Health Financial Systems	RUSH MEMORIAL	μοςρι ται		Inlie	u of Form CMS-2552-10	0
This report is required by law (42 USC 1395g; 42 CF payments made since the beginning of the cost report	R 413.20(b)). Fai	lure to repo		in all interim		_
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPO AND SETTLEMENT SUMMARY	RT CERTIFICATION	Provider CC	F	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 6/28/2017 4:43 pm	
PART I - COST REPORT STATUS						
Provider use only 2. [] Manually submitted cost repor 3. [1] If this is an amended report 4. [F] Medicare Utilization. Enter "	t enter the number	of times the _" for low.	e provider res	Date: 6/28/20 ubmitted this c		n
use only (1) As Submitted 7. Contr (2) Settled without Audit 8. [N]	Received: actor No. Initial Report f Final Report for	or this Provi this Provide	der CCN 12. [		or Code: 4 Jumn 1 is 4: Enter nes reopened = 0-9.	
PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATI ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UND PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY O ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MA	ER FEDERAL LAW. R INDIRECTLY OF <i>F</i>	FURTHERMORE,	IF SERVICES	DENTIFIED IN TH	HIS REPORT WERE	
CERTIFICATION BY OFFICER OR ADMINIS	STRATOR OF PROVID	ER(S)				
I HEREBY CERTIFY that I have read the above electronically filed or manually submitted Expenses prepared by RUSH MEMORIAL HOSPITAL ending 12/31/2016 and to the best of my kno complete and prepared from the books and re except as noted. I further certify that I health care services, and that the services laws and regulations.	cost report and (15–1304) for wledge and belies cords of the prov am familiar with	the Balance S the cost rep f, this repor vider in acco the laws and	Sheet and Stat porting period of and stateme prdance with a f regulations	ement of Revenu beginning 01/0 nt are true, co pplicable instr regarding the p	e and 1/2016 and rrect, uctions, rovision of	
	(Si gned	)				
	(Si gheu		er or Administ	rator of Provid	ler(s)	
		Ti tl e				
		Date				
		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY 1.00 Hospital	0	-170, 346	1, 036, 603	3 0	9, 424 1. 00	0
2.00 Subprovi der – TPF	0	-170, 340	1, 030, 000		9, 424 1.00	
3. 00 Subprovider - IRF	0	0	(		0 3.00	
5.00 Swing bed - SNF	0	-7, 239	(		0 5.00	
6.00 Swing bed - NF	0				0 6.00	
200. 00 Total	0	-177, 585	1, 036, 603	3 0	9, 424 200. 00	J

0 -177, 585 1, 036, 603 0 The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	N Pi		er CCN: 1	5-1304	Period: From 01/01/ To 12/31/		Worksh Part I Date/T 6/28/2		epare
	1.00	2.00	0		3.00			4.00			
20	Hospital and Hospital Health Care Co	PO Box:									1
00 00	Street: 1300 NORTH MAIN STREET City: RUSHVILLE	State: IN	Zir	n Code	: 46173-	Coun	ty: RUSH				1.
		Component Name			CBSA	Provi der		Payme	ent Syst	tem (P,	2.
				nber	Number	Туре	Certified		, 0, or		
								V	XVIII		
		1.00	2.	00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componer				00045		0.0 /04 /0000		-		-
0	Hospital Subprovider - IPF	RUSH MEMORIAL HOSP	TTAL 151	1304	99915	1	08/01/2000	N	0	0	3.
0	Subprovider - IRF										5.
0	Subprovider - (Other)										6
0	Swing Beds - SNF	RUSH SWING BEDS	15Z	Z304	99915		08/01/2000	N	0	N	7
0	Swing Beds - NF										8.
0	Hospital-Based SNF										9.
00	Hospital-Based NF										10
00 00	Hospital-Based OLTC Hospital-Based HHA										11
00	Separately Certified ASC										13
00	Hospi tal -Based Hospi ce										14
00	Hospital-Based Health Clinic - RHC		1								15
00	Hospital-Based Health Clinic - FQHC										16
00	Hospital-Based (CMHC) I										17.
00 00	Renal Dialysis Other										18.
00	Jotnei						From:		To	);	17
							1.00		2.		
00	Cost Reporting Period (mm/dd/yyyy)						01/01/2	016	12/31	/2016	20
00	Type of Control (see instructions)						2				21
00	Inpatient PPS Information Does this facility qualify and is it	currently, receivin	a paymont	s for	dienron	ortionato	N				22
00	share hospital adjustment, in accord										22
	for yes or "N" for no. Is this facil										
	amendment hospital?) In column 2, er				. ,						
01	Did this hospital receive interim ur						N		Ν	1	22
	period? Enter in column 1, "Y" for y										
	reporting period occurring prior to for no for the portion of the cost r										
	(see instructions)	eporting period occ	surring on								
02	Is this a newly merged hospital that	requires final unc	compensate	d care	e paymen	ts to be	N		N	1	22
	determined at cost report settlement			n coli		Y" for ve	s				
	or "N" for no, for the portion of th	a cost reporting pa					-				
	In column 2, "Y" for ves or "N" for	e cost reporting pe	eriod prio	r to (	October	1. Enter					
		no, for the portion	eriod prio n of the c	r to (	October	1. Enter					
03	or after October 1.	no, for the portion	n of the c	or to ( cost re	October eporting	1. Enter period o	n		N	1	22
03	or after October 1. Did this hospital receive a geograph of the OMB standards for delineating	no, for the portion ic reclassification statistical areas	n of the c n from urb adopted b	or to ( cost re an to y CMS	october porting rural a in FY20	1. Enter period o s a resul 15? Enter	n t N		٢	I	22
03	or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for	no, for the portion ic reclassification statistical areas no for the portion	n of the c n from urb adopted b of the co	or to ( cost re an to by CMS ost rep	October eporting rural a in FY20 porting	1. Enter period o s a resul 15? Enter period	n t N		٢	1	22
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03	or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on c	no, for the portion statistical areas no for the portion 2, "Y" for yes or " r after October 1.	n of the c n from urb adopted b of the co 'N" for no (see inst	or to ( cost re oan to by CMS ost rep ofor t ructic	October eporting in FY20 porting the port	1. Enter period o s a resul 15? Enter period ion of th s this	n t N e		٢	J	22
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00	or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting per lin-state Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible unpaid	no, for the portion ic reclassification statistical areas no for the portion 2, "Y" for yes or " r after October 1. t more than 499 bec "Y" for yes or "N" dicaid days on line f census days, or 3 is cost reporting p iod? In column 2, , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in	n of the connormal of t	r to ( oost re y CMS sst rep for 1 ructic inted i for 25 of dis ferent <u>for 5</u> In-St Medic eligi unpa day	betober eporting in FY20 borting the port ons) Doe n accord below? scharge. t from ti yes or " ate 0 aid 9 ble Me ble Me s 0	1. Enter period of s a resul 15? Enter period ion of th s this dance wit In column Is the he method <u>N" for no</u> ut-of State di cai d d days <u>3.00</u>	n t N e h State H Medicaid eligible unpaid	ledi ca IMO da	id Co ys Mea	Other di cai d days 6. 00	23
00	or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on c hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible unpaid column 5, and other Medicaid days in col	no, for the portion ic reclassification statistical areas no for the portion 2, "Y" for yes or " r after October 1. t more than 499 bec "Y" for yes or "N" dicaid days on line f census days, or 3 is cost reporting p iod? In column 2, , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6.	n of the connormal of t	r to ( oost re y CMS sst rep for 1 ructic inted i for 25 of dis ferent <u>for 5</u> In-St Medic eligi unpa day	betober eporting in FY20 borting the port ons) Doe n accord below? scharge. t from ti yes or " ate 0 aid 9 ble Me ble Me s 0	1. Enter period of s a resul 15? Enter period ion of th s this dance wit In column Is the he method <u>N" for no</u> ut-of State di cai d d days <u>3.00</u>	n t N e h State H Medicaid eligible unpaid	ledi ca IMO da	id Co ys Mea	Other di cai d days 6. 00	23
00	or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting per lin-state Medicaid paid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible unpaid	no, for the portion ic reclassification statistical areas no for the portion 2, "Y" for yes or " r after October 1. t more than 499 bec "Y" for yes or "N" dicaid days on line f census days, or 3 is cost reporting p iod? In column 2, , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state	n of the connormal of t	r to ( oost re y CMS sst rep for 1 ructic inted i for 25 of dis ferent <u>for 5</u> In-St Medic eligi unpa day	october eporting in FY20 porting the port on accord below? scharge. trom ti yes or "" ble Me id pai s 0 0	1. Enter period of s a resul 15? Enter period ion of th s this dance wit In column Is the he method N" for no vit-of State di cai d d days 3.00 0	n t N e h h Out-of M State H Medicaid el igible unpaid 4.00 0	ledi ca IMO da	id C ys Mea 0	Other di cai d days 6. 00	23
00	or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting per Medicaid eligible unpaid days in colum out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter the Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	no, for the portion ic reclassification statistical areas no for the portion 2, "Y" for yes or " r after October 1. t more than 499 bee "Y" for yes or "N" dicaid days on line f census days, or 3 is cost reporting p iod? In column 2, , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state umn 2,	n of the connormal of t	r to ( oost re y CMS sst rep for 1 ructic inted i for 25 of dis ferent <u>for 5</u> In-St Medic eligi unpa day	october eporting in FY20 porting the port on accord below? scharge. trom ti yes or "" ble Me id pai s 0 0	1. Enter period of s a resul 15? Enter period ion of th s this dance wit In column Is the he method N" for no vit-of State di cai d d days 3.00 0	n t N e h h Out-of M State H Medicaid el igible unpaid 4.00 0	ledi ca IMO da	id C ys Mea 0	Other di cai d days 6. 00	23
00	or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per Medicaid eligible unpaid days in col out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid eligible unpaid days in col out-of-state Medicaid paid in the provider is an IRF, enter th Medicaid eligible unpaid days in col out-of-state Medicaid days in column 1, the Medicaid eligible unpaid days in column 1, the Medicaid eligible unpaid days in column 2, state Medicaid days in column 3, and column 3, the Medicaid eligible unpaid days in column 1, the Medicaid eligible unpaid days in column	no, for the portion ic reclassification statistical areas no for the portion 2, "Y" for yes or " r after October 1. t more than 499 bee "Y" for yes or "N" dicaid days on line f census days, or 3 is cost reporting p iod? In column 2, , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state umn 2, 3, out-of-state	n of the connormal of t	r to ( oost re y CMS sst rep for 1 ructic inted i for 25 of dis ferent for 3 In-St Medic eligi unpa day	october eporting in FY20 porting the port on accord below? scharge. trom ti yes or "" ble Me id pai s 0 0	1. Enter period of s a resul 15? Enter period ion of th s this dance wit In column Is the he method N" for no vit-of State di cai d d days 3.00 0	n t N e h h Out-of M State H Medicaid el igible unpaid 4.00 0	ledi ca IMO da	id C ys Mea 0	Other di cai d days 6. 00	23
00	or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on co hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in the used in the prior cost reporting per Medicaid eligible unpaid days in colum out-of-state Medicaid paid days in col out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter the Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	no, for the portion ic reclassification statistical areas no for the portion 2, "Y" for yes or " r after October 1. t more than 499 bec "Y" for yes or "N" dicaid days on line f census days, or 3 is cost reporting p iod? In column 2, , enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state in-state umn 2, 3, out-of-state umn 4, Medicaid	n of the connormal of t	r to ( oost re y CMS sst rep for 1 ructic inted i for 25 of dis ferent for 3 In-St Medic eligi unpa day	october eporting in FY20 porting the port on accord below? scharge. trom ti yes or "" ble Me id pai s 0 0	1. Enter period of s a resul 15? Enter period ion of th s this dance wit In column Is the he method N" for no vit-of State di cai d d days 3.00 0	n t N e h h Out-of M State H Medicaid el igible unpaid 4.00 0	ledi ca IMO da	id C ys Mea 0	Other di cai d days 6. 00	23

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ТА	Provider CC	1	Period: From 01/01/				
					Го 12/31/		6/28/20	017 4:4	<u>2 pm</u>
					Urban/Rur 1.00		Date of 2.0		-
6. 00	Enter your standard geographic classification (not wa	ige) sta	atus at the beg	inning of the		2	2.0	0	26.0
7.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	ige) sta	atus at the end			2			27.0
5. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			H status in		0			35. C
					Begi nni r	ng:	Endi		
6 00	Enter applicable beginning and ending dates of SCH st	atue (	Subscript Lino	26 for number	1.00		2.0	)0	36.0
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	s.	·			0			37.0
7. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo				N				37.0
3. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38.0
	enter subsequent dates.				Y/N		Y/		
9.00	Deep this facility qualify for the inpatient been tal		at adjuctment f		1.00		2.0		20 (
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	)? Ente juiremer or "N"	er in column 1 nts in accordan for no. (see i	"Y" for yes ce with 42 nstructions)	N		N		39. C
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. E	Enter "Y" for y		N		N		40. (
						V 1.00	XVIII 2.00	XI X 3.00	-
5. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	nt for a	di sproporti onat	e share in ac	cordance	N	N	N	45.0
b. 00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46. (
	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47.0 48.0
b. 00	Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y"	for yes	N			56. (
7.00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	yes or h of th'	r "N" for no in nis cost report plete Worksheet	column 1. lf ing period?	column 1 Enter "Y"				57.0
3. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ursemer	nt for physicia	ns' services	as				58.
	Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2,			N			59.
J. UU	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"					N			60. (
		Y/N	I ME	Direct GME	IME		Di rect	GME	
		1.00	2.00	3.00	4.00		5.0	00	1
. 00	Did your hospital receive FTE slots under ACA	N				0.00			61.
. 01	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care		0.00	0.0	nd.				61.
	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.0					
. 02	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)		0.00	0. 0	00				61.
. 03	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)		0.00	0. 0	0				61.
. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	o				61.
1 05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0.00	0.0	0				61.0

ealth Financial Systems IOSPITAL AND HOSPITAL H				<u>HOSPITAL</u>	N: 15-1304 Pe	eri od:	u of Form CMS-2 Worksheet S-2	
						rom 01/01/2016	Part I Date/Time Pre 6/28/2017 4:4	pared
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
I.06 Enter the amount used for cap reli care or general s	ef and/or FTEs	that are nonprimary		0.00	0.00			61.
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	1
specialty, if any for each new prog column 1, the pro program code, ent	y, and the number gram. (see instru- gram name, enter er in column 3, and enter in col	y each new program of FTE residents uctions) Enter in in column 2, the the IME FTE umn 4, direct GME				0.00	0.00	61.
1.20 Of the FTEs in li program specialty residents for eac instructions) Ent enter in column 2	ne 61.05, specia r, if any, and th ch expanded program fer in column 1, r, the program co weighted count a	ne number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0. 00	61.
							1.00	-
		th Resources and Se						
		s that your hospital funding (see instruc		d in this cost	reporting peri	od for which	0.00	62.
2.01 Enter the number during in this co	of FTE residents ost reporting per	s that rotated from a riod of HRSA THC prog sidents in Nonprovid	a Teachi gram. (s	see instruction		your hospital	0.00	62.
3.00 Has your facility	r trai ned resi dei	nts in nonprovider se umn 1. If yes, comple	ettings	during this co	instructions)		N	63.
					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			<u> </u>		1.00	2.00	3.00	1
		r FTE Residents in No Jly 1, 2009 and befo			inis base year	is your cost r	reporting	
4.00 Enter in column 1 in the base year resident FTEs att settings. Enter resident FTEs tha	, if line 63 is period, the numl ributable to ro in column 2 the it trained in you	yes, or your facili ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in I + column 2)). (see	ty trair n-primar all nor d non-pr n columr	ned residents ry care nprovider rimary care n 3 the ratio	0.00			
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	3.00	4.00	5.00	
5.00 Enter in column 1 is yes, or your f trained residents year period, the associated with p FTEs for each pri program in which residents. Enter the program code, column 3, the num unweighted primar residents attribu rotations occurri non-provider sett column 4, the num unweighted primar resident FTEs tha your hospital. En	Facility Fin the base program name orimary care you trained in column 2, enter in uber of y care FTE ttable to ng in all ings. Enter in uber of y care tt trained in				0.00	0.00	0. 000000	1 65.1

Health Financial Systems	RUSH M	MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE CO	MPLEX IDENTIFICATION DA	TA Provider CC		eriod: rom 01/01/2016 o 12/31/2016	Worksheet S-2 Part I Date/Time Pre 6/28/2017 4:43	pared:
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Currer	nt Year FTF Residents in	n Nonprovider Setting	1.00 SEffective fo	2.00 2.00	3.00	
<ul> <li>66.00 Enter in column 1 the number of FTEs attributable to rotations</li> <li>Enter in column 2 the number of FTEs that trained in your hosp</li> </ul>	2010 of unweighted non-primar occurring in all nonpr of unweighted non-primar	ry care resident rovider settings. ry care resident	0.00			66.00
(column 1 divided by (column 1	+ column 2)). (see ins Program Name	structions) Program Code	Unweighted	Unweighted	Ratio (col. 3/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	(7.00
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 attributabl to rotations occurring in all non-provider settings. Enter i column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)	e n		0.00	0.00	0. 000000	67.00
				1.0		
Inpatient Psychiatric Facility	/ PPS			1.00	0 2.00 3.00	
70.00 Is this facility an Inpatient Enter "Y" for yes or "N" for	Psychiatric Facility (I	PF), or does it conta	ain an IPF subp	provider? N		70.00
71.00 If line 70 yes: Column 1: Did recent cost report filed on or 42 CFR 412.424(d)(1)(iii)(c)) program in accordance with 42 Column 3: If column 2 is Y, ir (see instructions)	the facility have an ap before November 15, 20 Column 2: Did this faci CFR 412.424 (d)(1)(iii) dicate which program ye	004? Enter "Y" for ye lity train residents )(D)? Enter "Y" for ye	es or "N" for r in a new teach es or "N" for r	no. (see ni ng no.	0	71.00
Inpati ent Rehabilitation Facil75.00Is this facility an Inpatient		y (IRF), or does it co	ontain an IRF	N		75.00
Subprovider? Enter "Y" for ye 76.00 If line 75 yes: Column 1: Did recent cost reporting period e no. Column 2: Did this facilit CFR 412.424 (d)(1)(iii)(D)? Er indicate which program year be	es and "N" for no. the facility have an ap ending on or before Nove Ty train residents in a ater "Y" for yes or "N"	oproved GME teaching p ember 15, 2004? Enter new teaching program for no. Column 3: If	orogram in the "Y" for yes or in accordance column 2 is Y,	"N" for with 42	0	76.00
					1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospi 81.00 Is this a LTCH co-located with "Y" for yes and "N" for no.				period? Enter	N N	80. 00 81. 00
TEFRA Providers85.00Is this a new hospital under 486.00Did this facility establish a §413.40(f)(1)(ii)? Enter "Y"	new Other subprovider (	(excluded unit) under			N	85. 00 86. 00
87.00 Is this hospital a "subclause			(1)(B)(iv)(II)?	'Enter "Y"	Ν	87.00
for yes or "N" for no.				V	XIX	
Title V and XIX Services				1.00	2.00	
90.00 Does this facility have title		hospital services? Er	nter "Y" for	N	Y	90.00
yes or "N" for no in the appli 91.00 Is this hospital reimbursed fo		nrough the cost report	t either in	N	N	91.00
full or in part? Enter "Y" for 92.00 Are title XIX NF patients occu	yes or "N" for no in t	the applicable column.			N	92.00
instructions) Enter "Y" for ye	es or "N" for no in the	applicable column.	, ,			
93.00 Does this facility operate an "Y" for yes or "N" for no in t		urposes of title V and	d XIX? Enter	N	N	93.00
94.00 Does title V or XIX reduce cap applicable column.		or yes, and "N" for no	o in the	N	Ν	94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	L HOSPITAL Provider C		eriod: rom 01/01/	2016	<u>of</u> For Workshe Part I Date/Ti 6/28/20	et S-2 me Pre	2 epared:
			V		XI	Х	_
			1.00		2.0		
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 yes applicable column.			0. 00 N		0. ( N		95.00 96.00
97.00 If line 96 is "V", enter the reduction percentage in the app Rural Providers	plicable colum	n.	0.00		0.0	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 payment	Y N				105. 00 106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see inst . 25 and the p	ructions) lf rogram is cost	N				107.00
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 sche	dule? See 42	N Spoor	h	Pocnir	atory	108.00
	1. 00	2.00	Speec 3.00		Respir 4. (		-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N		4. (		109.00
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (410	)A Demo)fo	-	1. ( N		110. 00
				1.00	2.00	3.00	-
Miscellaneous Cost Reporting Information							
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" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	. If column 2 i nt for long te	is "E", enter i rm care (incluc	n column les	N		0	115.00
116.00 Is this facility classified as a referral center? Enter "Y" 117.00 Is this facility legally-required to carry malpractice insu	for yes or "N rance? Enter "'	' for no. Y" for yes or "	N" for	N Y			116. 00 117. 00
no. 118.00 Is the mal practice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1	f the policy i	S	1			118.00
jerannemade. Enter 2 in the portey is decurrence.		Premi ums	Losse	s	Insur	ance	
		1.00	2.00				_
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	0	3.0		0118.01
		200, 430	1.00		2. (		_
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scher and amounts contained therein.			N		2.0		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold			N		Ν		119.00 120.00
§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 amendmen Enter in column 2 "Y" for yes or "N" for no	ualifies for t	ne Outpatient					
"N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla	ualifies for t nts? (see inst	ne Outpatient ructions)	Y				121.00
<ul> <li>"N" for no. Is this a rural hospital with &lt; 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the column</li></ul>	ualifies for th nts? (see inst antable device Enter "Y" for	ne Outpatient ructions) s charged to yes or "N"	Y				121. 00 122. 00
<ul> <li>"N" for no. Is this a rural hospital with &lt; 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included.</li> <li>Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for</li> </ul>	ualifies for th nts? (see inst antable device Enter "Y" for he Worksheet A	ne Outpatient ructions) s charged to yes or "N" line number					
<ul> <li>"N" for no. Is this a rural hospital with &lt; 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included.</li> <li>Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter enter the set of the cost of the cost of the cost of the center of the center</li></ul>	ualifies for th nts? (see inst antable device: Enter "Y" for he Worksheet A or yes and "N" nter the certi	ne Outpatient ructions) s charged to yes or "N" line number for no. If	N				122. 00
<ul> <li>"N" for no. Is this a rural hospital with &lt; 100 beds that queen Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 1</li> </ul>	ualifies for the nts? (see instru- antable device: Enter "Y" for he Worksheet A or yes and "N" nter the certif 2. ter the certif	ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date	N				122. 00 125. 00
<ul> <li>"N" for no. Is this a rural hospital with &lt; 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2.</li> <li>127.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2.</li> </ul>	ualifies for the nts? (see inst antable devices Enter "Y" for he Worksheet A or yes and "N" nter the certifient ter the certifient 2. ter the certifient	ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date	N				122.00 125.00 126.00
<ul> <li>"N" for no. Is this a rural hospital with &lt; 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>127.00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>128.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> </ul>	ualifies for the nts? (see inst antable devices Enter "Y" for he Worksheet A or yes and "N" nter the certif 2. ter the certif 2. ter the certif 2.	ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date	N				122.00 125.00 126.00 127.00
<ul> <li>"N" for no. Is this a rural hospital with &lt; 100 beds that queen Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>127.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>128.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>129.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>129.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>130.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> </ul>	ualifies for the nts? (see instantable devices Enter "Y" for he Worksheet A for yes and "N" nter the certification of the certification	ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date cation date cation date in	N				122.00 125.00 126.00 127.00 128.00
<ul> <li>"N" for no. Is this a rural hospital with &lt; 100 beds that queen Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.</li> <li>121.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no.</li> <li>122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information</li> <li>125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>126.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>128.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>128.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> <li>128.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2</li> </ul>	ualifies for the nts? (see inst antable devices Enter "Y" for he Worksheet A or yes and "N" nter the certif 2. ter the certif 2. ter the certif 2. er the certifie enter the certifie umn 2. r, enter the certifie	ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date cation date in tification	N				122. 00 125. 00 126. 00 127. 00 128. 00 129. 00

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL			In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	CN: 15-1304			Worksheet S-2	
				To	01/01/2016 12/31/2016	Part     Date/Time Pre	pared <sup>.</sup>
						6/28/2017 4:4	
					1 00	2.00	-
133.00 If this is a Medicare certified ot	her transplant center ent	er the certifi	cation da	te	1.00	2.00	133.00
in column 1 and termination date,	if applicable, in column 2						133.00
134.00 If this is an organ procurement or	ganization (OPO), enter th	e OPO number i	n column	1			134.00
and termination date, if applicabl	e, in column 2.						-
All Providers 140.00Are there any related organization	or home office costs as d	lefined in CMS	Pub 15_1		N		140.00
chapter 10? Enter "Y" for yes or "					IN IN		140.00
are claimed, enter in column 2 the							
1.00	2.00				3.00		
If this facility is part of a chai home office and enter the home off				ne name a	and address	of the	
141. 00 Name:	Contractor's Name:			actor's I	Number:		141.00
142.00 Street:	PO Box:						142.00
143.00 Ci ty:	State:		Zip C	ode:			143.00
						1.00	-
144.00 Are provider based physicians' cos	ts included in Worksheet A	?				1.00 Y	144.00
					1.00	2.00	
145.00 If costs for renal services are cl					N	N	145.00
inpatient services only? Enter "Y" no, does the dialysis facility inc							
period? Enter "Y" for yes or "N"		101 1113 0031	reporting				
146.00 Has the cost allocation methodolog		sly filed cost	: report?		Ν		146.00
Enter "Y" for yes or "N" for no ir		5-2, chapter 4	10, §4020)	lf			
yes, enter the approval date (mm/c	ld/yyyy) in column 2.						
						1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y" for y	es or "N" for	no.			N	147.00
148.00 Was there a change in the order of						N	148.00
149.00 Was there a change to the simplifi	ed cost finding method? En				<b>T</b> ' 11 V	N N	149.00
	-	Part A 1.00	Part 2.00		<u>Title V</u> 3.00	Title XIX 4.00	-
Does this facility contain a provi	der that qualifies for an						
or charges? Enter "Y" for yes or "							
155.00 Hospi tal		N	N		N	N	155.00
156.00 Subprovider - IPF 157.00 Subprovider - IRF		N	N N		N N	N N	156.00 157.00
158. 00 SUBPROVI DER		IN	IN IN		IN .	IN IN	158.00
159.00 SNF		Ν	N		Ν	N	159.00
160.00 HOME HEALTH AGENCY		N	N		Ν	N	160.00
161.00 CMHC			N		N	N	161.00
						1.00	
Multicampus						1.00	
165.00 Is this hospital part of a Multica	mpus hospital that has one	or more campu	uses in di	fferent	CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.	News	Country	Ctata	7:	- CDCA		
	Name 0	County 1.00	State 2.00	Zip Cod 3.00	e CBSA 4.00	FTE/Campus 5.00	-
166.00 If line 165 is yes, for each		1.00	2.00	3.00	4.00		166.00
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)							
						1.00	
Health Information Technology (HI 167.00 Is this provider a meaningful user					ī.	Y	167.00
168.00 If this provider is a CAH (line 10					er the		167.00
reasonable cost incurred for the H				<i>,,</i>			
168.01 If this provider is a CAH and is r					rdshi p		168. 01
exception under §413.70(a)(6)(ii)? 169.00  f this provider is a meaningful u					optor the	0.00	169.00
transition factor. (see instructio			1110 100	· J IN J,	Shiel the	0.00	1.07.00
· · · · · · · · · · · · · · · · · · ·							

Health Financial Systems RUSH M	IEMORI AL HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		eriod: rom 01/01/2016	Worksheet S-2 Part I	2
	T			
		Begi nni ng	Endi ng	
		1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and e period respectively (mm/dd/yyyy)	ending date for the reporting	01/01/2016	12/31/2016	170.00
		1.00	0.00	-
		1.00	2.00	
171.00 If line 167 is "Y", does this provider have any days section 1876 Medicare cost plans reported on Wkst. S- "Y" for yes and "N" for no in column 1. If column 1 i 1876 Medicare days in column 2. (see instructions)	3, Pt. I, line 2, col. 6? Enter	N	C	171.00

	Financial         Systems         RUSH         MEMORIAL           AL         AND         HOSPITAL         HEALTH         CARE         REIMBURSEMENT         QUESTIONNALRE		CN: 15-1304	Peri od:	u of Form CM Worksheet S	
				From 01/01/2016 To 12/31/2016	Part II Date/Time P	
				Y/N	<u>6/28/2017</u> 4 Date	:42 pm
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	esponses. Ent	er all dates in t	he	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					_
. 00	Has the provider changed ownership immediately prior to the			N		1.
	reporting period? If yes, enter the date of the change in c	olumn 2. (see				_
			Y/N 1.00	Date 2.00	V/I 3.00	
. 00	Has the provider terminated participation in the Medicare P	rogram? If	N 1.00	2.00	3.00	2.
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for				
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	N			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A		4. (
. 00	Are the cost report total expenses and total revenues diffe		N			5.
	those on the filed financial statements? If yes, submit rec			Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities			I		_
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider i	s N		6.
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved		during the	N N		7. 8.
. 00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		0	N		9.
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o		the current	Ν		10.
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11.
				-	Y/N 1.00	
	Bad Debts			I		
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 13.
4. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? I1	fyes, see in	structions.	N	14.
5.00	Did total beds available change from the prior cost reporti	Par	yes, see ins rt A	Par	N t B	15.
		Y/N	Date	Y/N	Date	_
	PS&R Data	1.00	2.00	3.00	4.00	
6. 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	Y	05/02/2017	Y	05/02/2017	16.
7.00	instructions) 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	Ν		Ν		17.
3. 00	in columns 2 and 4. (see instructions) 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	Ν		Ν		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19.

10SPL1	Financial Systems RUSH MEMORIA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CC	N: 15-1304	Peri od:	u of Form CMS- Worksheet S-2	
				From 01/01/2016 To 12/31/2016	Part II	epared
		Descri	ption	Y/N	Y/N	
		0		1.00	3.00	
0.00	If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20. (
	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
1.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. (
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS HO	)SPI TALS)			
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, see				N	22.
3. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to appraisa	ars made dur	ng the cost	N	23.
4.00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during f	this cost re	eporting period?	Ν	24.
5.00	Have there been new capitalized leases entered into during	the cost report	ting period?	?lfyes, see	Ν	25.
6. 00	instructions. Were assets subject to Sec.2314 of DEFRA acquired during th	ne cost reportiu	na period? l	f ves see	N	26.
	instructions.		0.1	5		
7.00	Has the provider's capitalization policy changed during the copy. Interest Expense	e cost reportino	] period? If	fyes, submit	N	27.
B. 00	Were new loans, mortgage agreements or letters of credit en	ntered into duri	ng the cost	t reporting	N	28.
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ot Service F	Reserve Fund)	Y	29.
0. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If yes	s, see	N	30.
. 00	instructions. Has debt been recalled before scheduled maturity without is instructions.	ssuance of new o	debt? If yes	s, see	Ν	31.
2.00	Purchased Services	aviana fumiaha	d through or	antroatual	N	32.
	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru	uctions.	0			
3. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.	piled pertaining	j to competi	tive blading? IT	Ν	33.
	Provi der-Based Physi ci ans					
4. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement with	provi der-ba	ased physi ci ans?	Y	34.
5.00	If line 34 is yes, were there new agreements or amended exi		ts with the	provi der-based	Ν	35.
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date	
				1.00	2.00	
	Home Office Costs				2100	
6. 00	Were home office costs claimed on the cost report?			N		36.
7.00	If line 36 is yes, has a home office cost statement been pr	repared by the H	nome office?	? N		37.
8. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off			ŕ N		38.
9. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			5, N		39.
0. 00	see instructions. If line 36 is yes, did the provider render services to the instructions.	home office? I	fyes, see	Ν		40.
		1. (	00	2.	00	
	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	MI CHAEL		ALESSANDRI NI		41.
1. 00		1				1
	respectively. Enter the employer/company name of the cost report	BLUE & CO., LLC	;			42.
2. 00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LLC	2	MALESSANDRI NI @		42.

Heal th	Financial Systems RUSH ME	MORIA	L HOSPI TAL	In Lie	u of Form CMS-:	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	E	Provider CCN: 1	Period: From 01/01/2016	Worksheet S-2 Part II	
				To 12/31/2016		
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	ı	CONSULTANT			41.00
	held by the cost report preparer in columns 1, 2, and	3,				
	respecti vel y.					
42.00	Enter the employer/company name of the cost report					42.00
	preparer.					
43.00	Enter the telephone number and email address of the co	ost				43.00
	report preparer in columns 1 and 2, respectively.					

