PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RUSH MEMORIAL HOSPITAL (15-1304) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned)	
	Officer or Administrator of Provider(s)
Title	
Date	

number of times reopened = 0-9.

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	330, 005	-426, 997	0	182, 992	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	41, 053	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	371, 058	-426, 997	0	182, 992	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1304 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/23/2018 4:25 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1300 NORTH MAIN STREET 1.00 1.00 PO Box: State: IN 2.00 City: RUSHVILLE Zip Code: 46173-County: RUSH 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fied Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal RUSH MEMORIAL HOSPITAL 151304 99915 08/01/2000 N 0 3.00 Subprovider - IPF 4.00 4.00 Subprovi der - IRF 5.00 5 00 Subprovider - (Other) 6.00 6.00 Swing Beds - SNF 7.00 RUSH SWING BEDS 15Z304 99915 08/01/2000 N 0 N 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 Hospi tal -Based HHA 12.00 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 15.00 Hospital - Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 01/01/2017 20.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2017 20 00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 22.00 N share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this cost reporting Ν 22.01 Ν period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2, or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this

	i, enter it i date of admission, 2 it census days, or	3 II date	or di schar	ge. is the				
	method of identifying the days in this cost reporting	g period dit	fferent fro	om the metho	od			
	used in the prior cost reporting period? In column 2	2, enter "Y	' for yes c	or "N" for r	no.			
	<u> </u>	In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	pai d days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6.00	
24. 00	If this provider is an IPPS hospital, enter the	0	0	0	0	(0 0	24. 00
	in-state Medicaid paid days in column 1, in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid paid days in column 3,							
	out-of-state Medicaid eligible unpaid days in column							
	4, Medicaid HMO paid and eligible but unpaid days in							
	column 5, and other Medicaid days in column 6.							
25.00	If this provider is an IRF, enter the in-state	o	0	0	0	(ol	25. 00
	Medicaid paid days in column 1, the in-state							
	Medicaid eligible unpaid days in column 2,							
	out-of-state Medicaid days in column 3, out-of-state							
	Medicaid eligible unpaid days in column 4, Medicaid							
	HMO paid and eligible but unpaid days in column 5.							
				•	•		•	

23.00

hospital contain at least 100 but not more than 499 beds (as counted in accordance with

1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the

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

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

	TAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DATA F		HOSPI TAL Provi der Co	CN: 15-1304	Peri od:	wof Form CMS-: Worksheet S-2	
	THE AND HOST THE HEALTH GARE GOW	LEX TEENTITION DA	ii.			From 01/01/2017 To 12/31/2017	Part I	pared:
			Y/N	IME	Direct GME	I ME	Direct GME	
			1. 00	2. 00	3. 00	4. 00	5. 00	
61. 04	surgery allopathic and/or osteop current cost reporting period. (s	eathic FTEs in the see instructions).						61. 04
51. 05	Enter the difference between the and/or general surgery FTEs and primary care and/or general surgent 61.04 minus line 61.03). (see in	the current year's pery FTE counts (line						61. 05
61. 06	Enter the amount of ACA \$5503 avused for cap relief and/or FTEs care or general surgery. (see in	vard that is being that are nonprimary						61. 06
				ogram Name	Program Code		Unweighted Direct GME FTE Count	
	00.11 575 1 11 14 05		1.00			3.00	4. 00	
61. 10	Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instruction in the program name. Enter program code. Enter in column 3, unweighted count. Enter in column FTE unweighted count.	er of FTE residents cuctions) Enter in er in column 2, the the IME FTE				0.00	0.00	61. 10
61. 20	Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog- instructions) Enter in column 1, Enter in column 2, the program of 3, the IME FTE unweighted count. the direct GME FTE unweighted count.	he number of FTE gram. (see the program name. code. Enter in column Enter in column 4,				0.00	0.00	61. 20
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)								
62. 00	Enter the number of FTE resident	s that your hospital	trai nec			riod for which	1.00	62. 00
	Enter the number of FTE resident your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting pe	s that your hospital funding (see instructs s that rotated from a priod of HRSA THC prog	trainec ctions) a Teachi gram. (s	l in this cost ng Health Cen see instruction	reporting per ter (THC) into		0.00	62. 00
62. 01	Enter the number of FTE resident your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re Has your facility trained reside	s that your hospital funding (see instructs that rotated from a strict of the strict o	trained ctions) a Teachi gram. (s er Setti ettings	ng Health Censee instruction ngs during this c	reporting per ter (THC) intons) ost reporting	your hospital period? Enter	0.00	
62. 01	Enter the number of FTE resident your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re	s that your hospital funding (see instructs that rotated from a strict of the strict o	trained ctions) a Teachi gram. (s er Setti ettings	ng Health Censee instruction ngs during this c	reporting per ter (THC) into ns) ost reporting 67. (see insti Unweighted FTEs Nonprovider	peri od? Enter- ructions) Unwei ghted FTEs in	0.00	62. 01
62. 01	Enter the number of FTE resident your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting pe Teaching Hospitals that Claim Re Has your facility trained reside	s that your hospital funding (see instructs that rotated from a strict of the strict o	trained ctions) a Teachi gram. (s er Setti ettings	ng Health Censee instruction ngs during this c	reporting per ter (THC) into ns) ost reporting 67. (see insti Unweighted FTEs Nonprovider Site	peri od? Enter-ucti ons) Unwei ghted FTEs in Hospi tal	0.00 0.00 N Ratio (col. 1/ (col. 1 + col. 2))	62. 01
62. 01	Enter the number of FTE resident your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting per Teaching Hospitals that Claim Re Has your facility trained reside "Y" for yes or "N" for no in col	s that your hospital funding (see instructions that rotated from a firit od of HRSA THC progesidents in Nonprovider secumn 1. If yes, complete	trained ctions) a Teachi gram. (s er Setti ettings ete line	I in this cost ng Health Cen see instruction ngs during this cost es 64 through	reporting per ter (THC) into ns) ost reporting 67. (see instr Unweighted FTEs Nonprovider Site 1.00	period? Enterructions) Unweighted FTEs in Hospital 2.00	0.00 0.00 N Ratio (col. 1/ (col. 1 + col. 2))	62. 01
62. 01	Enter the number of FTE resident your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting perseating Hospitals that Claim Reflas your facility trained reside "Y" for yes or "N" for no in col	s that your hospital funding (see instruct shat rotated from a cried of HRSA THC progressidents in Nonprovider secumn 1. If yes, complete the complete for the	trained ctions) a Teachi gram. (s er Setti ettings ete line	In this cost In	reporting per ter (THC) into ns) ost reporting 67. (see instr Unweighted FTEs Nonprovider Site 1.00 This base yea	period? Enter-uctions) Unweighted FTEs in Hospital 2.00 r is your cost r	0.00 0.00 N Ratio (col. 1/ (col. 1 + col. 2)) 3.00	62.01
62. 01	Enter the number of FTE resident your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting per Teaching Hospitals that Claim Researching Has your facility trained reside "Y" for yes or "N" for no in color "Y" for yes or "N" for no in color that begins on or after senter in column 1, if line 63 is in the base year period, the number ident FTEs attributable to resident FTEs attributable to resident senter in column 1.	s that your hospital funding (see instructs that rotated from a period of HRSA THC progresidents in Nonprovider secumn 1. If yes, complete the progression of the pro	trainections) a Teachi gram. (ser Setti ettings ete line comprovid re June ty trair n-primar all nor	In this cost In	reporting per ter (THC) into ns) ost reporting 67. (see instr Unweighted FTEs Nonprovider Site 1.00	period? Enter-uctions) Unweighted FTEs in Hospital 2.00 r is your cost r	0.00 0.00 N Ratio (col. 1/ (col. 1 + col. 2)) 3.00	62.01
62. 01	Enter the number of FTE resident your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting per Teaching Hospitals that Claim Reflas your facility trained reside "Y" for yes or "N" for no in col "Y" for yes or "N" for no in col in the base year period that begins on or after Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in your period that the settings that trained in your hospitals are settings.	s that your hospital funding (see instruct that rotated from a rotated from a rotated from a find of HRSA THC programmers in Nonprovider secumn 1. If yes, complete that it is a secure of unweighted nor that ions occurring in a number of unweighted for the funding that is the funding that is the formal court in the number of unweighted for the funding that is that it is th	trainections) a Teachi gram. (seer Setti ettings ete line onprovice re June ty train -primar all non dinon-princolumn	der Settings- 30, 2010. der seidents der settings- ing this control to the set of the s	reporting per ter (THC) into ns) ost reporting 67. (see instr Unweighted FTEs Nonprovider Site 1.00 This base yea	period? Enter-uctions) Unweighted FTEs in Hospital 2.00 r is your cost r	0.00 0.00 N Ratio (col. 1/ (col. 1 + col. 2)) 3.00	62.01
62. 01	Enter the number of FTE resident your hospital received HRSA PCRE Enter the number of FTE resident during in this cost reporting per Teaching Hospitals that Claim Re Has your facility trained reside "Y" for yes or "N" for no in col "Y" for yes or "N" for no in col Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to resettings. Enter in column 2 the	s that your hospital funding (see instruct that rotated from a rotated from a rotated from a find of HRSA THC programmers in Nonprovider secumn 1. If yes, complete that it is a secure of unweighted nor that ions occurring in a number of unweighted for the funding that is the funding that is the formal court in the number of unweighted for the funding that is that it is th	trainections) a Teachi gram. (see Setti ettings ete line comprovide ty train n-primar all nor d non-pr n column instruc	der Settings- 30, 2010. der seidents der settings- ing this control to the set of the s	reporting per ter (THC) into ns) ost reporting 67. (see instr Unweighted FTEs Nonprovider Site 1.00 This base yea	peri od? Enter ructions) Unwei ghted FTEs in Hospital 2.00 r is your cost r 00 Unwei ghted FTEs in	0.00 0.00 N Ratio (col. 1/ (col. 1 + col. 2)) 3.00	63.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1304 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/23/2018 4:25 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO	CN: 15-1304	Peri od: From 01/01/2017 To 12/31/2017	Worksheet S- Part I Date/Time Pr 5/23/2018 4:	epared:
					1. 00	
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00
5. 00 6. 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 0 86. 0
	Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l classified u	under sectio	n	N	87. 0
	1.00 (a) (1) (b) (1.7) 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0			V 1. 00	XI X 2. 00	
	Title V and XIX Services	F-	\/			00.0
	Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	i services? Ei	nter "Y" for	N	Y	90.0
	Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the appli	N	N	91. 0		
	00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see					
3. 00	instructions) Enter "Y" for yes or "N" for no in the applical Does this facility operate an ICF/IID facility for purposes o		d XIX? Enter	N	N	93. 0
	"Y" for yes or "N" for no in the applicable column.					04.0
4.00	applicable column.	N	N	94.0		
	00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0. 00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the					95. 0 96. 0
	applicable column.					
8. 00	00 If line 96 is "Y", enter the reduction percentage in the applicable column. 00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in					97. 0
8. 01	column 1 for title V, and in column 2 for title XIX. 1 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for					98. 0
8. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or			Y	Y	98. 0
8. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a criti reimbursed 101% of inpatient services cost? Enter "Y" for yes				N	98. 0
8. 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH i outpatient services cost? Enter "Y" for yes or "N" for no in			N d	N	98. 0
8. 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add bad Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co				Y	98. 0
8. 06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost : Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98. 0
	Rural Providers					105 0
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all-i	inclusive metH	nod of payme	nt Y		105. 0 106. 0
for outpatient services? (see instructions) 07.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for L&R 1. Training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If 1. Yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost						107. 0
00 .80	reimbursed. If yes complete Wkst. D-2, Pt. II. 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	dul e? See 4	2 N		108. 0
		Physi cal	Occupation		Respi ratory	
09. 00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	1. 00 Y	2.00 N	3. 00 Y	4. 00 N	109. 0

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-13		eriod: rom 01/01/ o 12/31/		Workshe Part I Date/Ti 5/23/20	me Pro	epared:
			1. 00		2.0	00	-
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is participated all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	st reporting period? umn 1 is Y, enter th ticipating in column	Enter e 2.	N				111.0
				1. 00	2. 00	3. 00	
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" 1	If column 2 is "E", t for long term care s) based on the defin for yes or "N" for no	enter i (includ ition i	n column les n CMS	N N		0	115. 0
17.00 s this facility legally-required to carry malpractice insurance no.	, and the second se			Y 1			117. 0
18.00 s the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence.							118.0
	Prem	iums	Losses	5	Insura	ance	
	1.0	00	2.00		3. 0	00	-
18.01 List amounts of malpractice premiums and paid losses:		91, 951		0			0 118. 0
			1. 00		2.0	00	
18.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Harmless provision in ACA §3121 and applicable amendments?	Harmless provision i column 1, "Y" for yealifies for the Outpa	ers n ACA s or tient	N N		N		118. C
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implan	ntable devices charge	d to	Y				121. (
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			N				122. (
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N" for no.	lf	N				 125. (
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, en		date					126. (
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, entering in column 1 and termination date, if applicable, in column 2.	er the certification	date					127. (
28.00 If this is a Medicare certified liver transplant center, ente in column 1 and termination date, if applicable, in column 2.	er the certification	date					128.
29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	the certification d						129.
0.00 If this is a Medicare certified pancreas transplant center, and date in column 1 and termination date, if applicable, in column 1	umn 2.						130.
(1.00) If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 2.00 If this is a Medicare certified is let transplant center, enternal and the center of the cen	umn 2.						131.
(2.00) If this is a Medicare certified islet transplant center, entoin column 1 and termination date, if applicable, in column 2. (3.00) If this is a Medicare certified other transplant center, entoin manager and the context of the cont							132.
in column 1 and termination date, if applicable, in column 2. 4.00 of this is an organ procurement organization (000), enter the							134.
and termination date, if applicable, in column 2. All Providers							
10.00 Are there any related organization or home office costs as de	efined in CMC Dub. 1E	-1	N				140.

