11: Pl ant Fund	
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	663, 382		0 0	0	
00	Temporary investments	7, 337		0 0	0	
00	Notes receivable	0		0 0	0	
00 00	Accounts receivable Other receivable	6, 712, 451		0 0	0	
00	Allowances for uncollectible notes and accounts receivable			0 0	0	
	Inventory	0		0 0	0	
00	Prepaid expenses	0		0 0	0	
00	Other current assets	1, 752, 586		0 0	0	9.
0. 00	Due from other funds	0		0 0	0	10.
. 00	Total current assets (sum of lines 1-10)	9, 135, 756		0 0	0	11.
	FIXED ASSETS	100 700	1			1 10
. 00	Land	188, 708		0 0	0	
. 00 . 00	Land improvements Accumulated depreciation	326, 007 -504, 904		0 0	0	
	Buildings	15, 659, 542			0	
	Accumul ated depreciation	-1, 995, 350		0 0	0	
	Leasehold improvements	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Fixed equipment	823, 458		0 0	0	
00	Accumulated depreciation	-220, 331		0 0	0	20.
. 00	Automobiles and trucks	0		0 0	0	21.
. 00	Accumulated depreciation	0		0 0	0	22.
	Major movable equipment	13, 472, 836		0 0	0	
	Accumulated depreciation	-14, 606, 260		0 0	0	
	Minor equipment depreciable	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	HIT designated Assets Accumulated depreciation	0		0 0	0	
	Mi nor equi pment-nondepreci abl e			0 0	0	
	Total fixed assets (sum of lines 12-29)	13, 143, 706		0 0	0	
	OTHER ASSETS	10,110,700	1			
00	Investments	0	I	0 0	0	31.
00	Deposits on Leases	0		0 0	0	32.
00	Due from owners/officers	0		0 0	0	33.
	Other assets	3, 372, 339		0 0	0	
	Total other assets (sum of lines 31-34)	3, 372, 339		0 0	0	
00	Total assets (sum of lines 11, 30, and 35)	25, 651, 801		0 0	0	36.
	CURRENT LI ABI LI TI ES	2 221 210	1		0	1 27
00	Accounts payable	2, 231, 319 1, 489, 661		0 0	0	
	Salaries, wages, and fees payable Payroll taxes payable	1, 469, 001		0 0	0	
	Notes and Loans payable (short term)	3, 283, 111			0	
	Deferred income	0,200,111		0 0	0	1 .0
	Accelerated payments	0				42
	Due to other funds	426, 378		0 0	0	43
00	Other current liabilities	780, 138		0 0	0	44
00	Total current liabilities (sum of lines 37 thru 44)	8, 210, 607		0 0	0	45.
	LONG TERM LIABILITIES		1			
1	Mortgage payable	0		0 0	0	
00	Notes payable	0		0 0	0	
	Unsecured Loans			0	0	
00 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49	5, 538, 418 5, 538, 418		0 0	0	
	Total liabilites (sum of lines 45 and 50)	5, 538, 418 13, 749, 025		0 0		
00	CAPITAL ACCOUNTS	13, 749, 025	1	0	0	1 51
00	General fund balance	11, 902, 776				52
00	Specific purpose fund	,		0		53
	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant				0	57
00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
00	Total fund balances (sum of lines 52 thru 58)	11, 902, 776		0 0	0	
00	Total liabilities and fund balances (sum of lines 51 and	25, 651, 801		0 0	0	60

	Financial Systems	RUSH MEMORIAL				eu of Form CMS-2	2552-10
STATEN	ENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 151304	Period: From 01/01/2014 To 12/31/2014		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	so an
1.00	Fund balances at beginning of period	1.00	2.00	3.00	4.00	5.00	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-66, 724				2.00
3.00	Total (sum of line 1 and line 2)		11, 902, 776		0		3.00
4.00		0			0	0	4.00
5.00		0			0	0	5.00
6.00		0			0	0	6.00
7.00		0			0	0	7.00
8.00 9.00		0			0	0	8.00 9.00
9.00 10.00	Total additions (sum of line 4-9)	0	0		0	-	9.00 10.00
11.00	Subtotal (line 3 plus line 10)		11, 902, 776				11.00
12.00		0	11,702,770		0	0	12.00
13.00		0			0	0	13.00
14.00		0			0	0	14.00
15.00		0			0	0	15.00
16.00		0			0	0	16.00
17.00		0	0		0	0	17.00
18.00 19.00	Total deductions (sum of lines 12–17) Fund balance at end of period per balance		0 11, 902, 776				18. 00 19. 00
19.00	sheet (line 11 minus line 18)		11, 702, 770				19.00
		Endowment Fund	PI ant	Fund			
		6,00	7.00	8,00	_		
1.00	Fund balances at beginning of period	6.00 0	7.00	8.00	0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)	0	7.00	8.00	0		2.00
2.00 3.00	5 5 1			8.00	0		2.00 3.00
2.00 3.00 4.00	Net income (loss) (from Wkst. G-3, line 29)	0	7.00	8.00			2.00 3.00 4.00
2.00 3.00 4.00 5.00	Net income (loss) (from Wkst. G-3, line 29)	0	0 0				2.00 3.00 4.00 5.00
2.00 3.00 4.00 5.00 6.00	Net income (loss) (from Wkst. G-3, line 29)	0					2.00 3.00 4.00 5.00 6.00
2.00 3.00 4.00 5.00 6.00 7.00	Net income (loss) (from Wkst. G-3, line 29)	0	0 0 0				2.00 3.00 4.00 5.00 6.00 7.00
2.00 3.00 4.00 5.00 6.00	Net income (loss) (from Wkst. G-3, line 29)	0	0 0 0 0				2.00 3.00 4.00 5.00 6.00
2.00 3.00 4.00 5.00 6.00 7.00 8.00	Net income (loss) (from Wkst. G-3, line 29)	0	0 0 0 0				2.00 3.00 4.00 5.00 6.00 7.00 8.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\end{array}$	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2)	0	0 0 0 0		0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00 \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00 \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9)	0	0 0 0 0 0 0 0		0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9)	0	0 0 0 0 0 0 0 0 0 0		0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9)	0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 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 14.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9)	0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9)	0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Total additions (sum of line 4-9)	0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0		$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00 \end{array}$