	Financial Systems	RUSH MEMORIAL				u of Form CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1304	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Pre 6/28/2017 4:4	pared:
						I/P Days / O/P	
						<u>Visits / Trips</u>	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Available 3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30. 00	25	9, 1		0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovider					_	4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed NF		05	0.4		0	•
7.00 8.00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT		25	9, 1	50 46, 344. 00	0	7.00 8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9, 1	50 46, 344. 00	0	
15.00	CAH visits			.,.		0	15.00
16.00	SUBPROVIDER - IPF						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	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	
29.00 30.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF		0		0		31.00
32.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room		0		U		32.00
JZ. UI	outpatient days (see instructions)						32.01
~~ ~~	LTCH non-covered days						33.00

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	RUSH MEMORIAL	Provi der C	N· 15-1304	Peri od:	eu of Form CMS-2 Worksheet S-3	
105111	AL AND HOST THE HEALTH OAKE COMPLEX STATISTIC			511. 13 1304	From 01/01/2016 To 12/31/2016	Part I	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 341	10	1, 93		10.00	1.00
	8 exclude Swing Bed, Observation Bed and	1,011		., , ,			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	124	90				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	311	0	32	7		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	3	2		6.00
7.00	Total Adults and Peds. (exclude observation	1, 652	10	2, 29	0		7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1, 652	10	2, 29	0.00	280. 21	14.00
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER - IPF						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)	0	0		0		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
27.00	Total (sum of lines 14-26)				0.00	280. 21	27.00
28.00	Observation Bed Days		0	64	6		28.00
29.00	Ambulance Trips	528					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
00.00	outpatient days (see instructions)	_					
33.00	LTCH non-covered days	0					33.00

iospi t	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1304	Period: From 01/01/2016 To 12/31/2016		pared:
		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	
. 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)		0	30	34 3	604	1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider			:	32 7 0		2.00 3.00
1.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
o. 00	Hospital Adults & Peds. Swing Bed NF						6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGICAL INTENSIVE CARE UNIT						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY						13.00
4.00	Total (see instructions)	0.00	0	30	94 3	604	14.0
5.00	CAH visits						15.0
6.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVIDER - IRF						17.0
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19. C
20.00	NURSING FACILITY						20. C
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPICE						24.0
4.10	HOSPICE (non-distinct part)						24. 1
5.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC						26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.2
7.00	Total (sum of lines 14-26)	0.00					27.0
8.00	Observation Bed Days						28.0
9.00	Ambulance Trips						29. (
0. 00	Employee discount days (see instruction)						30. (
1.00	Employee discount days - IRF						31. (
2.00	Labor & delivery days (see instructions)						32. (
2. 01	Total ancillary labor & delivery room						32. (
	outpatient days (see instructions)						
3 00	LTCH non-covered days						33.

Heal th	Financial Systems RUSH MEN	NORIAL HOSPITAL		In Lie	u of Form CMS	-2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-1304	Peri od:	Worksheet S-	10
				From 01/01/2016 To 12/31/2016	Date/Time Pr 6/28/2017 4:	
	· · · · · · · · · · · · · · · · · · ·				0/20/2011 1.	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 colu	umn 3 divided by li	ne 202 columi	ו 8)	0.35243	9 1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				2, 127, 08	7 2.00
3.00	Did you receive DSH or supplemental payments from Medic	cai d?				3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supp	plemental payments	from Medicai	1?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payme	ents from Medicaid			(	0 5.00
6.00	Medi cai d charges				10, 354, 18	6 6.00
7.00	Medicaid cost (line 1 times line 6)				3, 649, 21	9 7.00
8.00	Difference between net revenue and costs for Medicaid	program (line 7 min	us sum of li	nes 2 and 5; if	1, 522, 13	2 8.00
	< zero then enter zero)	-				
	Children's Health Insurance Program (CHIP) (see instruc	ctions for each lin	e)			
9.00	Net revenue from stand-alone CHIP					0 9.00
10.00	Stand-alone CHIP charges					0 10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)					0 11.00
12.00	Difference between net revenue and costs for stand-alor	ne CHIP (line 11 mi	nus line 9; i	f < zero then		0 12.00
	enter zero)	<pre>// / / / / / / / / / / / / / / / / / /</pre>				_
	Other state or local government indigent care program (					
13.00	Net revenue from state or local indigent care program					0 13.00
14.00	Charges for patients covered under state or local indig	gent care program (	Not included	in lines 6 or		0 14.00
15 00	10)	- 1 : 14)				
15.00	State or local indigent care program cost (line 1 times					0 15.00
16.00	Difference between net revenue and costs for state or I	local indigent care	program (III	ne 15 minus line		0 16.00
	13; if < zero then enter zero) Uncompensated care (see instructions for each line)					-
17.00	Private grants, donations, or endowment income restrict	ted to funding char	ity care			0 17.00
18.00	Government grants, appropriations or transfers for supp				497, 24	
19.00	Total unreimbursed cost for Medicaid , CHIP and state a			c (sum of lines	1, 522, 13	
19.00	8, 12 and 16)	anu rocar rhurgent		s (sum of filles	1, 522, 15	2 19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
			1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instr	ructions)	321, 8	98 0	321, 89	8 20.00
21.00	Cost of patients approved for charity care (line 1 time	es line 20)	113, 4	49 0	113, 44	9 21.00
22.00	Partial payment by patients approved for charity care			0 0		0 22.00
23.00	Cost of charity care (line 21 minus line 22)		113, 4	49 0	113, 44	9 23.00
			•			
					1.00	
24.00	Does the amount in line 20 column 2 include charges for		nd a length o	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indige					
25.00	If line 24 is "yes," charges for patient days beyond a			th of stay limit		0 25.00
26.00	Total bad debt expense for the entire hospital complex	• • •			3, 378, 00	
27.00	Medicare bad debts for the entire hospital complex (see				507, 63	
28.00	Non-Medicare and non-reimbursable Medicare bad debt exp				2, 870, 36	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad		1 times line	e 28)	1, 011, 62	
30.00	Cost of uncompensated care (line 23 column 3 plus line				1, 125, 07	
31.00	Total unreimbursed and uncompensated care cost (line 19	9 plus line 30)			2, 647, 20	9  31.00

	Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-1304	Period:	Worksheet A	
					From 01/01/2016 To 12/31/2016	Date/Time Pre 6/28/2017 4:4	
	Cost Center Description	Sal ari es	Other	Total (col.	1 Recl assi fi cati		
	·			+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
4 00	GENERAL SERVICE COST CENTERS		0.014.700	0.044.70		0.044.700	1 1 00
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	2/7 7/4	2, 314, 782				1.00 4.00
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	367, 764 2, 044, 457	2, 815, 289 1, 914, 357			3, 183, 052 4, 073, 596	4.00 5.00
7.00	00700 OPERATION OF PLANT	2,044,437	546, 819			4, 073, 398	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	220, 303	040, 819		0 56, 525	56, 525	
9.00	00900 HOUSEKEEPING	308, 768	149, 320				9.00
10.00	01000 DI ETARY	331,042	242, 097	573, 13			10.00
11.00	01100 CAFETERIA	001,012	0		0 389, 018		
13.00	01300 NURSING ADMINISTRATION	214, 865	710				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	49,873	64, 327	114, 20		113, 193	14.00
16.00	01600 MEDICAL RECORDS & LI BRARY	386, 524	94, 551				16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	1, 316, 271	82, 683	1, 398, 95	4 -602, 061	796, 893	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	555, 280	305, 897	861, 17	7 -34, 695	826, 482	50.00
51.00	05100 RECOVERY ROOM	0	840	84	0 34, 695	35, 535	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	723, 915	1, 001, 628	1, 725, 54	-6, 272	1, 719, 271	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
60.00	06000 LABORATORY	610, 678	814, 982			.,,	60.00
65.00	06500 RESPI RATORY THERAPY	83, 850	8, 495			92, 238	
66.00	06600 PHYSI CAL THERAPY	236, 005	116, 263				66.00
67.00	06700 OCCUPATIONAL THERAPY	134, 164	1, 027				67.00
68.00	06800 SPEECH PATHOLOGY	87, 626	225				
69.00	06900 ELECTROCARDI OLOGY	166, 962	2, 870				69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 72.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	12, 664				71.00
	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	S S	246, 953 3, 795, 820			246, 953	
73.00	OUTPATIENT SERVICE COST CENTERS	462, 839	5, 795, 620	4, 258, 65	-2, 999	4, 255, 660	/3.00
90.00	09000 CLINIC	3, 550, 487	1, 115, 094	4, 665, 58	573, 573	5, 239, 154	90.00
	09100 EMERGENCY	788, 279	1, 085, 090				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	100,217	1,000,070	1,073,30	52,700	1, 040, 403	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	II					72.00
95.00	09500 AMBULANCE SERVICES	573, 957	75, 594	649, 55	-8, 056	641, 495	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		13, 213, 909	16, 808, 377	30, 022, 28	6 0	30, 022, 286	118.00
	NONREI MBURSABLE COST CENTERS			•			1
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
	19300 NONPAID WORKERS	0	0		0 0	0	193.00
	19301 FOUNDATI ON	59, 465	1, 504	60, 96	9 0		193. 01
	19302 OCCUPATIONAL MEDICINE	0	0		0 0	0	193. 02
	07950 OTHER NON REIMBURSABLE COST CENTERS	0	0		0 0		194.00
200.00	TOTAL (SUM OF LINES 118-199)	13, 273, 374	16, 809, 881	30, 083, 25	5 0	30, 083, 255	200. 00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	RUSH MEMORIAL	Provi der CCN:	15-1304		of Form CMS-2552- Worksheet A
RECEAS	STITICATION AND ADJUSTMENTS OF TRIAL DALANCE C	I ENTENDED	TTOVIGET CON.	10 1004	From 01/01/2016	
						Date/Time Prepared 6/28/2017 4:42 pm
	Cost Center Description	Adjustments	Net Expenses			572072017 4.42 pm
	·	(See A-8) F	or Allocation			
	1	6.00	7.00			
	GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-698, 191	1, 616, 591			1.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 534	3, 180, 518			4. C
5.00	00500 ADMINISTRATIVE & GENERAL	-683, 371	3, 390, 225			5. C
7.00	00700 OPERATION OF PLANT	-15	768, 690			7.0
8.00	00800 LAUNDRY & LINEN SERVICE	0	56, 525			8. C
9.00	00900 HOUSEKEEPI NG	-402	401, 143			9.0
10.00	01000 DI ETARY	-1, 554	182, 567			10.0
11.00	01100 CAFETERI A	-215, 445	173, 573			11.0
13.00	01300 NURSI NG ADMI NI STRATI ON	-380	100, 413			13.0
14.00	01400 CENTRAL SERVICES & SUPPLY	0	113, 193			14. C
16.00	01600 MEDICAL RECORDS & LIBRARY	-6, 090	474, 069			16.0
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	I I				
30. 00	03000 ADULTS & PEDIATRICS	-2, 631	794, 262			30.0
	ANCI LLARY SERVI CE COST CENTERS	L				
50.00	05000 OPERATI NG ROOM	-435, 698	390, 784			50. C
51.00	05100 RECOVERY ROOM	0	35, 535			51. C
53.00	05300 ANESTHESI OLOGY	0	0			53.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	-608, 531	1, 110, 740			54. C
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0			55. C
60.00	06000 LABORATORY	-8, 682	1, 416, 978			60.0
65.00	06500 RESPI RATORY THERAPY	0	92, 238			65. C
66.00	06600 PHYSI CAL THERAPY	-99	383, 472			66.0
67.00	06700 OCCUPATIONAL THERAPY	0	166, 891			67.0
68.00	06800 SPEECH PATHOLOGY	0	24, 309			68.0
69.00	06900 ELECTROCARDI OLOGY	-2	169, 382			69.0
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.0
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	-589	92, 309			71.0
	07200 I MPL. DEV. CHARGED TO PATIENT	0	246, 953			72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	-57, 521	4, 198, 139			73.0
~~ ~~	OUTPATIENT SERVICE COST CENTERS	0.757.044	1 101 100			
90.00	09000 CLINIC	-3, 757, 964	1, 481, 190			90.0
91.00	09100 EMERGENCY	0	1, 840, 403			91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.0
~ ~ ~	OTHER REIMBURSABLE COST CENTERS	0.50	( 11 0 15			
95.00	09500 AMBULANCE SERVICES	-250	641, 245			95.0
	SPECIAL PURPOSE COST CENTERS	( 170 0 (a)	00 540 007			
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	-6, 479, 949	23, 542, 337			118.0
192 00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0			192. 0
	19300 NONPALD WORKERS	0	0			193. 0
	19301 FOUNDATI ON	0	60, 969			193. 0
	19302 OCCUPATIONAL MEDICINE	0	00, 909			193. 0
	07950 OTHER NON REIMBURSABLE COST CENTERS	0	0			193.0
	TOTAL (SUM OF LINES 118-199)	-6, 479, 949	23, 603, 306			200. 0

Heal th	Financial Systems		RUSH MEMORIAL	ΗΩ\$ΡΙ ΤΔΙ	Inlie	u of Form CMS-2552-10
	SIFICATIONS			Provi der CCN: 15-1304	Peri od: From 01/01/2016 To 12/31/2016	Worksheet A-6 Date/Time Prepared: 6/28/2017 4:42 pm
		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, 525		1.00
	0		0	56, 525		
	B - DIETARY/ CAFETERIA					
1.00	CAFETERI A	11.00	224, 695	164, 323		1.00
	0		224, 695	164, 323		
	C - MED SUPPLY RECLASS					
1.00	MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	80, 234	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	<u>0</u>		14.00
	0		80, 234	0		
	D - AMBULANCE RECLASS			1		
1.00	OPERATION OF PLANT	7.00	1, 583	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	1, 013	0		2.00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	52	0		3.00
4.00	EMERGENCY		3,032	<u>0</u>		4.00
	0		5, 680	0		
	E – SALARY RECLASS					
1.00	ADMINI STRATI VE & GENERAL	5.00	114, 782	0		1.00
2.00	RECOVERY ROOM	51.00	34, 695	0		2.00
3.00	PHYSI CAL THERAPY	66.00	31, 771	0		3.00
4.00	OCCUPATI ONAL THERAPY		3 <u>1,7</u> 71	<u>0</u>		4.00
	0		213, 019	0		
	F - PHYSICIAN RECLASS	· · · · · · · ·		-		
1.00			<u> </u>	<u>0</u>		1.00
	TOTALS		580, 627			
500.00	Grand Total: Increases		1, 104, 255	220, 848		500.00

Heal th	Financial Systems		RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2552-10
RECLAS	SIFICATIONS			Provider (	CCN: 15-1304	Peri od:	Worksheet A-6
						From 01/01/2016	Data (Tima Dranaradi
						To 12/31/2016	Date/Time Prepared: 6/28/2017 4:42 pm
		Decreases				· ·	0/20/2017 1.12 pm
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Re	f.	
	6. 00	7.00	8.00	9.00	10.00		
	A - LAUNDRY AND LINEN						
1.00	HOUSEKEEPING	9.00	0	5 <u>6, 5</u> 25		Q	1.00
	0		0	56, 525	)		
	B - DIETARY/ CAFETERIA						
1.00	DI ETARY	<u> </u>	224, 695	<u>164, 3</u> 23		Q	1.00
	0		224, 695	164, 323	6		
	C - MED SUPPLY RECLASS				1	1	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1		0	1.00
2.00	HOUSEKEEPI NG	9.00	0	18		0	2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 007		0	3.00
4.00	MEDI CAL RECORDS & LI BRARY	16.00	0	916		0	4.00
5.00	ADULTS & PEDIATRICS	30.00	0	22, 447		0	5.00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	6, 324		0	6.00
7.00	RESPI RATORY THERAPY	65.00	0	107		0	7.00
8.00	PHYSI CAL THERAPY	66.00	0	468		0	8.00
9.00	OCCUPATI ONAL THERAPY	67.00	0	71		0	9.00
10.00	ELECTROCARDI OLOGY	69.00	0	448		0	10.00
11.00	DRUGS CHARGED TO PATIENTS	73.00	0	2, 999		0	11.00
12.00	CLINIC	90.00	0	7, 054		0	12.00
13.00	EMERGENCY	91.00	0	35, 998		0	13.00
14.00	AMBULANCE_SERVICES		º	2, 376		Ō	14.00
	0		0	80, 234			
	D - AMBULANCE RECLASS						
1.00	AMBULANCE SERVICES	95.00	5, 680	0	)	0	1.00
2.00		0.00	0	0	)	0	2.00
3.00		0.00	0	0	)	0	3.00
4.00			0	0	<u> </u>	0	4.00
	0		5, 680	0	)		
	E - SALARY RECLASS					-	
1.00	NURSING ADMINISTRATION	13.00	114, 782	0	)	0	1.00
2.00	OPERATING ROOM	50.00	34, 695	0	)	0	2.00
3.00	SPEECH PATHOLOGY	68.00	63, 542	0		0	3.00
4.00	<u> </u>		0	0	)	Q	4.00
	0		213, 019	0	)		
	F - PHYSICIAN RECLASS	00!			.1		
1.00	ADULTS & PEDIATRICS	<u>30.</u> 00	580, 627	0	)	Q	1.00
	TOTALS		580, 627	0	)	_	
500.00	Grand Total: Decreases		1, 024, 021	301, 082	<u>'</u>	1	500.00

Heal th	Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Li	eu of Form CMS-:	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1304	Period: From 01/01/2016 To 12/31/2016		pared:
				Acqui si ti on	S		
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES		_			
1.00	Land	188, 708	0		0 (	0 0	1.00
2.00	Land Improvements	358, 351	62, 873		0 62, 873	3 0	2.00
3.00	Buildings and Fixtures	15, 976, 114	209, 916		0 209, 910	6 0	3.00
4.00	Building Improvements	17, 559	191, 506		0 191, 500	6 0	4.00
5.00	Fixed Equipment	921, 137	269, 314		0 269, 314	4 0	5.00
6.00	Movable Equipment	13, 732, 268	718, 152		0 718, 153	2 0	6.00
7.00	HIT designated Assets	0	0		0	0 0	7.00
8.00	Subtotal (sum of lines 1-7)	31, 194, 137	1, 451, 761		0 1, 451, 76	1 0	8.00
9.00	Reconciling Items	0	0		0	o l	9.00
10.00	Total (line 8 minus line 9)	31, 194, 137	1, 451, 761		0 1, 451, 76	1 0	10.00
		Endi ng Bal ance					
		5	Depreciated				
			Assets				
		6.00	7.00	1			
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES		•			
1.00	Land	188, 708	0				1.00
2.00	Land Improvements	421, 224	0	1			2.00
3.00	Buildings and Fixtures	16, 186, 030	0				3.00
4.00	Building Improvements	209,065	0				4.00
5.00	Fixed Equipment	1, 190, 451	0				5.00
6.00	Movable Equipment	14, 450, 420	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	32, 645, 898	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	32, 645, 898	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		Provider CO		Period:	Worksheet A-7 Part II	
					From 01/01/2016 To 12/31/2016		
			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	SHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 785, 805	0	216, 00	9 312, 968	0	1.00
3.00	Total (sum of lines 1-2)	1, 785, 805	0	216, 00	9 312, 968	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	SHEET A, COLUN	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2, 314, 782				1.00
3.00	Total (sum of lines 1-2)	0	2, 314, 782				3.00

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2016 To 12/31/2016		pared:
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col	instructions)	Insurance	
	1.00	2.00	2)	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		2.00	3.00	4.00	5.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	0	0		0 1.000000	0	3.00
	ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
	6,00	d Costs 7.00	through 7) 8.00	9,00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		7.00	8.00	9.00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 1, 152, 500	0	1.00
3.00 Total (sum of lines 1-2)	0			0 1, 152, 500		3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
	11.00	12.00	13.00	instructions) 14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		12.00	13.00	14.00	15.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	151, 123	312, 968		0 0	1, 616, 591	1.00
3.00 Total (sum of lines 1-2)	151, 123			0 0		3.00
		•	-			

4DJUST	MENTS TO EXPENSES				eriod: rom 01/01/2016 0 12/31/2016	Worksheet A-8 Date/Time Prep	pared
				Expense Classification on		6/28/2017 4:42	
				To/From Which the Amount is t	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - NEW CAP	1.00	2.00	3.00 NEW CAP REL COSTS-BLDG &	<u>4.00</u> 1.00	5.00 0	1. C
	REL COSTS-BLDG & FIXT (chapter 2)			FIXT	0.00		
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		(	*** Cost Center Deleted ***	2.00	0	
. 00	Investment income - other (chapter 2)		(		0.00	0	-
. 00	Trade, quantity, and time discounts (chapter 8)		l		0.00	0	
6.00	Refunds and rebates of expenses (chapter 8)		(		0.00	0	
5.00	Rental of provider space by suppliers (chapter 8)		(		0.00	0	
. 00	Telephone services (pay stations excluded) (chapter 21)		C		0.00	0	7.
8. 00	Television and radio service (chapter 21)		C		0.00	0	
9.00 10.00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -4, 779, 696	5	0.00	0 0	
1. 00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.
2.00	Related organization transactions (chapter 10)	A-8-1	C			0	12.
3.00 4.00	Laundry and linen service Cafeteria-employees and guests		(		0. 00 0. 00	0	
4.00 5.00	Rental of quarters to employee and others		(		0.00	0	
6. 00	Sale of medical and surgical supplies to other than		C		0.00	0	16.
7.00	patients Sale of drugs to other than patients		C	D	0.00	0	17.
8. 00	Sale of medical records and abstracts		C		0.00	0	18.
9.00	Nursing school (tuition, fees, books, etc.)		C		0.00	0	19.
0.00	Vending machines Income from imposition of		(		0. 00 0. 00	0	
1.00	interest, finance or penal ty charges (chapter 21)		C		0.00	0	21.
2.00			C		0. 00	0	22.
3. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	C	RESPI RATORY THERAPY	65.00		23.
4.00	therapy costs in excess of limitation (chapter 14) Adjustment for physical	A-8-3	(	PHYSI CAL THERAPY	66.00		24.
	therapy costs in excess of limitation (chapter 14)						
5.00	Utilization review - physicians' compensation		C	)*** Cost Center Deleted ***	114.00		25.
6. 00	(chapter 21) Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG &	1.00	0	26.
7.00	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-MVBLE EQUIP		C	FIXT )*** Cost Center Deleted ***	2.00	0	27.
8.00	Non-physician Anesthetist		(	*** Cost Center Deleted ***	19.00		28.
9. 00 0. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	(	) DOCCUPATI ONAL THERAPY	0.00 67.00	0	29. 30.
0. 99	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30. 00		30.
1. 00	instructions) Adjustment for speech	A-8-3	C	SPEECH PATHOLOGY	68.00		31.
2, 00	pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for	А	-633 305	NEW CAP REL COSTS-BLDG &	1.00	Q	32.
	Depreciation and Interest CAFETERIA	В		FIXT CAFETERIA	11.00		33.

Health Fir	nancial Systems		RUSH MEMORIA	I HOSPITAI	Inlie	eu of Form CMS-2	2552-10
	TS TO EXPENSES			Provider CCN: 15-1304	Peri od:	Worksheet A-8	
					From 01/01/2016		
					To 12/31/2016		pared:
				Evenence Classification a	n Waskahaat A	6/28/2017 4:4	2 pm
				Expense Classification o To/From Which the Amount is			
					s to be Aujusteu		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33. 01 JAI	IL MEALS	В	-120, 741	CAFETERIA	11.00	0	33.01
33. 02 VEN	NDING MACHINES	В	-1,015	ADMINISTRATIVE & GENERAL	5.00	0	33.02
34.00 SAL	LE OF DRUGS	В	-22, 687	DRUGS CHARGED TO PATIENTS	73.00	0	34.00
35.00 SAL	LE OF SUPPLIES	В	-589	MEDICAL SUPPLIES CHARGED TO	71.00	0	35.00
				PATI ENTS			
37.00 PHY	YSICIAN APPLICATION FEES	В	-7, 250	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00 MEE	DICAL RECORDS TRANSCRIPTION	В	-6,090	MEDICAL RECORDS & LIBRARY	16.00	0	38.00
FEE							
41.00 COF	PIER FEES	В	-17, 140	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00 ATH	HLETIC TRAINER - SCHOOL REV	В	-15, 725	ADMI NI STRATI VE & GENERAL	5.00	0	42.00
42.01 WEL	LLNESS PROGRAM	В	-2,534	EMPLOYEE BENEFITS DEPARTMEN	IT 4.00	0	42.01
	CUPATIONAL HEALTH	В	-20, 374	CLINIC	90.00	0	45.00
	LE OF SCRAP	В		RADI OLOGY-DI AGNOSTI C	54.00		
	SC. INCOME	В		ADMI NI STRATI VE & GENERAL	5.00		
	SC. INCOME	В		DI ETARY	10.00		
	SC. INCOME	В		PHYSICAL THERAPY	66.00		
1	SC. INCOME	В		AMBULANCE SERVICES	95.00		
45.08 INT	TEREST INCOME	В	-64, 886	NEW CAP REL COSTS-BLDG &	1.00	11	45.08
			4 (40		F 00		45 00
	LEPHONE SALARY	В		ADMI NI STRATI VE & GENERAL	5.00		
	LEPHONE OTHER	A		ADMI NI STRATI VE & GENERAL	5.00		
	LEPHONE BENEFITS	A		ADMI NI STRATI VE & GENERAL	5.00		
	VERTI SI NG	A A		ADMI NI STRATI VE & GENERAL	5.00		
	A & AHA LOBBYING BATES	A		ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL	5.00 5.00		
	BATES	B		OPERATION OF PLANT	7.00		
	BATES	В		HOUSEKEEPI NG	9.00		
1	BATES	B		DI ETARY	10.00		
	BATES	B		NURSING ADMINISTRATION	13.00		
	BATES	B		ADULTS & PEDIATRICS	30.00		
	BATES	В		OPERATING ROOM	50.00		
	BATES	В		RADI OLOGY-DI AGNOSTI C	54.00		
4	BATES	В		LABORATORY	60.00		
	BATES	В		ELECTROCARDI OLOGY	69.00		
	BATES	В		DRUGS CHARGED TO PATIENTS	73.00		
	F EXPENSE	В		ADMI NI STRATI VE & GENERAL	5.00		
	FE SITTER CLASS FEES	A		ADMI NI STRATI VE & GENERAL	5.00		
	TAL (sum of lines 1 thru 49)		-6, 479, 949				50.00
	ransfer to Worksheet A,						
col	lumn 6, line 200.)						

(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 HOSPITAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (		Peri od:	Worksheet A-8	3-2
						From 01/01/2016 To 12/31/2016		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		OPERATING ROOM	448, 746	433, 685			-	1.00
2.00		RADI OLOGY-DI AGNOSTI C	635, 588	608, 421			-	2.00
3.00		LABORATORY	36, 000	0	,		0	3.00
4.00		CLINIC	4, 228, 465	3, 737, 590			0	4.00
5.00		EMERGENCY	997, 582	0	997, 582	2 0	0	5.00
6.00	0.00		0	0	(		0	6.00
7.00	0.00		0	0	(	0 0	0	7.00
8.00	0.00		0	0	(	0 0	0	8.00
9.00	0.00		0	0	(	0 0	0	9.00
10.00	0.00		0	0	(	0 0	0	10.00
200.00			6, 346, 381	4, 779, 696	1, 473, 83		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			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		OPERATING ROOM	0	0			-	1.00
2.00		RADI OLOGY-DI AGNOSTI C	0	0				2.00
3.00		LABORATORY	0	0			0	3.00
4.00		CLINIC	0	0		-	0	4.00
5.00		EMERGENCY	0	0		-	0	5.00
6.00	0.00		0	0	(	0 0	0	6.00
7.00	0.00		0	0	(	0 0	0	7.00
8.00	0.00		0	0		-	0	8.00
9.00	0.00		0	0	(		0	9.00
10.00	0.00		0	0		-	0	10.00
200.00			0	0		,	0	200.00
	Wkst. A Line #	5	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00		14		17.00	10.00		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		OPERATING ROOM	0	0				1.00
2.00		RADI OLOGY-DI AGNOSTI C	0	0				2.00
3.00		LABORATORY	0	0				3.00
4.00		CLINIC	0	0				4.00
5.00		EMERGENCY	0	0		-		5.00
6.00	0.00		0	0				6.00
7.00	0.00		0	0				7.00
8.00	0.00		0	0				8.00
9.00	0.00		0	0				9.00
10.00	0.00		0	0				10.00
200.00			0	0	(	4, 779, 696		200.00

	Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2016 To 12/31/2016		pared:
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS NEW BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	2 pm
		0	1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	1, 616, 591	1, 616, 591				1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 180, 518		3, 192, 24			4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	3, 390, 225	235, 405	530, 79			5.00
7.00	00700 OPERATION OF PLANT	768, 690	132, 742	54, 54			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	56, 525	5, 210		0 61, 735	13, 195	8.00
9.00	00900 HOUSEKEEPI NG	401, 143	25, 415	75,90	3 502, 461	107, 392	9.00
10.00	01000 DI ETARY	182, 567	48, 982	26, 14	3 257, 692	55, 077	10.00
11.00	01100 CAFETERI A	173, 573	16, 280	55, 23	6 245, 089	52, 383	11.00
13.00	01300 NURSING ADMINISTRATION	100, 413	10, 824	24,60	3 135, 840	29, 033	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	113, 193	34, 796	12, 26	0 160, 249	34, 250	14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	474,069		95, 01			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · ·		· · ·	- · · ·		1
30.00	03000 ADULTS & PEDI ATRI CS	794, 262	116, 285	181, 08	9 1, 091, 636	233, 318	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	390, 784	95, 535	127, 97	3 614, 292	131, 294	50.00
51.00	05100 RECOVERY ROOM	35, 535	11, 053	8, 52	9 55, 117	11, 780	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 110, 740	133, 516	177, 96	9 1, 422, 225	303, 975	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
60.00	06000 LABORATORY	1, 416, 978	36, 626	150, 12	0 1, 603, 724	342, 767	60.00
65.00	06500 RESPI RATORY THERAPY	92, 238	2, 306	20, 61	2 115, 156	24, 613	65. OC
66.00	06600 PHYSI CAL THERAPY	383, 472	83, 285	65, 82			66.00
67.00	06700 OCCUPATI ONAL THERAPY	166, 891	22, 599	40, 79		49, 218	67.00
68.00	06800 SPEECH PATHOLOGY	24, 309	4, 734	5, 92			68.00
69.00	06900 ELECTROCARDI OLOGY	169, 382	7, 075	41, 04			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	92, 309	0	19, 72		-	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	246, 953		17,72	0 246, 953		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 198, 139	6, 266	113, 77			73.00
75.00	OUTPATIENT SERVICE COST CENTERS	4,170,137	0,200	115,77	4, 310, 102	722, 737	/ 5. 00
90.00	09000 CLINIC	1, 481, 190	445, 412	1, 015, 52	6 2, 942, 128	628, 827	90.00
	09100 EMERGENCY	1, 840, 403		194, 52			91.00
		1, 640, 403	07,902	194, 32	2, 102, 829	449, 442	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				0		92.00
95.00	09500 AMBULANCE SERVICES	641, 245	22, 528	139, 69	803, 470	171, 727	95.00
95.00	SPECIAL PURPOSE COST CENTERS	041, 245	22, 320	139,09	003,470	1/1, /2/	95.00
118.00		23, 542, 337	1, 601, 631	3, 177, 62	2 23, 512, 759	4, 137, 072	110 00
116.00	NONRELMBURSABLE COST CENTERS	23, 342, 337	1,001,031	3, 177, 02	23, 312, 739	4, 137, 072	1110.00
			0		0 0		192.00
102 00	19200 PHYSI CLANS' PRI VATE OFFI CES		0		0 0		
		0	0	14, 61	0 0 8 90, 547		193.00
193.00	19300 NONPALD WORKERS	10.010			SU 90 547	19 353	193.01
193. 00 193. 01	19301 FOUNDATI ON	60, 969	14, 960	14, 01	,0,34,		100 00
193. 00 193. 01 193. 02	19301 FOUNDATION 19302 OCCUPATIONAL MEDICINE	60, 969 0	14, 960 0	14, 01	0 0	0	
193.00 193.01 193.02 194.00	19301 FOUNDATION 19302 OCCUPATIONAL MEDICINE 07950 OTHER NON REIMBURSABLE COST CENTERS	60, 969 0 0	14, 960 0 0	14, 01		0 0	193. 02 194. 00
193.00 193.01 193.02 194.00 200.00	19301 FOUNDATION 19302 OCCUPATIONAL MEDICINE 07950 OTHER NON REIMBURSABLE COST CENTERS Cross Foot Adjustments	60, 969 0 0	14, 960 0 0	14, 01		0	194. 00 200. 00
193. 00 193. 01 193. 02	19301 FOUNDATION 19302 OCCUPATIONAL MEDICINE 07950 OTHER NON REIMBURSABLE COST CENTERS Cross Foot Adjustments Negative Cost Centers	60, 969 0 0 23, 603, 306	0 0 0	3, 192, 24	0 0 0 0 0 0 0 0	0 0 0	194. 00 200. 00 201. 00

	Financial Systems	RUSH MEMORIAL	_ HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1304	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 6/28/2017 4:4	
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPIN	G DI ETARY	CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	1, 160, 300					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	4, 888	79, 818				8.00
9.00	00900 HOUSEKEEPI NG	23, 844	5, 602				9.00
10.00	01000 DI ETARY	45, 955	2, 297				10.00
11.00	01100 CAFETERI A	15, 274	0	-,		321, 375	1
13.00	01300 NURSI NG ADMI NI STRATI ON	10, 155	0			1, 648	
14.00	01400 CENTRAL SERVICES & SUPPLY	32, 646	0			3, 296	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	23, 580	0	13, 32	22 0	19, 612	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	109, 100	52, 046	61, 63	38 386, 984	37, 411	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	89, 631	5, 224	50, 63	39 0	13, 844	50.00
51.00	05100 RECOVERY ROOM	10, 370	0	5, 8	59 0	1, 648	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	125, 266	3, 375	70, 7	71 0	26, 204	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
60.00	06000 LABORATORY	34, 363	0	19, 41	14 0	23, 897	60.00
65.00	06500 RESPI RATORY THERAPY	2, 163	672	1, 22	22 0	4, 285	65.00
66.00	06600 PHYSI CAL THERAPY	78, 138	1, 571	44, 14	46 0	7,087	66.00
67.00	06700 OCCUPATI ONAL THERAPY	21, 202	723	11, 9	79 0	3, 955	67.00
68.00	06800 SPEECH PATHOLOGY	4, 442	31	2, 5	10 0	494	68.00
69.00	06900 ELECTROCARDI OLOGY	6, 638	0	3, 75	50 0	5, 274	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	5, 879	0	3, 32	21 0	11, 537	73.00
	OUTPATIENT SERVICE COST CENTERS	· · ·					
90.00	09000 CLI NI C	417, 888	0	236, 04	92 0	97, 567	90.00
91.00	09100 EMERGENCY	63, 706	8, 277	35, 99	92 0	29, 336	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	21, 136	0	11, 94	41 0	31, 973	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		1, 146, 264	79, 818	631, 30	59 386, 984	319, 068	1118.00
	NONREI MBURSABLE COST CENTERS						
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
	19300 NONPAI D WORKERS	0	0		0 0		193.00
	19301 FOUNDATI ON	14,036	0				193.01
	2 19302 OCCUPATI ONAL MEDI CI NE	0	0		0 0		193.02
	07950 OTHER NON REIMBURSABLE COST CENTERS	0	0		0 0		194.00
200.00			0			0	200.00
201.00		0	0		0 0	0	201.00
202.00	5	1, 160, 300	79, 818	639, 29	386, 984	321, 375	
		.,	, 510			32., 370	1