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1304 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: To 5/23/2018 4:25 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143. 00 Ci ty: State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν N 148 00 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N N 155.00 156.00 Subprovider - IPF Ν Ν Ν Ν 156.00 157.00 Subprovi der - IRF 157 00 N Ν Ν N 158. 00 SUBPROVI DER 158. 00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160. 00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161. 00 1.00 Multicampus 165.00 s this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00

reasonable cost incurred for the HIT assets (see instructions)			
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a	hardshi p		168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)			
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N	"), enter the	0.00	169. 00
transition factor. (see instructions)			
	Begi nni ng	Endi ng	
	1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting	01/01/2017	12/31/2017	170. 00
period respectively (mm/dd/yyyy)			
	1. 00	2.00	
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in	N	(171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section			
1876 Medicare days in column 2. (see instructions)			

167 00

0168.00

Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act

168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the

167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1304 Peri od: Worksheet S-2 From 01/01/2017 Part II Date/Time Prepared: 12/31/2017 5/23/2018 4:25 pm Date 1. 00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1. 00 2. 00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Υ Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 N 7 00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the N 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 N 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Ν 15.00 see instructions Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data Was the cost report prepared using $\overline{\text{the PS\&R Report onl y?}}$ 04/10/2018 04/10/2018 16.00 Υ 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for Ν N 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 19.00 N Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

BOSPITAL AND HOSPITAL HEALTH CARE RELIMBLESTIGNT QUESTIONNAIRE Provider COX: 15-1304 Perford: From 01/17/2017 Perform 01/2017/2017 Perform 01/2017/2017/2017 Perform 01/2017/2017/2017/2017/2017/2017/2017/20	Heal th	Financial Systems RUSH MEMORIA	AL HOSPITAL		In Lie	u of Form CN	IS-2552-10
Bescription	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1304	From 01/01/2017	Part II Date/Time F	Prepared:
Provided Section 17 Its yes, were adjustments ander to PSAR N N D.0.00			Descr	ipti on	Y/N		1. 20 piii
Report data for Other? Describe the other adjustments: Y/N Bate Y/N Bate		-	()			
Y/N Date Y/N	20. 00				N	N	20. 00
21.00 Was the cost report prepared only using the provider's N N 21.00 records? If yes, see instructions. COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)			Y/N	Date	Y/N	Date	
records? If yes, see Instructions. COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 22.00 Have changes occurred in the Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 22.00 1.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 22.00 1.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 1.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 22.00 1.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 22.00 1.00 Have changes occurred in the Medicare depreciation during the cost reporting period? If yes, see N 25.00 N 26.00 Have changes occurred in the Medicare during the cost reporting period? If yes, see N 26.00 N 27.00 Have there been new capitalization policy changed during the cost reporting period? If yes, see N 26.00 N 27.00 Have she provider's capitalization policy changed during the cost reporting period? If yes, submit to the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 27.00 N 28.00 Have real loans, mortgage agreements or letters of credit entered into during the cost reporting to the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 28.00 N 29.00 Hid the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Y 29.00 N 29.00 Hid the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Y 29.00 N 29.00 Hid the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Y 29.00 N 29.00 Hid the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 Hid the provider have a funded depreciation account and/or bond				2.00		4. 00	
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arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If No., see instructions. Provider-Based Physicians 33.00 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. 7 34.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based No. 15.00 Were home office cost reporting period? If yes, see instructions. Home Office Costs							
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If N see instructions. 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? Y see instructions. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N see instructions. N	32. 00			d through co	ontractual	N	32. 00
34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 physicians during the cost reporting period? If yes, see instructions. N	33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app		g to competi	tive bidding? If	N	33. 00
If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00							
physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00	34. 00		rrangement with	provi der-ba	sed physicians?	Y	34. 00
Home Office Costs 36. 00 Were home office costs claimed on the cost report? N 36. 00 37. 00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 37. 00 16 Ine 36 is yes, has a home office cost statement been prepared by the home office? N 37. 00 18 Ine 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. N 38. 00 38. 00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. N 39. 00 40. 00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40. 00 40. 00 Instructions. N 40. 00 41. 00 Cost Report Preparer Contact Information	35. 00			its with the	provi der-based	N	35. 00
Home Office Costs 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 41.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report BLUE & CO., LLC preparer. 43.00 Enter the telephone number and email address of the cost 317-633-4705 LHACKETT@BLUEANDCO.COM 43.00		property of the second			Y/N	Date	
36.00 37.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? N 37.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 41.00 Enter the employer/company name of the cost report preparer. 42.00 Enter the telephone number and email address of the cost 317-633-4705 LHACKETT@BLUEANDCO.COM 43.00 Enter the telephone number and email address of the cost 317-633-4705					1. 00	2. 00	
37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 16 yes, see instructions. 17 Iine 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 18 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 19 If line 36 is yes, did the provider render services to the home office? If yes, see 10 If line 36 is yes, did the provider render services to the home office? If yes, see 10 If line 36 is yes, did the provider render services to the home office? If yes, see 10 If line 36 is yes, did the provider render services to the home office? If yes, see 10 If line 36 is yes, did the provider render services to the home office? If yes, see 10 If line 36 is yes, did the provider render services to the home office? If yes, see N 10 If line 36 is yes, did the provider render services to the home office? If yes, see N 10 If line 36 is yes, did the provider render services to the home office? If yes, see N 10 If line 36 is yes, did the provider render services to the home office? If yes, see N 10 If line 36 is yes, did the provider render services to the home office? If yes, see N 10 If line 36 is yes, did the provider render services to the home office. N 10 If line 36 is yes, did the provider render services to other chain components? If yes, see N 10 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 10 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. N 10 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. N 10 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. N 10 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. N 10 If line 36 is yes,	27.00						24.00
38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 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, respectively. Enter the employer/company name of the cost report BLUE & CO., LLC 42.00 preparer. BLUE & CO., LLC LHACKETT@BLUEANDCO.COM 43.00		If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			36. 00 37. 00
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report BLUE & CO. , LLC 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 317-633-4705 LHACKETT@BLUEANDCO. COM 43.00	38. 00	If line 36 is yes , was the fiscal year end of the home off			- N		38. 00
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 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, respectively. 42.00 Enter the employer/company name of the cost report BLUE & CO., LLC 42.00 Enter the telephone number and email address of the cost 317-633-4705 LHACKETT@BLUEANDCO. COM 43.00	39. 00	If line 36 is yes, did the provider render services to other			s, N		39. 00
Cost Report Preparer Contact Information 41.00 Enter the first name, I ast name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report BLUE & CO., LLC 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 317-633-4705 LHACKETT@BLUEANDCO.COM 43.00	40. 00	If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report BLUE & CO., LLC 43.00 Enter the telephone number and email address of the cost 317-633-4705 LHACKETT@BLUEANDCO.COM 43.00		instructions.	1				
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 317-633-4705 LANDON HACKETT 41.00 42.00			1.	00	2.	00	
held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report BLUE & CO., LLC 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 317-633-4705 LHACKETT@BLUEANDCO.COM 43.00							
42.00 Enter the employer/company name of the cost report BLUE & CO., LLC 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 317-633-4705 LHACKETT@BLUEANDCO.COM 43.00	41. 00	held by the cost report preparer in columns 1, 2, and 3,	LANDON		HACKETT		41. 00
43.00 Enter the telephone number and email address of the cost 317-633-4705 LHACKETT@BLUEANDCO.COM 43.00	42. 00	Enter the employer/company name of the cost report	BLUE & CO., LL	С			42. 00
	43. 00	Enter the telephone number and email address of the cost	317-633-4705		LHACKETT@BLUEAI	NDCO. COM	43. 00

Heal th	Financial Systems RUSH MEMOR	AL HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1304	Peri od: From 01/01/2017	Worksheet S-2 Part II		
		_	To 12/31/2017	Date/Time Pre 5/23/2018 4:2		
		3. 00				
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	SENI OR MANAGER			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 cost				43.00	
	report preparer in columns 1 and 2, respectively.					

| Period: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Health Financial Systems RUSH MOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1304

						То	12/31/2017	Date/Time Prep 5/23/2018 4: 2	
								1/P Days / 0/P	5 pili
								Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CA	AH Hours	Title V	
		Line Number			Avai I abl e				
		1.00		2. 00	3.00		4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 12	5	35, 448. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)								2.00
3.00	HMO IPF Subprovider								3. 00
4.00	HMO IRF Subprovider								4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF							0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF							0	6. 00
7.00	Total Adults and Peds. (exclude observation			25	9, 12	5	35, 448. 00	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)			25	9, 12	5	35, 448. 00	0	14.00
15. 00	CAH visits							0	15. 00
16.00	SUBPROVI DER - I PF								16.00
17. 00	SUBPROVI DER - I RF								17. 00
18. 00 19. 00	SUBPROVI DER								18.00
	SKILLED NURSING FACILITY								19.00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE								20. 00 21. 00
21.00	HOME HEALTH AGENCY								21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)								23. 00
24. 00	HOSPICE								24. 00
24. 00	HOSPICE (non-distinct part)	30. 00							24. 10
25. 00	CMHC - CMHC	30.00							25. 00
26. 00	RURAL HEALTH CLINIC								26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						0	26. 25
27. 00	Total (sum of lines 14-26)	07.00		25				o .	27. 00
28. 00	Observation Bed Days			20	1			0	28. 00
29. 00	Ambul ance Tri ps							· ·	29. 00
30.00	Employee discount days (see instruction)								30.00
31. 00	Employee discount days - IRF								31. 00
32. 00	Labor & delivery days (see instructions)			0		o			32. 00
32. 01	Total ancillary labor & delivery room			· ·					32. 01
	outpatient days (see instructions)								
33. 00	LTCH non-covered days						ļ		33. 00
33. 01	LTCH site neutral days and discharges						ļ		33. 01
					•		'		

				'	0 12/31/2017	5/23/2018 4: 2	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	33p3.13.112			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	1, 037	107	1, 477			1.00
2.00	HMO and other (see instructions)	31	5				2. 00
3.00	HMO IPF Subprovider	o	o				3. 00
4.00	HMO IRF Subprovider	o	o				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	203	o	203			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		o	14			6, 00
7.00	Total Adults and Peds. (exclude observation	1, 240	107	1, 694			7. 00
8. 00	beds) (see instructions) 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, 240	107	1, 694	0.00	264. 66	
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVIDER - I PF		Ĭ	· ·			16. 00
17. 00	SUBPROVIDER - I RF						17. 00
18. 00							18.00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00							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	1	ol	ol	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	ol	ol	0	0.00	0.00	
27. 00					0.00	264. 66	27. 00
28. 00	,		o	771			28. 00
29. 00		598					29. 00
30. 00	•			0			30.00
31. 00	. 3			0			31.00
32. 00	. 3	o	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00		o	ļ				33. 00
33. 01	LTCH site neutral days and discharges	o					33. 01

					12/31/2017	5/23/2018 4: 2	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	335	36	494	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)				2		2.00
3.00	HMO IPF Subprovider			9	3		3.00
4. 00	HMO IRF Subprovider				O O		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				٩		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	335	36	494	
15. 00	CAH visits		_				15. 00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0	l		33. 01