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 151304		: 1/01/2014 2/31/2014		epared:
	Cost Center Description	1	Inpati ent	Out	patient	Total	
			1.00		2.00	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services		1			I	
1.00	Hospi tal		2, 422, 8	00		2, 422, 800	
2.00	SUBPROVIDER - IPF						2.0
3.00 4.00	SUBPROVIDER - IRF						3.0
4.00 5.00	SUBPROVIDER Swing bed - SNF			0		C	
6.00	Swing bed - NF			0			
7.00	SKILLED NURSING FACILITY			0			7.0
8.00	NURSI NG FACILITY						8.0
9.00	OTHER LONG TERM CARE						9.0
10.00	Total general inpatient care services (sum of lines 1-9)		2, 422, 8	00		2, 422, 800	10.0
	Intensive Care Type Inpatient Hospital Services		•			•	
11.00	I NTENSI VE CARE UNI T						11.0
12.00	CORONARY CARE UNIT						12.0
13.00	BURN INTENSIVE CARE UNIT						13.0
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.0
15.00	OTHER SPECIAL CARE (SPECIFY)						15.0
16.00	Total intensive care type inpatient hospital services (sum of I	ines		0		C	16. 0
17.00	11-15) Total inpatient routine care services (sum of lines 10 and 16)		2, 422, 8	00		2, 422, 800	17.0
18.00	Ancillary services		3, 680, 9		7, 568, 575		
19.00	Outpati ent servi ces		146, 8		7, 204, 190		
20.00	RURAL HEALTH CLINIC		110,0	0	0		
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0		
22.00	HOME HEALTH AGENCY				-		22.0
23.00	AMBULANCE SERVICES			0	931, 816	931, 816	23.0
24.00	СМНС						24.0
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.0
26.00	HOSPICE						26.0
27.00	PROFESSIONAL FEES				5, 624, 088		
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	6, 250, 5	86 5	1, 328, 669	57, 579, 255	28.0
	G-3, line 1) PART II - OPERATING EXPENSES						-
29.00	Operating expenses (per Wkst. A, column 3, line 200)		1	2	7, 993, 432		29.0
30.00	ADD (SPECIFY)			0	1, 775, 452		30.0
31.00				0			31.0
32.00				0			32.0
33.00				0			33.0
34.00				0			34.0
35.00				0			35.0
36.00	Total additions (sum of lines 30-35)				0		36.0
37.00	DEDUCT (SPECI FY)			0			37.0
38.00				0			38.0
39.00				0			39.0
40.00				0			40.0
41.00 42.00	Total deductions (sum of lines 37-41)			0	0		41.0
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfor		1	0 7, 993, 432		42.0
43.00	to Wkst. G-3, line 4)	( ci ansi el		2	1, 773, 432		43.0

Health Financial Systems		RUSH MEMORIAL H	OSPI TAL	In Lieu of Form CMS-2552-10		
STATEMENT OF REVENUES AND EXPENSES			Provider CCN: 151304	Peri od:	Worksheet G-3	
				From 01/01/2014 To 12/31/2014	Date/Time Pre	narod
	10 12/31/2014	5/29/2015 11:0				
					1.00	
1.00	Total patient revenues (from Wkst. G-	57, 579, 255				
2.00	Less contractual allowances and disco		S		32, 193, 059	
3.00	Net patient revenues (line 1 minus li				25, 386, 196	
4.00	Less total operating expenses (from W		3)		27, 993, 432	
5.00	Net income from service to patients (	-2, 607, 236	5.00			
	OTHER INCOME					
6.00	Contributions, donations, bequests, e	tc			0	
7.00	Income from investments				0	
8.00	Revenues from telephone and other mis		servi ces		0	
9.00	Revenue from television and radio ser	vice			0	
10.00	Purchase di scounts				0	
11.00	Rebates and refunds of expenses				0	
12.00	Parking lot receipts				0	
13.00	Revenue from Laundry and Linen servic				0	
14.00	Revenue from meals sold to employees				0	
15.00	Revenue from rental of living quarter				0	15.00
16.00			an patients		0	16.00
17.00					0	
18.00	Revenue from sale of medical records				0	
19.00	Tuition (fees, sale of textbooks, uni	forms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee s	hops, and canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	NONOPERATING REVENUE				1, 364, 980	24.00
24.02	OTHER OPERATING REVENUE				1, 023, 056	24.02
24.03	REV DIFF BETWEEN INTERNAL IS AND TB				0	24.03
25.00	Total other income (sum of lines 6-24	)			2, 388, 036	25.00
26.00	Total (line 5 plus line 25)				-219, 200	26.00
27.00	VARIANCE OF HAF BETWEEN TB AND AFS				0	27.00
27.01	0				-152, 476	27.01
28.00	Total other expenses (sum of line 27	and subscripts)			-152, 476	
	Net income (or loss) for the period (				-66, 724	20 00