Health Financial Systems	RUSH MEMORIAL	- HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	CN: 15-1304	Period: From 01/01/2016		
				To 12/31/2016	Date/Time Prep 6/28/2017 4:4:	pared: 2 pm
Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	Subtotal	Intern &	
	ADMI NI STRATI ON	SERVICES & SUPPLY	RECORDS & LI BRARY		Residents Cost & Post	
		JUPPLI	LIDKART		Stepdown	
					Adjustments	
	13.00	14.00	16.00	24.00	25.00	
GENERAL SERVICE COST CENTERS	•					
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI 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 NURSING ADMINISTRATION	182, 413					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	248, 885				14.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	977	778, 71	4		16.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	34, 603	14, 957	334, 58	2, 356, 276	0	30.00
ANCI LLARY SERVI CE COST CENTERS	1					
50. 00 05000 OPERATI NG ROOM	12, 749	33, 468	73, 58		0	50.00
51.00 05100 RECOVERY ROOM	1, 528	203		0 86, 505	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	24, 178	10, 892	89, 09		0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
60. 00 06000 LABORATORY	22, 156	109, 373		0 2, 155, 694	0	60.00
65. 00 06500 RESPI RATORY THERAPY	4, 519	862	1, 65		0	65.00
66. 00 06600 PHYSI CAL THERAPY	6, 561	2, 197		0 786, 113	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2,077	172		0 319, 607	0	67.00
68. 00 06800 SPEECH PATHOLOGY	1, 531	55		0 51, 499	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	4, 913	562		0 285, 124	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 135, 978	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	10 ((2)	33, 462		0 333, 197 0 5, 275, 911	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	10, 662	3, 393		0 5, 275, 911	0	73.00
90. 00 09000 CLINIC	0	16, 657		0 4, 339, 159	0	90.00
91. 00 09100 EMERGENCY	26, 949	17, 316	279, 80		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	20, 747	17, 510	219,00	3,013,030	0	
OTHER REIMBURSABLE COST CENTERS					0	72.00
95. 00 09500 AMBULANCE SERVICES	29, 987	4, 339		0 1, 074, 573	0	95.00
SPECIAL PURPOSE COST CENTERS	277707	1,007				, , , , , , , , , , , , , , , , , , , ,
118.00 SUBTOTALS (SUM OF LINES 1-117)	182, 413	248, 885	778, 71	4 23, 469, 133	0	118.00
NONREI MBURSABLE COST CENTERS		,		.,,,		
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
193. 01 19301 FOUNDATI ON	0	0		0 134, 173		193.01
193. 02 19302 OCCUPATI ONAL MEDI CI NE	0	0		0 0	0	193.02
194.00 07950 OTHER NON REIMBURSABLE COST CENTERS	0	0		0 0		194.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	182, 413	248, 885	778, 71	4 23, 603, 306	0	202.00
·		·				

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL	In Lieu of Form CM	S-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1304	Period:         Worksheet B           From 01/01/2016         Part I           To         12/31/2016           6/28/2017         4	repared:
Cost Center Description	Total 26.00			. 12 pm
GENERAL SERVICE COST CENTERS	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				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
16.00 01600 MEDICAL RECORDS & LI BRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			
30. 00 03000 ADULTS & PEDIATRICS	2, 356, 276			30, 00
ANCI LLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	1,024,723			50.00
51.00 05100 RECOVERY ROOM	86, 505			51.00
53. 00 05300 ANESTHESI OLOGY	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2,075,976			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			55.00
60. 00 06000 LABORATORY	2, 155, 694			60.00
65. 00 06500 RESPI RATORY THERAPY	155, 142			65.00
66. 00 06600 PHYSI CAL THERAPY	786, 113			66.00
67.00 06700 OCCUPATI ONAL THERAPY	319, 607			67.00
68.00 06800 SPEECH PATHOLOGY	51, 499			68.00
69. 00 06900 ELECTROCARDI OLOGY	285, 124			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	135, 978			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	333, 197			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 275, 911			73.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	4, 339, 159			90.00
91. 00 09100 EMERGENCY	3, 013, 656			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS	• •			
95. 00 09500 AMBULANCE SERVICES	1,074,573			95.00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1-117)	23, 469, 133			118.00
NONREI MBURSABLE COST CENTERS				
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.00
193.00 19300 NONPALD WORKERS	0			193.00
193. 01 19301 FOUNDATI ON	134, 173			193.01
193. 02 19302 OCCUPATI ONAL MEDI CI NE	0			193.02
194.0007950 OTHER NON REIMBURSABLE COST CENTERS	0			194.00
200.00 Cross Foot Adjustments	0			200.00
201.00 Negative Cost Centers	0			201.00
Lon ogati to boot bontono				201.00

	Financial Systems	RUSH MEMORIA				eu of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1304	Period: From 01/01/2016 To 12/31/2016		pared: 2 pm
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS NEW BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
	1	0	1.00	2A	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0		11, 72			4.00
5.00	00500 ADMINISTRATIVE & GENERAL	0		235, 40			
7.00	00700 OPERATION OF PLANT	0	132, 742	132, 74			
8.00	00800 LAUNDRY & LINEN SERVICE	0	5, 210	5, 21			1
9.00	00900 HOUSEKEEPI NG	0	25, 415	25, 41			
10.00	01000 DI ETARY	0	48, 982	48, 98			
11.00	01100 CAFETERI A	0		16, 28			
13.00	01300 NURSI NG ADMI NI STRATI ON	0		10, 82			
14.00	01400 CENTRAL SERVICES & SUPPLY	0		34, 79			
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	25, 133	25, 13	33 349	7, 252	16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1			-		-
30.00	03000 ADULTS & PEDIATRICS	0	116, 285	116, 28	35 665	13, 323	30.00
	ANCI LLARY SERVICE COST CENTERS	1	05 505	05.54			
50.00	05000 OPERATING ROOM	0		95, 53			
51.00	05100 RECOVERY ROOM	0		11, 05		673	
53.00	05300 ANESTHESI OLOGY	0	-	100 54	0 0	-	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		133, 51			
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	o., .,	0 0	-	
60.00		0	36, 626	36, 62		19, 573	
65.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	2, 306	2, 30			
66.00		0	83, 285	83, 28			
67.00	06700 OCCUPATIONAL THERAPY	0	22, 599	22, 59			1
68.00		0	4,734	4, 73			1
69.00		0	7, 075	7,07			
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0 0 72	-	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0			0 12		
72.00	07200 TMPL. DEV. CHARGED TO PATTENT	0		6, 26	-		
73.00	OUTPATIENT SERVICE COST CENTERS	0	0,200	0, 20	410	52,711	/3.00
90.00	09000 CLINIC	0	445, 412	445, 41	2 3, 726	35, 909	90.00
90.00 91.00	09100 EMERGENCY	0		67, 90			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	07, 702	07, 90	0	25,005	92.00
72.00	OTHER REIMBURSABLE COST CENTERS				0		92.00
95.00	09500 AMBULANCE SERVICES	0	22, 528	22, 52	28 513	9, 806	95.00
95.00	SPECIAL PURPOSE COST CENTERS	0	22, 320	22, 32	-0  515	9,000	95.00
118.00		0	1, 601, 631	1, 601, 63	11, 668	236, 250	1118 00
110.00	NONREIMBURSABLE COST CENTERS	0	1,001,031	1,001,00	11,000	230, 230	
192 00	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0	192.00
	19300 NONPALD WORKERS	0	-		0 0		192.00
	19301 FOUNDATI ON	0	-	14, 96	-		193.00
	19302 OCCUPATIONAL MEDICINE		14, 900	14, 90	0 0		193.02
	07950 OTHER NON REIMBURSABLE COST CENTERS		0		0 0		194.00
200.00					0		200.00
200.00	3		0		0 0	0	200.00
201.00	0	0	1, 616, 591	1, 616, 59	0		
202.00		0	1,010,091	1,010,05	11,722	237,300	1202.00

Heal th	Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
	ATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1304	Peri od:	Worksheet B	
					From 01/01/2016		
					To 12/31/2016	Date/Time Pre 6/28/2017 4:4	
	Cost Center Description	OPERATION 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 1		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	00700 OPERATION OF PLANT	144, 610	( 570				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	609	6, 572		(0)		8.00
9.00	00900 HOUSEKEEPING	2,972	461				9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	5, 727 1, 904	189 0			21, 854	10.00
13.00	01300 NURSING ADMINISTRATION	1, 904	0		76 0 16 0	21,854	1
13.00	01400 CENTRAL SERVICES & SUPPLY	4,069	0	-		224	
16.00	01600 MEDICAL RECORDS & LIBRARY	2, 939	0	., -	35 0		1
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	2,939	0	1	55 0	1, 334	10.00
30, 00	03000 ADULTS & PEDIATRICS	13, 597	4, 285	3, 4	00 59, 571	2, 544	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	13, 377	4,203	J. 3, 4	57, 571	2, 344	30.00
50.00	05000 OPERATI NG ROOM	11, 171	430	2, 7	93 0	941	50.00
51.00	05100 RECOVERY ROOM	1, 292	0		23 0	112	
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	15, 612	278		-	1, 782	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	1
60.00	06000 LABORATORY	4, 283	0			1, 625	
65.00	06500 RESPIRATORY THERAPY	270	55		67 0	291	
66,00	06600 PHYSI CAL THERAPY	9, 738	129			482	
67.00	06700 OCCUPATI ONAL THERAPY	2, 642	60		61 0	269	
68.00	06800 SPEECH PATHOLOGY	554	3		38 0	34	1
69.00	06900 ELECTROCARDI OLOGY	827	0		07 0	359	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	-	0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	733	0	1	83 0	785	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	52,082	0	13, 0	22 0	6, 634	90.00
91.00	09100 EMERGENCY	7,940	682	1, 9	85 0	1, 995	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	н — — н					
95.00	09500 AMBULANCE SERVI CES	2,634	0	6	59 0	2, 174	95.00
	SPECIAL PURPOSE COST CENTERS	· · · · ·		•			
118.00	SUBTOTALS (SUM OF LINES 1-117)	142, 861	6, 572	34, 8	23 59, 571	21, 697	118.00
	NONREI MBURSABLE COST CENTERS						
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0	192.00
193.00	19300 NONPAI D WORKERS	0	0		0 0	0	193.00
193.01	19301 FOUNDATI ON	1, 749	0	4	37 0	157	193.01
	19302 OCCUPATIONAL MEDICINE	0	0		0 0	0	193. 02
194.00	07950 OTHER NON REIMBURSABLE COST CENTERS	0	0		0 0	0	194.00
200.00							200.00
201.00		0	0		0 0		201.00
202.00	TOTAL (sum lines 118-201)	144, 610	6, 572	35, 2	60 59, 571	21, 854	202.00

Heal th	Financial Systems	RUSH MEMORIAL	- HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1304	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Pre 6/28/2017 4:4	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	16.00	24.00	25.00	
4 00	GENERAL SERVICE COST CENTERS	1					1 1 00
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
4.00 5.00							
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00 7.00
7.00 8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
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	14, 266					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	14, 200	42, 107				14.00
16.00	01600 MEDICAL RECORDS & LI BRARY	0	42, 107	37, 90	דו		16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	105	37, 90			10.00
30, 00	03000 ADULTS & PEDIATRICS	2,707	2, 530	16, 28	235, 194	0	30.00
00.00	ANCI LLARY SERVICE COST CENTERS	2,707	2,000	10,20	200,171		00.00
50.00	05000 OPERATI NG ROOM	997	5, 662	3, 58	32 129, 078	0	50.00
51.00	05100 RECOVERY ROOM	119	34	0,00	0 13,637	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0 10,007	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 891	1, 843	4, 33	37 181, 174	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1,0,1	1, 010	1, 00	0 0	0	
60.00	06000 LABORATORY	1, 733	18, 505		0 83, 967	0	60.00
65.00	06500 RESPI RATORY THERAPY	353	146	ş	5,049	0	65.00
66.00	06600 PHYSI CAL THERAPY	513	372		0 103, 696	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	162	29		0 29, 383	0	67.00
68.00	06800 SPEECH PATHOLOGY	120	9		0 6,041	0	68.00
69.00	06900 ELECTROCARDI OLOGY	384	95		0 11, 753	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 439	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	5, 661		0 8,675	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	834	574		0 62, 504	0	•
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	2, 818		0 559, 603	0	90.00
91.00	09100 EMERGENCY	2, 108	2, 930	13, 62	125, 543	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS	· · ·					1
95.00	09500 AMBULANCE SERVI CES	2, 345	734		0 41, 393	0	95.00
	SPECIAL PURPOSE COST CENTERS	· ·					1
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	14, 266	42, 107	37, 90	07 1, 598, 129	0	118. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
	19300 NONPALD WORKERS	0	0		0 0		193.00
	19301 FOUNDATI ON	0	0		0 18, 462		193.01
	19302 OCCUPATI ONAL MEDI CI NE	0	0		0 0		193.02
	07950 OTHER NON REIMBURSABLE COST CENTERS	0	0		0 0		194.00
200.00			-		0		200.00
201.00		0	о		0 0	0	201.00
202.00	5	14, 266	42, 107	37, 90	1, 616, 591		202.00

LLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1304	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepare 6/28/2017 4:42 pr
Cost Center Description	Total 26.00			
GENERAL SERVICE COST CENTERS	26.00		· · · · ·	
00 00100 NEW CAP REL COSTS-BLDG & FIXT				1
00 00400 EMPLOYEE BENEFITS DEPARTMENT				4
00 00500 ADMINI STRATI VE & GENERAL				5
00 00700 OPERATION OF PLANT				7
00 00800 LAUNDRY & LI NEN SERVI CE				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 MEDICAL RECORDS & LIBRARY				16
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · ·			
D. 00 03000 ADULTS & PEDIATRICS	235, 194			30
ANCI LLARY SERVI CE COST CENTERS				
D. 00 05000 OPERATING ROOM	129, 078			50
1.00 05100 RECOVERY ROOM	13, 637			51
3. 00 05300 ANESTHESI OLOGY	0			53
4. 00 05400 RADI OLOGY-DI AGNOSTI C	181, 174			54
5. 00 05500 RADI OLOGY-THERAPEUTI C	0			55
D. 00 06000 LABORATORY	83, 967			60
5. 00 06500 RESPI RATORY THERAPY	5, 049			65
6. 00 06600 PHYSI CAL THERAPY	103, 696			66
7.00 06700 OCCUPATI ONAL THERAPY	29, 383			67
B. 00 06800 SPEECH PATHOLOGY	6, 041			68
9. 00 06900 ELECTROCARDI OLOGY	11, 753			69
0. 00 07000 ELECTROENCEPHALOGRAPHY	0			70
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 439			71
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	8, 675			72
3. 00 07300 DRUGS CHARGED TO PATIENTS	62, 504			73
OUTPATIENT SERVICE COST CENTERS	550 (00			
0. 00 09000 CLINIC	559, 603			90
1.00 09100 EMERGENCY	125, 543			91
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)				92
OTHER REIMBURSABLE COST CENTERS 5. 00 09500 AMBULANCE SERVICES	41, 393			95
SPECIAL PURPOSE COST CENTERS	41, 393			95
18.00 SUBTOTALS (SUM OF LINES 1-117)	1, 598, 129			118
NONREI MBURSABLE COST CENTERS	1, 370, 127			110
92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			192
93. 00 19300 NONPALD WORKERS	0			192
93. 01 19301 FOUNDATI ON	18, 462			193
93. 02 19302 OCCUPATIONAL MEDICINE	10, 402			193
94. 00 07950 OTHER NON REIMBURSABLE COST CENTERS	0			194
00.00 Cross Foot Adjustments	0			200
01.00 Negative Cost Centers	0			200
D2. 00 TOTAL (sum lines 118-201)	1, 616, 591			201

Heal th	Financial Systems	RUSH MEMORIAI	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					rom 01/01/2016 o 12/31/2016	Date/Time Pre	nared
					0 12/31/2010	6/28/2017 4:4	
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	NEW BLDG &		Reconciliatior	ADMI NI STRATI VE		
		FIXT	BENEFI TS		& GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
		1.00	SALARI ES)	<b>F</b> A	5 00	7 00	
	GENERAL SERVICE COST CENTERS	1.00	4.00	5A	5.00	7.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	91, 850					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	666	12, 985, 844				4.00
5.00	00500 ADMINI STRATI VE & GENERAL	13, 375	2, 159, 239		19, 446, 881		5.00
7.00	00700 OPERATION OF PLANT	7, 542	221, 886			70, 267	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	296	221,000			296	8.00
9.00	00900 HOUSEKEEPING	1, 444	308, 768			1, 444	9.00
10.00	01000 DI ETARY	2, 783	106, 347			2, 783	
11.00	01100 CAFETERI A	925	224, 695	-	2011012	925	11.00
	01300 NURSI NG ADMI NI STRATI ON	615	100, 083			615	13.00
	01400 CENTRAL SERVICES & SUPPLY	1, 977	49, 873			1, 977	14.00
	01600 MEDICAL RECORDS & LIBRARY	1, 428	386, 524	1		1, 428	16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	1,420	500, 524		J J74, 217	1, 420	10.00
30.00	03000 ADULTS & PEDI ATRI CS	6,607	736, 657	0	1, 091, 636	6, 607	30.00
00.00	ANCI LLARY SERVICE COST CENTERS	0,007	700,007		1,071,000	0,007	00.00
50.00	05000 OPERATING ROOM	5, 428	520, 585	0	614, 292	5, 428	50.00
	05100 RECOVERY ROOM	628	34, 695			628	51.00
	05300 ANESTHESI OLOGY	0_0	01,070			0_0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 586	723, 967			7, 586	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0			0	55.00
60.00	06000 LABORATORY	2, 081	610, 678		-	2, 081	60.00
65.00	06500 RESPI RATORY THERAPY	131	83, 850			131	65.00
66.00	06600 PHYSI CAL THERAPY	4, 732	267, 776			4, 732	66.00
	06700 OCCUPATI ONAL THERAPY	1, 284	165, 935			1, 284	67.00
68.00	06800 SPEECH PATHOLOGY	269	24, 084			269	68.00
	06900 ELECTROCARDI OLOGY	402	166, 962			402	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0			0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	80, 234	( c	112, 033	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0			0	72.00
	07300 DRUGS CHARGED TO PATIENTS	356	462, 839			356	73.00
	OUTPATIENT SERVICE COST CENTERS	· · · · · ·	· · · ·				
90.00	09000 CLI NI C	25, 307	4, 131, 114	(	2, 942, 128	25, 307	90.00
91.00	09100 EMERGENCY	3, 858	791, 311	0	2, 102, 829	3, 858	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	1, 280	568, 277	0	803, 470	1, 280	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		91,000	12, 926, 379	-4, 156, 425	19, 356, 334	69, 417	118.00
	NONREIMBURSABLE COST CENTERS			<b>1</b>	r		
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
	19300 NONPALD WORKERS	0	0		0 0		193.00
	19301 FOUNDATI ON	850	59, 465	0	90, 547	850	193. 01
	19302 OCCUPATI ONAL MEDI CI NE	0	0	0	0 0	0	193. 02
	07950 OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0 0	0	194.00
200.00	5						200. 00
201.00							201.00
202.00	Cost to be allocated (per Wkst. B,	1, 616, 591	3, 192, 240		4, 156, 425	1, 160, 300	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	17. 600338	0. 245825		0. 213732	16. 512730	
204.00			11, 722		237, 355	144, 610	204.00
	Part II)						
205.00			0. 000903		0.012205	2.058007	205.00
		1 1		1	1		

Health Financial Systems	RUSH MEMORIA	I HOSPI TAI		Inlie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CC	CN: 15-1304 P	eri od:	Worksheet B-1	
				rom 01/01/2016		
				o 12/31/2016	Date/Time Pre 6/28/2017 4:4	
Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG	
	LINEN SERVICE	(SQUARE	(MEALS		ADMI NI STRATI ON	
	(POUNDS OF	FEET)	SERVED)	. ,		
	LAUNDRY)				(DI RECT	
					NRSING HRS)	
	8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS	[			1		1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	28, 495					8.00
9. 00 00900 HOUSEKEEPING	28,493					9.00
10. 00 01000 DI ETARY	820		100			10.00
11. 00 01100 CAFETERIA	020	925	100			11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	615	0		248, 710	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	1, 977	C		0	
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	1, 428	C		0	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	18, 580	6, 607	100	227	47, 181	30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 865		C		17, 382	
51.00 05100 RECOVERY ROOM	0	628	C		2, 083	
53. 00 05300 ANESTHESI OLOGY	0	0	C	U U	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 205	7, 586	C	,	32, 965	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	C	-	0	55.00
60. 00 06000 LABORATORY	0	2, 081	C		30, 208	1
65. 00 06500 RESPI RATORY THERAPY	240		C		6, 162	
66. 00 06600 PHYSI CAL THERAPY	561	4, 732	C		8, 946	
67. 00 06700 OCCUPATI ONAL THERAPY	258		C		2,832	
68. 00 06800 SPEECH PATHOLOGY	11	269	C	Ű	2,087	
69. 00 06900 ELECTROCARDI OLOGY	0	402	C	02	6, 699	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		Ŭ	0	70.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	-	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	356			14, 537	•
OUTPATIENT SERVICE COST CENTERS	0	550		/ /0	14, 337	/ 3. 00
90. 00 09000 CLINIC	0	25, 307	C	592	0	90.00
91. 00 09100 EMERGENCY	2,955		C		36, 743	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	_,		-			92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	1, 280	C	194	40, 885	95.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	28, 495	67, 677	100	1, 936	248, 710	118.00
NONREI MBURSABLE COST CENTERS	-		-	-		
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0		C			192.00
193. 00 19300 NONPAI D WORKERS	0			-		193.00
193. 01 19301 FOUNDATI ON	0	850	C			193.01
193. 02 19302 OCCUPATI ONAL MEDI CI NE	0	0	C	Ű		193.02
194.00 07950 OTHER NON REIMBURSABLE COST CENTERS	0	0	C	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	70 010	420, 200	204 004	221 275	102 /12	201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	79, 818	639, 299	386, 984	321, 375	182, 413	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	2. 801123	9. 329155	3, 869. 840000	164. 807692	0. 733437	203.00
204.00 Cost to be allocated (per Wkst. B,	6, 572					203.00
Part II)	0,012	00,200	57,571	2.,001	,200	
205.00 Unit cost multiplier (Wkst. B, Part	0. 230637	0. 514542	595.710000	11. 207179	0. 057360	205.00
					1	

Health Fir	nancial Systems	RUSH MEMORIA	_ HOSPI TAL		In Lieu	」of Form CMS-	2552-10
	CATION - STATISTICAL BASIS		Provider CCN:	15-1304	Peri od:	Worksheet B-1	
					From 01/01/2016		
					To 12/31/2016	Date/Time Pre 6/28/2017 4:4	
	Cost Center Description	CENTRAL	MEDI CAL			0/20/2011 1.1	
	· · · · · · · · · · · · · · · · · · ·	SERVICES &	RECORDS &				
		SUPPLY	LI BRARY				
		(COSTED	(TIME				
		REQUIS.)	SPENT)				
		14.00	16.00				
	IERAL SERVICE COST CENTERS	I					1
	100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	500 ADMINISTRATIVE & GENERAL						5.00
	700 OPERATION OF PLANT						7.00
	300 LAUNDRY & LINEN SERVICE 200 HOUSEKEEPING						8.00 9.00
	DOO DI ETARY						10.00
	100 CAFETERI A						11.00
	BOO NURSI NG ADMI NI STRATI ON						13.00
	400 CENTRAL SERVICES & SUPPLY	1,031,912					14.00
	500 MEDICAL RECORDS & LIBRARY	4, 050	94, 400				16.00
	PATIENT ROUTINE SERVICE COST CENTERS	1,000	71,100				10.00
	DOO ADULTS & PEDIATRICS	62, 013	40, 560				30.00
	CILLARY SERVICE COST CENTERS	, -, -					
50.00 050	DOO OPERATING ROOM	138, 763	8, 920				50.00
	IOO RECOVERY ROOM	840	0				51.00
	BOO ANESTHESI OLOGY	0	o				53.00
54.00 054	400 RADI OLOGY-DI AGNOSTI C	45, 161	10, 800				54.00
55.00 055	500 RADI OLOGY - THERAPEUTI C	0	o				55.00
60.00 060	DOO LABORATORY	453, 471	o				60.00
65.00 065	500 RESPI RATORY THERAPY	3, 572	200				65.00
	500 PHYSI CAL THERAPY	9, 111	0				66.00
	700 OCCUPATIONAL THERAPY	714	0				67.00
	BOO SPEECH PATHOLOGY	228	0				68.00
	200 ELECTROCARDI OLOGY	2, 332	0				69.00
	DOO ELECTROENCEPHALOGRAPHY	0	0				70.00
	100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0				71.00
	200 IMPL. DEV. CHARGED TO PATIENT	138, 740	0				72.00
	BOO DRUGS CHARGED TO PATIENTS	14,068	0				73.00
	PATIENT SERVICE COST CENTERS	69,064	0				90.00
	100 EMERGENCY	71, 793	33, 920				90.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	/1, /73	33, 420				92.00
	IER REIMBURSABLE COST CENTERS						72.00
	500 AMBULANCE SERVICES	17, 992	0				95.00
	CIAL PURPOSE COST CENTERS	11, 772					70.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,031,912	94, 400				118.00
	IREI MBURSABLE COST CENTERS						
	200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
193.00193	BOO NONPALD WORKERS	0	О				193.00
	301 FOUNDATI ON	0	0				193.01
193. 02 193	302 OCCUPATIONAL MEDICINE	0	0				193. 02
194.00079	950 OTHER NON REIMBURSABLE COST CENTERS	0	o				194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	248, 885	778, 714				202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 241188	8. 249089				203.00
204.00	Cost to be allocated (per Wkst. B,	42, 107	37, 907				204.00
205.00	Part II)	0 040005	0 401557				205.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 040805	0. 401557				203.00
I	1	I I	1				I.

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 6/28/2017 4:4	
		Title	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) 1.00	2.00	3.00	4,00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	2, 356, 276		2, 356, 2	76 0	0	30.00
ANCI LLARY SERVI CE COST CENTERS	2, 350, 270		2, 330, 2	70 0	0	30.00
50, 00 05000 OPERATING ROOM	1,024,723		1, 024, 7	23 0	0	50.00
51. 00 05100 RECOVERY ROOM	86, 505		86, 50		0	51.00
53. 00 05300 ANESTHESI OLOGY	0		00,0	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 075, 976		2, 075, 9	76 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		, , , , , ,	0 0	0	55.00
60. 00 06000 LABORATORY	2, 155, 694		2, 155, 6	94 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	155, 142	0	155, 14		0	65.00
66.00 06600 PHYSI CAL THERAPY	786, 113	0	786, 1	13 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	319, 607	0	319, 60	07 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	51, 499	0	51, 49	99 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	285, 124		285, 12	24 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	135, 978		135, 9		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	333, 197		333, 19		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	5, 275, 911		5, 275, 9	11 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	4, 339, 159		4, 339, 1		0	
91.00 09100 EMERGENCY	3, 013, 656		3, 013, 6		0	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	523, 182		523, 18	32	0	92.00
OTHER REI MBURSABLE COST CENTERS	4 074 570		4 074 5	70		05 00
95. 00 09500 AMBULANCE SERVICES	1,074,573		1, 074, 5		0	
200.00Subtotal (see instructions)201.00Less Observation Beds	23, 992, 315 523, 182	0	23, 992, 3 523, 18			200. 00 201. 00
201.00 Less observation Beds 202.00 Total (see instructions)	23, 469, 133	0				201.00
	23, 409, 133	0	23, 409, 1	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		Provider C		Period: From 01/01/2016 To 12/31/2016		
	-		XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.007.450		0.007.45			0.0.00
30. 00 03000 ADULTS & PEDI ATRI CS	2, 897, 459		2, 897, 45	.9		30.00
ANCI LLARY SERVI CE COST CENTERS	000 700	0.000.7//	0.70/ //	0 0 0 70 ( 00	0.00000	50.00
50. 00 05000 OPERATING ROOM	323, 702	2, 382, 766			0.00000	50.00
51.00 05100 RECOVERY ROOM	43, 648	737, 050			0.00000	51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.00000		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 200, 999	19, 250, 952				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0. 000000		55.00
60. 00 06000 LABORATORY	1, 046, 072	9, 964, 414				
65.00 06500 RESPI RATORY THERAPY	117, 896	312, 995				
66. 00 06600 PHYSI CAL THERAPY	261, 778	1, 381, 510				66.00
67.00 06700 OCCUPATI ONAL THERAPY	168, 015	527, 024				67.00
68.00 06800 SPEECH PATHOLOGY	70, 152	75, 392				68.00
69. 00 06900 ELECTROCARDI OLOGY	84, 180	1, 328, 158	1, 412, 33		0. 000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0. 000000		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	219, 560	2, 495, 206				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2,044	235, 939				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 414, 250	11, 047, 185	12, 461, 43	0. 423379	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	2, 622	1, 148, 441				90.00
91.00 09100 EMERGENCY	65, 109	5, 853, 476				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	825, 041	825, 04	0. 634128	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS			-			
95.00 09500 AMBULANCE SERVICES	0	1, 107, 638			0.00000	
200.00 Subtotal (see instructions)	7, 917, 486	58, 673, 187	66, 590, 67	3		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	7, 917, 486	58, 673, 187	66, 590, 67	3		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: 15-1304	Peri od: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 6/28/2017 4:4	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
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
	1				

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-1304	Period: From 01/01/2016 To 12/31/2016		pared: 2 pm
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 356, 276		2, 356, 2	76 0	2, 356, 276	30.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	1, 024, 723		1, 024, 7		1, 024, 723	
51.00 05100 RECOVERY ROOM	86, 505		86, 5		86, 505	
53.00 05300 ANESTHESI OLOGY	0			0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 075, 976		2, 075, 9		2, 075, 976	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0 455 4	0 0	0	
60. 00 06000 LABORATORY	2, 155, 694		2, 155, 6		2, 155, 694	
65. 00 06500 RESPIRATORY THERAPY	155, 142		100/1		155, 142	•
66.00 06600 PHYSI CAL THERAPY	786, 113	0	786, 1		786, 113	•
67.00 06700 OCCUPATI ONAL THERAPY	319, 607	0	319, 6		319, 607	•
68.00 06800 SPEECH PATHOLOGY	51, 499		51, 4		51, 499	
69. 00 06900 ELECTROCARDI OLOGY	285, 124		285, 1		285, 124	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		105.0	0 0	0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	135, 978		135, 9		135, 978	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	333, 197 5, 275, 911		333, 1 5, 275, 9		333, 197 5, 275, 911	
OUTPATIENT SERVICE COST CENTERS	5, 275, 911		5, 275, 9	11 0	5, 275, 911	73.00
90. 00 09000 CLINIC	4, 339, 159		4, 339, 1	59 0	4, 339, 159	90.00
91. 00 09100 EMERGENCY	3, 013, 656		3, 013, 6		3, 013, 656	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	523, 182		523, 1		523, 182	
OTHER REIMBURSABLE COST CENTERS	525, 102		525, 1	52	525, 102	72.00
95. 00 09500 AMBULANCE SERVICES	1,074,573		1, 074, 5	73 0	1, 074, 573	95.00
200.00 Subtotal (see instructions)	23, 992, 315				23, 992, 315	
201.00 Less Observation Beds	523, 182		523, 1		523, 182	
202.00 Total (see instructions)	23, 469, 133					
	,,, .00	, o				

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016		
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 897, 459		2, 897, 45	59		30.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	323, 702	2, 382, 766			0. 000000	50.00
51.00 05100 RECOVERY ROOM	43, 648	737, 050	780, 69		0.00000	51.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0.000000		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 200, 999	19, 250, 952	20, 451, 95			
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0.000000	0.00000	55.00
60. 00 06000 LABORATORY	1, 046, 072	9, 964, 414	11, 010, 48	0. 195786	0.00000	60.00
65. 00 06500 RESPI RATORY THERAPY	117, 896	312, 995	430, 89	0. 360049	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	261, 778	1, 381, 510	1, 643, 28	0. 478378	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	168, 015	527, 024	695, 03	0. 459840	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	70, 152	75, 392	145, 54	0. 353838	0.00000	68.00
69.00 06900 ELECTROCARDI OLOGY	84, 180	1, 328, 158	1, 412, 33	0. 201881	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0.000000	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	219, 560	2, 495, 206	2, 714, 76	0. 050088	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2,044	235, 939	237, 98	1. 400087	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 414, 250	11, 047, 185	12, 461, 43	0. 423379	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	2,622	1, 148, 441	1, 151, 06	3. 769697	0.00000	90.00
91.00 09100 EMERGENCY	65, 109	5, 853, 476	5, 918, 58	0. 509185	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	825, 041	825, 04	0. 634128	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS					-	1
95. 00 09500 AMBULANCE SERVICES	0	1, 107, 638	1, 107, 63	0. 970148	0.00000	95.00
200.00 Subtotal (see instructions)	7, 917, 486	58, 673, 187				200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	7, 917, 486	58, 673, 187	66, 590, 67	3		202.00
				1	•	