UJI I I	Financial Systems RUSH MEMORIAL HOSPITAL AL UNCOMPENSATED AND INDIGENT CARE DATA Provider	CCN: 15-1304	Peri od:	worksheet S-1	
	AL UNCOMPENSATED AND THOUGHT CARE DATA PLOVIDE	CCN. 13-1304	From 01/01/2017	WOLKSHEET 3-1	U
			To 12/31/2017	Date/Time Pre 5/23/2018 4:2	pared 5 pm
					, p
	Uncomponented and indigent care cost computation			1.00	
. 00	Uncompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by	line 202 colum	n 8)	0. 364467	1. (
. 00	Medicaid (see instructions for each line)	TTTIE 202 COTUIN	11 0)	0.304407	1.0
. 00	Net revenue from Medicaid			2, 574, 096	2. (
. 00	Did you receive DSH or supplemental payments from Medicaid?			Υ	3. (
. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental payme	nts from Medic	ai d?	Y	4. (
. 00	If line 4 is no, then enter DSH and/or supplemental payments from Medic	ai d		0	
. 00	Medi cai d charges			8, 935, 561	
. 00 . 00	Medicaid cost (line 1 times line 6)	inua aum af li	noo 2 and E. if	3, 256, 717	
. 00	Difference between net revenue and costs for Medicaid program (line 7 m < zero then enter zero)	THUS SUM OF FE	nes 2 and 5; 11	682, 621	8.0
	Children's Health Insurance Program (CHIP) (see instructions for each I	ne)			1
. 00	Net revenue from stand-alone CHIP	,		0	9.0
0. 00	Stand-alone CHIP charges			0	
1. 00	Stand-alone CHIP cost (line 1 times line 10)			0	
2. 00	Difference between net revenue and costs for stand-alone CHIP (line 11	minus line 9;	if < zero then	0	12. (
	enter zero) Other state or local government indigent care program (see instructions	for each line)		
3. 00	Net revenue from state or local indigent care program (Not included on			0	13. (
4. 00	Charges for patients covered under state or local indigent care program		,	0	1
	10)				
5. 00	State or local indigent care program cost (line 1 times line 14)			0	
6. 00	Difference between net revenue and costs for state or local indigent ca	re program (li	ne 15 minus line	0	16. (
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and st	ate/local indi	gont care program		1
				ns (see	1
	instructions for each line)		gent care program	is (see	
7. 00	Private grants, donations, or endowment income restricted to funding ch	arity care	gent care program	0	1
8. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital	arity care operations		506, 024	18. (
	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid , CHIP and state and local indigen	arity care operations		0	18.0
8. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital	arity care operations	s (sum of lines	506, 024	18.0
8. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid , CHIP and state and local indigen	arity care operations t care program Uninsured patients	s (sum of lines	0 506, 024 682, 621 Total (col. 1 + col. 2)	18. 0
8. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid , CHIP and state and local indigen 8, 12 and 16)	arity care operations t care program Uninsured	s (sum of lines	0 506, 024 682, 621 Total (col. 1	18. 0
8. 00 9. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid , CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line)	arity care operations t care program Uninsured patients 1.00	Insured patients 2.00	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00	18. (19. (
8. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid , CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility	arity care operations t care program Uninsured patients	Insured patients 2.00	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00	18. (19. (
8. 00 9. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions)	unity care operations to care program Uninsured patients 1.00	Insured patients 2.00	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00	18. (19. (20. (
8. 00 9. 00 0. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions)	arity care operations t care program Uninsured patients 1.00	Insured patients 2.00	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00	18. (19. (20. (21. (
8. 00 9. 00 0. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unrelimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as	unity care operations to care program Uninsured patients 1.00	Insured patients 2.00	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00	18. (19. (20. (21. (
8. 00 9. 00 0. 00 1. 00 2. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	Uni nsured patients 1.00 178,0	Insured patients 2.00	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00 178, 004 64, 877	20. 0 21. 0 22. 0
8. 00 9. 00 0. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unrelimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	unity care operations to care program Uninsured patients 1.00	Insured patients 2.00	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00 178, 004 64, 877	20. C 21. C
8. 00 9. 00 0. 00 1. 00 2. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care	Uni nsured patients 1.00 178,0	Insured patients 2.00	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00 178, 004 64, 877	20. (22. (
8. 00 9. 00 0. 00 1. 00 2. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unrelimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)	Uninsured patients 1.00 178,0 64,8	Insured patients 2.00 004 0 0 0 0 0 0 0 0	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00 178, 004 64, 877 0 64, 877	20. (21. (23. (
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unrelimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days b imposed on patients covered by Medicaid or other indigent care program?	Uninsured patients 1.00 178,0 64,8	Insured patients 2.00 004 0 077 0 0 077 0 0 077 0 0 077 0 0 077 0 0 077 0	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00 178, 004 64, 877 0 64, 877	20. (21. (23. (24. (
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unrelimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22)	Uninsured patients 1.00 178,0 64,8	Insured patients 2.00 004 0 077 0 0 077 0 0 077 0 0 077 0 0 077 0 0 077 0	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00 178, 004 64, 877 0 64, 877	20. (21. (23. (24. (
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unrelimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days b imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indige	Uninsured patients 1.00 178,0 64,8 eyond a Length	Insured patients 2.00 004 0 077 0 0 077 0 0 077 0 0 077 0 0 077 0 0 077 0	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00 178, 004 64, 877 0 64, 877	20. (21. (23. (24. (25. (
9. 00 00. 00 11. 00 22. 00 44. 00 55. 00 66. 00 77. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days b imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indige stay limit Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see	Uninsured patients 1.00 178,0 64,8 eyond a length nt care program	Insured patients 2.00 004 0 077 0 0 077 0 0 077 0 0 077 0 0 077 0 0 077 0	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00 178, 004 64, 877 0 64, 877 1.00 N 0 3, 307, 961 378, 436	20. (21. (22. (23. (25. (26. (27. (
88.00 99.00 11.00 22.00 44.00 44.00 66.00 77.00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days b imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indige stay limit Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see instruction Medicare allowable bad debts for the entire hospital complex (see instruction	Uninsured patients 1.00 178,0 64,8 eyond a length nt care program	Insured patients 2.00 004 0 077 0 0 077 0 0 077 0 0 077 0 0 077 0 0 077 0	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00 178, 004 64, 877 0 64, 877 1.00 N 0 3, 307, 961 378, 436 582, 210	20. (21. (22. (25. (25. (27. (27. (27. (27. (27. (27. (27. (27
0. 00 0. 00 11. 00 44. 00 55. 00 77. 00 77. 01 88. 00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unrelimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days b imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indige stay limit Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see in Medicare allowable bad debts for the entire hospital complex (see instruction)	Uninsured patients 1.00 178,0 64,8 eyond a length at care programs s) structions)	Insured patients 2.00 004 0 677 0 0 of stay limit m's length of	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00 178, 004 64, 877 0 64, 877 1.00 N 0 3, 307, 961 378, 436 582, 210 2, 725, 751	20. (21. (22. (23. (26. (27. (27. (28. (
88.00 99.00 11.00 22.00 44.00 44.00 66.00 77.00	Private grants, donations, or endowment income restricted to funding ch Government grants, appropriations or transfers for support of hospital Total unreimbursed cost for Medicaid, CHIP and state and local indigen 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discounts (see instructions) Payments received from patients for amounts previously written off as charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient days b imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indige stay limit Total bad debt expense for the entire hospital complex (see instruction Medicare reimbursable bad debts for the entire hospital complex (see instruction Medicare allowable bad debts for the entire hospital complex (see instruction	Uninsured patients 1.00 178,0 64,8 eyond a length at care programs s) structions)	Insured patients 2.00 004 0 677 0 0 of stay limit m's length of	0 506, 024 682, 621 Total (col. 1 + col. 2) 3.00 178, 004 64, 877 0 64, 877 1.00 N 0 3, 307, 961 378, 436 582, 210	20. (C 21. (C 23. (C 25. (C 26. (C 27. (C 27. (C 29. (C) 29. (

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provi der CO		Peri od:	Worksheet A	
				From 01/01/2017 To 12/31/2017	Date/Time Pre	nared·
				10 12/31/2017	5/23/2018 4: 2	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
·			+ col . 2)	ons (See A-6)	Trial Balance	
			,	` ′	(col. 3 +-	
					col . 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		2, 189, 642	2, 189, 64	2 0	2, 189, 642	1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	388, 721	3, 254, 615	3, 643, 33	6, 369	3, 649, 705	4.00
5.00 00500 ADMINISTRATIVE & GENERAL	2, 132, 071	2, 443, 245	4, 575, 31	6 18, 656	4, 593, 972	5. 00
7.00 00700 OPERATION OF PLANT	283, 072	621, 686	904, 75	25, 962	930, 720	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	O	0		59, 288	59, 288	8. 00
9. 00 00900 HOUSEKEEPI NG	280, 670	152, 648	433, 31	34, 414	398, 904	9. 00
10. 00 01000 DI ETARY	332, 613	254, 223	586, 83	-402, 058	184, 778	10.00
11. 00 01100 CAFETERI A	O	0		426, 932	426, 932	11. 00
13.00 01300 NURSING ADMINISTRATION	197, 892	3, 208	201, 10	-124, 370	76, 730	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	53, 243	75, 534	128, 77		127, 048	14. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	347, 130	69, 975	417, 10	-721	416, 384	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			•		
30. 00 03000 ADULTS & PEDI ATRI CS	1, 674, 471	88, 216	1, 762, 68	7 -804, 668	958, 019	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	589, 390	557, 067	1, 146, 45	7 -273, 411	873, 046	50.00
51.00 05100 RECOVERY ROOM	0	4, 555	4, 55	5 31, 321	35, 876	51.00
53. 00 05300 ANESTHESI OLOGY	o	0		ol ol	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	980, 963	840, 408	1, 821, 37	1 -7, 327	1, 814, 044	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		ol ol	0	55. 00
60. 00 06000 LABORATORY	624, 149	811, 747	1, 435, 89	6 ol	1, 435, 896	60.00
65. 00 06500 RESPI RATORY THERAPY	102, 992	7, 555	110, 54		110, 459	65. 00
66. 00 06600 PHYSI CAL THERAPY	232, 207	104, 930	337, 13		366, 464	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	150, 461	558	151, 01		180, 578	67. 00
68.00 06800 SPEECH PATHOLOGY	88, 671	239	88, 91		29, 752	68. 00
69. 00 06900 ELECTROCARDI OLOGY	148, 523	3, 354	151, 87		151, 447	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		ol	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	13, 734	13, 73	4 319, 428	333, 162	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	54, 410	54, 41		54, 410	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	523, 485	4, 372, 852	4, 896, 33		4, 893, 088	73. 00
OUTPATIENT SERVICE COST CENTERS			.,		.,	
90. 00 09000 CLI NI C	2, 197, 553	142, 741	2, 340, 29	4 808, 894	3, 149, 188	90.00
90. 01 09001 SURGI CAL ASSOCI ATES	77, 327	529, 395	606, 72		605, 309	90. 01
90. 02 09002 ORTHOPAEDI CS	43, 755	301, 237	344, 99.		344, 805	90. 02
90. 03 09003 RHEUMATOLOGY	512, 081	9, 271	521, 35		520, 686	90. 03
90. 04 09004 ENDOCRI NOLOGY	114, 150	7, 454	121, 60		121, 604	90. 04
90. 05 09005 PEDI ATRI CS	297, 731	14, 715	312, 44		312, 342	90. 05
90.06 09006 WOMEN'S HEALTH	299, 095	10, 471	309, 56		306, 575	90.06
90. 07 09007 PAI N MANAGEMENT	84, 908	5, 381	90, 28		90, 157	90. 07
91. 00 09100 EMERGENCY	853, 963	1, 132, 014	1, 985, 97		1, 953, 008	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	222,123	.,,	.,		.,,	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	598, 270	74, 897	673, 16	7 -5, 651	667, 516	95. 00
SPECIAL PURPOSE COST CENTERS	2.0, 2.0	,		., ., .,	221/212	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	14, 209, 557	18, 151, 977	32, 361, 53	4 0	32, 361, 534	118. 00
NONREI MBURSABLE COST CENTERS	.,,,	-, -,,,,,	, , , , , , , , , ,	<u> </u>	. ,,	1
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		lo lo	0	192. 00
193. 00 19300 NONPALD WORKERS	ol	n		ol ol		193. 00
193. 01 19301 FOUNDATION	63, 614	30	63, 64	4 0	63, 644	
193. 02 19302 OCCUPATI ONAL MEDI CI NE	0	0		ol ol		193. 02
194. 00 07950 OTHER NON REIMBURSABLE COST CENTERS	Ö	0		ol ol		194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	14, 273, 171	18, 152, 007	32, 425, 17	8 0	32, 425, 178	
, , , , , , , , , , , , , , , , , , , ,				-1		