COMPUTATION OF RATIO OF COSTS TO CHARGES         Provider CCN: 15-1304         Period: From 01/01/2016 To 12/31/2016         Worksheet C Part 1 Date/Time Prepared: 0 12/31/2016           Impart ent Routine Service Cost Center Description         PPS Inpatient Ratio 11.00         Title XIX         Hospital         Cost           Impart ent Routine Service Cost Centers         11.00         30.00         30.00         30.00           0.00 05000/AUUETs & PEDIATRICS         11.00         51.00         50.00         50.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         55.00         56.00         56.00         56.00         56.00         56.00         66.00         66.00         66.00	Health Financial Systems	RUSH MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
Cost Center Description         PPS Inpatient Ratio         Inpatient Ratio         Inpatient Ratio           11.00         Impatient Initial         Impatient Ratio         Impatient Ratio	COMPUTATION OF RATIO OF COSTS TO CHARGES			From 01/01/2016 To 12/31/2016	Part I Date/Time Pre	
Ratio         11.00           30.00         03000 ADULTS & PEDIATRICS         30.00           ANCILLARY SERVICE COST CENTERS         50.00         05000 OPERATING ROOM         0.000000         51.00           53.00         05000 OPERATING ROOM         0.000000         51.00         53.00         53.00           54.00         05400 RADIOLOGY - DIAGNOSTIC         0.000000         54.00         55.00           55.00         06500 RADIOLOGY - DIAGNOSTIC         0.000000         66.00         66.00           65.00         06500 RADIOLOGY - THERAPEUTIC         0.000000         65.00         66.00           65.00         06500 RESPI RATORY THERAPEUTIC         0.000000         66.00         66.00           66.00         06700 OCUPATIONAL THERAPY         0.000000         66.00         66.00           67.00         06700 OCUPATIONAL THERAPY         0.000000         68.00         69.00           69.00         06700 OCUPATIONAL THERAPY         0.000000         70.00         70.00           71.00         7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS         0.000000         71.00         71.00           72.00         07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS         0.000000         71.00         72.00           73.00         07300 DRUGS			Title XIX	Hospi tal	Cost	
11.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         11.00         11.00         10.00         11.00         11.00         11.00         10.00000         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00         15.00	Cost Center Description	PPS Inpatient				
INPATI ENT ROUTI NE SERVI CE COST CENTERS         30.00           30.00         03000 ADULTS & PEDIATRI CS         30.00           ANCI LLARY SERVI CE COST CENTERS         50.00         50.00         50.00         51.00         65.00         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         53.00         53.00         53.00         53.00         53.00         54.00         54.00         55.00         ADI OLOGY - DI AGNOSTI C         0.000000         55.00         55.00         66.00         67.00         60.00         67.00						
30. 00       03000   ADULTS & PEDIATRICS       30. 00         ANCILLARY SERVICE COST CENTERS       50. 00         50. 00       05000 (PERATING ROOM       0. 000000         51. 00       05100 (RECOVERY ROOM       0. 000000         53. 00       05300 (ANESTHESI OLOGY       0. 000000         54. 00       05300 (ANESTHESI OLOGY       0. 000000         55. 00       05500 RADI OLOGY-THERAPEUTI C       0. 000000         60. 00       06000 (LABORATORY       0. 000000         60. 00       06000 PHYSI CAL THERAPY       0. 000000         61. 00       06000 PHYSI RATORY THERAPY       0. 000000         66. 00       06000 PHYSI CAL THERAPY       0. 000000         66. 00       06000 SPEECH PATHOLOGY       0. 000000         68. 00       06000 SPEECH PATHOLOGY       0. 000000         68. 00       06900 ELECTROCARDED HALOGRAPHY       0. 000000         70. 00       07000 ELECTROENCEPHALOGRAPHY       0. 000000         71. 00       07100 MEDICAL SUPPLIES CHAREGE TO PATIENTS       0. 000000         72. 00       07300 DRUGS CHAREGE TO PATIENTS       0. 000000         73. 00       073000 DRUGS CHAREGE TO PATIENTS       0. 000000         71. 00       07100 MEDICAL SUPPLIES CHAREGE TO PATIENTS       0. 000000 </td <td></td> <td>11.00</td> <td></td> <td></td> <td></td> <td></td>		11.00				
ANCI LLARY SERVICE COST CENTERS           50. 00         05000         DPERATING ROOM         0.000000         50.00           51. 00         05000         DPERATING 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         G6000         LABORATORY         0.000000         60.00           65. 00         06500         RESPI RATORY THERAPY         0.000000         66.00           66. 00         06000         DCUPATI ONAL THERAPY         0.000000         66.00           67. 00         06700         0CUPATI ONAL THERAPY         0.000000         67.00           68. 00         06900         ELECTROCARDI OLOGY         0.000000         68.00           69. 00         OPODE ELECTROCARDI OLOGY         0.000000         68.00           71. 00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0.000000         70.00           71. 00         07300         DRUGS CHARGED TO PATI ENTS         0.000000         71.00      <		1 1				_
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         55.00           55.00         05500         RADI OLOGY-THERAPEUTI C         0.000000         60.00           60.00         CABORATORY         0.000000         60.00           60.00         CABORATORY         0.000000         60.00           66.00         CABORATORY         0.000000         60.00           66.00         CABORATORY         0.000000         66.00           66.00         CABORATORY         0.000000         67.00           66.00         CABORATORY         0.000000         67.00           67.00         CACUPATIONAL THERAPY         0.000000         67.00           68.00         CABORATORY         0.000000         67.00           69.00         CABORATORY         0.000000         70.00           71.00         DELCTROCARDI OLOGY         0.000000         71.00           72.00         73.00         DIVPATIENT SERVICE CA						30.00
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       66.00         64.00       06600       PHYSI CAL THERAPY       0.000000       66.00         65.00       06600       SPEECH PATHOLOGY       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       68.00         69.00       ELECTROCARDI OLOGY       0.000000       70.00         70.00       O7200       IMEL CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71.00         71.00       72.00       07300       REGENCY       0.000000       73.00         70.00       7200       IMPL. DELY       0.000000       73.00       73.00         72.00       07300       REGENCY       0.000000       91.00       91.00         90.00       09000						_
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-DI AGNOSTI C       0.000000       65.00         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       67.00         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07200       ILECTROCARDED TO PATI ENT       0.000000       72.00         73.00       DRUGS CHARGED TO PATI ENTS       0.000000       72.00         73.00       DRUGS CHARGED TO PATI ENT       0.000000       72.00         73.00       DRUGS CHARGED TO PATI ENTS       0.000000       72.00         73.00       DRUGS CHARGED TO PATI ENTS       0.0						
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000       54.00         55.00       05500       RADI OLOGY-THERAPEUTI C       0.000000       60.00         60.00       06000       LABORATORY       0.000000       60.00         65.00       06500       RESPI RATORY THERAPY       0.000000       60.00         66.00       06600       PHYSI CAL THERAPY       0.000000       66.00         67.00       06700       0CUPATI ONAL THERAPY       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       68.00         70.00       71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       71.00       72.00         73.00       ORUGS CHARGED TO PATI ENTS       0.000000       73.00       90.00       91.00         90100       EMERCENCY       0.000000       91.00       91.00       91.00       91.00         91.00       09100       CLINEC COST CENTERS       0.000000       91.00       92.00       92.00         00100L						
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       66.00         66.00       06600       PHYSI CAL THERAPY       0.000000       67.00         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       68.00         70.00       D7000       ELECTROCARDI OLOGAPHY       0.000000       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       0.000000       73.00         0.000000       CLINIC       0.000000       90.00       90.00         90.00       OPGOOD CLINIC       0.000000       91.00       90.00         91.00       OPGOOD CLINIC       0.000000       91.00       92.00         92.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
60.00       06000       LABORATORY       0.00000       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       0CCUPATI 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       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07200 I MPL.       DEV. CHARGED TO PATI ENTS       0.000000       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       73.00         00170       09100       EMERGENCY       0.000000       90.00         90.00       09100       EMERGENCY       0.000000       91.00         92.00       OPSEON       AMBULANCE SERVICE SENTION PART)       0.000000       91.00         92.00       OPSEON AMBULANCE SERVICES       0.000000       95.00       95.00         00100						
65.00       06500       RESPIRATORY THERAPY       0.00000       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       66.00         67.00       06700       0CCUPATIONAL THERAPY       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       68.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07300       DRUGS CHARGED TO PATI ENT       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       72.00         90.00       09000       CLI NI C       0.000000       90.00         91.00       09100       EMERGENCY       0.000000       91.00         92.00       09200       DSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       91.00         92.00       09500       AMBULANCE SERVI CES       0.000000       92.00         95.00       09500       AMBULANCE SERVI CES       0.000000       95.00         200.00						
66.00         06600         PHYSI CAL THERAPY         0.000000         67.00           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         68.00           70.00         07000         ELECTROCARDI OLOGY         0.000000         70.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0.000000         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0.000000         72.00           73.00         07200         DRUGS CHARGED TO PATI ENTS         0.000000         73.00           0UTPATI ENT SERVICE COST CENTERS         0.000000         73.00         90.00         91.00           91.00         09100         EMERGENCY         0.000000         91.00         91.00           92.00         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0.000000         91.00         92.00           09500         AMBULANCE SERVI CES         0.000000         95.00         95.00         200.00         201.00         201.00						
67.00       06700       0CCUPATIONAL THERAPY       0.000000       67.00         68.00       06800       SPEECH PATHOLOGY       0.000000       68.00         69.00       06900       ELECTROCARDIOLOGY       0.000000       69.00         70.00       07000       ELECTROCARDIOLOGY       0.000000       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       73.00         00000       01000       EMERGENCY       0.000000       90.00         91.00       09100       EMERGENCY       0.000000       91.00         92.00       OSSERVATION BEDS (NON-DISTINCT PART)       0.000000       91.00         92.00       OPSTON AMBULANCE SERVICES       0.000000       95.00         00000       Subtotal (see instructions)       0.000000       95.00         200.00       Less Observation Beds       0.000000       201.00						
68.00       06800       SPEECH PATHOLOGY       0.000000       68.00         69.00       06900       ELECTROCARDIOLOGY       0.000000       69.00         70.00       07000       ELECTRONCEPHALOGRAPHY       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       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       73.00         00000       CLINIC       0.000000       90.00       90.00         91.00       09000       CLINIC       0.000000       91.00         92.00       OSEXVATION BEDS (NON-DISTINCT PART)       0.000000       91.00         92.00       OSEXVATION BEDS (NON-DISTINCT PART)       0.000000       92.00         0THER REI MBURSABLE COST CENTERS       0.000000       92.00       95.00         00500       AMBULANCE SERVICES       0.000000       95.00       95.00         200.00       Subtotal (see instructions)       200.00       201.00       201.00						
69.00       06900       ELECTROCARDI OLOGY       0.000000       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENT       0.000000       72.00         00       07000       ELECTROCARGED TO PATI ENTS       0.000000       72.00         00       07000       CLINIC       0.000000       90.00         90.00       09000       CLINIC       0.000000       91.00         91.00       09100       EMERGENCY       0.000000       91.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       0.000000       92.00         071.00       OTHOR REI MBURSABLE COST CENTERS       0.000000       95.00       95.00         95.00       09500       AMBULANCE SERVICES       0.000000       95.00         200.00       Subtotal (see instructions)       200.00       201.00         201.00       Less Observation Beds       201.00       201.00		0. 000000				67.00
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           000000         CLINIC         0.000000         73.00           90.00         09100         EMERGENCY         0.000000         90.00           91.00         09200         DSERVATION BEDS (NON-DISTINCT PART)         0.000000         91.00           92.00         09500         AMBULANCE SERVICES         0.000000         95.00           95.00         09500         AMBULANCE SERVICES         0.000000         95.00           200.00         Subtotal (see instructions)         200.00         201.00         201.00						
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENT       0.000000       73.00         00TPATI ENT SERVICE COST CENTERS       0.000000       73.00         90.00       09100       EMERGENCY       0.000000       90.00         91.00       9200       OBSERVATI ON BEDS (NON-DI STINCT PART)       0.000000       91.00         92.00       OPSERVATI ON BEDS (NON-DI STINCT PART)       0.000000       92.00         01HER REI MBURSABLE COST CENTERS       0.000000       95.00       95.00         95.00       09500 AMBULANCE SERVICES       0.000000       95.00         200.00       Subtotal (see instructions)       200.00       201.00       201.00	69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
72.00         07200         IMPL. DEV. CHARGED TO PATIENT         0.000000         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0.000000         73.00           0UTPATIENT SERVICE COST CENTERS         0.000000         90.00         90.00           90.00         09100         EMERGENCY         0.000000         91.00           92.00         09200         DBSERVATION BEDS (NON-DISTINCT PART)         0.000000         91.00           95.00         09500         AMBULANCE SERVICES         0.000000         95.00           200.00         Subtotal (see instructions)         0.000000         201.00         201.00	70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
73.00         07300         DRUGS CHARGED TO PATIENTS         0.00000         73.00           0UTPATIENT SERVICE COST CENTERS         0.00000         90.00         90.00         90.00         90.00         90.00         90.00         90.00         91.00         90.00         91.00         92.00         92.00         92.00         92.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         200.00         201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
OUTPATIENT SERVICE COST CENTERS         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         91.00         90.00         91.00         92.00         92.00         000000         91.00         92.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
90.00         09000         CLINIC         0.00000         90.00           91.00         09100         EMERGENCY         0.000000         91.00           92.00         095ERVATION BEDS (NON-DISTINCT PART)         0.000000         92.00           0THER REI MBURSABLE COST CENTERS         0.000000         95.00         95.00           95.00         09500 AMBULANCE SERVICES         0.000000         95.00           200.00         Subtotal (see instructions)         200.00         201.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
91.00         09100         EMERGENCY         0.000000         91.00           92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         0.000000         92.00           0THER         REI MBURSABLE COST CENTERS         0.000000         95.00           95.00         09500         AMBULANCE SERVICES         0.000000         95.00           200.00         Subtotal (see instructions)         200.00         201.00         201.00	OUTPATIENT SERVICE COST CENTERS					
92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         0.000000         92.00           0THER         REI MBURSABLE COST CENTERS         0.000000         95.00         95.00         95.00         95.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         200.00         201.00		0. 000000				90.00
OTHER REIMBURSABLE COST CENTERS         95.00       09500       AMBULANCE SERVICES       0.000000       95.00         200.00       Subtotal (see instructions)       200.00       200.00       201.00	91. 00 09100 EMERGENCY	0. 000000				91.00
95.00         09500         AMBULANCE SERVICES         0.000000         95.00           200.00         Subtotal (see instructions)         200.00         200.00         201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00
200.00 201.00Subtotal (see instructions) Less Observation Beds200.00 201.00	OTHER REIMBURSABLE COST CENTERS					
201.00 Less Observation Beds 201.00	95. 00 09500 AMBULANCE SERVI CES	0. 000000				95.00
	200.00 Subtotal (see instructions)					200.00
202.00         Total (see instructions)         202.00	201.00 Less Observation Beds					201.00
	202.00   Total (see instructions)					202.00

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	NL COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges		t Inpatient	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	r	1		r	
50.00 05000 OPERATING ROOM	129, 078					
51.00 05100 RECOVERY ROOM	13, 637	780, 698				
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	181, 174	20, 451, 951	0. 00885		6, 745	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000		0	
60. 00 06000 LABORATORY	83, 967	11, 010, 486			5, 201	60.00
65. 00 06500 RESPI RATORY THERAPY	5,049	430, 891			696	65.00
66. 00 06600 PHYSI CAL THERAPY	103, 696	1, 643, 288	0.06310	3 136, 673	8, 624	66.00
67.00 06700 OCCUPATI ONAL THERAPY	29, 383	695, 039	0. 04227	5 71, 026	3, 003	67.00
68.00 06800 SPEECH PATHOLOGY	6, 041	145, 544	0. 04150	6 37, 709	1, 565	68.00
69. 00 06900 ELECTROCARDI OLOGY	11, 753	1, 412, 338	0. 00832	2 57, 345	477	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 439	2, 714, 766	0. 00053	0 31, 362	17	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	8, 675	237, 983	0. 03645	2 1, 955	71	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	62, 504	12, 461, 435	0. 00501	6 810, 715	4, 067	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	559, 603	1, 151, 063	0. 48616	2 0	0	90.00
91.00 09100 EMERGENCY	125, 543	5, 918, 585	0. 02121	2 23, 647	502	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	52, 222	825, 041	0.06329	6 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						]
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	1, 373, 764	62, 585, 576		2, 970, 420	44, 640	200. 00

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVI CE OTHER PASS	Provider C	CN: 15-1304	Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician Nu Anesthetist Cost	5		Medical Education Cost	4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
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 MEDI CAL 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 O7300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS					0	00.00
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) OTHER REIMBURSABLE COST CENTERS	0	0	1	0 0	0	92.00
	1		1			
95. 00 09500 AMBULANCE SERVICES		0		0	~	95.00
200.00   Total (lines 50-199)	0	0	1	0 0	0	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CN: 15-1304         Period: From 01/01/2016 To 12/31/2016         Worksheet D From 01/01/2016 To 12/31/2016           V         E         Cost Center Description         Total Outpatient Cost (sum of 4)         Total Outpatient Cost (sum of 4)         Total Outpatient Cost (sum of 8)         Not ILLARY SERVICE COST CENTERS         Inpatient Program Charges Col. 6 + col.         Inpatient Program Charges Col. 6 + col.         Inpatient Program Charges Col. 6 + col.         Inpatient Program Charges Col. 6 + col.         Program Charges Col. 6 + c	Heal th	Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Introduct GOULS         To         12/31/2016         Date/Time P repared: 6/28/2017 4: 42 pm Cost           Title XVIII         Hospital         Cost           Cost Center Description         Total Outpatient Cost (sum or col. 2, 3 and 4)         Total Charges (col. 5 + col. 7)         Total Charges (col. 6 + col. 7)         Inpatient Ratio of Cost to Charges (col. 6 + col. 7)         Inpatient Program Charges (col. 6 + col. 7)         Inpatient Program Charges           ANCILLARY SERVICE COST CENTERS           50.00         05000 (DPERATINC ROOM 05100 RECOVERY ROOM 51.00         0         2,706,468         0.000000         0.000000         280,532         50.00           50.00         05100 RECOVERY ROOM 6010 RECOVERY ROOM 53.00         0         22,706,468         0.000000         0.000000         16,776         51.00           50.00         05100 RECOVERY ROOM 6010 RECOVERY ROOM 600 06000 LABORATORY         0         20,451,951         0.000000         0.000000         681,955         50.00           600 05500 RADI LOGY - DI AGNOSTI C         0         0         0.000000         0.000000         681,955         60.00           600 00000 LABORATORY         0         11,010,486         0.000000         0.000000         7,094         65.00           600 06500 RESP			VICE OTHER PASS	S Provider C				
Image: construct construction         Image: construction constread constread construction construction construction constread co	THROUG	GH COSTS						pared <sup>.</sup>
Cost Center Description         Total Outpatient (cost (sum of col. 2, 3 and 4)         Total Charges (col. 5 + col. 7)         Ratio of Cost to Charges (col. 5 + col. 7)         Inpatient Program (charges (col. 6 + col. 7)           ANCI LLARY SERVICE COST CENTERS         0         0         2, 706, 468         0.00000         0.000000         280, 532         50.00           05000 (DPERATING ROOM 51.00         05000 (DPERATING ROOM 05000 (DPERATING ROOM 53.00         0         2, 706, 468         0.000000         0.000000         10.00           53.00         05400 (ANESTHESI OLOGY 0         0         2, 706, 468         0.000000         0.000000         16, 796         51.00           54.00         05400 (RADI OLOGY-DI AGNOSTI C         0         0         20, 451, 951         0.000000         0.000000         0         55.00           65.00         06500 (RESPI RATORY THERAPEUTI C         0         0         0.000000         0.000000         0.000000         681, 955         60.00           66.00         06600 (RESPI RATORY THERAPY         0         1430, 891         0.000000         0.000000         71, 026         67.00           68.00         06600 (SPECH PATHOROGRAPHY         0         1, 643, 288         0.000000         71, 026         67.00           69.00         06900 ELECTROCARADI OLOGY								
ANCI LLARY SERVICE COST CENTERS         Outpatient Cost (sum of 4)         (from Wkst. C, ell , col. 8)         to Charges (col. 5 + col. 7)         Ratio of Cost to Charges (col. 6 + col. 7)         Program Charges           50.00         05000 (DPERATI NG ROOM 05100 (DEVRY ROOM 53.00         0         2,706,468         0.00000         0.000000         280,532         50.00           51.00         05100 (RCOVERY ROOM 05100 (RCOVERY ROOM 53.00         0         7.00         8.00         0         0.000000         0.000000         280,532         50.00           53.00         05300 (ANESTHESI OLOGY         0         0         0         0.000000         0.000000         0.000000         0         53.00           54.00         05500 (RADI OLOGY-THERAPEUTI C         0         0         0.000000         0.000000         0.000000         0.000000         0.550.00           66.00         06600 PHYSI CAL THERAPEUTIC         0         0         11,010,486         0.000000         0.000000         0.000000         681,955         60.00           66.00         06600 PHYSI CAL THERAPY         0         1,643,288         0.000000         0.000000         71,026         67.00           66.00         06000 ELECTROCARDI OLOGY         0         1,412,338         0.000000         0.000000         7								
ANCI LLARY SERVICE COST CENTERS         Cost (sum of cl 4)         Part I, col 8)         (col 5 + col 7)         to Charges (col 6 + col 7)         Charges           50.00         05000         0PERATI NG ROM         0         7.00         8.00         9.00         10.00           50.00         05000         0PERATI NG ROM         0         2,706,468         0.000000         0.000000         16,796         51.00           51.00         05300         ANESTHESI 0LOGY         0         0         0.000000         0.000000         16,796         51.00           53.00         05400         RADI 0LOGY-DI AGNOSTI C         0         0         0.000000         0.000000         761,318         54.00           55.00         05500 RADI 0LOGY-THERAPEUTI C         0         0         0.000000         0.000000         0.000000         55.00           66.00         066000         LABARTORY         0         11,010,486         0.000000         0.000000         71,226         67.00           67.00         06000         LABARTORY         0         14,643,288         0.000000         0.000000         71,026         67.00           68.00         06900         ELCENCRARDIOLOGY         0         1,412,338         0.000000         0.		Cost Center Description						
Col. 2, 3 and 4)         8)         7)         (col. 6 + col. 7)           ANCI LLARY SERVICE COST CENTERS         6.00         7.00         8.00         9.00         10.00           50.00         05000         0PERATI NG ROOM         0         2,706,468         0.000000         0.000000         280,532         50.00           51.00         05100         RECOVERY ROOM         0         2,706,468         0.000000         0.000000         6,796         51.00           53.00         05300         ANESTHESI OLOGY         0         0         0.000000         0.000000         0         53.00           54.00         05400         RADI OLGY-THERAPEUTI C         0         0         0.000000         0         0.55.00           60.00         06000         LABORATORY         0         11,010,486         0.000000         0.000000         55.00           60.00         06000         LABORATORY         0         1430,891         0.000000         0.000000         13,673         66.00           60.00         06000         LASI X288         0.000000         13,667         66.00         67.00         667.00         0.000000         13,673         66.90         0.0000000         17,026         67.00								
4)         7)           6.00         7.00         8.00         9.00         10.00           50.00         05000         OPERATI NG ROM         0         2,706,468         0.000000         0.000000         280,532         50.00           51.00         05300         ARESTHESI OLOGY         0         0.000000         0.000000         0.000000         53.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0         20.451,951         0.000000         0.000000         0         55.00           50.00         06500         RADI OLOGY-THERAPEUTI C         0         0.000000         0.000000         0         55.00           60.00         06000         LABORATORY         0         11,010,486         0.000000         0.000000         65.00           65.00         06500         RESPI RATORY THERAPY         0         14,643,288         0.000000         0.000000         71,318         54.00           67.00         06700         0CUPATI ONAL THERAPY         0         430,891         0.000000         0.000000         71,326         67.00           69.00         06400         SPECH PATHOLOGY         0         145,544         0.000000         0.000000         7.00							Charges	
ANCI LLARY SERVICE COST CENTERS           6.00         7.00         8.00         9.00         10.00           ANCI LLARY SERVICE COST CENTERS         0         0.00000         280,532         50.00           50.00         05100         RECOVERY ROOM         0         280,698         0.000000         0.000000         16,796         51.00           53.00         05300         ANESTHESI OLOGY         0         0         0.000000         0.000000         0         53.00           54.00         05500         RADI OLOGY-DI AGNOSTI C         0         20,451,951         0.000000         0.000000         0         55.00           65.00         05500         RADI OLOGY-THERAPEUTI C         0         0         0.000000         0.000000         0         55.00           65.00         06500         RESPI RATORY THERAPEUTY         0         14,010,486         0.000000         0.000000         55.00         65.00           65.00         06600         PHYSI CAL THERAPY         0         1,643,288         0.000000         0.000000         71,026         67.00           67.00         06700         DCCUPATI ONAL THERAPY         0         1,45,544         0.000000         0.0000000         710         68.00				8)	/)			
ANCI LLARY SERVICE COST CENTERS           50. 00         05000         OPERATI NG ROM         0         2,706,468         0.000000         0.000000         280,532         50.00           51. 00         05300         ARCSTRESI OLOGY         0         780,698         0.000000         0.000000         16,796         51.00           53. 00         05400         REOVERY ROM         0         20,451,951         0.000000         0.000000         0         53.00           54. 00         05500         RADI OLOGY -DI AGNOSTI C         0         20,451,951         0.000000         0.000000         0         55.00           00. 00500         RADI OLOGY -THERAPEUTI C         0         0         0.000000         0.000000         0         55.00           05.00         06500         RESPI RATORY THERAPY         0         11,610,486         0.000000         0.000000         59,387         65.00           66. 00         06600         LABORATORY         0         1,643,288         0.000000         0.000000         71,026         67.00           67. 00         06700         0CCUPATI ONAL THERAPY         0         1,45,544         0.000000         0.000000         71,026         67.00           06900         ELEC				7.00	0.00	.,	10.00	
50.00       05000       OPERATI NG ROOM       0       2,706,468       0.000000       0.000000       280,532       50.00         51.00       05100       RECOVERY ROM       0       780,698       0.000000       0.000000       16,796         53.00       05300       ANESTHESI OLOGY       0       0       0.000000       0.000000       16,796         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0.000000       0.000000       761,318       54.00         55.00       05500       RADI OLOGY-THERAPEUTI C       0       0       0.000000       0.000000       681,955       60.00         60.00       LABORATORY       0       11,010,486       0.000000       0.000000       55.00         65.00       06500       RESPI RATORY THERAPY       0       1,643,288       0.000000       0.000000       71,026       67.00         66.00       6600       PHECH PATHOLOGY       0       145,544       0.000000       0.000000       37,709       68.00         69.00       06900       ELECTROCARDI OLOGY       0       145,544       0.000000       0.000000       37,709       68.00         69.00       06900       ELECTROCARDI OLOGY       0		ANCILLADY SEDVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
51.00       05100       RECOVERY ROOM       0       780,698       0.000000       0.000000       16,796       51.00         53.00       05300       ANESTHESI 0LOGY       0       0       0.000000       0.000000       0       53.00         54.00       05400       RADI 0LOGY-DI AGNOSTI C       0       20,451,951       0.000000       0.000000       0       055.00         65.00       05500       RADI 0LOGY-THERAPEUTI C       0       0       0.000000       0.000000       0       055.00         60.00       06600       LABORATORY       0       11,010,486       0.000000       0.000000       55.00         65.00       06500       RESPI RATORY THERAPY       0       430,891       0.000000       0.000000       57,387       65.00         66.00       PHYSI CAL THERAPY       0       1,643,288       0.000000       0.000000       71,026       67.00         68.00       06900       ELECTROCARDI 0LOGY       0       145,544       0.000000       0.000000       73,709       68.00         69.00       07000       ELECTROCARDI 0LOGY       0       1,412,338       0.000000       0.000000       71,002       71.00         71.00       07100       ME	50.00		0	2 706 469	0.0000	0 00000	200 522	50.00
53.00       05300       ANESTHESI OLOGY       0       0       0       0.000000       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       20,451,951       0.000000       0.000000       761,318       54.00         55.00       05500       RADI OLOGY-THERAPEUTI C       0       0       0.000000       0.000000       681,955       60.00         60.00       LABORATORY       0       11,010,486       0.000000       0.000000       681,955       60.00         65.00       06500       RESPI RATORY THERAPY       0       430,891       0.000000       0.000000       59,387       65.00         66.00       06600       PHYSI CAL THERAPY       0       1,643,288       0.000000       0.000000       71,026       67.00         67.00       05700       CCUPATI ONAL THERAPY       0       695,039       0.000000       0.000000       71,026       67.00         68.00       SPEECH PATHOLOGY       0       1,412,338       0.000000       0.000000       57,345       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0.000000       0.000000       31,362       71.00         71.00       07100			0					
54.00       05400       RADI OLOGY - DI AGNOSTI C       0       20, 451, 951       0.000000       0.000000       761, 318       54.00         55.00       05500       RADI OLOGY - THERAPEUTI C       0       0       0.000000       0.000000       0.000000       55.00         60.00       06000       LABORATORY       0       11, 010, 486       0.000000       0.000000       59, 387       60.00         65.00       06500       RESPI RATORY THERAPY       0       1, 643, 288       0.000000       0.000000       71, 026       67.00         66.00       06600       PHYSI CAL THERAPY       0       145, 544       0.000000       0.000000       71, 026       67.00         67.00       06700       0CCUPATI ONAL THERAPY       0       145, 544       0.000000       0.000000       37, 709       68.00         69.00       06900       ELECTROCARDI OLOGY       0       1, 412, 338       0.000000       0.000000       57, 345       69.00         70.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       2, 714, 766       0.000000       0.000000       1, 955       72.00         73.00       07300       DRUFACTENT SERVICE COST CENTERS       0       12, 461, 435       0.000000			0	1 700,090				
55.00       05500       RADI OLOGY-THERAPEUTI C       0       0       0.000000       0.000000       0       55.00         60.00       06000       LABORATORY       0       11,010,486       0.000000       0.000000       681,955       60.00         65.00       06500       RESPI RATORY THERAPY       0       430,891       0.000000       0.000000       59,87       65.00         66.00       06600       PHYSI CAL THERAPY       0       1,643,288       0.000000       0.000000       11,010,466       60.00         67.00       06700       0CCUPATI ONAL THERAPY       0       1,643,288       0.000000       0.000000       11,026       67.00         68.00       06800       SPEECH PATHOLOGY       0       145,544       0.000000       0.000000       37,709       68.00         69.00       06900       ELECTROCARDI OLOGY       0       1,412,338       0.000000       0.000000       37,709       69.00         70.00       07000       ELECTROCARDI OLOGY       0       0       0.000000       0.000000       1,95       72.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       2,714,766       0.000000       0.0000000       1,955       72.00			0	20 451 951				
60.00       06000       LABORATORY       0       11,010,486       0.000000       0.000000       681,955       60.00         65.00       06500       RESPI RATORY THERAPY       0       430,891       0.000000       0.000000       59,387       65.00         66.00       06600       PHYSI CAL THERAPY       0       1,643,288       0.000000       0.000000       71,026       67.00         67.00       06700       OCUPATI ONAL THERAPY       0       695,039       0.000000       0.000000       77,026       67.00         68.00       06800       SPEECH PATHOLOGY       0       145,544       0.000000       0.000000       37,709       68.00         69.00       06900       ELECTROCARDI OLOGY       0       1,412,338       0.000000       0.000000       57,345       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0.000000       0.000000       31,362       71.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       2,714,766       0.000000       0.000000       1,955       72.00         73.00       07300       PURGS CHARGED TO PATI ENTS       0       12,461,435       0.000000       0.000000       1,955       72.00 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>			0	0				
65.00       06500       RESPI RATORY THERAPY       0       430, 891       0.000000       0.000000       59, 387       65.00         66.00       06600       PHYSI CAL THERAPY       0       1, 643, 288       0.000000       0.000000       136, 673       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0       695, 039       0.000000       0.000000       71, 026       67.00         68.00       06800       SPEECH PATHOLOGY       0       145, 544       0.000000       0.000000       37, 709       68.00         69.00       06900       ELECTROCARDI OLOGY       0       1, 412, 338       0.000000       0.000000       57, 345       69.00         70.00       07000       ELECTROCARDI OLOGY       0       1, 412, 338       0.000000       0.000000       0       0.00000       0       0.000000       0       0.00000       0       0.00000       0       0.00000       0       0.000000       0       0.00000       0       0.00000       0       0.000000       0       0.00000       0       0.00000       0       0.00000       0       0.00000       1, 136, 363       0.000000       0.000000       1, 955       72.00       73.00       0       73.00 <t< td=""><td></td><td></td><td>0</td><td>11 010 486</td><td></td><td></td><td></td><td></td></t<>			0	11 010 486				
66.00       06600       PHYSI CAL THERAPY       0       1, 643, 288       0.000000       0.000000       136, 673       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0       695, 039       0.000000       0.000000       71, 026       67.00         68.00       06800       SPEECH PATHOLOGY       0       145, 544       0.000000       0.000000       37, 709       68.00         69.00       06900       ELECTROCARDI OLOGY       0       1, 412, 338       0.000000       0.000000       57, 345       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0.000000       1, 412, 338       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       0.000000       1, 362       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       0       237, 983			0					
67.00       06700       0CCUPATIONAL THERAPY       0       695,039       0.000000       0.000000       71,026       67.00         68.00       06800       SPEECH PATHOLOGY       0       145,544       0.000000       0.000000       37,709       68.00         69.00       06900       ELECTROCARDIOLOGY       0       1,412,338       0.000000       0.000000       57,345       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0.000000       0.000000       0       070.00         71.00       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       2,714,766       0.000000       0.000000       1,955       72.00         72.00       07300       DRUGS CHARGED TO PATIENT       0       237,983       0.000000       0.000000       1,955       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       12,461,435       0.000000       0.000000       1,955       72.00         73.00       09000       CLINIC       0       1,151,063       0.000000       0.000000       90.00         91.00       09200       DESERVATION BEDS (NON-DISTINCT PART)       0       5,918,585       0.000000       0.000000       2,00         92.00 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
68.00       06800       SPEECH PATHOLOGY       0       145,544       0.000000       37,709       68.00         69.00       06900       ELECTROCARDI OLOGY       0       1,412,338       0.000000       0.000000       57,345       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0.000000       0.000000       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       2,714,766       0.000000       0.000000       31,362       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       237,983       0.000000       0.000000       1,955       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       12,461,435       0.000000       0.000000       810,715       73.00         017.00       09000       CLI NI C       0       1,151,063       0.000000       0.000000       90.00       90.00         90.00       09200       DBERVATI ON BEDS (NON-DI STI NCT PART)       0       5,918,585       0.000000       0.000000       23,647       91.00         92.00       07400       DSERVATI ON BEDS (NON-DI STI NCT PART)       0       825,041       0.000000       0.000000			0					
69.00       06900       ELECTROCARDI OLOGY       0       1,412,338       0.000000       0.000000       57,345       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0.000000       0.000000       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       2,714,766       0.000000       0.000000       31,362       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       237,983       0.000000       0.000000       1,955       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       12,461,435       0.000000       0.000000       810,715       73.00         012,461,435       0.000000       0.000000       0.000000       0.000000       90.00       90.00         90.00       09000       CLINIC       0       1,151,063       0.000000       0.000000       23,647       91.00         91.00       09200       DBESERVATI ON BEDS (NON-DI STINCT PART)       0       825,041       0.000000       0.000000       23,647       91.00         92.00       09500       AMBULANCE SERVICES       95.00       95.00       95.00       95.00			0					
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0.000000         0.000000         0         70.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0         2,714,766         0.000000         0.000000         31,362         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATIENT         0         237,983         0.000000         0.000000         1,955         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0         12,461,435         0.000000         0.000000         810,715         73.00           017001         OP3000         CLINIC         0         1,151,063         0.000000         0.000000         90.00           90.00         09100         EMERGENCY         0         5,918,585         0.000000         0.000000         23,647         91.00           92.00         092200         0BSERVATI ON BEDS (NON-DI STINCT PART)         0         825,041         0.000000         0.000000         92.00           0THER REI MBURSABLE COST CENTERS         0         09500         AMBULANCE SERVICES         95.00         95.00	69.00	06900 ELECTROCARDI OLOGY	0	1, 412, 338	0. 00000	0. 000000	57, 345	69.00
72.00         07200         IMPL.         DEV.         CHARGED TO PATIENT         0         237,983         0.000000         0.000000         1,955         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0         12,461,435         0.000000         0.000000         810,715         73.00           00         09000         CLINIC         0         1,151,063         0.000000         0.000000         90.00           91.00         09100         EMERGENCY         0         5,918,585         0.000000         0.000000         23,647         91.00           92.00         09200         DBSERVATI ON BEDS (NON-DI STINCT PART)         0         825,041         0.000000         0.000000         0         92.00           0THER REI MBURSABLE COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00	70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0. 000000	0	70.00
73. 00       07300       DRUGS       CHARGED       TO       PATIENTS       0       12,461,435       0.000000       0.000000       810,715       73.00         00TPATIENT       SERVICE       COST       CENTERS       0       1,151,063       0.000000       0.000000       0       90.00       90.00         90.00       09100       EMERGENCY       0       1,151,063       0.000000       0.000000       23,647       91.00         92.00       09200       DBSERVATION       BEDS       (NON-DISTINCT PART)       0       825,041       0.000000       0.000000       0       92.00         0THER       REI MBURSABLE       COST       CENTERS       95.00       950.00       950.00       950.00       950.00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 714, 766	0. 00000	0.000000	31, 362	71.00
OUTPATI ENT SERVICE COST CENTERS         90.00         00000 CLINIC         90.00         92.00         92.00         92.00         92.00         92.00         92.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00         95.00	72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	237, 983	0. 00000	0.000000	1, 955	72.00
90.00         09000         CLINIC         0         1,151,063         0.00000         0.00000         0         90.00           91.00         09100         EMERGENCY         0         5,918,585         0.000000         0.000000         23,647         91.00           92.00         09200         OBSERVATION         BEDS (NON-DISTINCT PART)         0         825,041         0.000000         0.000000         0         92.00           0THER         REI MBURSABLE         COST CENTERS         95.00         9500         AMBULANCE SERVICES         95.00         95.00	73.00	07300 DRUGS CHARGED TO PATIENTS	0	12, 461, 435	0.00000	0 0. 000000	810, 715	73.00
91.00         09100         EMERGENCY         0         5, 918, 585         0.000000         0.000000         23, 647         91.00           92.00         09200         0BSERVATION         BEDS (NON-DISTINCT PART)         0         825, 041         0.000000         0.000000         0         92.00           0THER         REI MBURSABLE         COST CENTERS         95.00         09500         AMBULANCE SERVICES         95.00         95.00		OUTPATIENT SERVICE COST CENTERS						
92. 00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         0         825, 041         0.000000         0.000000         0         92. 00           OTHER REI MBURSABLE COST CENTERS         95. 00         09500         AMBULANCE SERVICES         95. 00			0					
OTHER REI MBURSABLE COST CENTERS         95.00       09500       AMBULANCE SERVI CES       95.00			0					
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00		0	825, 041	0.00000	0 0.00000	0	92.00
					1			
200.00   lotal (lines 50-199)   0  62,585,576   2,970,420 200.00								
	200.00	)   Total (lines 50-199)	0	62, 585, 576	1		2, 970, 420	200. 00

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-1304	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Pre 6/28/2017 4:4	pared: 2 pm
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 <u>x col. 10</u> ) 11.00	Outpatient Program Charges 12.00	Outpatient Program Pass-Throug Costs (col. <u>x col. 12)</u> 13.00			
ANCI LLARY SERVICE COST CENTERS	11.00	12.00	13.00			
ANCI LLARY SERVICE COST CENTERS           50. 00         05000         OPERATI NG ROOM           51. 00         05100         RECOVERY ROOM           53. 00         05300         ANESTHESI OLOGY           54. 00         05400         RADI OLOGY-DI AGNOSTI C           55. 00         05500         RADI OLOGY-THERAPEUTI C           60. 00         06000         LABORATORY           65. 00         06500         RESPI RATORY THERAPY           66. 00         06600         PHYSI CAL THERAPY           67. 00         06700         OCCUPATI ONAL THERAPY           68. 00         06800         SPEECH PATHOLOGY           69. 00         06900         ELECTROCARDI OLOGY           70. 00         07000         ELECTROENCEPHALOGRAPHY           71. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           72. 00         07200         IMPL. DEV. CHARGED TO PATI ENT           73. 00         07300         DRUGS CHARGED TO PATI ENTS				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		50.00 51.00 53.00 54.00 55.00 60.00 65.00 66.00 67.00 68.00 69.00 70.00 71.00 72.00 73.00
OUTPATIENT SERVICE COST CENTERS	- I		1			-
90.00         09000         CLINIC           91.00         09100         EMERGENCY           92.00         09200         OBSERVATION         BEDS (NON-DISTINCT PART)           OTHER         REIMBURSABLE         COST         CENTERS	0 0 0	0 0 0		0 0 0		90.00 91.00 92.00
95.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50-199)	0	0		0		95. 00 200. 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	Provider C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 6/28/2017 4:4	
		Title	XVIII	Hospi tal	Cost	
			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	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 378620		.,		0	
51.00 05100 RECOVERY ROOM	0. 110805		203, 69	0 8	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 101505		6, 440, 31		0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			0 0	0	55.00
60. 00 06000 LABORATORY	0. 195786		3, 678, 24		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 360049		97, 28		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 478378		477, 15		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 459840	0	185, 09	0 8	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 353838		21, 76		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 201881		545, 35	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 050088		32, 81	6 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1. 400087				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 423379	0	4, 340, 96	0 52, 132	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	3. 769697		456, 56	2 21, 908	0	
91. 00 09100 EMERGENCY	0. 509185	0	1, 313, 15	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 634128	0	342, 22	.6 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 970148			0		95.00
200.00 Subtotal (see instructions)		0	19, 590, 61	0 74,040	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	19, 590, 61	0 74, 040	0	202.00

Health Fina	ncial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS	-2552-10
APPORTI ONME	INT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST	Provider CO	CN: 15-1304	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pr 6/28/2017 4:	
			Title	XVIII	Hospi tal	Cost	
			sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	LARY SERVICE COST CENTERS	E 20 075					- 50.00
	D OPERATING ROOM	528, 075					50.00
	D RECOVERY ROOM	22, 571	0				51.00
	D ANESTHESI OLOGY	0	0				53.00
	D RADI OLOGY-DI AGNOSTI C	653, 724					54.00
	D RADI OLOGY-THERAPEUTI C	0	-				55.00
		720, 149					60.00
	D RESPI RATORY THERAPY	35, 029					65.00
	D PHYSI CAL THERAPY	228, 260					66.00
	O OCCUPATI ONAL THERAPY	85, 115					67.00
	D SPEECH PATHOLOGY	7,702					68.00
	D ELECTROCARDI OLOGY	110, 096	0				69.00
	D ELECTROENCEPHALOGRAPHY	0	0				70.00
	D MEDI CAL SUPPLIES CHARGED TO PATIENTS	1,644					71.00
	DIMPL. DEV. CHARGED TO PATIENT	85, 746					72.00
	D DRUGS CHARGED TO PATIENTS	1, 837, 871	22, 072				73.00
	ATIENT SERVICE COST CENTERS	1 701 100	00 507	1			
		1, 721, 100					90.00
	D EMERGENCY	668, 636					91.00
	O OBSERVATION BEDS (NON-DISTINCT PART)	217,015	0				92.00
	R REIMBURSABLE COST CENTERS						95.00
		0					200.00
200.00	Subtotal (see instructions)	6, 922, 733	104, 659				200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202 00	Net Charges (line 200 +/- line 201)	6 022 722	104, 659				202.00
202.00	Iner charges (True 200 +/ - True 201)	6, 922, 733	104,059	I			1202. UU

Health Financial Systems	RUSH MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Concernent	CN: 15-1304 CCN: 15-Z304	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pre 6/28/2017 4:4	
		Title	e XVIII	Swing Beds - SNF		z pili
			Charges	Swirtig Deus - Sivi	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	()	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coi ns			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	0. 378620	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 110805	0		0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 101505	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
60. 00 06000 LABORATORY	0. 195786	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 360049	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 478378	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 459840	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 353838	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 201881	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 050088	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1. 400087	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 423379	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	3. 769697	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 509185	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 634128	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0. 970148			0		95.00
200.00 Subtotal (see instructions)		0		0 0	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		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	Provider Component	CN: 15-1304 CCN: 15-Z304	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pre 6/28/2017 4:4	
	_	Title	XVIII	Swing Beds - SNF	Cost	
	Co	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						
50.00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				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 REIMBURSABLE COST CENTERS		•				1
95. 00 09500 AMBULANCE SERVI CES	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	0				202.00

)MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1304	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre 6/28/2017 4:43	pare
		Title XVIII	Hospi tal	Cost	<u> </u>
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	(c. oveluding nowhorn)		2, 936	1 1
00	Inpatient days (including private room days, excluding swing-bed day Inpatient days (including private room days, excluding swing-			2,930	2
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	3
	do not complete this line.	5, 5, 5, 5,	<b>J</b> .		
00	Semi-private room days (excluding swing-bed and observation k			1, 931	4
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	er 31 of the cost	327	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			-	
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	~ 31 of the cost	32	7
~~	reporting period			0	
00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	Sin days) after becember .	si oi the cost	0	8
00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	1, 341	9
	newborn days)	0	5		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	311	10
. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		coom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	''
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period			_	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
. 00	Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ac through December 21	of the cost		17
. 00	reporting period	tes thi ough becember 31 o	on the cost		
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost		18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	f the cost	137.32	19
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
	reporting period				
. 00	Total general inpatient routine service cost (see instruction			2, 356, 276	
. 00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	na period (line 6	0	23
	x line 18)		.9	-	
. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	4, 394	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost reporting	a pariod (line 9	0	25
. 00	x line 20)	Si di the cost reporting		0	20
. 00	Total swing-bed cost (see instructions)			269, 225	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 087, 051	27
~~	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	ed and observation bed cl	narges)	0	28
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 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)	nuo lino 20) ( init	ati ana)	0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		Strons)	0.00 0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	2, 087, 051	37
	27 minus line 36)	·			1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	UCTMENTS			-
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			809.88	38
	Program general inpatient routine service cost (line 9 x line	•		1, 086, 049	
. 00	Medically necessary private room cost applicable to the Progr	-		0	40
		9 + line 40)		1, 086, 049	

					From 01/01/2016 To 12/31/2016		
				XVIII	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	
	NURSERY (title V & XIX only)						42.
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			[		I	43.
	CORONARY CARE UNIT						43.
	BURN INTENSIVE CARE UNIT						45
. 00	SURGI CAL I NTENSI 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)			822, 804	48
	Total Program inpatient costs (sum of lines 4			ns)		1, 908, 853	
	PASS THROUGH COST ADJUSTMENTS					ſ	- I
. 00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst. D, sum	of Parts I and	0	50
00	)  Pass through costs applicable to Program inpa	atient ancillar	v services (fr	om Wkst D s	um of Parts II	0	51
	and IV)		<i>y</i> een n eee (n				
. 00	Total Program excludable cost (sum of lines !					0	
. 00	Total Program inpatient operating cost exclud		lated, non-phy	sician anesth	etist, and	0	53
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	54
	Target amount per discharge					0.00	55
	Target amount (line 54 x line 55)					0	
	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting period	ending 1996 u	ndated and co	mnounded by the	0.00	
. 00	market basket	bor tring period	chung 1770, u		inpounded by the	0.00	ή °,
	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					0	61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		S (TTHES 54 X	00), 01 1% 01	the target		
. 00	Relief payment (see instructions)	lie er de er erie)				0	62
	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	to through Doos	mbor 21 of the	aget reporti	ng partiad (Caa	251, 873	
. 00	instructions) (title XVIII only)	is through bece		cost reporti	ng period (see	201, 0/3	
. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65
	instructions)(title XVIII only)			->		054.070	
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVII	l only). For	251, 873	66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost re	porting period	0	67
	(line 12 x line 19)	0				-	
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repo	orting period	0	68 (
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	coutino costs (	lino 67 - lino	60)		0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU			,		0	1 07
. 00	Skilled nursing facility/other nursing facili						70
	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71
	Program routine service cost (line 9 x line 7		(lipo 14 v li	no 2E)			72
. 00 . 00	Medically necessary private room cost applica Total Program general inpatient routine servi			ne 35)			73
	Capital -related cost allocated to inpatient i			orksheet B, F	art II, column		75
	26, line 45)			-			
	Per diem capital-related costs (line 75 ÷ lin						76
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus	· · · · · · · · · · · · · · · · · · ·					77
-	Aggregate charges to beneficiaries for excess		rovi der record	s)			79
	Total Program routine service costs for compa			· · · ·	us line 79)		80
	Inpatient routine service cost per diem limit						81
	Inpatient routine service cost limitation (li		•				82
	Reasonable inpatient routine service costs (see in		S)				83
	Program inpatient ancillary services (see ins Utilization review - physician compensation		ns)				84
	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	<u> </u>				
. 00	Total observation bed days (see instructions)					646	
. 00	Adjusted general inpatient routine cost per o					809.88	

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	235, 194	2, 356, 276	0. 09981	6 523, 182	52, 222	90.00
91.00 Nursing School cost	0	2, 356, 276	0.00000	0 523, 182	0	91.00
92.00 Allied health cost	0	2, 356, 276	0.00000	0 523, 182	0	92.00
93.00 All other Medical Education	0	2, 356, 276	0.00000			93.00

2.00       Injestient days (including private room days, excluding saing-bed and newtorulin bed days).       2,577       2.0         3.00       Private room days (accluding saing-bed and observation bed days).       17 you have only private room days.       3.0         4.00       Seel private room days (accluding saing-bed and observation bed days).       17 you have only private room days.       3.0         5.00       Treporting period (f calendar year, enter 0 on this line).       19.0       3.0         6.00       Total sing sheld f Yupe Inpatient days (including private room days) after December 31 of the cost       2.0         7.00       Total sing sheld f Yupe Inpatient days (including private room days) after December 31 of the cost       0.0         0.00       Total sing sheld f Yupe Inpatient days (angluding private room days) after December 31 of the cost       0.0         1.00       Sking hed Ski Type Inpatient days applicable to the Yup (including private room days)       0       10.0         1.00       Sking hed Ski Type Inpatient days applicable to the Yup (including private room days)       0       10.0         1.00       Sking hed Ski Type Inpatient days applicable to the Yup (including private room days)       0       10.0         1.00       Sking hed Ski Type Inpatient days applicable to the Yup (including private room days)       0       10.0         1.00       Sking hed Ski Type Inpatient days applicable to		Financial Systems RUSH MEMORIAL HOSF	rovider CCN: 15-1304	Peri od: From 01/01/2016 To 12/31/2016		pared:
PMM 1         ALL REMUMBER COMPONENTS           1:00         Inpatter days         Including private room days and swing-back days.         2.03           1:00         Inpatter days         Including swing-back days.         2.03           1:00         Firster and days.         2.03         1.00           1:00         Firster and days.         2.03         1.00           1:00         Firster and days.         2.03         1.00         2.03           1:00         Firster and days.         2.00         1.00         2.03         2.03           1:00         Total sam g-back SK type inpatient days (including private room days) through becember 31 of the cost         2.07         0.00           1:00         Total sam g-back SK type inpatient days (including private room days) after December 31 of the cost         0.00           1:00         Sam g-back SK type inpatient days applicable to title XVIII only (including private room days)         0.00           1:00         Sam g-back SK type inpatient days applicable to 1110 XVII only (including private room days)         0.00           1:00         Sam g-back SK type inpatient days applicable to 1110 XVII only (including private room days)         0.00           1:00         Sam g-back SK type inpatient days applicable to 1110 XVII only (including private room days)         0.010           1:00			Title XIX	Hospi tal		2 pm
PART 1 - ALL PROVIDER COMPORENTS           INPART INFORMET         PART 1 - PART AND		Cost Center Description		-	1.00	
1.00       Inpatient days (including private room days, and seing-bed days, excluding newborn)       2,246       1.00         2.00       Inputient days (including private room days, accluding saing-bed and newborn days)       1.7       2.0         3.00       Private room days, (excluding saing-bed and observation bed days)       1.7       1.9       1.9         3.00       Finite finite during general inter during seing-bed and observation bed days)       1.7       1.9       1.9       3.0         5.00       Total saing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting peried (including private room days) after December 31 of the cost reporting peried (including private room days) after December 31 of the cost reporting peried (including private room days) after December 31 of the cost reporting peried (including private room days) after December 31 of the cost reporting peried (including private room days) after December 31 of the cost reporting peried (including private room days) after December 31 of the cost reporting peried (including private room days) after December 31 of the cost reporting peried (including private room days) after December 31 of the cost reporting peried (including private room days) after December 31 of the cost reporting peried (including private room days) applicable to title XVII noly (including private room days)       10         10.00       Samp-bed W type inpatient days applicable to title XVII noly (including private room days)       0       10         11.00       Samp-bed W type inpatient days applicable to title XVII noly (including private room days)       <						
2.00       Injestient days (including private room days, excluding saing-bed and neshorn days)       2,577       2.0         3.00       Private room days (excluding saing-bed and observation bed days).       17 you have only private room days, and the cost reporting period. Type Inpetient days (including private room days), attract back days.       3.0         5.00       Treparting period. Type Inpetient days (including private room days), attract back days.       1.93       4.0         6.00       Total sain g-bed K Type Inpetient days (including private room days) atter beceaber 31 of the cost reporting period (ir calendar year, enter 0 on this line).       0.0       0.0         7.00       Total sain g-bed K Type Inpetient days (including private room days) atter beceaber 31 of the cost reporting period (ir calendar year, enter 0 on this line).       0.0       0.0         0.00       Total sing-bod K Type Inpatient days applicable to the Yorgan (excluding private room days) atter back days)       0.0       0.0         1.00       Swing-bod SK Type inpatient days applicable to the Yorgan (excluding private room days) atter back days)       0.0       10.0         1.00       Swing-bod SK Type inpatient days applicable to the Yorgan (excluding swing-bod days)       0.1       10.0         1.00       Swing-bod SK Type inpatient days applicable to the Yorgan (excluding swing-bod days)       0.1       10.0         1.00       Swing-bod SK Type inpatient days applicable to the Yorgan (excluding swing-bod days)	1 00		excluding newborn)		2 936	1.00
do not complete this line.       1.0         Some private room days (excluding swing-bed and observation bed days)       1.0         5.00       Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (f calendar year, enter 0 on this line)       2.0         7.00       Total swing-bed W type inpatient days (including private room days) through December 31 of the cost reporting period       6.0         7.00       Total swing-bed W type inpatient days (including private room days) through December 31 of the cost reporting period       8.0         7.00       Total swing-bed W type inpatient days (including private room days) through December 31 of the cost reporting period (f calendar year, enter 0 on this line)       8.0         9.00       Total swing-bed W type inpatient days applicable to title XUII only (including private room days)       0.0         10.00       Swing-bed SW type inpatient days applicable to title XUII only (including private room days)       0.0         11.00       Swing-bed SW type inpatient days applicable to title XUII only (including private room days)       0.0         11.00       Swing-bed SW type inpatient days applicable to title XUII only (including private room days)       0.0         11.00       Swing-bed SW type inpatient days applicable to title XUII only (including swing-bed aws)       0.0         12.01       Swing-bed SW type inpatient days applicable to the Program (excluding swing-bed aws)       0.0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>2.00</td>						2.00
4.00       Semi_private room days (excluding swing-bed and observation bed days)       1,931       4.00         5.00       Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period       6.00         7.00       Total swing-bed SW type inpatient days (including private room days) through December 31 of the cost reporting period       6.00         7.00       Total swing-bed W type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost       0.00         0.00       Swing-bed SW type inpatient days (including vivate room days) after December 31 of the cost       0.00         0.00       Swing-bed SW type inpatient days applicable to the Program (excluding swing-bed and       0.00         0.00       Swing-bed SW type inpatient days applicable to the XWII only (including private room days) after       0.10         1.00       Swing-bed W type inpatient days applicable to the XWII only (including private room days) after       0.10         1.00       Swing-bed W type inpatient days applicable to the XWI only (including swing-bed days)       0.10         1.00       Swing-bed W type inpatient days applicable to the XWI only (including swing-bed days)       0.10         1.00       Swing-bed W type inpatient days applicable to the XWI only (including swing-bed days)       0.10         1.00       Swing-bed W type inpatient days applicable to the XWI	3.00		. If you have only pr	ivate room days,	0	3.00
5.00       Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) through December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including ystate room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including perivate room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost applicable to services applicable to services after December 31 of the cost applicable to services applicable to services after December 31 of the cost applicable 30. <t< td=""><td>4.00</td><td></td><td>davs)</td><td></td><td>1, 931</td><td>4.00</td></t<>	4.00		davs)		1, 931	4.00
0.00       Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0 </td <td></td> <td>Total swing-bed SNF type inpatient days (including private room o</td> <td>5 /</td> <td>r 31 of the cost</td> <td></td> <td>5.00</td>		Total swing-bed SNF type inpatient days (including private room o	5 /	r 31 of the cost		5.00
. To Total sing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period         32           0. Total sing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period         8.0           10. Total sing-bed NF type inpatient days applicable to the Program (excluding swing-bed and to the cost reporting period (if calendar year. enter 0 on this line)         9.0           10. OS Swing-bed SF type inpatient days applicable to title XVII only (including private room days) through December 31 of the cost reporting period (if calendar year. enter 0 on this line)         10.0           11. OS Swing-bed NF type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (if calendar year. enter 0 on this line)         11.0           12. OS Swing-bed NF type inpatient days applicable to title XVII only (including private room days)         13.0         51.0           13. OS Swing-bed NF type inpatient days applicable to title XVI only (including private room days)         13.0         13.0           14. OB Molicaner rate for swing-bed SF services applicable to services through December 31 of the cost reporting period         14.0         14.0           15. OB Molicaner rate for swing-bed SF services applicable to services after December 31 of the cost reporting period         15.0         15.0           16. OB Molicaner rate for swing-bed NF services applicable to services after December 31 of the cost reporting period         16.0         16.0         16.0	6 00		dave) after December	31 of the cost	0	6 00
reporting period       8.0         0.0       Total sing-bod NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0.0       8.0         0.0       Total inpatient days including private room days)       10.0       8.0       0.0         10.0       Swing-bed NF type inpatient days applicable to title XVIII only (including private room days)       0.0       0.0         11.00       Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0.1         12.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0.1       0.1         13.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0.1       0.1         14.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0.1       10.0         14.00       Medica ro rate for swing-bed NF services applicable to services through December 31 of the cost reporting period       10.0         10.00       Medica ro rate for swing-bed NF services applicable to services through December 31 of the cost reporting period       10.0         10.00       Medica ro rate for swing bed NF services applicable to services after December 31 of the cost reporting period       10.0<	0.00		days) arter becember	ST OF THE COST	0	0.00
8.00       Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar years, enter 0 on this line)       0.00       0.00         9.00       Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)       0.00       0.00         9.00       Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after room days) after days applicable to title XVIII only (including private room days)       0       10.00         9.00       Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period       0       10.00         10.00       Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) after December 31 of the cost reporting period       0       12.00         10.00       Now factor rate for for swing-bed SNF services applicable to services through December 31 of the cost reporting period       0       14.00         10.00       Medicaid rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       16.00         10.00       Medicaid rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 3 x line) 13.00       17.00       18.00         10.00       Medicaid rate for swing-bed SNF type services after December 31 of the cost reporting period (line 3 x line) 13.00       2.36,276       21.	7.00		ays) through December	31 of the cost	32	7.00
reporting period (if calendar year, enter 0 on this line)         10           0.0 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newform days)         10           0.0 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after         11.0           11.00 Swing-bed SWF type inpatient days applicable to title SV or XIX only (including private room days) after         11.0           12.0 Swing-bed SWF type inpatient days applicable to titles V or XIX only (including private room days) after         11.0           13.00 Swing-bed WT type inpatient days applicable to titles V or XIX only (including private room days) after proceedure 31 of the cost reporting period (if calendar year, enter 0 on this line)         12.0           14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)         0         13.0           15.00 Total nursery days (title V or XIX only)         0         15.0           16.00 Mursery days (title V or XIX only)         0         16.0           17.00 Medicare rate for swing-bed SWF services applicable to services through December 31 of the cost reporting period (ing period wing-bed SWF type inpatient noutine service cast (see instructions)         17.0           18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost         137.32         19.0           19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost         0.0	8 00		avs) after December 3	1 of the cost	0	8.00
newborn days)       10.0         10.0       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)       10.0         12.00       Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line)       11.0         13.00       Swing-bed W type inpatient days applicable to titles V or XIX only (including private room days)       0       12.0         14.00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       13.0         15.00       Total nursery days (title V or XIX only)       0       15.0         16.00       Nursery days (title V or XIX only)       0       15.0         17.00       Medical are rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       18.0         18.00       Medical are tate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 × 117.0       22.0         19.00       Medical general inpatient routine service sthrough December 31 of the cost reporting period (line 6 × 117.0       22.0         20.00       Swing-bed NF type iservices after December 31 of the cost reporting period (line 6 × 118.0       23.06         21.00       Swing-bed SNF type services	0.00	reporting period (if calendar year, enter 0 on this line)			J. J	
10.00       Swing-bed Ski <sup>†</sup> type inpatient days applicable to title XVIII only (including private room days)       0       0.0         11.00       Swing-bed Ski <sup>†</sup> type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (ic calendar year, enter 0 on this line)       0       10.0         12.00       Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       12.0         13.00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       13.00         14.00       Medical y necessary private room days applicable to the Program (excluding swing-bed days)       0       14.00         15.00       Total nursery days (title V or XIX only)       0       15.00         16.00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         17.00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       18.0         18.00       Medical rate for Swing-bed NF services after December 31 of the cost reporting period (line 6 x line 17)       2.2.86,276 21.0         10.00       Medical rate for SW ing-bed NF services after December 31 of the cost reporting period	9.00		he Program (excluding	swing-bed and	10	9.00
11:00       Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       11:0         12:00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period       0       12:00         13:00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0       13:00         14:00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       13:00         16:00       Total nursery days (title V or XIX only)       0       16:00         17:00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost       17:0         18:00       Medical rate for swing-bed SNF services applicable to services after December 31 of the cost       18:0         19:00       Medical rate for swing-bed SNF services applicable to services after December 31 of the cost       12:0         10:00       Total general inpatient routine service cost (see instructions)       2:356.776       2:0         20:00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x 118:0       2:0       2:0         21:00       Total general inpatient routine service cost (see instructions)       2:356.776	10.00	5,	(including private r	oom days)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)       12.0         Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0       13.0         10.0       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)       0       13.0         11.0       Swing-bed NF type inpatient days applicable to the the Vorgram (excluding swing-bed days)       0       14.0         11.0       Weid care rate for swing-bed SNF services applicable to services through December 31 of the cost       15.0         11.0       Weid care rate for swing-bed SNF services applicable to services after December 31 of the cost       17.0         12.0       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost       17.0         12.0       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost       17.0         12.0       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost       18.0         12.0       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost       0.00         12.0       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost       0.00         12.0       Medicare rate for swing-bed SNF type services after December 31 of the cost       0.00         12.0						
12.00       Swing-bed NF type inpatient days applicable to itiles v or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       12.00         13.00       Swing-bed NF type inpatient days applicable to itiles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       13.00         14.00       Medical y necessary private room days applicable to the Program (excluding swing-bed days)       0       16.00         15.00       Total nursery days (title V or XIX only)       0       16.00         16.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       17.00         18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       12.0, 20         19.00       Medicaid rate for swing-bed SNF services applicable to services after December 31 of the cost       0.00       20.0         21.00       Total general inpatient routine service cost (see instructions)       2,356,276       21.00       2,356,276       21.00       22.05,276,276       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00	11.00			oom days) after	0	11.00
13:00       Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)       0       13:0         14:00       Medically necessary private room days applicable to the Program (excluding swing-bed days)       0       15:0         15:00       Total nursery days (title V or XIX only)       0       15:0       0         15:00       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17:00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18:0         19:00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       20:00 <td< td=""><td>12.00</td><td>Swing-bed NF type inpatient days applicable to titles V or XIX o</td><td></td><td>e room days)</td><td>0</td><td>12.00</td></td<>	12.00	Swing-bed NF type inpatient days applicable to titles V or XIX o		e room days)	0	12.00
after December'31 of the cost reporting period (if calendar year, enter 0 on this line)       14.0         ALO Medically necessary private room days applicable to the Program (excluding swing-bed days)       0         15.00       Total nursery days (title V or XIX only)       0         50.00       Norsery days (title V or XIX only)       0         50.00       Norsery days (title V or XIX only)       0         50.00       Norsery days (title V or XIX only)       0         50.00       Norsery days (title V or XIX only)       0         50.00       Norsery days (title V or XIX only)       0         50.00       Norsery days (title V or XIX only)       0         50.00       Norsery days (title V or XIX only)       0         50.00       Magnetic data rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line freporting period cal d rate for swing-bed NF service cost (see instructions)       2.356, 276         21.00       Total general inpatient routine service cost (see instructions)       2.356, 276       21.0         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line f x line 18)       2.300         24.00       Swing-bed cost (see instructions)       2.302, 200       2.067, 252         25.00       Swing-bed cost applicable to NF type services after December 31 of t	12 00		nly (including privat	a room days)	0	12 00
15:00       Total nursery days (title V or XIX only)       0       15:00       15:00       0       15:00       16:00       15:00       16:00       15:00       16:00       16:00       15:00       16:00       15:00       16:00       16:00       16:00       16:00       16:00       16:00       16:00       16:00       16:00       16:00       16:00       16:00       16:00       16:00       16:00       16:00       16:00       16:00       16:00	13.00				0	13.00
16:00       Nursery days' (title 'v r XX only)       0       16:00         SWING BED ADJUSTIONT       Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period       17.00         17:00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period       18.00         18:00       Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period       137.32         19:00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line for swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 × line 17)       2.356.276       21.00         21:00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 × line 18)       23.00         24:00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 × line 19)       2.06, 2.00         25:00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 × line 20)       2.087.051         26:00       Total swing-bed cost (see instructions)       2.087.051         26:00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 × line 20)       0         27:00       Swing-bed cost applicable to NF type service cost net 0 swing-bed cost rep			(excluding swing-bed	days)		
SWING BED ADJUSTMENT         Interview           17.00         Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period         17.00           18.00         Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period         18.00           19.00         Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period         137.32           20.00         Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period         0.00           20.00         Tate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17)         2,356,276           20.00         Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 18)         2,356,276           20.00         Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)         0.20           20.00         Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)         0.26.00           20.00         General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)         2,087,051           27.00         General inpatient routine service cost ret of swing-bed and observation bed charges)         0.30           20.00         Swing-bed c						
reporting period       18.00       Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost       18.00         19.00       Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost       137.32         20.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         20.00       Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost       0.00         20.00       Medicaid rate for swing-bed NF services cost (see instructions)       2.356.276         21.00       Total general inpatient routine service cost (see instructions)       2.356.276         22.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18)       0.23.00         23.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)       0.23.00         24.00       Swing-bed cost (see instructions)       269.02       26.00         25.00       Swing-bed cost (see instructions)       269.02       26.00         26.00       Total swing-bed cost (see instructions)       269.25       26.00         27.00       General inpatient routine service cost net of swing-bed cost (line 21 winus line 26)       2.087.051       0.00         28.00       Semigradian toutine service	10.00				0	10.00
18.00Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period18.019.00Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period137.3220.00Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period0.0020.00Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period0.0020.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line s line 17)2.356,27621.00Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line s line 18)4.30424.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line s line 20)2.90,22525.00Swing-bed cost (see instructions) z line 20)269,22526.00Total swing-bed cost (see instructions) z line 20)269,22527.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 0 Private room charges (excluding swing-bed and observation bed charges) 0 0028.00General inpatient routine service cost/charge ratio (line 27 + line 28) 0 00.00000030.00Average periate room perid eim charge (line 29 + line 3) 0 0.0000000.000000031.00Average periate room perid eim charge (line 32 minus line 33) (see instructions) 0 0.0000.00000032.00Average periate room cost differential (line 34 × line 31) 0 0.0000.000 </td <td>17.00</td> <td></td> <td>through December 31 c</td> <td>f the cost</td> <td></td> <td>17.00</td>	17.00		through December 31 c	f the cost		17.00
reporting period137.3219.0019.00Medicaid arter for swing-bed NF services applicable to services through December 31 of the cost reporting period137.3219.0020.00Medicaid arter for swing-bed NF services applicable to services after December 31 of the cost reporting period0.0020.0021.00Total general inpatient routine service cost (see instructions) 5 x line 17)2.356.27621.0023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line x line 18)023.0024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 18)4.39424.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 20)2.69,22526.0026.00Total swing-bed cost (see instructions) x line 20)269,22526.0025.0026.00Total swing-bed cost (see instructions) x line 20)2.69,25526.0028.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) Private room charges (excluding swing-bed charges) 0.000.000000020.0020.00Semi-private room charges (excluding swing-bed charges) 0.000.000000031.0030.00Semi-private room per diem charge (line 29 + line 30) 0.000.000000031.0031.00Average per diem private room cost differential (line 32 minus line 33) 0.000.00031.0031.00Average per diem private room cost differential (line 32 minus line 33) 0.00 <t< td=""><td>18.00</td><td></td><td>after December 31 of</td><td>the cost</td><td></td><td>18.00</td></t<>	18.00		after December 31 of	the cost		18.00
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21.00Total general inpatient routine service cost (see Instructions)2, 356, 27621.0022.00Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line x line 18)00023.00Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line x line 18)00024.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line x line 19)4, 39424.0025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)026.0026.00Total swing-bed cost (see instructions)269, 22526.0026.00Total swing-bed cost (see instructions)269, 22526.0027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)2.087, 05127.00PRI VATE ROOM DIFFERENTIAL ADJUSTMENT028.00General inpatient routine service cost charges (excluding swing-bed charges)030.00Semi-private room charges (excluding swing-bed charges)031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.0032.00Average per diem private room cost differential (line 34 × line 31)0.0032.00Average per diem private room cost differential (line 34 × line 31)0.0033.00Average per diem private room cost differential (line 34 × line 35)037.00General inpatient routine service cost per diem cost and private room cost differential (line 27 minus	20.00	Medicaid rate for swing-bed NF services applicable to services a	fter December 31 of t	he cost	0.00	20.00
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23.00       Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)       0       23.00         24.00       Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 7 x line 19)       4,394       24.00         25.00       Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)       0       269,225         26.00       Total swing-bed cost (see instructions)       2,087,051       2,087,051         27.00       General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)       2,087,051       27.00         28.00       General inpatient routine service charges (excluding swing-bed and observation bed charges)       0       28.00         29.00       Private room charges (excluding swing-bed charges)       0       0       0         31.00       General inpatient routine service cost/charge ratio (line 27 + line 28)       0.000000       31.00         32.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       32.00         33.00       Average per diem private room cost differential (line 34 x line 31)       0.00       36.00         34.00       Average per diem private room cost differential (line 34 x line 31)       0.00       36.00         35.00       Averag		5 1 7	31 of the cost report	ing period (line		
x line 18)x line 18)24.00Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line4, 39425.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8025.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8026.00Total swing-bed cost (see instructions)269, 22526.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)2, 087, 05127.00General inpatient routine service charges (excluding swing-bed and observation bed charges)028.00General inpatient routine service cost /charges (excluding swing-bed and observation bed charges)029.00Private room charges (excluding swing-bed charges)030.00Semi-private room charges (excluding swing-bed charges)031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.000000033.00Average per diem private room per diem charge (line 30 + line 4)0.0034.00Average per diem private room cost differential (line 34 x line 31)0.0035.00Average per diem private room cost differential (line 3 x line 35)037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 087, 05137.00Average per diem private room cost differential (line 3 x line 35)037.00General inpatient routine service cost per diem (see instructions)36.0037.00General inpatient routine service cost	~~ ~~					
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25.00Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)00025.0026.00Total swing-bed cost (see instructions)269,22526.0027.00260,22526.0027.00PRIVATE ROOM DIFFERENTIAL ADJUSTMENT209,22520.0027.00200,027.0029.0029.0029.0029.0029.0029.0029.00029.00029.00029.00029.00029.00029.000029.000029.000029.00000029.000000000029.00	24.00		1 of the cost reporti	ng period (line	4, 394	24.00
x line 20)26.00Total swing-bed cost (see instructions)269,22526.027.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)2,087,05127.00PRIVATE ROOM DIFFERENTIAL ADJUSTMENT29.0029.00029.00029.0020.00Private room charges (excluding swing-bed charges)029.00029.0030.00Semi-private room charges (excluding swing-bed charges)0029.0031.00General inpatient routine service cost/charge ratio (line 27 + line 28)0.00000031.0032.00Average private room per diem charge (line 29 + line 3)0.0032.0033.00Average semi-private room cost differential (line 32 minus line 33) (see instructions)0.0034.0035.00Average per diem private room cost differential (line 34 x line 31)0.0035.0036.00Private room cost differential adjustment (line 3 x line 35)0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 087, 05137.0238.00Adjusted general inpatient routine service cost per diem (see instructions)80.0888.0938.00Adjusted general inpatient routine service cost (line 9 x line 38)80.9380.9340.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	25 00		of the cost reporting	period (line 8	0	25 00
27.00General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)2,087,05127.00PRIVATE ROOM DIFFERENTIAL ADJUSTMENTCeneral inpatient routine service charges (excluding swing-bed and observation bed charges)028.0028.0029.00Private room charges (excluding swing-bed charges)029.00029.0030.00Semi-private room charges (excluding swing-bed charges)030.0030.0031.00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0.00000031.0032.00Average private room per diem charge (line 30 ÷ line 3)0.0033.0034.00Average per diem private room charge differential (line 32 minus line 33) (see instructions)0.0033.0035.00Average per diem private room cost differential (line 3 x line 31)0.0035.0037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 087,05137.0037.01Z7 minus line 36)PART 11 - HOSPITAL AND SUBPROVIDERS ONLY28.00PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS809.8838.0038.00Adjusted general inpatient routine service cost (line 9 x line 38)809.8038.0890.00Program general inpatient routine service cost (line 9 x line 38)809.8038.0090.00Medically necessary private room cost applicable to the Program (line 14 x line 35)040.00	20.00			perrou (rrne u	0	23.00
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30. 00Semi-private room charges (excluding swing-bed charges)030. 031. 00General inpatient routine service cost/charge ratio (line 27 ÷ line 28)0. 00000031. 032. 00Average private room per diem charge (line 29 ÷ line 3)0. 0032. 033. 00Average semi-private room per diem charge (line 30 ÷ line 4)0. 0032. 034. 00Average per diem private room cost differential (line 32 minus line 33) (see instructions)0. 0033. 035. 00Average per diem private room cost differential (line 3 x line 31)0. 0035. 036. 00Private room cost differential adjustment (line 3 x line 35)0. 0035. 037. 00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 087, 05137. 027 minus line 36)PART II - HOSPITAL AND SUBPROVIDERS ONLY0. 0038. 00PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS809. 8838. 039. 00Program general inpatient routine service cost (line 9 x line 38)8. 09939. 040. 00Medically necessary private room cost applicable to the Program (line 14 x line 35)040. 0		General inpatient routine service charges (excluding swing-bed an	nd observation bed ch	arges)		1
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33.00       Average semi-private room per diem charge (line 30 ÷ line 4)       0.00       33.00         34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.00         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       34.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       0.00       35.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,087,051       0       36.00         7.00       PART 11 - HOSPI TAL AND SUBPROVIDERS ONLY       27 minus line 36)       0       37.00         PART 11 - HOSPI TAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       809.88       38.00         38.00       Adjusted general inpatient routine service cost (line 9 x line 38)       8,099       39.00       809.88       38.00       39.00       809.88       38.00       39.00       40.00       40.00       40.00       40.00       40.00       40.00       40.00			ine 28)			
34.00       Average per diem private room charge differential (line 32 minus line 33) (see instructions)       0.00       34.0         35.00       Average per diem private room cost differential (line 34 x line 31)       0.00       35.00         36.00       Private room cost differential adjustment (line 3 x line 35)       0       0       36.00         37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,087,051       37.00       36.00       2,087,051       37.00         PART 11 - HOSPITAL AND SUBPROVIDERS ONLY       PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS       809.88       38.00         38.00       Adjusted general inpatient routine service cost (line 9 x line 38)       8,099       39.00       809.88       38.09       39.00       8,099       39.00       40.00<						
35.00Average per diem private room cost differential (line 34 x line 31)0.0035.036.00Private room cost differential adjustment (line 3 x line 35)036.037.00General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)2,087,051PART II - HOSPITAL AND SUBPROVIDERS ONLYPROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS38.00Adjusted general inpatient routine service cost per diem (see instructions)809.8839.00Program general inpatient routine service cost (line 9 x line 38)8,09940.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0			line 33)(see instruc	tions)		
37.00       General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,087,051 27 minus line 36)       37.00       38.00       38.00       38.00       38.00       38.00       38.00       38.00       38.00       38.00       38.00       38.00       39.00       Program general inpatient routine service cost (line 9 x line 38)       38.00       39.00       40.0						
27 minus line 36)       PART II - HOSPITAL AND SUBPROVIDERS ONLY         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS         38. 00       Adjusted general inpatient routine service cost per diem (see instructions)       809.88       38.0         39. 00       Program general inpatient routine service cost (line 9 x line 38)       8,099       39.00       99.00         40. 00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0       40.00				66 month of a large		36.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS         38.00       Adjusted general inpatient routine service cost per diem (see instructions)       809.88         39.00       Program general inpatient routine service cost (line 9 x line 38)       8,099         40.00       Medically necessary private room cost applicable to the Program (line 14 x line 35)       0	37.00		private room cost di	TTEPENTIAL (LINE	2, 087, 051	37.00
38. 00Adjusted general inpatient routine service cost per diem (see instructions)809. 8839. 00Program general inpatient routine service cost (line 9 x line 38)8, 09940. 00Medically necessary private room cost applicable to the Program (line 14 x line 35)0		PART II - HOSPITAL AND SUBPROVIDERS ONLY				
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40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.0			-			1
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 8,099 41.0	40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40.00