Peri od: From 01/01/2017 To 12/31/2017 Worksheet A

Date/Time Prepared: 5/23/2018 4:25 pm

				5/23/2018 4: 2	5 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-544, 123	1, 645, 519		1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-15, 067	3, 634, 638		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-1, 013, 018	3, 580, 954		5. 00
7.00	00700 OPERATION OF PLANT	0	930, 720		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0			8. 00
9.00	00900 HOUSEKEEPI NG	-218			9.00
10. 00	01000 DI ETARY	-839			10.00
11. 00	01100 CAFETERI A	-234, 797			11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	-390			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-983			14. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	-6, 956		•	16. 00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0, 730	407, 420		10.00
30. 00	03000 ADULTS & PEDIATRICS	-1, 241	956, 778		30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	-1, 241	750,770		30.00
50. 00	05000 OPERATING ROOM	-424, 915	448, 131		50.00
51. 00	05100 RECOVERY ROOM	-424, 913			51.00
		-		·	
53.00	05300 ANESTHESI OLOGY	452 420		l .	53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	-453, 430			54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			55. 00
60. 00	06000 LABORATORY	-459		•	60.00
65. 00	06500 RESPI RATORY THERAPY	0	110, 459		65. 00
66. 00	06600 PHYSI CAL THERAPY	-614			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0			67. 00
68. 00	06800 SPEECH PATHOLOGY	0	'		68. 00
69. 00	06900 ELECTROCARDI OLOGY	-4	151, 443	•	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0			70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-261	332, 901		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	54, 410		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-83, 365	4, 809, 723		73. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	-2, 336, 965	812, 223		90.00
90. 01	09001 SURGI CAL ASSOCI ATES	-492, 282	113, 027		90. 01
90. 02	09002 ORTHOPAEDI CS	-284, 819	59, 986		90. 02
90. 03	09003 RHEUMATOLOGY	-501, 404	19, 282		90. 03
90.04	09004 ENDOCRI NOLOGY	-127, 394	-5, 790		90. 04
90. 05	09005 PEDI ATRI CS	-254, 848		•	90. 05
90.06	09006 WOMEN'S HEALTH	-283, 798			90.06
90. 07	09007 PAI N MANAGEMENT	-70, 495		•	90. 07
91. 00	09100 EMERGENCY	70,170			91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1, 700, 000		92.00
72.00	OTHER REIMBURSABLE COST CENTERS				72.00
95. 00	09500 AMBULANCE SERVICES	0	667, 516		95. 00
73.00	SPECIAL PURPOSE COST CENTERS		007, 310		75.00
118. 00		-7, 132, 685	25, 228, 849		118. 00
110.00		-7, 132, 003	25, 220, 049		1110.00
102.00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES		0		192. 00
		0		l .	
	19300 NONPAID WORKERS	0		l .	193. 00
	19301 FOUNDATION	0		l .	193. 01
	19302 OCCUPATIONAL MEDICINE	0			193. 02
	07950 OTHER NON REIMBURSABLE COST CENTERS	7 400 (05			194. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	-7, 132, 685	25, 292, 493		200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2017 Date/Time Prepared: 5/23/2018 4:25 pm Provider CCN: 15-1304

	To 12/31/2017 Date/lime Pi 5/23/2018 4:					
. 20 pm	072072010 1.			Increases		
		0ther	Sal ary	Li ne #	Cost Center	
		5. 00	4. 00	3. 00	2. 00	
					A - LAUNDRY AND LINEN	
1.0		5 <u>9, 2</u> 88	0		LAUNDRY & LINEN SERVICE	1.00
		59, 288	0		0	
					B - DIETARY/ CAFETERIA	
1.0		18 <u>4, 9</u> 51	<u>241, 9</u> 81	<u>11.</u> 00	CAFETERI A	1.00
		184, 951	241, 981		0	
					C - MED SUPPLY RECLASS	
1.0		319, 428	0	71. 00	MEDICAL SUPPLIES CHARGED TO	1.00
					PATI ENTS	
2.0		0	0	0.00		2.00
3.0		0	0	0.00		3.00
4.0		0	0	0.00		4.00
5.0		0	0	0. 00		5.00
6.0		0	0	0.00		6.00
7.0		0	0	0.00		7.00
8.0		0	0	0.00		8.00
9. 0		0	o	0.00		9.00
10.0		0	o	0.00		10.00
11.0		0	o	0.00		11.00
12.0		0	o	0.00		12.00
13. 0		0	0	0.00		13.00
14.0		0	o	0.00		14.00
15. 0		0	0	0.00		15. 00
16. 0		0	o	0.00		16. 00
17. 0		Ö	Ö	0.00		17. 00
18. 0		Ö	Ö	0.00		18. 00
19. 0		Ö	0	0.00		19. 00
20.0		Ö	0	0.00		20.00
21.0		Ö	0	0.00		21. 00
22.0		o	o	0.00		22. 00
23. 0		o	0	0.00		23. 00
23.0		31 9 , 428	 	— — -0.00		23.00
		317, 420	<u> </u>		D - AMBULANCE RECLASS	
1.0		0	188	4.00	EMPLOYEE BENEFITS DEPARTMENT	1. 00
2. 0		o	1, 094	7. 00	OPERATION OF PLANT	2. 00
3. 0		0	487	30.00	ADULTS & PEDIATRICS	3. 00
4. 0		0	58	54.00	RADI OLOGY-DI AGNOSTI C	4. 00
5. 0			1, 047	91.00	EMERGENCY	5. 00
3. 0		<u>0</u>	$-\frac{1,047}{2,874}$	— — 91. 00	D D D D D D D D D D D D D D D D D D D	5.00
		U	2,874		E - SALARY RECLASS	
۹ ,			/ 210	4.00		1 00
1. 0		0	6, 218		EMPLOYEE BENEFITS DEPARTMENT	1.00
2. 0		0	18, 656	5.00	ADMINISTRATIVE & GENERAL	2.00
3. 0		0	24, 874	7.00	OPERATION OF PLANT	3.00
4.0		0	24, 874	9.00	HOUSEKEEPI NG	4.00
5.0		0	24, 874	10.00	DI ETARY	5.00
6.0		0	34, 672	51.00	RECOVERY ROOM	6.00
7.0		0	29, 566	66.00	PHYSI CAL THERAPY	7.00
8.0		0	29, 566	67.00	OCCUPATI ONAL THERAPY	8.00
9. 0		0	24, 874	<u> </u>	CLINIC	9.00
_		0	218, 174		0	
		1			F - PHYSICIAN RECLASS	
1.0		<u>0</u>	78 <u>5, 6</u> 14	<u>90.</u> 00	CLINIC	1.00
			785, 614		0	
500.0		563, 667	1, 248, 643		Grand Total: Increases	500.00

RECLASSI FI CATIONS

Provider CCN: 15-1304

Peri od: Worksheet A-6 From 01/01/2017

Date/Time Prepared:

500.00

12/31/2017

5/23/2018 4:25 pm Decreases Cost Center Li ne # Sal ary 0ther Wkst. A-7 Ref. 6.00 7.00 8.00 9.00 10.00 - LAUNDRY AND LINEN 1.00 HOUSEKEEPI NG 9.00 59, 288 0 1.00 59, 288 B - DIETARY/ CAFETERIA 1.00 DI ETARY 10.00 241, 981 184, 951 0 1.00 241, 981 184, 951 C - MED SUPPLY RECLASS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 37 0 1.00 2.00 OPERATION OF PLANT 7.00 0 0 2.00 CENTRAL SERVICES & SUPPLY 14.00 0 0 3.00 1,729 3.00 4 00 MEDICAL RECORDS & LIBRARY 16.00 0 0 4 00 721 19, 541 ADULTS & PEDIATRICS 0 0 5.00 30.00 5.00 6.00 RECOVERY ROOM 51.00 0 3, 351 0 6.00 7.00 RADI OLOGY-DI AGNOSTI C 54.00 0 7, 385 0 7.00 RESPIRATORY THERAPY 0 0 65.00 8 00 88 8 00 0 9.00 PHYSICAL THERAPY 66.00 239 9.00 10.00 OCCUPATIONAL THERAPY 67.00 o 0 10.00 68.00 0 0 11.00 SPEECH PATHOLOGY 27 11.00 0 12.00 ELECTROCARDI OLOGY 69.00 12.00 430 0 0 13.00 DRUGS CHARGED TO PATIENTS 73.00 3, 249 13.00 CLINIC 90.00 o 1, 594 0 14.00 14.00 0 0 SURGICAL ASSOCIATES 90.01 1, 413 15.00 15.00 16.00 ORTHOPAEDI CS 90.02 0 187 0 16.00 17.00 RHEUMATOLOGY 90.03 0 0 17.00 666 18.00 PEDI ATRI CS 90.05 0 104 0 18.00 0 0 19.00 WOMEN'S HEALTH 90.06 2, 991 19 00 20.00 PAIN MANAGEMENT 90.07 0 132 0 20.00 EMERGENCY 91.00 0 34, 016 0 21.00 21.00 AMBULANCE SERVICES 95.00 o 2, 777 0 22.00 22.00 23.00 OPERATING ROOM 50.00 238, 738 0 23.00 0 319, 428 D - AMBULANCE RECLASS AMBULANCE SERVICES 1.00 1.00 95.00 2,874 0 0 2.00 0.00 0 0 2.00 3.00 0.00 0 0 0 3.00 0 4.00 0.00 0 0 4.00 0.00 5.00 0 0 5.00 2, 874 0 SALARY RECLASS 1.00 NURSING ADMINISTRATION 13.00 124, 370 0 0 1.00 OPERATING ROOM 0 2.00 50.00 34, 673 0 2.00 3.00 SPEECH PATHOLOGY 68.00 59, 131 0 0 3.00 0 0.00 0 4.00 4.00 5.00 0.00 ol 0 5.00 0 0.00 0 6.00 0 6.00 7.00 0.00 0 0 0 7.00 8.00 0.00 0 0 0 8.00 9.00 9.00 0.00 0 218, 174 - PHYSICIAN RECLASS 30.00 1 00 ADULTS & PEDIATRICS 785, 614 0 0 1 00

785, 614

563, 667

1, 248, 643

500.00 Grand Total: Decreases

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS RUSH MEMORIAL HOSPITAL

| Period: | Worksheet A-7 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-1304

				To	12/31/2017	Date/Time Prep 5/23/2018 4:2	
				Acqui si ti ons		3/23/2010 4.2	o piii
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	188, 708	0	0	0	0	1.00
2.00	Land Improvements	421, 224	19, 914	0	19, 914	14, 830	2.00
3.00	Buildings and Fixtures	16, 186, 031	8, 525	0	8, 525	629, 140	3. 00
4.00	Building Improvements	209, 065	4, 436, 439	0	4, 436, 439	-2, 929, 226	4. 00
5.00	Fixed Equipment	1, 190, 451	31, 035	0	31, 035	11, 392	5. 00
6.00	Movable Equipment	14, 450, 420	763, 513	0	763, 513	4, 260, 935	
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	32, 645, 899	5, 259, 426	0	5, 259, 426		8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	32, 645, 899	5, 259, 426	0	5, 259, 426	1, 987, 071	10. 00
		Endi ng Bal ance	Fully				
			Depreciated				
		(00	Assets				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	6.00	7. 00				
1. 00	Land	188, 708	0				1. 00
2.00			U				2. 00
3.00	Land Improvements	426, 308	0				3. 00
4. 00	Buildings and Fixtures	15, 565, 416 7, 574, 730	0				4. 00
4. 00 5. 00	Building Improvements Fixed Equipment	1, 210, 094	0				4. 00 5. 00
6.00	Movable Equipment	10, 952, 998	0				6. 00
7. 00	HIT designated Assets	10, 932, 998	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	35, 918, 254	0				8. 00
9. 00	Reconciling Items	33, 710, 234	0				9. 00
10. 00	Total (line 8 minus line 9)	35, 918, 254	0				10. 00
10.00	Trotal (Trie o militas Trie 7)	33, 710, 234	υĮ			ļ	10.00

Heal th	Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Peri od:	Worksheet A-7	
					From 01/01/2017 o 12/31/2017		nared:
					0 12/31/201/	5/23/2018 4: 2	
			SL	JMMARY OF CAPI	ΓAL		
					T		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	instructions)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	<u>KSHEET A, COLUM</u>	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	1, 712, 923	0	206, 622	270, 097	0	1. 00
3.00	Total (sum of lines 1-2)	1, 712, 923	0	206, 622	270, 097	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2, 189, 642				1. 00
3.00	Total (sum of lines 1-2)	0	2, 189, 642				3. 00
							-