	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-1304	Period: From 01/01/2016	Worksheet D-1	1
					To 12/31/2016	Date/Time Pre	
			Tit	le XIX	Hospi tal	6/28/2017 4:4 Cost	42 pii
	Cost Center Description	Total Inpatient Costl	Total npatient Day	Average Per sDiem (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) 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
. 00	SURGI CAL I NTENSI 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)			13, 997	7 48
. 00	Total Program inpatient costs (sum of lines			ons)		22, 096	5 49
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program inpa	atient routine s	services (fro	om Wkst. D, su	m of Parts I and	C	50
. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillary	v services (1	From Wkst D	sum of Parts II	0	51
. 00	and IV)		y 301 11 003 (1	Tom with D,			1 5 1
. 00	Total Program excludable cost (sum of lines !	50 and 51)				0	52
. 00	Total Program inpatient operating cost exclude		lated, non-pl	nysician anest	hetist, and	0	53
	medical education costs (line 49 minus line !	52)					-
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient operati	ng cost and tai	rget amount (	[line 56 minus	line 53)	0	57
. 00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period e	endi ng 1996,	updated and c	ompounded by the	0.00	59
. 00	market basket Lesser of lines 53/54 or 55 from prior year of	rost report up	dated by the	market basket		0.00	0 60
. 00	If line 53/54 is less than the lower of lines						
	which operating costs (line 53) are less than	n expected costs	s (lines 54 >	(60), or 1% o	f the target		
	amount (line 56), otherwise enter zero (see i	nstructions)					
. 00 . 00	Relief payment (see instructions)	ont (coo instru	ations)				) 62 ) 63
. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST						1 03
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decer	mber 31 of th	ne cost report	ing period (See	(	64
	instructions)(title XVIII only)	-					
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the	cost reportin	g period (See	0	) 65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	no coste (lino d	64 plus lipo	65) (+i +l o XVI	II only) For		66
. 00	CAH (see instructions)		b4 prus rine	05)(1118 XV	ri oniy). Toi		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31	of the cost r	eporting period	0	67
	(line 12 x line 19)	-					
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	f the cost rep	orting period	0	) 68
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	coutino costs (l	lino 67 - lir	0 69)			69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU					<u> </u>	
. 00	Skilled nursing facility/other nursing facili				)		70
. 00	Adjusted general inpatient routine service co	ost per diem (li	ine 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line						72
. 00 . 00	Medically necessary private room cost applica Total Program general inpatient routine servi						73
. 00	Capital -related cost allocated to inpatient	•		·	Part II column		74
	26, line 45)		55515 (1100				``
. 00	Per diem capital-related costs (line 75 ÷ lin						76
. 00	Program capital-related costs (line 9 x line						77
00	Inpatient routine service cost (line 74 minus		rouldor roca	de)			78
00 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	· · ·		,	nus line 70)		80
00	Inpatient routine service cost per diem limi				nuo 1110 /7)		81
00	Inpatient routine service cost limitation (li		)				82
00	Reasonable inpatient routine service costs (s						83
. 00	Program inpatient ancillary services (see ins						84
	Utilization review - physician compensation						85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rougn 85)			1	86
. 00	Total observation bed days (see instructions)					646	5 87
. 00	Adjusted general inpatient routine cost per o	diem (line 27 ÷	line 2)			809.88	3  85

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	235, 194	2, 356, 276	0. 09981	6 523, 182	52, 222	90.00
91.00 Nursing School cost	0	2, 356, 276	0.00000	0 523, 182	0	91.00
92.00 Allied health cost	0	2, 356, 276	0.00000	0 523, 182	0	92.00
93.00 All other Medical Education	0	2, 356, 276	0. 00000	0 523, 182	0	93.00

Health Financial Systems RUSH MEMORIAL H	IOSPI TAL		In Lie	eu of Form CMS-	2552-10
I NPATI ENT ANCI LLARY SERVI CE COST APPORTI ONMENT	Provider C		Period: From 01/01/2016 To 12/31/2016		pared:
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1100	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			1, 843, 177		30.00
ANCI LLARY SERVI CE COST CENTERS				1	
50. 00 05000 OPERATI NG ROOM		0. 3786	20 280, 532	106, 215	50.00
51.00 05100 RECOVERY ROOM		0. 1108	05 16, 796	1, 861	51.00
53. 00 05300 ANESTHESI OLOGY		0.0000	0 00	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1015	761, 318	77, 278	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000	0 00	0	55.00
60. 00 06000 LABORATORY		0. 1957	681, 955	133, 517	60.00
65. 00 06500 RESPI RATORY THERAPY		0.3600	49 59, 387	21, 382	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 4783	78 136, 673	65, 381	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 4598	40 71, 026	32, 661	67.00
68.00 06800 SPEECH PATHOLOGY		0. 3538	38 37, 709	13, 343	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 2018	31 57, 345	11, 577	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000	0 00	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 0500	38 31, 362	1, 571	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		1.4000	37 1, 955	2, 737	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4233	79 810, 715	343, 240	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		3. 7696	97 0	0	90.00
91. 00 09100 EMERGENCY		0. 5091	35 23, 647	12, 041	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6341	28 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)			2, 970, 420	822, 804	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)		I	2, 970, 420		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT         Provider CN: 15-1304 Component CCI: 15-2304         Period: From 01/01/2016 To 12/31/2016         Worksheet D-3 Date/Time Prepared: <i>J2/31/2016</i> Cost Center Description         Title XVIII         Swing Beds - SNF         Cost           Cost Center Description         Ratio of Cost 0 0         Inpatient To Charges         Program (Cost         Program (Cost         Program (Cost         Program (Cost         Program (Cost         Program (Cost         Inpatient Program (Cost         Program (Cost         0         30.00           30.00         000000 ADULTS & PEDI ATRI CS ANCILLARY SERVICE COST CENTERS         0         30.00         30.00           50.00         050000 REDURTRY ROM         0.378620         1.003         380         50.00         0         51.00         55.00         <	Health Financial Systems RUSH MEMORI	AL HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
Component CCN: 15-2304         To         12/31/2016         Date/Time Prepared: for the XVIII           Title XVIII         Swing Beds - SNF         Cost           To Cost Center Description         Ratio of Cost         Inpatient Program Charges         Inpatient Program Costs (col. 1 x col. 2)           30.00         03000/ADUTS & PEDIATRICS         0         3.00         3.00           50.00         05000/PERATING ROM         0.378620         1.003         380         50.00           50.00         05500 RADIATRICS         0         0         0         53.00         0.53.00         0         55.00         0         55.00         0         55.00         0         0         55.00         0         0         55.00         0         55.00         0         0         55.00         0         0         55.00         0         0         55.00         0         0         55.00         0         0         55.00         0         0         55.00         0         0         0         0         55.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1304		Worksheet D-3	
Impact of the second problem is the second		Component				narod
Title XVIII         Swing Beds - SNF         Cost           Cost Center Description         Ratio of Cost To Charges         Inpatient Program Costs (col. 1 x col. 2)         Inpatient Program Costs (col. 1 x col. 2)           30.00         03000 ADULTS & PEDIATRICS         0         3.00           ANCILLARY SERVICE COST CENTERS         0         30.00           50.00         05000 (PERATING ROM         0.378620         1,003         380         50.00           51.00         05000 (PERATING ROM         0.378620         1,003         380         50.00           51.00         05000 (PERATING ROM         0.110805         0         0         51.00           52.00         05500 RADIOLOGY-THERAPEUTIC         0.000000         0         55.00           6600         06500 RADIOLOGY-THERAPEUTIC         0.101505         32,111         3,259         54.00           660.00         6600 PMSIGLAT HERAPY         0.458378         73.76,66         65.00         65.00         65.00         65.00         65.00         65.00         66.00         66.00         55.00         66.00         66.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00 <td></td> <td>component</td> <td>CCN. 13-2304</td> <td>10 12/31/2010</td> <td></td> <td></td>		component	CCN. 13-2304	10 12/31/2010		
Investigation         To Charges         Program Costs (col. 1 x col. 2)         Program Costs (col. 1 x col. 2)           30. 00         03000 ADULTS & PEDIATRICS         0         3.00         3.00           50. 00         05000 (PERATING ROOM         0.378620         1,003         380         50.00           51. 00         05300 (ADULTS & PEDIATRICS         0         0         30.00         3.00           50. 00         05000 (DERATING ROOM         0.378620         1,003         380         50.00           51. 00         05300 (ADULTS & PEDIATRICS         0         0         0         51.00           50. 00         05300 (ADUCTS & PEDIATRICS         0         0         0         51.00           50. 00         05300 (ADUCTS & PEDIATRICS         0         0         0         51.00           50.00         05300 (ADUCTS & PEDIATRICS         0         0         0         51.00           50.00         05300 (ADUCTS & PEDIATRICS         0         0         0         55.00           60.00         06000 (ADUCY - DERAPENPEUTIC         0         0.00000         0         55.00           60.00         06600 (PERSTINATORY THERAPENPTIC         0         0.195786         28.656         5.610         60.00 <td></td> <td>Title</td> <td></td> <td></td> <td>Cost</td> <td></td>		Title			Cost	
INPATIENT ROUTINE SERVICE COST CENTERS         0         3.00           30.00         33000 ADULTS & PEDIATRICS         0         30.00           ANCILLARY SERVICE COST CENTERS         0         30.00         3000 ADULTS & PEDIATRICS         30.00           50.00         05000 OPERATING ROOM         0.378620         1,003         380         50.00           51.00         05100 RECOVERY ROOM         0.110805         0         0         51.00           51.00         05300 ADULTS + PEDIATRICS         0.00000         0         51.00           51.00         05300 ANESTHESI OLOGY         0.000000         0         53.00           52.00         05500 RADI OLOGY-THERAPEUTI C         0.101505         32.111         32.55           50.00         05500 RADI OLOGY-THERAPEUTI C         0.3300049         12.595         4.535           50.00         06000 CUPATI ONAL THERAPY         0.478378         78.737         37.666         66.00           60.00         06000 SPEECH PATHORY THERAPY         0.353838         7.502         2.654         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00	Cost Center Description					
INPATI ENT ROUTI NE SERVICE COST CENTERS         0         3.00         3.00           30.00         03000 ADULTS & PEDI ATRICS         0         3.00         3.00           AUXIC LLARY SERVICE COST CENTERS         0         3.00         3.00         3.00           50.00         05000 OPERATI NG ROOM         0.378620         1.003         380         50.00           51.00         05100 RECOVERY ROOM         0.110805         0         0         51.00           53.00         05300 ANESTHESI DLOGY         0.000000         0         0         55.00           0.0000 CABORATORY         0.000000         0         0         55.00         0.000000         0         0         55.00           0.0500 RADI OLOGY - THERAPEUTI C         0.000000         0         0         55.00         0.05000         28.656         5.610         60.00           0.0500 RESPI RATORY THERAPY         0.478378         78.737         37.666         60.00         60.00         60.00         60.00         60.00         2.054         68.00         66.00         67.00         0.6500 RESPI RATORY THERAPY         0.478378         78.737         37.666         60.00         60.00         60.00         60.00         60.00         60.00         60.00			To Charges			
INPATIENT ROUTINE SERVICE COST CENTERS           0.00         03000 ADULTS & PEDIATRICS         0         30.00           ANCILLARY SERVICE COST CENTERS         0         30.00           ANCILLARY SERVICE COST CENTERS         0         30.00           50.00         05000 PERATIN CROM         0.378620         1.003         380           51.00         05100 RECOVERY ROOM         0.110805         0         0         51.00           53.00         05300 ANESTHESI OLOGY         0.000000         0         0.53.00         55.00           54.00         05500 RADI OLOGY-THERAPEUTIC         0.000000         0         0.55.00           60.00         06500 RESPI RATORY THERAPEUTIC         0.000000         0         0.55.00           60.00         06500 RESPI RATORY THERAPY         0.350049         12.595         4.00           61.00         06500 RESPI RATORY THERAPY         0.478378         78.737         37.666         66.00           62.00         06500 SPEECH PATHOLOGY         0.353838         7.502         2.654         68.00           69.00         06900 ELECTROCARDI OLOGY         0.353838         7.502         2.654         68.00           60.00         05000 RESPI LECTROCARDI OLOGY         0.353838         7.502				Charges		
INPATI ENT ROUTI NE SERVICE COST CENTERS         0         30.00           30.00         OGOO ADULTS & PEDI ATRICS         0         30.00           ANCILLARY SERVICE COST CENTERS         0         30.00           50.00         OSO00 (PERATING ROOM         0.378620         1,003         380         50.00           51.00         OSO00 (ANESTHESI OLOGY         0.000000         0         51.00         0         51.00         0.000000         0         53.00         51.00         0.000000         0         53.00         51.00         0.000000         0         53.00         51.00         0.000000         0         55.00         0.000000         0         0         55.00         0.000000         0         0         55.00         0.000000         0         0         55.00         0.000000         0         0         0         55.00         0.000000         0         0         0         50.00         0.00000         0         0         0         0.00000         0         0         0         0.00000         0         0         0.00000         0         0         0         0.00000         0         0         0         0         0.0000         0         0         0.0000         0			1.00	2.00		
30.00 <u>3000</u> ADULTS & PEDIATRICS       0       30.00         ANCILLARY SERVICE COST CENTERS       0       30.00         ANCILLARY SERVICE COST CENTERS       0       50.00         50.00       05000       PERATING ROOM       0.110805       0       51.00         51.00       05100       RECOVERY ROOM       0.110805       0       51.00         53.00       05300       AMESTHESI OLOGY       0.000000       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.101505       32,111       3.299         55.00       05500       RADI OLOGY-THERAPEUTI C       0.000000       0       0       55.00         60.00       06000       LABORATORY       0.360049       12,595       4,535       65.00       65.00       6500       RSPR TATORY THERAPY       0.378620       1,003       800       66.00       6000       6000       PLEOTRATORY       0.380049       12,295       4,535       65.00       66.00       66.00       6000       SPEECH PATHOLOGY       0.353838       7,502       2,664       66.00       69.00       66.00       69.00       0.000000       0       0       70.00       0.000000       0       0       70.00       0.00000 <td></td> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td></td>			1.00	2.00	3.00	
ANCI LLARY SERVICE COST CENTERS           50. 00         05000         OPERATI NG ROM         0. 378620         1,003         380         50. 00           51. 00         05100         RECOVERY ROOM         0. 110805         0         0         51. 00           53. 00         05300         ANESTHESI OLOGY         0. 000000         0         0         53. 00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0. 101505         32, 111         3, 259         54. 00           55. 00         05500         RADI OLOGY-THERAPEUTI C         0. 000000         0         0         55. 00           60. 00         06000         LABORATORY         0. 360049         12, 595         4, 535         65. 00           65. 00         06500         RESPI RATORY THERAPY         0. 478378         78, 737         73, 666         66. 00           64.00         06400         PHYSI CAL THERAPY         0. 478378         78, 737         73, 756         66. 69. 00           65.00         06500         RESPI RATORY THERAPY         0. 478378         78, 737         73, 766         66. 69. 00           64.00         0         04500         SEECH PATHOLOGY         0. 201881         2, 306         466         69.			1	0	1	30.00
50.00         05000         OPERATI NG ROOM         0.378620         1,003         380         50.00           51.00         05100         RECOVERY ROOM         0.110805         0         0         51.00           53.00         05300         ANESTHESI OLOGY         0.000000         0         0         53.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0.000000         0         0         55.00           55.00         05500         RESPIRATORY THERAPEUTI C         0.000000         0         0         55.00           60.00         LABORATORY         0.360049         12,595         4,535         65.00         0         66.00         66.00         66.00         0.459840         69,812         32,102         67.00         67.00         0.6000 LABORATORY         0.33838         7,502         2,654         68.00         0         69.812         32,102         67.00         67.00         0         69.00         0.6900 ELECTROCARDI OLOGY         0.33838         7,502         2,654         68.00         69.00         0.000000         0         70.00         68.00         0.6900 ELECTROCARDI OLOGY         0.201881         2,306         466         69.00         70.00         70.00         70.00				0		30.00
51.00       05100       RECOVERY ROOM       0.110805       0       51.00         53.00       05300       ANESTHESI OLOGY       0.000000       0       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.101505       32,111       3,259       54.00         05500       RADI OLOGY-THERAPEUTI C       0.000000       0       0       055.00         60.00       06000       LABORATORY       0.195786       28.656       5,610       60.00         65.00       RESPI RATORY THERAPY       0.360049       12,595       4,535       66.00       66.00       66.00       66.00       0.478378       78,737       7.666       66.00       67.00       0.6700       0.201PATI ONAL THERAPY       0.459840       69,812       32,102       67.00       68.00       69.00       ELECTROCARDI OLOGY       0.353838       7,502       2,654       68.00       69.00       0.00000       0       0       70.00       70.00       0       70.00       70.00       0       70.00       70.00       0       70.00       70.00       0       70.00       72.00       72.01       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00			0.37862	0 1 003	380	50 00
53.00       05300       ANESTHESI OLOGY       0       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.101505       32,111       3,259       54.00         05.00       RADI OLOGY-THERAPEUTI C       0.000000       0       0       55.00       0       0.000000       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.101505       32,111       3,259       54.00         55.00       05500       RADI OLOGY-THERAPEUTI C       0.000000       0       0       55.00         60.00       06000       LABORATORY       0.195786       28,656       5,610       60.00         65.00       05500       RESPI RATORY THERAPY       0.360049       12,595       4,535       65.00         66.00       06000       D4700       000000       0.478378       78,737       37,666       66.00         67.00       06700       0CUPATI ONAL THERAPY       0.478378       78,737       37,666       66.00         68.00       06800       SPEECH PATHOLOGY       0.353838       7,502       2,654       68.00         69.00       04900       ELECTROCARDI OLOGY       0.201881       2,306       466       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.050088       2,521       126       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.423379       92.037       38,967       73.00 <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>53.00</td>					0	53.00
60.00       06000       LABORATORY       0.195786       28,656       5,610       60.00         65.00       06500       RESPI RATORY THERAPY       0.360049       12,595       4,535       65.00         66.00       06600       PHYSI CAL THERAPY       0.478378       78,737       37,666       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.478378       78,737       32,102       67.00         68.00       06800       SPEECH PATHOLOGY       0.353838       7,502       2,654       68.00         69.00       06900       ELECTROCARDI OLOGY       0.201881       2,306       466       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.423379       92,037       38,967         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.423379       92,037       38,967       73.00         09100       CHINIC       COST CENTERS       0       90.00       91.00       91.00       91.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00<	54. 00 05400 RADI OLOGY-DI AGNOSTI C				3, 259	54.00
65.00       06500       RESPI RATORY THERAPY       0.360049       12,595       4,535       65.00         66.00       06600       PHYSI CAL THERAPY       0.478378       78,737       37,666       66.00         67.00       0CCUPATI ONAL THERAPY       0.459840       69,812       32,102       67.00         68.00       06800       SPEECH PATHOLOGY       0.353838       7,502       2,654       68.00         69.00       06900       ELECTROCANCEPHALOGRAPHY       0.000000       0       0       70.00         71.00       07000       ELECTROCANCEPHALOGRAPHY       0.000000       0       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.050088       2,521       126       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.423379       92.037       38,967       73.00         00       07000       CLINIC       3.769697       0       0       90.00       91.00       91.00       92.03       92.03       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00	55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 00000	0 0	0	55.00
66.00       06600       PHYSI CAL THERAPY       0.478378       78,737       37,666       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.459840       69,812       32,102       67.00         68.00       06800       SPEECH PATHOLOGY       0.353838       7,502       2,654       68.00         69.00       06900       ELECTROCARDI OLOGY       0.201881       2,306       466       69.00         70.00       07000       ELECTROCNCEPHALOGRAPHY       0.0000000       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.050088       2,521       126       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0.423379       92,037       38,967       73.00         0.0170.0       DRUGS CHARGED TO PATIENTS       0.509185       0       0       91.00         90.00       09000       CLINIC       3.769697       0       0       91.00         91.00       09100       EMERGENCY       0.634128       0       0       92.00         92.00       DSERVATI ON BEDS (NON-DI STINCT PART)       0.634128       0       0       92.00         92.00       OPSEON AMBULANCE SERVI CES <td>60. 00 06000 LABORATORY</td> <td></td> <td>0. 19578</td> <td>6 28, 656</td> <td>5, 610</td> <td>60.00</td>	60. 00 06000 LABORATORY		0. 19578	6 28, 656	5, 610	60.00
67.00       06700       0CCUPATI ONAL THERAPY       0.459840       69,812       32,102       67.00         68.00       06800       SPEECH PATHOLOGY       0.353838       7,502       2,654       68.00         69.00       06900       ELECTROCARDIOLOGY       0.201881       2,306       466       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.050088       2,521       126       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       1.400877       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.423379       92,037       38,967       73.00         90.00       09000       CLI NI C       3.769697       0       0       90.00       91.00         91.00       09100       EMERGENCY       0.634128       0       0       92.00         92.00       OBSERVATI ON BEDS (NON-DI STINCT PART)       0.634128       0       0       92.00         95.00       OPSEON       AMBULANCE SERVICES       327,280       125,765       200.00       201.00       201.00						•
68.00         06800         SPEECH PATHOLOGY         0.353838         7,502         2,654         68.00           69.00         06900         ELECTROCARDIOLOGY         0.201881         2,306         466         69.00           70.00         07000         ELECTROCARDIOLOGY         0.201881         2,306         466         69.00           70.00         07000         ELECTROCARDENCEPHALOGRAPHY         0.000000         0         0         70.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0.050088         2,521         126         71.00           72.00         07200         JMPL. DEV. CHARGED TO PATIENTS         0.423379         92,037         38,967         73.00           0.010         DUTPATI ENT SERVICE COST CENTERS         0         0.423379         92,037         38,967         73.00           90.00         09000         CLINIC         3.769697         0         0         90.00         91.00         91.00         91.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>•</td></td<>						•
69.00       06900       ELECTROCARDI OLOGY       0.201881       2,306       466       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       70.00         71.00       07100       MEDI CAL       SUPPLIES CHARGED TO PATIENTS       0.050088       2,521       126       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       1.400087       0       0       72.00         73.00       OTODUGS CHARGED TO PATIENTS       0.423379       92,037       38,967       73.00         0UTPATIENT SERVICE COST CENTERS       0.509185       0       0       90.00       91.00       91.00       91.00       91.00       91.00       92.00         90.00       09100       EMERGENCY       0.634128       0       0       92.00         92.00       OBSERVATION BEDS (NON-DI STINCT PART)       0.634128       0       92.00       92.00         95.00       09500       AMBULANCE SERVICES       327,280       125,765       200.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00						
70.00         07000         ELECTROENCEPHALOGRAPHY         0.000000         0         70.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0.050088         2,521         126         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATIENT         1.400087         0         0         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0.423379         92,037         38,967         73.00           0UTPATIENT SERVICE COST CENTERS         0         0.423379         92,037         38,967         73.00           90.00         09000         CLINIC         3.769697         0         0         90.00           91.00         09200         DBSERVATION BEDS (NON-DISTINCT PART)         0.634128         0         0         91.00           92.00         0BSERVATION BEDS (NON-DISTINCT PART)         0.634128         0         0         92.00           0THER REIMBURSABLE COST CENTERS         0         0         92.00         95.00         95.00         95.00         95.00         200.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00         201.00						
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.050088       2,521       126       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       1.400087       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.423379       92,037       38,967       73.00         0000       09000       CLINIC       0.509185       0       0       90.00       90.00       91.00       92.00       92.00       92.00       91.00       92.00						
72.00       07200       IMPL. DEV. CHARGED TO PATIENT       1.40087       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.423379       92,037       38,967       73.00         0UTPATIENT SERVICE COST CENTERS       0       0.423379       92,037       38,967       73.00         90.00       09000       CLINIC       3.769697       0       0       90.00         91.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0.634128       0       0       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0.634128       0       0       92.00         0THER RIMBURSABLE COST CENTERS       50.00       0       95.00       0       95.00       200.00       201.00       125,765       200.00       201.00         201.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       125,765       200.00       201.00					-	
73.00       DRUGS CHARGED TO PATIENTS       0.423379       92,037       38,967       73.00         0UTPATIENT SERVICE COST CENTERS       0       0       90.00       09000       CLINIC       3.769697       0       0       90.00         90.00       09000       CLINIC       0.509185       0       0       91.00       92.00         92.00       0BSERVATION BEDS (NON-DISTINCT PART)       0.634128       0       0       92.00         95.00       09500       AMBULANCE SERVICES       95.00       327,280       125,765       200.00         201.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       0       201.00       0						
OUTPATI ENT SERVICE COST CENTERS           90.00         09000         CLINIC         3.769697         0         90.00           91.00         09100         EMERGENCY         0.509185         0         0         91.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         0.634128         0         0         92.00           0THER REI MBURSABLE COST CENTERS         0         0         95.00         09500         AMBULANCE SERVICES         95.00         200.00         201.00         Total (sum of lines 50-94 and 96-98)         327,280         125,765         200.00         201.00         201.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         201.00					-	
90.00       09000       CLINIC       3.769697       0       0       90.00         91.00       09100       EMERGENCY       0.509185       0       0       91.00         92.00       0BSERVATION BEDS (NON-DISTINCT PART)       0.634128       0       0       92.00         0THER       REI MBURSABLE COST CENTERS       95.00       09500       AMBULANCE SERVICES       95.00       95.00       200.00       201.00       125,765       200.00       201.00			0. 42337	9 92,037	38, 967	/3.00
91.00         09100         EMERGENCY         0.509185         0         0         91.00           92.00         0BSERVATION BEDS (NON-DISTINCT PART)         0.634128         0         0         92.00           0THER REIMBURSABLE COST CENTERS         0         0         92.00         95.00         95.00         95.00         95.00         95.00         95.00         200.00         201.00         125,765         200.00         201.00         201.00         0         125,765         200.00         201.00         201.00         0         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         125,765         200.00         201.00         201.00         201.00         201.00         125,765         200.00         201.00         201.00         201.00         201.00         201.00         201.00			2 76060	7 0	0	
92. 00         09200         OBSERVATION         BEDS (NON-DISTINCT PART)         0.634128         0         92. 00           0THER         REI MBURSABLE COST CENTERS         95. 00         9500         AMBULANCE SERVICES         95. 00         950. 00         200. 00         125, 765         200. 00         201. 00         125, 765         200. 00         201. 00         0         125, 765         200. 00         201. 00         125, 765         200. 00         201. 00         125, 765         200. 00         201. 00         125, 765         200. 00         201. 00         125, 765         200. 00         201. 00         125, 765         200. 00         201. 00         125, 765         200. 00         201. 00         125, 765         200. 00         201. 00         125, 765         200. 00         201. 00         125, 765         200. 00         201. 00         125, 765         200. 00         201. 00         125, 765         200. 00         201. 00         125, 765         200. 00         201. 00         125, 765         200. 00         201. 00         125, 765         200. 00         201. 00         100         100         100         100         100         100         100         100         100         100         100         100         100         100					-	
OTHER REIMBURSABLE COST CENTERS95.0009500AMBULANCE SERVICES Total (sum of lines 50-94 and 96-98) Less PBP Clinic Laboratory Services-Program only charges (line 61)327, 280125, 765200. 00201.00Less PBP Clinic Laboratory Services-Program only charges (line 61)0201. 00						
95. 00         09500         AMBULANCE SERVICES         95. 00           200. 00         Total (sum of lines 50-94 and 96-98)         327, 280         125, 765         200. 00           201. 00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201. 00         201. 00			0.03412	0 0	0	72.00
200.00         Total (sum of lines 50-94 and 96-98)         327, 280         125, 765         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00						95.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00				327, 280	125, 765	
		rges (line 61)				
		5		327, 280		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT         Provider CCN: 15-1304         Period: From 01/01/2016 To 12/31/2016         Worksheet D-3 bit/Time Prepared: b/28/2017 4:42 pm b/2017 4:42 pm	Health Financial Systems RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
Cost Center Description         Ratio of Cost To Charges         Inpatient Program Charges         Inpatient Program Costs (col. 1 x col. 2)           1.00         2.00         3.00           30.00         003000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS         0         30.00           50.00         05000 (DEFARTING ROM S1000 (DEFARTING ROM ANCILLARY SERVICE COST CENTERS         0         30.00           50.00         05000 (DEFARTING ROM S1000 (DEFECH RATINOLOGY S1000 (DEFECH PATHOLOGY S1000 (DEFECH PATHOLOGY S1000 (DEFECH ROM DEFECH PATHOLOGY S1000 (DEFARTING ROM S1145 S7 71.00 S1000 (DEFARTING ROM S1145 S7 71.00 S1000 (DEFARTING ROM PATIENTS S1000 (DEFARTING ROM PATIENTS S1000 (DEFARTING ROM PATIENTS S1000 (DEFARTING ROM PATIENTS S1000 (DEFARTING ROM PATIENT S1000 (DEFARTING	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
To Charges         Program Costs (col 1 x col 2)           1.00         2.00         3.00           30.00         03000 ADULTS & PEDIATRICS ANDULTS & PEDIATRICS         0         30.00           50.00         05000 OPERATING ROOM         0.378620         4,071         1,541           50.00         05000 OPERATING ROOM         0.378620         4,071         1,541           51.00         05000 OPERATING ROOM         0.110805         1,094         121           51.00         05000 ADULTS & PEDIATRICS         0         0         55.00           50.00         05000 APERATING ROOM         0.110805         1,094         121           51.00         05000 ADULTS & PEDIATRICS         0         0         0           50.00         05000 ADULTS & PEDIATRICS         0.000000         0         0           51.00         05000 ADULTS & PEDIATRICS         0.000000         0         0           50.00         05000 ADULTS & PEDIATRICS         0.000000         0         0           60.00         06000 LABORATORY         0.101505         9.202         934         54.00           60.00         06000 PHYSICAL THERAPY         0.360049         446         161         65.00           61.00		Ti tl	e XIX	Hospi tal	Cost	
INPATI ENT ROUTINE SERVICE COST CENTERS         0         30.00           30.00         JI.00         2.00         3.00           30.00         JOSOOJ ADULTS & PEDIATRICS         0         30.00           ANCILLARY SERVICE COST CENTERS         0         30.00           50.00         DOSOOJ PERATING ROOM         0.378620         4.071         1.541         50.00           51.00         DS100 (RECOVERY ROOM         0.110805         1.094         121         51.00           53.00         DS300 (ANESTHESI OLOGY         0.000000         0         0         53.00           54.00         DS500 (RADI OLOGY-THERAPEUTI C         0.101505         9.202         934         54.00           55.00         DS500 (RADI OLOGY-THERAPEUTI C         0.195786         5.945         1.164         60.00           66.00         D6600 PHYSI CAL THERAPY         0.360049         4446         161         65.00           66.00         D6600 SPEEL TATORY THERAPY         0.35383         40         14         68.00           66.00         D6600 SPEECH PATHOLOGY         0.21881         494         100         69.00           69.00         D6800 SPEECH PATHOLOGY         0.21881         494         100         69.00	Cost Center Description		Ratio of Cos			
INPATI ENT ROUTI NE SERVI CE COST CENTERS         0         3.0.00           30. 00         03000 ADULTS & PEDI ATRI CS         0         30.00           ANCI LLARY SERVI CE COST CENTERS         0         30.00           50. 00         05000 OPERATI NG ROOM         0.378620         4,071         1,541           50. 00         05000 OPERATI NG ROOM         0.110805         1,094         121         51.00           51. 00         05100 RECOVERY ROOM         0.101505         9,202         934         54.00           52. 00         05500 RADI OLOGY - DI AGNOSTI C         0.000000         0         0         55.00           60. 00         6000 CONO LABORATORY         0.195786         5.945         1,164         60.00           60. 00         6000 CABORATORY         0.380049         446         161         65.00           67.00         06700 CUCUPATI ONAL THERAPY         0.478378         325         155         66.00           60.00         06000 ELECTROCARDI OLOGY         0.238338         40         14         68.00           69.00         07000 ELECTROCARDI OLOGY         0.35338         40         14         68.00           69.00         07000 ELECTROCARDI OLOGY         0.208088         1.145			To Charges	Program		
INPATI ENT NOUTINE SERVICE COST CENTERS           30.00         03000/ ADULTS & PEDI ATRICS         0         30.00           ANCILLARY SERVICE COST CENTERS         0         30.00           50.00         05000/ APURTING ROOM         0.378620         4,071         1,541         50.00           51.00         05100         RECOVERY ROOM         0.110805         1,094         121         51.00           53.00         05300         ANESTHESI OLOGY         0.000000         0         0         53.00           54.00         05400 RADI OLOGY-DI AGNOSTI C         0.101505         9,202         934         54.00           65.00         06500 REDI OLOGY-DI AGNOSTI C         0.101505         9,455         1,164         60.00           66.00         06500 REDI RATORY THERAPEUTI C         0.300049         446         161         65.00           66.00         06500 RESPI RATORY THERAPY         0.478378         325         155         66.00           67.00         0CUPATI ONAL THERAPY         0.478378         325         155         66.00           0.0000 ELECTROCARAI OLOGY         0.21881         494         100         69.00           0.00000 OLINAL OLGY CHARGED TO PATIENTS         0.203379         12,977         5,494<				Charges		
INPATI ENT ROUTI NE SERVI CE COST CENTERS         0         30.00           30.00         03000 ADULTS & PEDIATRI CS         0         30.00           ARCICLARY SERVI CE COST CENTERS         0         30.00           50.00         05000 OPERATI NG ROOM         0.378620         4.071         1.541         50.00           51.00         05000 ANESTHESI OLOGY         0.000000         0         0         53.00           53.00         05300 RADI OLOGY-DI AGNOSTI C         0.101505         9.202         934         54.00           55.00         05500 RADI OLOGY-THERAPEUTI C         0.000000         0         0         55.00           60.00         06000 LABORATORY         0.195786         5.945         1.164         60.00           65.00         06500 RESPI RATORY THERAPY         0.360049         446         161         65.00           66.00         06000 PLEST CAL THERAPY         0.459840         293         135         67.00           67.00         06700 OCCUPATI ONAL THERAPY         0.459840         293         135         67.00           68.00         06800 SPEECH PATHOLOGY         0.35338         40         14         68.00           71.00         071000 KELOCARDI OLOGY         0.201881         494<						
30.00       3000 ADULTS & PEDIATRICS       0       30.00         ANCILLARY SERVICE COST CENTERS       0       30.00         ANCILLARY SERVICE COST CENTERS       0       1.541         50.00       OSO00 (PERATING ROOM       0.378620       4,071       1.541         51.00       05100 RECOVERY ROOM       0.110805       1,094       121       51.00         53.00       05300 ANESTHESI OLOGY       0.000000       0       0       53.00         54.00       05400 RADI OLOGY-JHERAPEUTI C       0.101505       9,202       934       54.00         55.00       05500 RADI OLOGY-THERAPEUTI C       0.000000       0       0       55.00         60.00       06000 LABORATORY       0.360049       446       161       65.00         65.00       06500 RESPI RATORY THERAPY       0.378838       325       155       66.00         61.00       06400 PHYSI CAL THERAPY       0.353838       40       14       48.00       69.00       0.000000       0       70.00         62.00       06900 ELECTROCARDI OLOGY       0.353838       40       14       68.00       69.00       71.00       69.00       70.00       70.00       71.00       71.00       71.00       71.00       71.00			1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS           50. 00         05000         OPERATING ROM         0.378620         4,071         1,541         50. 00           51. 00         05300         ANESTHESIOLOGY         0.000000         0         53. 00           53. 00         05300         ANESTHESIOLOGY         0.000000         0         0         53. 00           54. 00         05400         RADIOLOGY-DI AGNOSTI C         0.101505         9,202         934         54. 00           55. 00         05500         RADIOLOGY-THERAPEUTI C         0.000000         0         0         55. 00           60.00         C6000         LABORATORY         0.195786         5,945         1,164         60. 00           66. 00         06600         PHYSI CAL THERAPY         0.380049         446         161         65. 00           67. 00         06700         DCCUPATIONAL THERAPY         0.459840         293         135         67. 00           68. 00         OBBOS         SPEECH PATHOLOGY         0.231881         494         100         69. 00         69. 00         69. 00         1468. 00         69. 00         69. 00         145         57         71. 00           71. 00         07100         MEDI CAL SUP				_ 1		
50.00       05000       OPERATING ROOM       0.378620       4,071       1,541       50.00         51.00       05100       RECOVERY ROOM       0.110805       1.094       121       51.00         53.00       05300       ANESTHESI 0LOGY       0.000000       0       0       53.00         54.00       05400       RADI 0LOGY-DI AGNOSTI C       0.000000       0       0       0       55.00         05500       ANESTHESI 0LOGY       0.000000       0       0       0       55.00         05500       RADI 0LOGY-THERAPEUTI C       0.000000       0       0       55.00         06000       LABORATORY       0.195786       5,945       1,164       60.00         06600       PHYSI CAL THERAPY       0.360049       446       161       65.00         06600       PHYSI CAL THERAPY       0.459840       293       135       67.00         067.00       0CCUPATI ONAL THERAPY       0.353838       40       14       68.00       69.00       0.6900       ELECTROCARDI 0LOGY       0.353838       40       14       68.00       69.00       71.00       71.00       71.00       71.00       72.00       0.500088       1,145       57       71.00       <				0		30.00
51.00       05100       RECOVERY ROOM       0.110805       1,094       121       51.00         53.00       05300       ANESTHESI OLOGY       0.00000       0       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.101505       9,202       934       54.00         05500       RADI OLOGY-THERAPEUTI C       0.000000       0       0       55.00         06000       LABORATORY       0.360049       446       161       66.00         06400       DESPI RATORY THERAPY       0.360049       446       161       66.00         06600       RESPI RATORY THERAPY       0.459840       293       135       67.00         067.00       OCCUPATI ONAL THERAPY       0.459840       293       135       67.00         06800       SPEECH PATHOLOGY       0.353838       40       14       68.00         09.00       OF000       ELECTROCARDI OLOGY       0.353838       40       14       68.00         09.00       OF100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       0       71.00         71.00       OT200       IMELC TROENCEPHALOGRAPHY       0.423379       12.977       5.494       73.00         00 </td <td></td> <td></td> <td></td> <td>- 1</td> <td></td> <td></td>				- 1		
53.00       05300       ANESTHESI OLOGY       0       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.101505       9,202       934         55.00       0500       RADI OLOGY-THERAPEUTI C       0.000000       0       55.00         60.00       06000       LABORATORY       0.195786       5,945       1,164       60.00         65.00       06500       RESPI RATORY THERAPY       0.360049       446       161       65.00         66.00       06500       PHYSI CAL THERAPY       0.478378       325       155       67.00         06700       0CCUPATI ONAL THERAPY       0.459840       293       135       67.00         06800       SPEECH PATHOLOGY       0.353838       40       14       68.00         69.00       06900       ELECTROENCENHALOGRAPHY       0.000000       0       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.050088       1,145       57       71.00         73.00       07200       ILECTROENCEPHALOGRAPHY       0.432379       12,977       5,494       73.00         73.00       07200       ILMUEL AUCE COST CENTERS       0.423379       12,977       5,494 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.101505       9,202       934       54.00         55.00       05500       RADI OLOGY-THERAPEUTI C       0.000000       0       55.00         60.00       06000       LABORATORY       0.195786       5,945       1,164       60.00         65.00       05500       RESPI RATORY THERAPY       0.360049       4446       161       65.00         66.00       06600       PHYSI CAL THERAPY       0.478378       325       155       66.00         67.00       06700       0CUPATI ONAL THERAPY       0.459840       293       135       67.00         68.00       SPECH PATHOLOGY       0.201881       494       100       69.00       06900       ELECTROCARDI OLOGY       0.40000       0       70.00       70.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.00       72.01       74.45       57       71.00         71.00       07100       MEUCALSCHARGED TO PATI ENTS       0.050088       1,145       57       73.00         72.00       07200       INRUSCHAGED TO PATI ENT						
55.00       05500       RADI OLOGY-THERAPEUTI C       0.000000       0       0       55.00         60.00       06000       LABORATORY       0.195786       5,945       1,164       60.00         65.00       06500       RESPI RATORY THERAPY       0.360049       446       161       65.00         66.00       06600       PHYSI CAL THERAPY       0.478378       325       155       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.459840       293       135       67.00         68.00       06800       SPEECH PATHOLOGY       0.353838       40       14       68.00         69.00       06900       ELECTROCARDI OLOGY       0.201881       494       100       69.00         70.00       OT000       ELECTROCARDI OLOGY       0.000000       0       70.00       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.050088       1,145       57       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.423379       12,977       5,494       73.00         0017DATI ENT SERVICE COST CENTERS       0       0       0       90.00       90000       CLIN C       3.769697       842	53. 00 05300 ANESTHESI OLOGY				0	53.00
60.00       06000       LABORATORY       0.195786       5,945       1,164       60.00         65.00       06500       RESPI RATORY THERAPY       0.360049       446       161       65.00         66.00       06600       PHYSI CAL THERAPY       0.478378       325       155       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.478378       325       155       67.00         68.00       06800       SPEECH PATHOLOGY       0.353838       40       14       68.00         69.00       06900       ELECTROCARDI OLOGY       0.201881       494       100       69.00         70.00       07000       ELCTROENCEPHALOGRAPHY       0.000000       0       70.00       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.050088       1,145       57       71.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.423379       12,977       5,494       73.00         09100       CHINIC       0.9100       MERGENCY       0.509185       1,860       947       90.00         91.00       09100       EMERGENCY       0.509185       1,860       947       91.00       92.00         <	54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 10150	9, 202	934	
65.00       06500       RESPI RATORY THERAPY       0.360049       446       161       65.00         66.00       06600       PHYSI CAL THERAPY       0.478378       325       155       66.00         67.00       0CCUPATI ONAL THERAPY       0.459840       293       135       67.00         68.00       06800       SPEECH PATHOLOGY       0.353838       40       14       68.00         69.00       06900       ELECTROCARDI OLOGY       0.201881       494       100       69.00         70.00       07000       ELECTROCARDI OLOGY       0.201881       494       100       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.423379       12,977       5,494       73.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.423379       12,977       5,494       73.00         0017100       MEDI CAL SUPPLIES COST CENTERS       90.00       09000       CLI NI C       3.769697       842       3,174       90.00         91.00       09100       EMERGENCY       0.509185       1,860       947       91.00       9	55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000	0 0	0	55.00
66.00       06600       PHYSI CAL THERAPY       0.478378       325       155       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.459840       293       135       67.00         68.00       06800       SPEECH PATHOLOGY       0.353838       40       14       68.00         69.00       06900       ELECTROCARDI OLOGY       0.201881       494       100       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.050088       1,145       57       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.423379       12,977       5,494       73.00         0017PATI ENT SERVICE COST CENTERS       0.0509185       1,860       947       91.00         91.00       09100       EMERGENCY       0.509185       1,860       947       91.00         92.00       OSERVATI ON BEDS (NON-DI STI NCT PART)       0.634128       0       0       92.00         075000       AMBULANCE SERVI CES       38,734       13,997       200.00       201.00       201.00       201.00	60. 00 06000 LABORATORY		0. 19578	36 5, 945	1, 164	60.00
67.00       06700       0CCUPATI ONAL THERAPY       0.459840       293       135       67.00         68.00       06800       SPEECH PATHOLOGY       0.353838       40       14       68.00         69.00       06900       ELECTROCARDI OLOGY       0.201881       494       100       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.450088       1,145       57       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.423379       12,977       5,494       73.00         0.0100       DUTPATI ENT SERVI CE COST CENTERS       0.423379       12,977       5,494       73.00         90.00       09000       CLI NI C       3.769697       842       3,174       90.00         91.00       09100       EMERGENCY       0.634128       0       0       92.00         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.634128       0       0       92.00         07HER REI MBURSABLE COST CENTERS       38,734       13,997       200.00       201.00       201.00       201.00       201.00       201.00       <	65. 00 06500 RESPI RATORY THERAPY		0.36004	19 446	161	65.00
68.00       06800       SPEECH PATHOLOGY       0.353838       40       14       68.00         69.00       06900       ELECTROCARDIOLOGY       0.201881       494       100       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.050088       1,145       57       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.423379       12,977       5,494       73.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.423379       12,977       5,494       73.00         00100       EMERGENCY       0.509185       1,860       947       91.00         91.00       09100       EMERGENCY       0.634128       0       0       92.00         92.00       OBSERVATI ON BEDS (NON-DI STINCT PART)       0.634128       0       0       92.00       92.00         00       092000       BERGENCY       0.634128       0       0       92.00       92.00         00       09500       AMBULANCE SERVICES       38,734       13,997       200.00       201.00       201.00       201.00       201.00       20	66. 00 06600 PHYSI CAL THERAPY		0. 4783	78 325	155	66.00
69.00       06900       ELECTROCARDIOLOGY       0.201881       494       100       69.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       70.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.050088       1,145       57       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       1.400087       0       72.00         73.00       OTODO RUGS CHARGED TO PATIENTS       0.423379       12,977       5,494         70.00       09000       CLINIC       3.769697       842       3,174       90.00         90.00       09100       EMERGENCY       0.634128       0       0       92.00         92.00       OSE MABULANCE SERVICES       Strinct PART)       0.634128       0       0       92.00         95.00       09500       ABBULANCE SERVICES       38,734       13,997       200.00       201.00	67. 00 06700 OCCUPATI ONAL THERAPY		0. 45984	10 293	135	67.00
70.00       07000       ELECTROENCEPHALOGRAPHY       0.000000       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.050088       1,145       57       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       1.400087       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.423379       12,977       5,494       73.00         00100       EMERGENCY       0.9000       CLINIC       3.769697       842       3,174       90.00         90.00       09200       OBSERVATI ON BEDS (NON-DISTINCT PART)       0.634128       0       0       92.00         00100       EMERGENCY       0.634128       0       0       92.00       0       95.00       0       95.00       0       95.00       95.00       200.00       28, 734       13, 997       200.00       201.00       201.00       28, 734       13, 997       200.00       201.00	68.00 06800 SPEECH PATHOLOGY		0.35383	38 40	14	68.00
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.050088       1,145       57       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       1.400087       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.423379       12,977       5,494       73.00         000       09000       CLINIC       0.509185       1,860       947       91.00         91.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0.634128       0       0       92.00         00HER REI MBURSABLE COST CENTERS       0       0       0       95.00       09500       AMBULANCE SERVICES       95.00       95.00       95.00       95.00       200.00       201.00       28, 734       13, 997       200.00       201.00       201.00       0       201.00       0       0       0       201.00       0       0       201.00       0       0       0       201.00       0       201.00       0       0       201.00       0       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00 </td <td>69. 00 06900 ELECTROCARDI OLOGY</td> <td></td> <td>0. 20188</td> <td>31 494</td> <td>100</td> <td>69.00</td>	69. 00 06900 ELECTROCARDI OLOGY		0. 20188	31 494	100	69.00
72.00       07200       I MPL. DEV. CHARGED TO PATIENT       1.400087       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.423379       12,977       5,494       73.00         0UTPATIENT SERVICE COST CENTERS       0       90.00       09000       CLINIC       3.769697       842       3,174       90.00         91.00       09100       EMERGENCY       0.509185       1,860       947       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0.634128       0       92.00         0THER REI MBURSABLE COST CENTERS       0       0       92.00       95.00       95.00       95.00       95.00       95.00       200.00       201.00       205.00       38,734       13,997       200.00       201.00	70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000	0 0	0	70.00
73.00       DRUGS CHARGED TO PATIENTS       0.423379       12,977       5,494       73.00         0UTPATIENT SERVICE COST CENTERS       0       3.769697       842       3,174       90.00         90.00       09000       CLINIC       3.769697       842       3,174       90.00         91.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0.634128       0       0       92.00         95.00       OPS00       AMBULANCE SERVICES       75.00       95.00       95.00       95.00       95.00       95.00       95.00       200.00       201.00       13,997       200.00       201.00       201.00       201.00       0       95.00       0       0       95.00       200.00       201.00       201.00       201.00       201.00       0       201.00       0       201.00       0       201.00       0       201.00       0       201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.05008	38 1, 145	57	71.00
OUTPATI ENT SERVICE COST CENTERS           90.00         09000 CLINIC         3.769697         842         3,174         90.00           91.00         09100 EMERGENCY         0.509185         1,860         947         91.00           92.00         09200 OBSERVATI ON BEDS (NON-DI STINCT PART)         0.634128         0         0         92.00           0THER REI MBURSABLE COST CENTERS         0         0         92.00         95.00         0         95.00         0         95.00         95.00         09500 AMBULANCE SERVICES         95.00         200.00         201.00         Total (sum of lines 50-94 and 96-98)         38,734         13,997         200.00         201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENT		1.40008	37 0	0	72.00
90. 00       09000       CLINIC       3.769697       842       3.174       90. 00         91. 00       09100       EMERGENCY       0.509185       1,860       947       91. 00         92. 00       09200       0BSERVATI ON BEDS (NON-DISTINCT PART)       0.634128       0       0       92. 00         0THER       REIMBURSABLE COST CENTERS       95. 00       09500       AMBULANCE SERVICES       95. 00       95. 00       200. 00       201. 00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       38, 734       13, 997       200. 00       201. 00	73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4233	79 12, 977	5, 494	73.00
91.00       09100       EMERGENCY       0.509185       1,860       947       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0.634128       0       0       92.00         0THER       REI MBURSABLE COST CENTERS       0       0       92.00       95.00       95.00       95.00       95.00       95.00       200.00       13,997       200.00       201.00       201.00       201.00       0       0       201.00       0       0       201.00       0       0       201.00       0	OUTPATIENT SERVICE COST CENTERS					1
92. 00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         0.634128         0         92. 00           0THER         REI MBURSABLE COST CENTERS         95. 00         9500         AMBULANCE SERVI CES         95. 00         95. 00         95. 00         95. 00         95. 00         200. 00         138, 734         13, 997         200. 00         201. 00         201. 00         201. 00         0         201. 00	90. 00 09000 CLINIC		3. 7696	97 842	3, 174	90.00
OTHER         REI MBURSABLE         COST         CENTERS           95. 00         09500         AMBULANCE         SERVI CES         95. 00           200. 00         Total (sum of lines 50-94 and 96-98)         38, 734         13, 997         200. 00           201. 00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201. 00	91. 00 09100 EMERGENCY		0. 50918	35 1, 860	947	91.00
95. 00         09500         AMBULANCE SERVICES         95. 00           200. 00         Total (sum of lines 50-94 and 96-98)         38, 734         13, 997         200. 00           201. 00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 63412	28 0	0	92.00
200.00         Total (sum of lines 50-94 and 96-98)         38,734         13,997         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00	OTHER REIMBURSABLE COST CENTERS					1
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	95. 00 09500 AMBULANCE SERVI CES					95.00
201.00     Less PBP Clinic Laboratory Services-Program only charges (line 61)     0     201.00	200.00   Total (sum of lines 50-94 and 96-98)			38, 734	13, 997	200.00
	201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.00
				38, 734		202.00

	Financial Systems RUSH MEMORIAL HOS ATION OF REIMBURSEMENT SETTLEMENT F	Provider CCN: 15-1304	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2016 To 12/31/2016	Part B	narod
			10 12/31/2010	6/28/2017 4:4:	
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	``````````````````````````````````````		7, 027, 392	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instruction PPS payments	ons)		0	2.00 3.00
4.00	Outlier payment (see instructions)			0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	5.00
6.00	Line 2 times line 5			0	6.0
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)	aal 12 line 200		0	8.00
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. IV Organ acquisitions	, cor. 13, rrne 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			7, 027, 392	
	COMPUTATION OF LESSER OF COST OR CHARGES			.,	
10 00	Reasonable charges			0	12.00
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)		0	12.00 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	c 0/)		0	
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for pay	5	Ŭ	0	
16.00	Amounts that would have been realized from patients liable for	payment for services o	on a chargebasis	0	16.00
17.00	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 00
18.00	Total customary charges (see instructions)			0.000000	18.00
19.00	Excess of customary charges over reasonable cost (complete only	ifline 18 exceeds li	ne 11) (see	0	19.00
	instructions)		, ,		
20. 00	Excess of reasonable cost over customary charges (complete only	ifline 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		7, 097, 666	21.00
		riisti ucti olis)		0,077,000	21.00
23.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance (for CAH, see instructions)			71, 472	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions)		3, 137, 676	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			3, 888, 518	
	instructions)		2 (		
28.00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28.00
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 3, 888, 518	29.00 30.00
30.00	Primary payer payments			5, 006, 516 5, 006	
32.00	Subtotal (line 30 minus line 31)			3, 883, 512	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	S)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			744, 401	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru-	ctions)		483, 861 686, 490	
37.00	Subtotal (see instructions)	ctrons)		4, 367, 373	
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
39.98	Partial or full credits received from manufacturers for replace	a aevices (see instruc	ctions)	0	39.98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 4, 367, 373	39.99 40.00
40.00	Sequestration adjustment (see instructions)			4, 307, 373	
41.00	Interim payments			3, 243, 423	
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)	a with ONC Dut 15 a	abanto: 1	1, 036, 603	
44.00	Protested amounts (nonallowable cost report items) in accordance §115.2	e with CMS Pub. 15-2,	cnapter 1,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
92.00 93.00	Time Value of Money (see instructions)			0	93.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CC	N: 15-1304	Period: From 01/01/2016 To 12/31/2016		
		Title		Hospi tal	Cost	
		I npati ent	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		1, 729, 7	18 0	3, 243, 423 0	1. ( 2. (
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. (
	Program to Provider	<u> </u>				
. 01	ADJUSTMENTS TO PROVIDER			0	0	3.0
. 02				0	0	3. (
. 03				0	0	3.
04 05				0	0	3. 3.
05	Provider to Program	I I		0	0	J.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53 54				0	0	3. 3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 729, 7	18	3, 243, 423	4.
	TO BE COMPLETED BY CONTRACTOR	<u> </u>				
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	5.
02				0	0	5.
03	Duran di alemente - Dura muram			0	0	5.
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.
50 51				0	0	5.
52				0	0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.
00 01	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER			0	1, 036, 603	6. 6.
02	SETTLEMENT TO PROGRAM		170, 3	46	0	6.
00	Total Medicare program liability (see instructions)		1, 559, 3		4, 280, 026	7.
		0		Contractor Number 1.00	NPR Date (Mo/Day/Yr) 2.00	
00	Name of Contractor	0		1.00	2.00	8.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CC	CN: 15-1304 CCN: 15-Z304	Period: From 01/01/2016 To 12/31/2016		
		component	5011. 13 2304	10 12/31/2010	6/28/2017 4:4	
			XVIII	Swing Beds - SN		
		I npati en	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider		379, 2		0	1.0
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	
03 04				0	0	
04				0	0	-
	Provider to Program			5		
50	ADJUSTMENTS TO PROGRAM			0	0	] 3
51				0	0	
52				0	0	
53 54				0	0	
54 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	
,,	3. 50-3. 98)			0	0	ľ
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E–3, line and column as appropriate)		379, 2	90	0	4
	TO BE COMPLETED BY CONTRACTOR				1	
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5
02				0	0	
03				0	0	5
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
5∠ 79	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
	5. 50-5. 98)			Ĭ		
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER			0	0	
02	SETTLEMENT TO PROGRAM		7, 2		0	
00	Total Medicare program liability (see instructions)		372, 0		0	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1.00	2.00	

Heal th	Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu						
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1304 Period: W From 01/01/2016 F						
	To 12/31/2016 Date/Tim						
				6/28/2017 4:42	2 pm		
		Title XVIII	Hospi tal	Cost			
				1.00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			604	1.00		
1.00	5						
	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12						
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2						
	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12						
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			66, 590, 673	5.00		
6.00	Total hospital charity care charges from Wkst. S-10, col. 3			321, 898	6.00		
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I	0	7.00		
	line 168						
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00		
9.00	Sequestration adjustment amount (see instructions)			0	9.00		
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)						
I NPATI ENT HOSPI TAL SERVICES UNDER THE I PPS & CAH							
30.00	30.00 Initial/interim HIT payment adjustment (see instructions)						
31.00	Other Adjustment (specify)			0	31.00		
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructior	ns)	0	32.00		