Health Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od:	Worksheet A-7	
				From 01/01/2017 To 12/31/2017	Part III Date/Time Prep	ared.
					5/23/2018 4: 25	
	COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
cost center beserver on	01033 A33C13	Leases	for Ratio	instructions)	Trisul direc	
		200000	(col. 1 - col.	,		
			2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 NEW CAP REL COSTS-BLDG & FLXT	35, 918, 254		35, 918, 254			1.00
3.00 Total (sum of lines 1-2)	35, 918, 254		35, 918, 254			3. 00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Relate				
		d Costs	through 7)			
DART LLL DESCRIPTION OF CARLEY COOTS OF	6.00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS			4 000 400		4 00
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		1, 280, 132		1. 00
3.00 Total (sum of lines 1-2)	0	0	<u> </u>	1, 280, 132	U	3. 00
		30	JIVIIVIART OF CAPT	IAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
DADT III DECONOLILIATION OF CARLTY COOTS	11.00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS C		070 007			4 (15 510	
1.00 NEW CAP REL COSTS-BLDG & FIXT	95, 290			0	1, 645, 519	1. 00
3.00 Total (sum of lines 1-2)	95, 290	270, 097		0	1, 645, 519	3. 00

Dependence of asset financiars on Norschapete A Dependence Depen						o 12/31/2017	Date/lime Prep 5/23/2018 4:25	
Dost Centur Description Resis/Gode (2) Amount Dost Centur Line # Biost A.7 Ref.								
1.00 Investment Income - NCB CAP COSTS - ND 6					To/From Which the Amount is	to be Adjusted		
1.00 Investment Income - NCB CAP COSTS - ND 6								
1.00 Investment Income - NCB CAP COSTS - ND 6								
1.00 Investment Income - NCB CAP COSTS - ND 6								
Triest T		Cost Center Description						
EL COSTS-BLD & FIXT (chapter 2) 0	1 00	Laurent Sanara NEW CAR	1.00					1 00
2 2 0 0 Investment I nome - CAP REL	1.00					1.00	0	1.00
1.00 1.00					1171			
Investment income - other	2.00			0	*** Cost Center Deleted ***	2.00	o	2.00
Chapter 2) 1.00 Trade, quantity, and time of scounts (chapter 8) 1.00 Rental of provider space by suppliers (chapter 8) 1.00 I elephone services (paper 8) 1.00 Parking lot (chapter 2) 1.00 Parking lot (chapter 1) 1.0								
1.00 Control	3. 00			0		0. 00	0	3. 00
discounts (chipter 8)	4 00			0		0.00	0	4 00
6. 00 Reparts (chapter 8) 6. 00 Reparts (chapter 8) 7. 00 Isle ipnome servic services (chapter 3) 7. 00 Isle ipnome services (chapter 3) 8. 00 Tollow sis an and radio service (chapter 21) 9. 00 Parking lot (chapter 22) 9. 00 Parking lot (chapter 21) 9. 00 Parking lot (chapter 14) 9. 00 Parking lot (chapter 14	1. 00			· ·		0.00	Ĭ	1. 00
Sental of provider space by suppliers (chapter 8) 0 0 0 0 0 0 0 0 0	5.00			0		0.00	0	5. 00
Supplier's (chapter 8)				0		0.00		
Telephone services (pay stations excluded) (chapter 21)	6.00			U		0.00	U	6.00
8. 07 Television and radio service	7. 00			0		0. 00	o	7. 00
Television and radio service (Chapter 21) 0 0 0 0 0 0 0 0 0								
Chapter 21 0	0.00	1 1				0.00		0.00
Parking Iof (chapter 21) A-8-2 -5,163,176 0 0.00 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.00 0.10 0.10 0.00 0.10 0.10 0.00 0.10 0.	8.00			0		0.00	٥	8.00
10.00 Provider-based physician A-8-2 -5,163,176 0 10.00 0 10.00 0 11.00 0 11.00 0 11.00 0 11.0	9. 00			0		0. 00	О	9. 00
11.00 Sale of scrap, waste, etc. (Chapter 23) 12.00 Related organization A-8-1 0 12.00 13.00 13.00 13.00 13.00 14.00 14.00 16.00	10.00		A-8-2	-5, 163, 176			0	10.00
Chapter 23)								
12.00 Related organization Chapter 10 Chapter 11 Chapter 10 Chapter 10 Chapter 10 Chapter 10 Chapter 11 Chapter 10 Chapter 10 Chapter 10 Chapter 10 Chapter 11 Chapter 10 Chapter 10 Chapter 10 Chapter 10 Chapter 11 Chapter 10 Chapter 11	11.00	l		0		0.00	0	11.00
transactions (chapter 10) 13.00 Laundry and Linen service 0 0 0.00 0.13.00 14.00 Cafeteria-employees and guests 0 0.00 0.00 0.14.00 15.00 Rental of quarters to employee and others 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of of the control	12. 00		A-8-1	0			0	12. 00
14.00 Caffeterial-employees and guests 0 0.00 0.								
15.00 Rental of quarters to employee and others 0 0 15.00 0 15.00 16.00 0 16.00 0 16.00 0 16.00 0 17.00 0 17.00 0 17.00 0 17.00 0 17.00 0 18.00 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0 18.00 0		1		0				
and others		. ,	1	0				
16.00 Sale of medical and surgical supplies to other than patients 0 0.00 0.	15.00			U		0.00	U	15.00
patients	16. 00			0		0.00	О	16. 00
17. 00 Sale of drugs to other than patients 0 0.00		••						
patients	17.00			0		0.00		17.00
18.00 Sale of medical records and abstracts 0 0 0 0 0 0 0 0 0	17.00			0		0.00	0	17.00
19.00 Nursing and allied health 0 0 0 0 0 0 0 0 0	18. 00			0		0. 00	o	18. 00
education (tuition, fees, books, etc.)								
Dooks, etc.) O Vending machines O O O O O O O O O	19. 00			0		0. 00	0	19. 00
20.00 Vending machines 0 0.00 0.00 0.20.00								
21.00 Income from imposition of interest, finance or penal ty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments A-8-3 ORESPIRATORY THERAPY 65.00 23.00	20. 00			0		0. 00	О	20.00
Charges (chapter 21) Chapter 14) Chapter 15) Chapter 16) Chapter 17) Chapter 17) Chapter 18) Chapter 19)				0				21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments								
Overpayments and borrowings to repay Medicare overpayments A-8-3 ORESPIRATORY THERAPY 65.00 23.00	22 00			0		0.00		22 00
Papay Medicare overpayments	22.00			0		0.00		22.00
therapy costs in excess of limitation (chapter 14) 24.00 Adj ustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL COSTS-BLDG & 1.00 0 26.00 (Chapter 21) 27.00 Depreciation - CAP REL COSTS-BLDG & 1.00 0 26.00 (COSTS-BLDG & FIXT 0 *** Cost Center Deleted *** 2.00 0 27.00 (COSTS-MVBLE EQUIP Non-physician Anesthetist 0 0 *** Cost Center Deleted *** 19.00 28.00 (Physicians' assistant 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
1 imitation (chapter 14)	23. 00	, ,	A-8-3	0	RESPI RATORY THERAPY	65. 00		23.00
24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14) A-8-3 0 PHYSICAL THERAPY 66. 00 24. 00 25. 00 Utilization review - physicians' compensation (chapter 21) 0 *** Cost Center Deleted *** 114. 00 25. 00 26. 00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT 0 NEW CAP REL COSTS-BLDG & 1. 00 0 26. 00 27. 00 Depreciation - CAP REL COSTS-MUBLE EQUIP 0 *** Cost Center Deleted *** 2. 00 0 27. 00 28. 00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19. 00 28. 00 29. 00 Physicians' assistant 0 COCCUPATIONAL THERAPY 67. 00 30. 00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 0 OCCUPATIONAL THERAPY 67. 00 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 SPEECH PATHOLOGY 68. 00 31. 00 32. 00 CAH HIT Adjustment for A -431,670 NEW CAP REL COSTS-BLDG & 1. 00 9 32. 00								
therapy costs in excess of	24. 00	` ' ′	A-8-3	Ω	PHYSICAL THERAPY	66. 00		24. 00
25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL COSTS-BLDG & 1.00 0 26.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 27.00 0 28.00 0 29.00 29.00 0 29.0	00	therapy costs in excess of		9	 -	55. 50		30
physicians' compensation (chapter 21)	05.00					444.00		
Chapter 21) Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 1.00 O 26.00	25. 00			0	*** Cost Center Deleted ***	114.00		25.00
26. 00 Depreciation - NEW CAP REL COSTS-BLDG & 1. 00 0 26. 00								
27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist 29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for A -8-3 O **** Cost Center Deleted **** 19. 00 28. 00 0 CCUPATIONAL THERAPY 67. 00 30. 00 30. 00 30. 00 30. 99 68. 00 31. 00 31. 00 32. 00 CAH HIT Adjustment for A -431, 670 NEW CAP REL COSTS-BLDG & 1. 00 9 32. 00	26. 00			0	NEW CAP REL COSTS-BLDG &	1.00	0	26.00
COSTS-MVBLE EQUIP Non-physici an Anesthetist O **** Cost Center Deleted *** 19.00 28.00 29.00 Physici ans' assistant O 0 0 0 0 29.00 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) A-8-3 O ADULTS & PEDIATRICS 30.00 30.99 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 O SPEECH PATHOLOGY A-8-3								
28. 00 Non-physician Anesthetist 0 **** Cost Center Deleted *** 19. 00 28. 00 29. 00 Physicians' assistant 0 0 00 0 29. 00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27. 00	l •		0	*** Cost Center Deleted ***	2. 00	이	27. 00
29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for A-8-3 OCCUPATIONAL THERAPY OADULTS & PEDIATRICS OADULTS & PEDIATRICS OSPEECH PATHOLOGY 68. 00 31. 00 31. 00 32. 00 A-8-3 OSPEECH PATHOLOGY A-8-3 OSPEECH PATHOLOGY OADULTS & PEDIATRICS	28 00			0	*** Cost Center Deleted ***	19 00		28 00
30.00 Adj ustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adj ustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adj ustment for A A-8-3 OCCUPATIONAL THERAPY 67.00 30.00				0	3031 Gantal Barata		1	
I imitation (chapter 14)		Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY		1	
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for A -431,670 NEW CAP REL COSTS-BLDG & 1.00 9 32.00								
instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for A -431,670 NEW CAP REL COSTS-BLDG & 1.00 9 32.00	30 00			^	ANULTS & PENLATPICS	30 00		30 00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for A -431,670 NEW CAP REL COSTS-BLDG & 1.00 9 32.00	JU. 77			U	ADOLIS & ILDIAINICS	30.00		JU. 77
i mi tation (chapter 14) 32.00 CAH HIT Adjustment for A -431,670 NEW CAP REL COSTS-BLDG & 1.00 9 32.00	31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
32.00 CAH HIT Adjustment for A -431,670 NEW CAP REL COSTS-BLDG & 1.00 9 32.00								
	33 00		Λ .	A21 470	NEW CAD DEL COSTS DIDC 0	1 00		32 00
	JZ. UU		"			1.00		J∠. UU
					•	·	'	

Provi der CCN: 15-1304 Peri od: Worksheet A-8 From 01/01/2017 | Worksheet A-8 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared:

				''	0 12/31/2017	5/23/2018 4: 2	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					•		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
	T	1.00	2. 00	3. 00	4. 00	5. 00	
33. 00	CAFETERI A	В		CAFETERI A	11. 00	0	
33. 01	JAIL MEALS	В		CAFETERI A	11. 00	0	
33. 02	VENDING MACHINES	В		ADMINISTRATIVE & GENERAL	5. 00	0	
34. 00	SALE OF DRUGS	В		DRUGS CHARGED TO PATIENTS	73. 00	0	
35. 00	SALE OF SUPPLIES	В	-261	MEDICAL SUPPLIES CHARGED TO	71. 00	0	35. 00
				PATI ENTS			
37.00	PHYSICIAN APPLICATION FEES	В		ADMINISTRATIVE & GENERAL	5. 00	0	
37. 01	NSF FEES	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	l .	37. 01
38. 00	MEDICAL RECORDS TRANSCRIPTION	В	-6, 956	MEDICAL RECORDS & LIBRARY	16. 00	0	38. 00
	FEES						
41. 00	COPI ER FEES	В		ADMINISTRATIVE & GENERAL	5. 00	0	
42.00	ATHLETIC TRAINER - SCHOOL REV	В	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	42. 00
42. 01	WELLNESS PROGRAM	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
45. 00	OCCUPATI ONAL HEALTH	В	-37, 903		90.00	0	
45. 01	MISC. INCOME	В	· ·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
45. 02	MISC. INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	
45. 03	MISC. INCOME	В		DI ETARY	10. 00	0	45. 03
45. 04	MI SC. I NCOME	В		PHYSI CAL THERAPY	66. 00	0	
45. 05	MI SC. I NCOME	В	· ·	DRUGS CHARGED TO PATIENTS	73. 00	0	
45.06	MISC. INCOME	В	-20, 748	RHEUMATOLOGY	90. 03	0	45. 06
45. 07	MISC. INCOME	В	0	AMBULANCE SERVICES	95.00	0	45. 07
45.08	INTEREST INCOME	В	-111, 332	NEW CAP REL COSTS-BLDG &	1. 00	11	45. 08
				FLXT			
45. 09	TELEPHONE SALARY	В		ADMINISTRATIVE & GENERAL	5. 00	0	45. 09
45. 10	TELEPHONE OTHER	A	-1, 094	ADMINISTRATIVE & GENERAL	5. 00	0	45. 10
45. 11	TELEPHONE BENEFITS	A		ADMINISTRATIVE & GENERAL	5. 00	0	45. 11
45. 12	ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	45. 12
45. 13	IHA & AHA LOBBYING	A	-3, 347	ADMINISTRATIVE & GENERAL	5. 00	0	45. 13
45. 14	REBATES	A	-1, 121	NEW CAP REL COSTS-BLDG &	1. 00	9	45. 14
				FLXT			
45. 15	REBATES	В		ADMINISTRATIVE & GENERAL	5. 00	0	45. 15
45. 16	REBATES	В		HOUSEKEEPI NG	9. 00	0	
45. 17	REBATES	В		DI ETARY	10. 00	0	
45. 18	REBATES	В		CAFETERI A	11. 00	0	
45. 19	REBATES	В		NURSING ADMINISTRATION	13. 00	0	45. 19
45. 20	REBATES	В		CENTRAL SERVICES & SUPPLY	14. 00	0	
45. 25	REBATES	В	· ·	ADULTS & PEDIATRICS	30.00	0	
45. 26	REBATES	В	· ·	OPERATING ROOM	50.00	0	45. 26
46. 00	REBATES	В	· ·	RADI OLOGY-DI AGNOSTI C	54. 00	0	46. 00
46. 01	REBATES	В		LABORATORY	60.00	0	
46. 02	REBATES	В		ELECTROCARDI OLOGY	69. 00	0	46. 02
46. 03	REBATES	В	· ·	DRUGS CHARGED TO PATIENTS	73. 00	0	
46. 04	REBATES	В		RHEUMATOLOGY	90. 03	0	46. 04
46. 05	HAF EXPENSE	В	-796, 563	ADMINISTRATIVE & GENERAL	5. 00	0	46. 05
46. 07	SAFE SITTER CLASS FEES	A	-405	ADMINISTRATIVE & GENERAL	5. 00	0	46. 07
50.00	TOTAL (sum of lines 1 thru 49)		-7, 132, 685				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						<u> </u>

⁽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.

Peri od: Worksheet A-8-2 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/23/2018 4: 25 pm

							5/23/2018 4:2	25 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'			Hours	
	1. 00	2, 00	3.00	4, 00	5. 00	6, 00	7. 00	
1. 00		OPERATI NG ROOM	429, 050	418, 72		C		1. 00
2.00		RADI OLOGY-DI AGNOSTI C	483, 300		·	l .		
3.00		LABORATORY	36, 000		0 36,000	l .		
4. 00		CLI NI C	2, 440, 506		· ·			1
5. 00		SURGI CAL ASSOCI ATES	524, 000				_	
		ORTHOPAEDI CS			· ·			
6.00			299, 029		· ·		0	
7.00		RHEUMATOLOGY	499, 653		·		0	, , , , ,
8. 00		ENDOCRI NOLOGY	129, 086					
9. 00		PEDI ATRI CS	264, 224		· ·	l .	0	7.00
10. 00		WOMEN'S HEALTH	298, 603		· ·		0	
11. 00		PAIN MANAGEMENT	70, 495				0	11. 00
12.00	91. 00	EMERGENCY	1, 035, 308		0 1, 035, 308	C	0	12. 00
200.00			6, 509, 254				0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RC	E Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8.00	9. 00	12. 00	13.00	14.00	
1.00	50.00	OPERATING ROOM	0		0 0	C	0	1. 00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	0		o c	C	0	2. 00
3.00	60, 00	LABORATORY	0		ol c		0	3.00
4.00	90. 00	CLINIC	0		ol d		0	4.00
5. 00		SURGI CAL ASSOCI ATES	0		o o		0	1
6. 00		ORTHOPAEDI CS	0		o o		l o	1
7. 00		RHEUMATOLOGY			0 0		0	1
8. 00		ENDOCRI NOLOGY			0 0	_	0	1
9. 00		PEDI ATRI CS			0 0		0	1
10. 00		WOMEN'S HEALTH					0	
11. 00		PALN MANAGEMENT			0 0		0	1
					-		_	
12.00	91.00	EMERGENCY	0		0 0		0	
200.00			0		0 0		0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment		
		ldenti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	4 00	0.00	14	1/ 00	47.00	40.00		
1.00	1. 00	2.00	15. 00	16. 00	17. 00	18.00		1 00
1.00		OPERATING ROOM	0		0 0			1.00
2.00		RADI OLOGY-DI AGNOSTI C	0		0 0			2. 00
3.00		LABORATORY	0		0 0			3. 00
4.00		CLI NI C	0		0 0			4. 00
5.00		SURGI CAL ASSOCI ATES	0		0 0	,		5. 00
6.00		ORTHOPAEDI CS	0		0 0	284, 819		6. 00
7.00	90. 03	RHEUMATOLOGY	0		0 0	480, 572		7. 00
8.00	90. 04	ENDOCRI NOLOGY	0		o c	127, 394		8. 00
9.00	90. 05	PEDI ATRI CS	0		o c	254, 848		9. 00
10.00		WOMEN'S HEALTH	0		o c			10.00
11. 00		PAIN MANAGEMENT	0		o c			11. 00
12. 00		EMERGENCY	0	•	o o			12.00
200.00	, , , , ,				o o	l .		200.00
200.00	1		1	ı	٥,	0, 100, 170	T	

	Financial Systems	RUSH MEMORIAL	_		In Lie	u of Form CMS-2	2552-10
	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der CC		Peri od: From 01/01/2017 To 12/31/2017	Worksheet A-8- Parts I-VI Date/Time Prep 5/23/2018 4:29	pared:
					Physical Therapy		
						1. 00	
	PART I - GENERAL INFORMATION					11 00	
1.00	Total number of weeks worked (excluding aides	s) (see instructi	ons)			2	
2. 00 3. 00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis	sor or theranist	was on provid	der site (see	instructions)	30 5	2. 00 3. 00
4. 00	Number of unduplicated days in which therapy nor therapist was on provider site (see insti	assistant was or				0	
5.00	Number of unduplicated offsite visits - super		oists (see ins	structions)		0	5. 00
6. 00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or them instructions)	apy assistants (i	nclude only v	isits made b		0	6. 00
7. 00	Standard travel expense rate					0.00	7. 00
8. 00	Optional travel expense rate per mile					0.00	
		Supervi sors 1.00	Therapists 2.00	Assi stants 3.00	Ai des 4. 00	Trai nees 5.00	
9. 00	Total hours worked	0.00	39. 50	0.0	_		9. 00
	AHSEA (see instructions)	0.00	81. 04	0.0		0. 00	
11. 00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	40. 52	40. 52	0.0	00		11. 00
	one-half of column 3, line 10)						
	Number of travel hours (provider site)	0	0		0		12.00
	Number of travel hours (offsite) Number of miles driven (provider site)	0 0	0		0		12. 01 13. 00
	Number of miles driven (offsite)	o	o		0		13. 01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1. 00	
14.00	Supervisors (column 1, line 9 times column 1,	line 10)				0	14. 00
	Therapists (column 2, line 9 times column 2,					3, 201	
16. 00 17. 00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 ar		atory therapy	or lines 14-	16 for all	0 3, 201	16. 00 17. 00
	others)	·					
	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li					0	18. 00 19. 00
	Total allowance amount (sum of lines 17-19 for		nerapy or line	es 17 and 18	for all others)	3, 201	
	If the sum of columns 1 and 2 for respiratory	therapy or colu	umns 1-3 for p	hysical ther	apy, speech path	nology or	1
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		entries on I	ines 21 and	22 and enter on	line 23	
	Weighted average rate excluding aides and tra		divided by sum	n of columns	1 and 2, line 9	0.00	21.00
21. 00	for respiratory therapy or columns 1 thru 3,	line 9 for all of	others)			0	00.00
22. 00	Weighted allowance excluding aides and traine						
22. 00		ees (line 2 times	s line 21)	JTATION - PRO	VIDER SITE		
22. 00 23. 00	Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	ees (line 2 times	s line 21)	JTATION - PRO	VIDER SITE	3, 201	23. 00
22. 00 23. 00 24. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11)	ees (line 2 times	s line 21)	JTATION - PRO	VI DER SI TE	3, 201	23. 00
22. 00 23. 00 24. 00 25. 00	Weighted allowance excluding aides and traine Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	ees (line 2 times	S line 21) EXPENSE COMPL		VI DER SI TE	3, 201	23. 00 24. 00 25. 00
22. 00 23. 00 24. 00 25. 00 26. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3	VANCE AND TRAVEL sum of lines 24	EXPENSE COMPL and 25 for al	I others)		3, 201 203 0	23. 00 24. 00 25. 00 26. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	Weighted allowance excluding aides and trained total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard	NANCE AND TRAVEL sum of lines 24 for respiratory	EXPENSE COMPL and 25 for al therapy or su	l others) um of lines 3	and 4 for all	3, 201 203 0 203	23. 00 24. 00 25. 00 26. 00 27. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)	NANCE AND TRAVEL sum of lines 24 for respiratory travel expense a	EXPENSE COMPL and 25 for al therapy or su	l others) um of lines 3	and 4 for all	3, 201 203 0 203 0	23. 00 24. 00 25. 00 26. 00 27. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of	sum of lines 24 for respiratory travel expense a Expense of columns 1 and	EXPENSE COMPL and 25 for al therapy or su	l others) um of lines 3	and 4 for all	3, 201 203 0 203 0 203	23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,	sum of lines 24 for respiratory travel expense of columns 1 and line 12)	EXPENSE COMPL and 25 for all therapy or sulat the provide 2, line 12)	l others) um oflines 3 er site (sum	and 4 for all	3, 201 203 0 203 0 203 0 203	23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of	sum of lines 24 for respiratory travel expense of columns 1 and line 12) sum of lines 29	and 25 for all therapy or sulat the provided 2, line 12) and 30 for all	I others) um of lines 3 er site (sum I others)	and 4 for all of lines 26 and	3, 201 203 0 203 0 203	23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	sum of lines 24 for respiratory travel expense a Expense Di columns 1 and line 12) sum of lines 29 s 1 and 2, line	and 25 for all therapy or sulat the provide 2, line 12) and 30 for all 3 for respira	I others) um of lines 3 er site (sum I others)	and 4 for all of lines 26 and	3, 201 203 0 203 0 203 0 0 0 0	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00	Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns)	sum of lines 24 for respiratory travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line 2 expense (line 2)	and 25 for al therapy or su at the provide 2, line 12) and 30 for al 13 for respira	I others) um of lines 3 er site (sum I others) atory therapy	and 4 for all of lines 26 and	3, 201 203 0 203 0 203 0 0 0 0	24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00

Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE

Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45,

0

0

0 39.00

0 40.00

0 41.00

0 42.00

0

36.00 37.00

38.00

43.00

0 44.00

0 45.00

Standard Travel Expense

or 46, as appropriate.