Health Financial Systems			RUSH MEMORIAL HOSPITAL		u of Form CMS-2552-1	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING B	EDS	Provider CCN: 15-1304 Component CCN: 15-Z304	Period: From 01/01/2016 To 12/31/2016	Worksheet E-2 Date/Time Pre	pared:
			Title XVIII	Swing Beds - SNF	6/28/2017 4:4 Cost	2 pm
	· · · · · ·			Part A	Part B	
				1,00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				2100	
1.00	Inpatient routine services - swing bed-SNF (	(see instructions)		254, 392	0	1.00
2.00	Inpatient routine services - swing bed-NF (s				-	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3,		t A, and sum of Wkst. D,	127, 023	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B)	) (For CAH, see in	structions)			
4.00	Per diem cost for interns and residents not	in approved teach	ing program (see		0.00	4.00
	instructions)					
5.00	Program days			311	0	5.00
6.00	Interns and residents not in approved teachi				0	6.00
7.00	Utilization review - physician compensation		thod only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus line	es 6 and 7)		381, 415	0	8.00
9.00	Primary payer payments (see instructions)			0	0	9.00
10.00	Subtotal (line 8 minus line 9)			381, 415	0	10.00
11.00	Deductibles billed to program patients (excl professional services)	ude amounts appli	cable to physician	0	0	11.00
12.00	Subtotal (line 10 minus line 11)			381, 415	0	12.00
13.00	Coinsurance billed to program patients (from for physician professional services)	m provider records	) (excl ude coi nsurance	1, 771	0	13.00
14.00	80% of Part B costs (line 12 x 80%)				0	14.00
15.00	Subtotal (enter the lesser of line 12 minus	line 13, or line	14)	379, 644	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIF	FY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment	t (see instruction	s)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT			0		16.55
17.00	Allowable bad debts (see instructions)			0	0	
17.01	Adjusted reimbursable bad debts (see instruc			0	0	
18.00	Allowable bad debts for dual eligible benefi	ciaries (see inst	ructions)	0	0	18.00
19.00	Total (see instructions)			379, 644	0	19.00
19.01	Sequestration adjustment (see instructions)			7, 593	0	19.01
20.00	Interim payments			379, 290	0	20.00
21.00	Tentative settlement (for contractor use onl			0	0	21.00
22.00	Balance due provider/program (line 19 minus			-7, 239	0	22.00
23.00	Protested amounts (nonallowable cost report chapter 1, §115.2	items) in accorda	nce with CMS Pub. 15-2,	0	0	23.00

		AL HOSPITAL		u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1304	Period: From 01/01/2016	Worksheet E-3 Part V	
			To 12/31/2016	Date/Time Pre	pared
				6/28/2017 4:4	
		Title XVIII	Hospi tal	Cost	
				1 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDIC			1.00	
1.00	Inpatient services	ARE FART A SERVICES - COST	KLIWDUKJEWENI	1, 908, 853	1 1.0
2.00	Nursing and Allied Health Managed Care payment (see instru	ictions)		1, 700, 000	
3.00	Organ acqui si ti on			0	
4.00	Subtotal (sum of lines 1 through 3)			1, 908, 853	
5.00	Primary payer payments			9, 306	5.0
6.00	Total cost (line 4 less line 5). For CAH (see instructions	5)		1, 918, 636	6.0
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routi ne servi ce charges			0	7.0
8.00	Ancillary service charges			0	
9.00	Organ acquisition charges, net of revenue			0	
10.00	Total reasonable charges			0	10.0
11 00	Customary charges	For normant for convious on	a aharra haala	0	1 1 1 0
11.00 12.00	Aggregate amount actually collected from patients liable f Amounts that would have been realized from patients liable			0	
12.00	had such payment been made in accordance with 42 CFR 413.1		in a charge basis	0	12.0
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	13(e)		0.000000	13.0
14.00	Total customary charges (see instructions)			0.000000	
15.00	Excess of customary charges over reasonable cost (complete	e only if line 14 exceeds li	ne 6) (see	0	
	instructions)	, , , , , , , , , , , , , , , , , , ,		-	
16.00	Excess of reasonable cost over customary charges (complete	e only if line 6 exceeds lir	ie 14) (see	0	16. C
	instructions)				
17.00	Cost of physicians' services in a teaching hospital (see i	nstructions)		0	17.0
10 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 10 0
18.00	Direct graduate medical education payments (from Worksheet	t E-4, TThe 49)		-	
19.00 20.00	Cost of covered services (sum of lines 6, 17 and 18) Deductibles (exclude professional component)			1, 918, 636 347, 676	
20.00	Excess reasonable cost (from line 16)			347,070	
22.00	Subtotal (line 19 minus line 20 and 21)			1, 570, 960	
23.00	Coinsurance			3, 542	
24.00	Subtotal (line 22 minus line 23)			1, 567, 418	
25.00	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		36, 581	
26.00	Adjusted reimbursable bad debts (see instructions)	,		23, 778	26.0
27.00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		27, 173	27.0
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1, 591, 196	28.0
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 50	Pioneer ACO demonstration payment adjustment (see instruct	tions)		0	
29.99	Recovery of Accel erated Depreciation			0	
30.00	Subtotal (see instructions)			1, 591, 196	
30.01	Sequestration adjustment (see instructions)			31, 824	
	Interim payments			1, 729, 718	
32.00	Tentative settlement (for contractor use only)	21 and 22)		0	
33.00 34.00	Balance due provider/program (line 30 minus lines 30.01, 3		chaptor 1	-170, 346	
54 (11)	Protested amounts (nonallowable cost report items) in acco	bruance with CMS Pub. 15-2,	chapter I,	0	34.0

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	Financial Systems RUSH MEMORIAL HO: ATION OF REIMBURSEMENT SETTLEMENT F	Provider CCN: 15-1304	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 01/01/2016 To 12/31/2016	Part VII	
				6/28/2017 4:4	
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV COMPUTATION OF NET COST OF COVERED SERVICES	ICES FOR TITLES V OR 2	ATX SERVICES		-
00	Inpatient hospital/SNF/NF services		22, 096		1 1.
00	Medical and other services		22,070	0	2.
00	Organ acquisition (certified transplant centers only)		0	-	3.
00	Subtotal (sum of lines 1, 2 and 3)		22, 096	0	4
00	Inpatient primary payer payments		0		5
00	Outpatient primary payer payments			0	6
00	Subtotal (line 4 less sum of lines 5 and 6)		22, 096	0	7
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges		4 000		
	Routine service charges		1, 822	0	8
	Ancillary service charges Organ acquisition charges, net of revenue		38, 734 0	0	10
	Incentive from target amount computation		0		10
	Total reasonable charges (sum of lines 8 through 11)		40, 556	0	
	CUSTOMARY CHARGES		10,000		1 ' ~
00	Amount actually collected from patients liable for payment for	services on a charge	0	0	113
	basis	5			
00	Amounts that would have been realized from patients liable for		on 0	0	14
	a charge basis had such payment been made in accordance with 42	CFR §413.13(e)			
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
	Total customary charges (see instructions)		40, 556	0	16
. 00	Excess of customary charges over reasonable cost (complete only	IT line 16 exceeds	18, 460	0	17
. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only	if line 4 exceeds li	0	0	18
00	16) (see instructions)	IT THE 4 EXCeeds IT		0	
. 00	Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20
. 00	Cost of covered services (enter the lesser of line 4 or line 16	)	22, 096	0	21
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c	ompleted for PPS provi	ders.		
	Other than outlier payments		0	0	
	Outlier payments		0	0	23
	Program capital payments		0		24
	Capital exception payments (see instructions)		0	0	25
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		22, 096	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		22,070	0	1 2 1
	Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		22, 096	0	
00	Deducti bl es		0	0	32
. 00	Coinsurance		0	0	33
00	Allowable bad debts (see instructions)		0	0	
	Utilization review		0		35
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	22, 096	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37
	Subtotal (line 36 ± line 37)		22, 096	0	
	Direct graduate medical education payments (from Wkst. E-4)			0	39
	Total amount payable to the provider (sum of lines 38 and 39)		22, 096	0	40
	Interim payments Balance due provider/program (line 40 minus line 41)		12, 672 9, 424	0	41
	Protested amounts (nonallowable cost report items) in accordanc	e with CMS Pub 15_2	9, 424	0	
	chapter 1, §115.2		0	0	<sup>- ۲</sup>

	Financial Systems RUSH MEMORIAL E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		Period: From 01/01/2016	u of Form CMS-2 Worksheet G	
y)				To 12/31/2016	Date/Time Pre 6/28/2017 4:4	
		General Fund	Speci fi c Purpose Fund	Endowment Fund		
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	3, 525, 729	(		0	
00	Temporary investments	2, 022, 144	(		0	
00 00	Notes receivable Accounts receivable	0 11, 153, 952			0	
00	Other receivable	1, 480, 048		-	0	
00	Allowances for uncollectible notes and accounts receivable	-6, 390, 657		0 0	0	
00	Inventory	851, 473	0	0 0	0	7.
00	Prepaid expenses	273, 641	0	-	0	
00	Other current assets	0	(		0	
00	Due from other funds	0	(	-	0	
00	Total current assets (sum of lines 1-10) FIXED ASSETS	12, 916, 330	(	0 0	0	11.
00	Land	0		0	0	12.
00	Land improvements	0			0	
	Accumulated depreciation	0	C		0	
	Buildings	32, 645, 899	0	0 0	0	15
	Accumulated depreciation	-20, 884, 827	0		0	
	Leasehold improvements	0	0		0	
	Accumulated depreciation	0		0	0	
	Fixed equipment	0			0	
	Accumulated depreciation Automobiles and trucks	0			0	
	Accumulated depreciation	0			0	
	Major movable equipment	0			0	
	Accumulated depreciation	0	(		0	
00	Minor equipment depreciable	0	(	0 0	0	25
	Accumulated depreciation	0	(	0 0	0	
	HIT designated Assets	0	(	-	0	
	Accumulated depreciation	0	(		0	
	Minor equipment-nondepreciable	0	(		0	
00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	11, 761, 072		0 0	0	30
00	Investments	0	(	0 0	0	31
00	Deposits on Leases	0			0	
00	Due from owners/officers	0	0	0 0	0	33
00	Other assets	0	0	0 0	0	34
00	Total other assets (sum of lines 31-34)	0	(		0	35
00	Total assets (sum of lines 11, 30, and 35)	24, 677, 402	(	00	0	36
00	CURRENT LI ABI LI TI ES	1 525 500				1
00	Accounts payable	1, 535, 500			0	
	Salaries, wages, and fees payable Payroll taxes payable	0				
	Notes and Loans payable (short term)	963, 824		0	0	
	Deferred income	000,021		o o	0	
00	Accelerated payments	0				42
00	Due to other funds	0	0	0 0	0	43
	Other current liabilities	6, 033, 926			0	
00	Total current liabilities (sum of lines 37 thru 44)	8, 533, 250	(	0 0	0	45
00	LONG TERM LI ABI LI TI ES					
00	Mortgage payable	2 722 444				
00 00	Notes payable Unsecured Loans	3, 722, 644			0	
00	Other long term liabilities	0				
	Total long term liabilities (sum of lines 46 thru 49)	3, 722, 644		0 0	0	
	Total liabilities (sum of lines 45 and 50)	12, 255, 894	(	0 0	0	
	CAPI TAL ACCOUNTS					
	General fund balance	12, 421, 508				52
00	Specific purpose fund		(		1	53
00	Donor created - endowment fund balance - restricted			0	ł	54
00	Donor created - endowment fund balance - unrestricted			0		55
00 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56 57
	Plant fund balance - reserve for plant improvement,				0	
00	replacement, and expansion				0	0
	Total fund balances (sum of lines 52 thru 58)	12, 421, 508	0	0 0	0	59
00						

Heal th	Financial Systems	RUSH MEMORIAL	HOSPI TAL			In Lie	u of Form CMS.	2552-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC		Fr To	riod: om 01/01/2016 12/31/2016	Worksheet G- Date/Time Pr 6/28/2017 4:	l epared: 12 pm
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	i
		1.00	2.00	2.00		4.00	F 00	
1.00	Fund balances at beginning of period	1.00	2.00 11,565,610	3.00		4.00	5.00	1.00
2.00 3.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		855, 898 12, 421, 508			0		2.00 3.00
3.00 4.00	Additions (credit adjustments) (specify)	0	12, 421, 306		0	0	(	
5.00		0			0			5.00
6.00 7.00		0			0 0		(	
8.00		0			0			8.00
9.00 10.00	Total additions (sum of line 4-9)	0	0		0	0	(	9.00
11.00	Subtotal (line 3 plus line 10)		12, 421, 508			0		11.00
12.00 13.00	Deductions (debit adjustments) (specify)	0			0		(	12.00
13.00		0			0		(	
15.00		0			0			15.00
16. 00 17. 00		0			0		(	) 16.00 ) 17.00
	Total deductions (sum of lines 12-17)		0			0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		12, 421, 508			0		19.00
		Endowment Fund	PI ant	Fund				
		6.00	7.00	8.00				
1.00 2.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0			1.00
2.00 3.00	Total (sum of line 1 and line 2)	0			0			3.00
4.00	Additions (credit adjustments) (specify)		0					4.00
5.00 6.00			0					5.00 6.00
7.00			0					7.00
8.00 9.00			0					8.00 9.00
10.00	Total additions (sum of line 4-9)	0	-		0			10.00
11.00 12.00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0		0			11.00 12.00
13.00			0					13.00
14.00 15.00			0					14.00 15.00
16.00			0					16.00
17.00 18.00	Total deductions (sum of lines 12-17)	o	0		0			17.00 18.00
18.00 19.00	Fund balance at end of period per balance	0			0			18.00
	sheet (line 11 minus line 18)							I

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	AL HOSPITAL Provider CO	N. 15_1204	Peri od:	Worksheet G-2	2552-10
STATEN	ENT OF PATTENT REVENUES AND OPERATING EXPENSES		2N: 15-1304	From 01/01/2016 To 12/31/2016	Parts I & II	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
1 00	General Inpatient Routine Services		2 007 4	50	2 007 450	1 00
1.00 2.00	Hospital SUBPROVIDER - IPF		2, 897, 4	59	2, 897, 459	1.00
2.00	SUBPROVIDER - IPF SUBPROVIDER - IRF					3.00
3.00 4.00	SUBPROVIDER - TRF					4.00
4.00 5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		2, 897, 4	59	2, 897, 459	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT					11.00
12.00	CORONARY CARE UNI T					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)	-E 11		0	0	15.00
16.00	Total intensive care type inpatient hospital services (sum 11-15)	or times		0	0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and	16)	2, 897, 4	50	2, 897, 459	17.00
18.00	Ancillary services	10)	4, 952, 2		54, 690, 886	
19.00	Outpatient services		67,7		7, 894, 688	
20.00	RURAL HEALTH CLINIC			0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES			0 1, 107, 638	1, 107, 638	23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	OCCUPATIONAL MEDICINE			0 0	0	27.00
27.01	PHYSI CI AN REVENUE	0 1 111 1	624, 7			27.01
28.00	Total patient revenues (sum of lines 17-27)(transfer colum G-3, line 1)	n 3 to WKST.	8, 542, 2	44 66, 343, 818	74, 886, 062	28.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			30, 083, 255		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00 42.00	Total deductions (sum of lines 37-41)			0		41.00
4Z. UU	TITLES 37-41)			0		
43.00	Total operating expenses (sum of lines 29 and 36 minus lin	a 12) (transfor		30, 083, 255		43.00

STATEMENT OF REVENUES AND EXPENSES       Provider CCN: 15-1304       Period: From 01/01/2016       Worksheet G-3         1.00       Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)       1.00       1.00       1.00         1.00       Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)       74,886,062       1.00         2.00       Less contractual allowances and discounts on patients' accounts       47,217,855       2.00         3.00       Net patient revenues (from Wkst. G-2, Part II, line 43)       30,083,255       4.00         5.00       Net income from service to patients (line 3 minus line 4)       -2,415,048       5.00         6.00       Contributions, donations, bequests, etc       0       6.00       7.00         0.00       Revenues from telephone and other miscellaneous communication services       0       9.00       8.00         0.00       Revenues from telephone and other miscellaneous communication services       0       1.00       10.00         1.00       Revenue from rental of expenses       0       1.00       10.00       10.00         1.00       Revenue from metal of living quarters       0       1.00       10.00         1.00       Revenue from sell of medical metrods and abstracts       0       11.00       12.00         1.00	Heal th	Financial Systems RU	USH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
To         12/31/2016         Date/Time Prepared: 6/28/2017 3:42 pm           1.00         Total patient revenues (from Wkst. 6-2, Part I, column 3, Line 28)         1.00         1.00           2.00         Less contractual allowances and discusto no patients' accounts         47,886,062         1.00           2.00         Less total operating expenses (from Wkst. 6-2, Part II, line 43)         27,668,207         3.00           3.00         Less total operating expenses (from Wkst. 6-2, Part II, line 43)         -2,415,048         5.00           0.00         Less total operating expenses (from Wkst. 6-2, Part II, line 43)         -2,415,048         5.00           0.01         Income from investments         0         6.00         0.01         1.00           0.01         Income from investments         0         7.00         1.00         8.00           0.00         Purchase discounts         0         1.00         1.00         1.00           1.00         Purchase discounts         0         1.00         1.00 <tr< td=""><td>STATE</td><td>IENT OF REVENUES AND EXPENSES</td><td>Provider CCN: 15-1304</td><td></td><td>Worksheet G-3</td><td></td></tr<>	STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-1304		Worksheet G-3	
Image: constraint of the second sec					Date/Time Pre	nared
1.00Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)74,866,0621.002.00Less contractual allowances and discounts on patients' accounts47,217,8552.003.00Less total operating expenses (from Wkst. G-2, Part II, line 43)30,083,2554.005.00Net income from service to patients (line 3 minus line 4)-2,415,0485.000.01Income from investments0-2,2415,0485.006.00Contributions, donations, bequests, etc07.007.00Income from investments07.008.00Revenue From television and radio service09.009.00Purchase discounts011.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts011.0013.00Revenue from rental of living quarters013.0014.00Revenue from sale of medical and surgical supplies to other than patients015.0016.00Revenue from sale of medical necords and abstracts018.0019.0010.00Retail of hospital space012.0018.0010.00Retail of hospital space012.0012.0012.00Retail of hospital space012.0013.00Revenue from sale of medical and surgical supplies to other than patients016.0010.00Revenue from sale of medical and surgical supplies to other than patients016.0013.00Revenue from sale of medical and surgical suppl				10 12/31/2010		
1.00Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)74,866,0621.002.00Less contractual allowances and discounts on patients' accounts47,217,8552.003.00Less total operating expenses (from Wkst. G-2, Part II, line 43)30,083,2554.005.00Net income from service to patients (line 3 minus line 4)-2,415,0485.000.01Income from investments0-2,2415,0485.006.00Contributions, donations, bequests, etc07.007.00Income from investments07.008.00Revenue From television and radio service09.009.00Purchase discounts011.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts011.0013.00Revenue from rental of living quarters013.0014.00Revenue from sale of medical and surgical supplies to other than patients015.0016.00Revenue from sale of medical necords and abstracts018.0019.0010.00Retail of hospital space012.0018.0010.00Retail of hospital space012.0012.0012.00Retail of hospital space012.0013.00Revenue from sale of medical and surgical supplies to other than patients016.0010.00Revenue from sale of medical and surgical supplies to other than patients016.0013.00Revenue from sale of medical and surgical suppl						
2.00Less contractual allowances and discounts on patients' accounts47,217,8552.003.00Net patient revenues (line 1 minus line 2)27,668,2073.004.00Less total operating expenses (from Wkst. G-2, Part II, line 43)30,083,2554.005.00Net income from service to patients (line 3 minus line 4)-2,415,0485.000.11RER INCOME0-2,415,0485.006.00Contributions, donations, bequests, etc06.007.00Income from telephone and other miscellaneous communication services08.009.00Revenues from telephone and other miscellaneous communication services09.0010.00Purchase discounts011.0010.00Parking lot receipts011.0011.00Revenue from meals sold to employees and guests012.0012.00Revenue from sale of medical and surgical supplies to other than patients014.0013.00Revenue from sale of frugs to other than patients017.0014.00Revenue from gifts, flowers, coffee shops, and canteen021.0010.00Revalid of hospital space021.0021.00Revalid for opting tions22.0022.0022.00Retal of hospital space021.0023.00Revenue from sale of medical records and abstracts012.0020.00Revenue from gifts, flowers, coffee shops, and canteen021.0021.00Revenue from gifts, flowers, coffee shops, and canteen0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
3.00Net patient revenues (line 1 minus line 2)27,668,2073.004.00Less total operating expenses (from Wkst. G-2, Part II, line 43)30,083,2554.000.00DTHER INCOME-2,415,04800.01Income from investments06.001.00Revenues from tel explainents (line 3 minus line 4)07.008.00Revenues from tel explainents06.001.00Revenues from tel explainents08.009.00Purchase discounts09.0010.00Purchase discounts09.0011.00Rebates and refunds of expenses010.0011.00Revenue from netal sold to employees and guests012.0013.00Revenue from meals sold to employees and guests013.0014.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of medical ecords and abstracts018.0018.00Revenue from sale of textbooks, uniforms, etc.)019.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)019.0020.00Rental of vending machines021.0021.00Rental of hospital space022.0022.00Rental of hospital space022.0022.00Rental of hospital space22.0022.00Total other interes (Sepecify)32.0022.00Total other interes (Sepecify)355,89823.00Total other expene						
4.00Less total operating expenses (from Wkst. G-2, Part II, line 43)30,083,2554.00Net income from service to patients (line 3 minus line 4)-2,415,0485.00OTHER INCOME-2,415,0486.007.00Income from investments07.008.00Revenues from telephone and other miscel laneous communication services08.009.00Revenue from television and radio service09.0011.00Rebates and refunds of expenses010.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts013.0013.00Revenue from mela sold to employees and guests014.0015.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of fundical and surgical supplies to other than patients018.0018.00Revenue from sale of textbooks, uniforms, etc.)019.0010.00Revenue from gifts, flowers, coffee shops, and canteen021.0022.00Rental of hospital space022.0023.00Governmental appropriations022.0024.00Total other income (sum of lines 6-24)32.27025.00Total other expenses (sum of line 27 and subscripts)028.00Total other expenses (sum of line 27 and subscripts)0			ients'accounts			
5.00Net income from service to patients (line 3 minus line 4)2,415,0485.00OTHER INCOMEOTHER INCOME06.000.00Income from investments07.008.00Revenues from telephone and other miscel aneous communication services08.009.00Revenues from television and radio service09.0010.00Purchase discounts010.0011.00Rebates and refunds of expenses010.0012.00Parking lot receipts012.0013.00Revenue from laundry and linen service013.0014.00Revenue from rental of living quarters014.0015.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of medical records and abstracts018.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)019.0020.00Rental of vending machines021.0021.00Rental of vending machines021.0022.00Rental of bospital space022.0023.00Cordermental appropriations022.0024.00OTHER OPERATING EXPENSES/INCOME2,719,11924.0025.00Total other expenses (sum of lines 6-24)3.270,94625.0026.00Total other expenses (sum of line 27 and subscripts)027.00						
OTHER I NCOME6.00Contributions, donations, bequests, etc07.00Income from investments08.00Revenues from telephone and other miscellaneous communication services09.00Revenue from television and radio service010.00Purchase discounts011.00Rebates and refunds of expenses012.00Parking lot receipts013.00Revenue from laundry and linen service014.00Revenue from sale of medical and surgical supplies to other than patients015.00Revenue from sale of medical and surgical supplies to other than patients017.00Revenue from sale of medical records and abstracts019.00Tuit ion (fees, sale of textbooks, uniforms, etc.)020.00Rental of vending machines021.00Rental of hospital space022.00Reval properations023.00Governmental appropriations024.00THER EXPENSES/I NCOME2,719,11924.00Total other income (sum of lines 6-24)3,270,94625.00Total other expenses (sum of line 27 and subscripts)020.01Total other expenses (sum of line 27 and subscripts)0						
6.00Contributions, donations, bequests, etc06.007.00Income from investments07.008.00Revenues from television and radio service09.009.00Revenue from television and radio service09.0010.00Purchase discounts010.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts012.0013.00Revenue from meals sold to employees and guests013.0015.00Revenue from sale of medical surgical supplies to other than patients015.0016.00Revenue from sale of medical records and abstracts016.0017.00Revenue from gifts, flowers, coffee shops, and canteen017.0019.00Cuernmetal appropriations021.0022.00Rental of hospital space022.0023.00Governmental appropriations022.0024.01NO-OPERATING EXPENSES/INCOME22.0051.82725.00Total other income (sum of lines 6-24)3.270.94625.0026.00Total other expenses (sum of line 27 and subscripts)028.00	5.00		s line 4)		-2, 415, 048	5.00
7.00       Income from investments       0       7.00         8.00       Revenues from telephone and other miscellaneous communication services       0       8.00         9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from rental of living quarters       0       14.00         15.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of medical records and abstracts       0       17.00         18.00       Revenue from gifts, flowers, coffee shops, and canteen       0       19.00         10.00       Rental of hospital space       0       21.00         21.00       Rental of obspital space       0       22.00         22.00       Rental of hospital space       0       23.00         22.00       Total other income (sum of lines 6-24)       3, 270.94       25.00         25.00       Total other inco					-	
8.00Revenues from telephone and other miscel laneous communication services08.009.00Revenue from television and radio service09.0010.00Purchase discounts010.0011.00Rebates and refunds of expenses011.0012.00Parking lot receipts012.0013.00Revenue from meals sold to employees and guests014.0015.00Revenue from rental of living quarters015.0016.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of medical records and abstracts018.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)019.0020.00Revanue from gifts, flowers, coffee shops, and canteen020.0021.00Revalue from grantal spopriations021.0022.00Rental of hospital space021.0023.00Governmental appropriations021.0024.00OTHER OPERATING EXPENSES/INCOME25.0123.0024.00Total other income (sum of lines 6-24)3,270,94625.0025.00Total (line 5 plus line 25)027.00855,89826.0026.00Total (line sexpenses (sum of line 27 and subscripts)028.0028.00						
9.00       Revenue from television and radio service       0       9.00         10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from rental of living quarters       0       14.00         15.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Rental of hospital space       0       21.00         21.00       Retal of hospital space       0       23.00         22.00       Retal of hospital space       0       23.00         23.00       Governmental appropriations       0       23.00         24.01       NON-DPERATING EXPENSES/INCOME       2,719,119       24.01         25.00       Total other income (sum of lines 6-24)       3,270,946       25.00         26.00       Total (line 5 plus line 25)       855,8					-	
10.00       Purchase discounts       0       10.00         11.00       Rebates and refunds of expenses       0       11.00         12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       0       14.00         15.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       17.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       18.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       21.00         21.00       Revalue from patients       0       21.00         22.00       Revenue from gifts, flowers, coffee shops, and canteen       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropri ations       0       23.00         24.00       OTHER OPERATING EXPENSES/INCOME       27.19, 119       24.00         25.00 <td></td> <td></td> <td>communication services</td> <td></td> <td>-</td> <td></td>			communication services		-	
11.00Rebates and refunds of expenses011.0012.00Parking lot receipts012.0013.00Revenue from laundry and linen service013.0014.00Revenue from meals sold to employees and guests014.0015.00Revenue from rental of living quarters015.0016.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of drugs to other than patients018.0018.00Revenue from gifts, flowers, coffee shops, and canteen019.0020.00Revenue from gifts, flowers, coffee shops, and canteen020.0021.00Rental of vending machines021.0023.00Governmental appropriations022.0024.01NON-OPERATI NG EXPENSES/INCOME2, 719, 11924. 0025.00Total other income (sum of lines 6-24)3, 270, 94625.0026.00Total (line 5 plus line 25)855, 89826.0028.00Total other expenses (sum of line 27 and subscripts)028.00					-	
12.00       Parking lot receipts       0       12.00         13.00       Revenue from laundry and linen service       0       13.00         14.00       Revenue from meals sold to employees and guests       0       13.00         15.00       Revenue from real of living quarters       0       14.00         16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of medical records and abstracts       0       17.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       23.00       22.00         24.01       NON-OPERATING EXPENSES/INCOME       2,719,119       24.00         25.00       Total other income (sum of lines 6-24)       3,270,946       25.00         26.00       Total (line 5 plus line 25)       0       27.00       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00					-	
13.00Revenue from laundry and linen service013.0014.00Revenue from meals sold to employees and guests014.0015.00Revenue from rental of living quarters015.0016.00Revenue from sale of medical and surgical supplies to other than patients015.0017.00Revenue from sale of drugs to other than patients017.0018.00Revenue from sale of textbooks, uniforms, etc.)018.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)019.0020.00Revenue from gifts, flowers, coffee shops, and canteen020.0021.00Rental of vending machines022.0023.00Governmental appropriations023.0024.00OTHER OPERATING EXPENSES/INCOME2,719,11924.0024.01NON-OPERATING EXPENSES/INCOME3,270,94625.0025.00Total other income (sum of lines 6-24)3,270,94625.0027.00OTHER EXPENSES (SPECIFY)027.0028.00Total other expenses (sum of line 27 and subscripts)028.00					-	
14.00Revenue from meals sold to employees and guests014.0015.00Revenue from rental of living quarters015.0016.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of medical records and abstracts018.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)019.0020.00Revenue from gifts, flowers, coffee shops, and canteen020.0021.00Rental of vending machines021.0022.00Rental of hospital space023.0023.00Governmental appropriations023.0024.01NON-OPERATING EXPENSES/INCOME2,719,11924.0025.00Total other income (sum of lines 6-24)3,270,94625.0027.00OTHER EXPENSES (SPECIFY)027.0028.00Total other expenses (sum of line 27 and subscripts)028.00					-	
15.00Revenue from rental of living quarters015.0016.00Revenue from sale of medical and surgical supplies to other than patients016.0017.00Revenue from sale of drugs to other than patients017.0018.00Revenue from sale of medical records and abstracts018.0019.00Tuition (fees, sale of textbooks, uniforms, etc.)019.0020.00Revenue from gifts, flowers, coffee shops, and canteen020.0021.00Rental of vending machines021.0022.00Rental of hospital space023.0024.00OTHER OPERATING EXPENSES/INCOME2,719,11924.0024.01NON-OPERATING EXPENSES/INCOME551,82724.0125.00Total other income (sum of lines 6-24)3,270,94625.0026.00Total other expenses (sum of line 27 and subscripts)028.00					-	
16.00       Revenue from sale of medical and surgical supplies to other than patients       0       16.00         17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING EXPENSES/INCOME       2, 719, 119       24.00         24.01       NON-OPERATING EXPENSES/INCOME       3, 270, 946       25.00         25.00       Total other income (sum of lines 6-24)       3, 270, 946       25.00         26.00       Total other expenses (sum of line 27 and subscripts)       0       27.00       28.00					-	
17.00       Revenue from sale of drugs to other than patients       0       17.00         18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       18.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.01       NON-OPERATING EXPENSES/INCOME       2, 719, 119       24.00         24.01       NON-OPERATING EXPENSES/INCOME       551, 827       24.01         25.00       Total other income (sum of lines 6-24)       3, 270, 946       25.00         26.00       Total (line 5 plus line 25)       855, 898       26.00         27.00       28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00					-	
18.00       Revenue from sale of medical records and abstracts       0       18.00         19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING EXPENSES/INCOME       2,719,119       24.00         24.01       NON-OPERATING EXPENSES/INCOME       551,827       24.01         25.00       Total other income (sum of lines 6-24)       3,270,946       25.00         26.00       Total (line 5 plus line 25)       855,898       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00					-	
19.00       Tuition (fees, sale of textbooks, uniforms, etc.)       0       19.00         20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING EXPENSES/INCOME       2,719,119       24.00         25.00       Total other income (sum of lines 6-24)       3,270,946       25.00         26.00       Total (line 5 plus line 25)       855,898       26.00         27.00       OTHER EXPENSES (SPECI FY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00					-	
20.00       Revenue from gifts, flowers, coffee shops, and canteen       0       20.00         21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING EXPENSES/INCOME       2,719,119       24.00         24.01       NON-OPERATING EXPENSES/INCOME       2,719,119       24.00         25.00       Total other income (sum of lines 6-24)       3,270,946       25.00         26.00       Total (line 5 plus line 25)       855,898       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00					-	
21.00       Rental of vending machines       0       21.00         22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING EXPENSES/INCOME       2,719,119       24.00         24.01       NON-OPERATING EXPENSES/INCOME       2,719,119       24.00         25.00       Total other income (sum of lines 6-24)       3,270,946       25.00         26.00       Total (line 5 plus line 25)       855,898       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00					-	
22.00       Rental of hospital space       0       22.00         23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING EXPENSES/INCOME       2,719,119       24.00         24.01       NON-OPERATING EXPENSES/INCOME       2,719,119       24.00         25.00       Total other income (sum of lines 6-24)       3,270,946       25.00         26.00       Total (line 5 plus line 25)       855,898       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00			anteen		-	
23.00       Governmental appropriations       0       23.00         24.00       OTHER OPERATING EXPENSES/INCOME       2,719,119       24.00         24.01       NON-OPERATING EXPENSES/INCOME       551,827       24.01         25.00       Total other income (sum of lines 6-24)       3,270,946       25.00         26.00       Total (line 5 plus line 25)       855,898       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00					-	
24.00       OTHER OPERATING EXPENSES/INCOME       2, 719, 119       24.00         24.01       NON-OPERATING EXPENSES/INCOME       551, 827       24.01         25.00       Total other income (sum of lines 6-24)       3, 270, 946       25.00         26.00       Total (line 5 plus line 25)       855, 898       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00					-	
24. 01       NON-OPERATING EXPENSES/INCOME       551, 827       24. 01         25. 00       Total other income (sum of lines 6-24)       3, 270, 946       25. 00         26. 00       Total (line 5 plus line 25)       855, 898       26. 00         27. 00       OTHER EXPENSES (SPECIFY)       0       27. 00         28. 00       Total other expenses (sum of line 27 and subscripts)       0       28. 00					-	
25.00       Total other income (sum of lines 6-24)       3, 270, 946       25.00         26.00       Total (line 5 plus line 25)       855, 898       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00						
26.00       Total (line 5 plus line 25)       855,898       26.00         27.00       OTHER EXPENSES (SPECIFY)       0       27.00         28.00       Total other expenses (sum of line 27 and subscripts)       0       28.00						
27.00         OTHER EXPENSES (SPECIFY)         0         27.00           28.00         Total other expenses (sum of line 27 and subscripts)         0         28.00						
28.00Total other expenses (sum of line 27 and subscripts)028.00						
			nts)		-	
$23.00$ invertinguine tor ross) for the period (time zo minus time $z\delta$ ) ( $855.8981.29.00$		Net income (or loss) for the period (line 26 minu			-	