Therapists (line 5 times column 2, line 11)

39.00 Standard travel expense (line 7 times the sum of lines 5 and 6)

Assistants (column 3, line 12.01 times column 3, line 10)

Optional Travel Allowance and Optional Travel Expense Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)

Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)

44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)

45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)

37.00 Assistants (line 6 times column 3, line 11)

Subtotal (sum of lines 36 and 37)

Subtotal (sum of lines 40 and 41)

38.00

40.00

41.00

42.00

43.00

	Financial Systems	RUSH MEMORIAL				eu of Form CMS-2	
	IABLE COST DETERMINATION FOR THERAPY SERVICES SUPPLIERS	-URNI SHED BY	Provi der CC		Period: From 01/01/2017 To 12/31/2017	Worksheet A-8- Parts I-VI Date/Time Prep 5/23/2018 4:25	pared:
				F	hysical Therapy		o piii
						1.00	
46. 00	Optional travel allowance and optional travel	expense (sum o	flines 42 an	d 43 – see in	structions)		46. 00
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
	DART V OVERTIME COMPUTATION	1.00	2. 00	3. 00	4. 00	5. 00	
47. 00	PART V - OVERTIME COMPUTATION Overtime hours worked during reporting	0.00	0.00	0.0	0.00	0.00	47. 00
47.00	period (if column 5, line 47, is zero or	0.00	0.00	0.0	0.00	0.00	47.00
	equal to or greater than 2,080, do not						
	complete lines 48-55 and enter zero in each						
	column of line 56)						
48. 00	Overtime rate (see instructions)	0. 00	0. 00	0. 0			48. 00
49. 00	· S	0. 00	0. 00	0. 0	0.00		49. 00
	allowance) (multiply line 47 times line 48)						
EO 00	CALCULATION OF LIMIT Percentage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50.00
30.00	(divide the hours in each column on line 47	0.00	0.00	0.0	0.00	0.00	30.00
	by the total overtime worked - column 5,						
	line 47)						
51.00	· ·	0. 00	0.00	0.0	0.00	0.00	51.00
	for one full-time employee times the						
	percentages on line 50) (see instructions)						
	DETERMINATION OF OVERTIME ALLOWANCE	24.24					
52. 00	Adjusted hourly salary equivalency amount	81. 04	0. 00	0. 0	0.00		52. 00
53. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0		0		53. 00
55.00	52)	o o	U		0		33.00
54.00	Maximum overtime cost (enter the lesser of	0	0		0		54.00
	line 49 or line 53)						
55.00	Portion of overtime already included in	0	0		0 0		55.00
	hourly computation at the AHSEA (multiply						
	line 47 times line 52)	_	_			_	
56. 00	Overtime allowance (line 54 minus line 55 -	0	0		0	0	56. 00
	if negative enter zero) (Enter in column 5						
	the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3						
	for all others.)						
	Tor directions.						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST A	ADJUSTMENT				
	Salary equivalency amount (from line 23)					3, 201	
58.00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 33,	34, or 35))			203	58. 00
58. 00 59. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite service	(from lines 33,	34, or 35)))		203 0	58. 00 59. 00
58. 00 59. 00 60. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56)	(from lines 33,	34, or 35)))		203 0 0	58. 00 59. 00 60. 00
58. 00 59. 00 60. 00 61. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servid Overtime allowance (from column 5, line 56) Equipment cost (see instructions)	(from lines 33,	34, or 35)))		203 0 0	58. 00 59. 00 60. 00 61. 00
58. 00 59. 00 60. 00 61. 00 62. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions)	(from lines 33,	34, or 35)))		203 0 0 0	58. 00 59. 00 60. 00 61. 00 62. 00
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62)	(from lines 33, ces (from lines	34, or 35)))		203 0 0 0 0 0 0 3, 404	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from	(from lines 33, ses (from lines of the lines	34, or 35)) 44, 45, or 46)		203 0 0 0 0 3, 404 1, 975	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servid Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63)	(from lines 33, ses (from lines of the lines	34, or 35)) 44, 45, or 46)		203 0 0 0 0 3, 404 1, 975	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from	(from lines 33, ces (from lines of n your records) B - if negative,	34, or 35)) 44, 45, or 46 enter zero)			203 0 0 0 0 3, 404 1, 975	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63) LINE 33 CALCULATION	(from lines 33, ses (from lines of ses (from lines of ses (from lines of ses (from lines 24, ses (from lines 33, ses (from lines 4,	34, or 35)) 44, 45, or 46 enter zero) and 25 for a	II others	others	203 0 0 0 0 3, 404 1, 975 0	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63) LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	(from lines 33, ses (from lines of ses (from lines of ses (from lines of ses (from lines 24, ses (from lines 33, ses (from lines 4,	34, or 35)) 44, 45, or 46 enter zero) and 25 for a	II others	others	203 0 0 0 0 3, 404 1, 975 0	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 100. 01 100. 02	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	(from lines 33, ses (from lines 4) a your records) 3 - if negative, sum of lines 24 a therapy or sum	34, or 35)) 44, 45, or 46 enter zero) and 25 for a of lines 3 a	II others nd 4 for all		203 0 0 0 0 3, 404 1, 975 0	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 100. 00 100. 01 100. 02	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 33 = line 24 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory LINE 34 CALCULATION	(from lines 33, es (from lines 4) ses (from lines 4) sum of lines 24 therapy or sum	34, or 35)) 44, 45, or 46 enter zero) and 25 for a of lines 3 a	II others nd 4 for all		203 0 0 0 0 3, 404 1, 975 0 203 0 203	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 100. 00 100. 01 100. 02
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Health Financial Systems	RUSH MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
REASONABLE COST DETERMINATION FOR THERAP OUTSIDE SUPPLIERS	Y SERVICES FURNISHED BY	Provider CCN: 15-1304	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8 Parts I-VI Date/Time Pre 5/23/2018 4:2	pared:
			Speech Pathology	Cost	
				1. 00	
PART I - GENERAL INFORMATION					

Supervisors Interaplists Assistants Aldes Trainees					Sp	eech Pathology	Cost	
New York Common Information Properties Properti							1.00	
1.00 1014 number of weeks worked (excluding alloes) (see Instructions) 1.5 1.00 1		DART I CENERAL INFORMATION					1.00	
Line 1 multiplied by 15 hours per week 225 2.00 3.00 Number of undoplicated days in which therapy usolitant was un provider site (see instructions) 37 3.00 Number of undoplicated days in which therapy usolitant was un provider site but not there supervisor 4.00	1 00		c) (coo instruc	ti onc)			15	1 00
3.00 Number of unduplicated days in which supervisor of therapis xts as on providers at the Case Instructions) 3.00			s) (see Ilistiuc	ti ons)				
Musber of unduji losted days in which thorapy assistant was an provider as it to but heither supervisor or not not repail staws an provider site (see Instructions) 5.00			sor or thoranis	t was on provi	dar sita (saa i	netructione)		
The content of the								
Number of unduplicated offsite of visits - supervisors or therapists (see instructions) 0.500	4.00			on provider si	te but her ther	super vi soi		4.00
Sumbler or unumulicated offsite wisits - therapy assistants (include only visits made by therapy) 0	5 00			anists (see in	structions)		0	5.00
assistant and on which supervisor and/or therapist was not present during the visit(s)) (see " 0 0 1 1 1 1 1 1 1 1						therany	0	
Instructions Instructions O	0.00							0.00
Standard travel expense rate per mile			Tapi St Was Not	present during	(110 11311(3))	(300		
Supplementary Supplementar	7. 00	1					0.00	7. 00
Supervisors Therepists Assistants Aldies Trainness		1						
1.00		, sp. s.	Supervi sors	Therapi sts	Assi stants	Ai des		
Total hours worked								
AMSEA (see instructions)	9. 00	Total hours worked	0.00	292. 00	0.00	0.00		9. 00
One-half of column 2, line 100 0 0 0 0 12.00	10.00	AHSEA (see instructions)	0.00	73. 84	0.00	0.00	0.00	10.00
00e-half of column 3, line 10) 12.00 Number of travel hours (provider site) 0 0 0 0 0 0 12.00 12.01 Number of travel hours (provider site) 0 0 0 0 0 0 0 13.00 13.00 Number of miles driven (provider site) 0 70 0 0 13.00 13.01 Number of miles driven (provider site) 0 70 0 0 13.00 13.01 Number of miles driven (provider site) 0 70 0 0 0 13.00 Part II - SMARY FOULVAIENCY COMPUTATION 14.00 Supprovisors (column 1, line 9 times column 1, line 10) 15.00 Therapists (column 2, line 9 times column 2, line 10) 15.00 Therapists (column 3, line 9 times column 2, line 10) 16.00 Assistants (column 3, line 9 times column 4, line 10) 17.00 Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all 21, 561 17, 00 others (column 4, line 9 times column 5, line 10) 18.00 Traines (column 4, line 9 times column 5, line 10) 19.00 Traines (column 5, line 9 times column 5, line 10) 19.00 Traines (column 6, line 9 times column 5, line 10) 19.00 Traines (column 6, line 9 times column 5, line 10) 19.00 Traines (column 6, line 9 times column 5, line 10) 19.00 Traines (column 6, line 9 times column 5, line 10) 19.00 Traines (column 6, line 9 times column 5, line 10) 19.00 Traines (column 6, line 9 times column 5, line 10) 19.00 Traines (column 6, line 9 times column 6, line 10) 19.00 Traines (column 6, line 9 times column 6, line 10) 19.00 Traines (column 6, line 9 times column 6, line 10) 19.00 Traines (column 6, line 9 times column 6, line 10) 19.00 Traines (column 6, line 9 times column 6, line 10) 19.00 Traines (column 6, line 9 times column 6, line 10) 19.00 Traines (column 6, line 9, lines column 6, line 10) 19.00 Traines (column 6, line 9, lines column 7, line 10) 19.00 Traines (column 6, line 9, lines column 7, line 10) 19.00 Traines (column 6, line 9, lines column 7, line 10) 19.00 Traines (column 6, line 9, lines column 7, line 10, line 2, line 9, line 10, l	11.00	Standard travel allowance (columns 1 and 2,	36. 92	36. 92	0.00			11. 00
12.00 Number of travel hours (provider site)		one-half of column 2, line 10; column 3,						
12.01 Number of travel hours (offsite) 0 0 0 0 12.01		one-half of column 3, line 10)						
13.00 Number of miles driven (provider site) 0 70 0 13.00	12.00	Number of travel hours (provider site)	0	0	0			12. 00
13.01 Number of miles driven (offsite)	12.01	Number of travel hours (offsite)	0	0	0			12. 01
Part II - SALARY EQUIVALENCY COMPUTATION	13.00	Number of miles driven (provider site)	0	70	0			13. 00
Part II - SALARY EQUIVALENCY COMPUTATION 10 14.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 16.00 15.00 16.0	13. 01	Number of miles driven (offsite)	0	0	0			13. 01
Part II - SALARY EQUIVALENCY COMPUTATION 10 14.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 16.00 15.00 16.0								
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16.00 Assistants (column 3, line 9 times column 3, line 10) 16.00 chters) 21.561 17.00	14.00						0	14. 00
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20.00 Total allowance amount (sum of lines 17-19 for respiratory therapy or clums 1 and 18 for all others) 21,561 1 1 1 1 1 1 1 1 1							_	
If the sum of col umns 1 and 2 for respiratory therapy or col umns 1-3 for physical therapy, speech pathol ogy or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23. 21.00 Very line amount from line 20. Otherwise complete lines 21-23. 22.01 Very line amount from line 20. Otherwise complete lines 21-23. 22.02 Very line amount from line 20. Otherwise complete lines 21-23. 22.03 Very line amount from line 20. Otherwise complete lines 21-25. 22.04 Very line amount from line 20. Otherwise complete lines 21-25. 22.05 Very line amount from line 20. Otherwise complete lines 21-25. 22.06 Very line amount from line 20. Otherwise complete lines 21-25. 22.07 Very line amount from line 20. Otherwise complete lines 21-25. 22.08 Very line amount from line 20. Otherwise complete lines 21-25. 22.09 Very line amount from line 20. Otherwise complete lines 21-25. 23.00 Very line amount from line 20. Otherwise complete lines 21-25. 24.00 Very line 21-25. 25.00 Very line 21-25. 26.00 Very line 21-25. 27.00 Very line 21-25. 28.00 Very line 21-25. 28.00 Very line 21-25. 29.00 Therapists (column 2, line 10 times column 3, line 12). 20.00 Very line 21-25. 20.00 Very line 21-							_	
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21.00 Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 0.00 21.00				no entries on l	lines 21 and 22	and enter on	line 23	
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23. 00 Part It StanDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE Standard Travel Allowance Standard Travel Allowance Therapists (line 3 times column 2, line 11) 1,366 25. 00	22 00							22.00
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25.00	24 00						1 366	24 00
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Optional Travel Allowance and Optional Travel Expense 29.00 Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) 30.00 Assistants (column 3, line 10 times column 3, line 12) 31.00 Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) 32.00 Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of Optional travel allowance and standard travel expense (line 28) 33.00 Standard travel allowance and standard travel expense (sum of lines 27 and 31) Optional travel allowance and standard travel expense (sum of lines 27 and 31) Optional travel allowance and optional travel expense (sum of lines 31 and 32) Optional travel Expense 36.00 Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) 37.00 Assistants (line 6 times column 3, line 11) 38.00 Subtotal (sum of lines 36 and 37) Optional travel expense (line 7 times the sum of lines 5 and 6) Optional travel allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)				p				
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Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE Standard Travel Expense 36. 00 Therapists (line 5 times column 2, line 11) 0 36. 00 37. 00 Assistants (line 6 times column 3, line 11) 0 37. 00 38. 00 Subtotal (sum of lines 36 and 37) 0 38. 00 39. 00 Optional Travel expense (line 7 times the sum of lines 5 and 6) 0 38. 00 Optional Travel Allowance and Optional Travel Expense 40. 00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 0 40. 00 41. 00 Assistants (column 3, line 12.01 times column 3, line 10) 0 41. 00 42. 00 Subtotal (sum of lines 40 and 41) 0 42. 00 Optional Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44. 00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44. 00	34.00	Optional travel allowance and standard trave	I expense (sum	of lines 27 and	d 31)		0	34.00
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36.00 Therapists (line 5 times column 2, line 11) 37.00 Assistants (line 6 times column 3, line 11) 38.00 Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 41.00 Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 41.00 Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 41.00 Assistants (column 3, line 12.01 times column 41.00 Assistants (column 3, line 12.01 times column 42.00 Assistants (column 3, line 12.01 times column 42.00 Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Assistants (column 4, line 10) Assistants (column 4, line 10) A		Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	ANCE AND TRAVEL	EXPENSE COMPU	TATION - SERVIC	ES OUTSIDE PRO	OVIDER SITE	
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38.00 Subtotal (sum of lines 36 and 37) 39.00 Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 38.00 0 39.00 0 40.00 0 40.00 0 41.00 0 42.00 0 42.00 0 43.00 0 44.00	36.00	Therapists (line 5 times column 2, line 11)					0	36. 00
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Optional Travel Allowance and Optional Travel Expense 40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00	38. 00	Subtotal (sum of lines 36 and 37)					0	38. 00
40.00 Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) 41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) 43.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 40.00 41.00 42.00 43.00 44.00 44.00	39. 00	Standard travel expense (line 7 times the su	m of lines 5 an	d 6)			0	39. 00
41.00 Assistants (column 3, line 12.01 times column 3, line 10) 42.00 Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 41.00 42.00 43.00 44.00								
42.00 Subtotal (sum of lines 40 and 41) 43.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 42.00 43.00 4	40. 00			2, line 10)			01	
43.00 Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 43.00			n 3, line 10)					
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00							_	
or 46, as appropriate. 44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00	43. 00							43. 00
44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) 0 44.00		•	Offsite Service:	s; Complete one	e of the follow	ing three line	s 44, 45,	
	44.55			6.11	1.00		=	44.55
45.00 uptional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions) 0 45.00								
	45.00	Toptional travel allowance and standard trave	expense (sum	or rines 39 and	u 4∠ - See Inst	.ructrons)	, 01	45.00

	BLE COST DETERMINATION FOR THERAPY SERVICES I SUPPLIERS	FURNI SHED BY	Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet A-8 Parts I-VI Date/Time Pre 5/23/2018 4:2	pared:
				!	Speech Pathology	Cost	
						1. 00	
6. 00	Optional travel allowance and optional travel		flines 42 and	d 43 – see in			46. 00
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
	PART V - OVERTIME COMPUTATION	1. 00	2.00	3. 00	4. 00	5. 00	
7. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0.00	0.0	0.00	0. 00	47. 0
	Overtime rate (see instructions)	0. 00	0.00	0.0	0.00		48. 0
	Total overtime (including base and overtime	0. 00	0.00	0.0	0.00		49. 0
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT						
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.0	0.00	0. 00	50. 00
1. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE	0. 00	0.00	0.0	0.00	0.00	51.0
	Adjusted hourly salary equivalency amount	73. 84	0.00	0.0	0.00		52. 0
3. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0		0 0		53. 0
4. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.0
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55. 0
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0		0 0	0	56. 0
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	res (from lines	44, 45, or 46))		21, 561 1, 366 0 0 0 0 22, 927 14, 016	58. 0 59. 0 60. 0 61. 0 62. 0 63. 0 64. 0
00. 01 00. 02	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 _INE 34 CALCULATION				others	1, 366 0 1, 366	100. 0
01. 00 01. 01 01. 02	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 0 101. 0 101. 0
02.00	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				mns 1-3, line		102. 0 102. 0
	13 for all others						

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1304

				То	12/31/2017	Date/Time Pre 5/23/2018 4:2	
			CAPI TAL			3/23/2010 4.2	J pili
			RELATED COSTS				
	Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
	·	for Cost	FLXT	BENEFITS		& GENERAL	
		Allocation		DEPARTMENT			
		(from Wkst A					
		col . 7)	1.00	4.00		5.00	
	CENEDAL CEDVICE COST CENTEDS	0	1. 00	4. 00	4A	5. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT	1, 645, 519	1, 645, 519				1. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 634, 638					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	3, 580, 954			4, 388, 849	4, 388, 849	5. 00
7. 00	00700 OPERATION OF PLANT	930, 720			1, 140, 362		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	59, 288	12, 626		71, 914		8. 00
9. 00	00900 HOUSEKEEPI NG	398, 686			506, 653		9. 00
10. 00	01000 DI ETARY	183, 939			267, 615		10.00
11. 00	01100 CAFETERI A	192, 135			273, 454		11. 00
13.00	01300 NURSING ADMINISTRATION	76, 340	11, 783	19, 323	107, 446	22, 559	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	126, 065	37, 877	13, 993	177, 935	37, 359	14. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	409, 428	25, 060	91, 232	525, 720	110, 378	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	956, 778	126, 581	233, 736	1, 317, 095	276, 532	30. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	440 101	102.002	145 700	(07.014	14/ 521	F0 00
50.00	05000 OPERATING ROOM	448, 131	103, 993		697, 914		50. 00 51. 00
51. 00 53. 00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	35, 876	12, 032 0	1	57, 020 0		51.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 360, 614	141, 353	1	1, 759, 797	1	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 300, 014	141, 333	1	1, 757, 777	307, 400	55. 00
60. 00	06000 LABORATORY	1, 435, 437	39, 869		1, 639, 344	1	60.00
65. 00	06500 RESPI RATORY THERAPY	110, 459	2, 510		140, 037		65. 00
66. 00	06600 PHYSI CAL THERAPY	365, 850			506, 245		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	180, 578			244, 426		67. 00
68. 00	06800 SPEECH PATHOLOGY	29, 752			40, 984		68. 00
69. 00	06900 ELECTROCARDI OLOGY	151, 443	7, 702	39, 035	198, 180	41, 609	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	332, 901	0	0	332, 901	69, 895	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	54, 410		0	54, 410		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 809, 723	6, 820	137, 581	4, 954, 124	1, 040, 151	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	040.000	0.40, 000	700 5/4	4 054 475	200 //5	00.00
90.00	09000 CLINIC	812, 223	248, 388		1, 851, 175		90.00
90. 01 90. 02	09001 SURGI CAL ASSOCI ATES 09002 ORTHOPAEDI CS	113, 027 59, 986	30, 079		163, 429		90. 01 90. 02
90. 02	09003 RHEUMATOLOGY	19, 282			92, 139 181, 435		90. 02
90. 03	09004 ENDOCRI NOLOGY	-5, 790			31, 108		90.03
90. 05	09005 PEDI ATRI CS	57, 494	27, 378		163, 121		90. 05
90. 06	09006 WOMEN'S HEALTH	22,777	20, 596		121, 981		90. 06
90. 07	09007 PAI N MANAGEMENT	19, 662			41, 977		90. 07
91. 00	09100 EMERGENCY	1, 953, 008			2, 251, 634		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	,			0		92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	667, 516	71, 424	156, 481	895, 421	187, 999	95. 00
440.00	SPECIAL PURPOSE COST CENTERS	05 000 040	4 (00 004	2 (22 (72	05 405 045	1 0/0 557	440.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	25, 228, 849	1, 629, 234	3, 630, 679	25, 195, 845	4, 368, 557	118.00
192 00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	n	192. 00
	19300 NONPALD WORKERS	0	0	l	0		193. 00
	19301 FOUNDATION	63, 644	16, 285		96, 648		
193. 02	19302 OCCUPATIONAL MEDICINE	0	0	0	0		193. 02
	07950 OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0		194. 00
200.00		1			0		200. 00
201.00			0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	25, 292, 493	1, 645, 519	3, 647, 398	25, 292, 493	4, 388, 849	202. 00

				10	12/31/2017	5/23/2018 4: 2	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	, p
	, , , , , , , , , , , , , , , , , , ,	PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT	1, 379, 788					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	13, 807	100, 820				8.00
9.00	00900 HOUSEKEEPI NG	30, 255	7, 076	650, 359			9.00
10.00	01000 DI ETARY	58, 309	2, 901	28, 390	413, 402		10.00
11. 00	01100 CAFETERI A	19, 381	0	9, 436	0	359, 684	11.00
13.00	01300 NURSING ADMINISTRATION	12, 885	0	6, 274	0	1, 945	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	41, 422	0		0	3, 891	
16.00	01600 MEDICAL RECORDS & LIBRARY	27, 405	0	13, 343	o	20, 231	1
	INPATIENT ROUTINE SERVICE COST CENTERS	,					
30.00	03000 ADULTS & PEDI ATRI CS	138, 429	65, 740	67, 401	413, 402	37, 155	30.00
	ANCILLARY SERVICE COST CENTERS				,		1
50.00	05000 OPERATI NG ROOM	113, 727	6, 599	55, 373	0	18, 286	50.00
51. 00	05100 RECOVERY ROOM	13, 158			o	1, 751	51.00
53. 00	05300 ANESTHESI OLOGY	0	0	0	o	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	154, 583	4, 263		o	33, 654	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	o	0	1
60.00	06000 LABORATORY	43, 601	0	-1	ol	27, 818	
65. 00	06500 RESPI RATORY THERAPY	2, 745	849		o	3, 891	
66. 00	06600 PHYSI CAL THERAPY	78, 297	1, 985	,	ol	9, 726	1
67. 00	06700 OCCUPATI ONAL THERAPY	18, 081	913		o	4, 280	1
68. 00	06800 SPEECH PATHOLOGY	3, 792	39		0	584	
69. 00	06900 ELECTROCARDI OLOGY	8, 423	Ó		Ö	4, 474	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0, 423	0		0	4, 474	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	-1	Ö	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	ĺ		Ö	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	7, 459			o	13, 617	1
73.00	OUTPATIENT SERVICE COST CENTERS	7,437	0	3, 032	<u> </u>	13, 017	73.00
90. 00	09000 CLINIC	271, 643	0	132, 262	o	85, 202	90.00
90. 00	09001 SURGI CAL ASSOCI ATES	32, 894	0	· ·	o	3, 307	
90. 01	09002 ORTHOPAEDI CS	22, 586			o	1, 945	1
90. 02	09003 RHEUMATOLOGY	30, 150	l e		0	9, 726	1
90. 03	09004 ENDOCRI NOLOGY	7, 543	0	,	0	389	
90. 05	09005 PEDI ATRI CS	29, 940	0		Ö	7, 976	1
90.06	09006 WOMEN' S HEALTH	22, 523	0		0	3, 891	1
90. 00	09007 PAI N MANAGEMENT	22, 323	0	10, 400	0	3, 112	1
91.00	09100 EMERGENCY	80, 832		-	0	28, 012	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	00,032	10, 433	34, 337	Ů,	20, 012	92.00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	78, 109	О	38, 031	o	34, 821	05 00
95.00	SPECIAL PURPOSE COST CENTERS	70, 109		30, 031	······································	34, 021	95. 00
118.00		1, 361, 979	100, 820	641, 688	413, 402	359, 684	110 00
110.00		1, 301, 979	100, 620	041,000	413, 402	339, 004	1110.00
102.00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES	0			٥١	0	100 00
		0			0		192. 00
	19300 NONPAL D WORKERS	17 000	0		0		193. 00
	19301 FOUNDATION	17, 809	0	-,	0		193. 01
	19302 OCCUPATIONAL MEDICINE	0		0	0		193. 02
	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 through 201)	1, 379, 788	100, 820	650, 359	413, 402	359, 684	J202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1304

				To	12/31/2017	Date/Time Pre 5/23/2018 4: 2	
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	Subtotal	Intern &	5 pili
	oost contor becomparen	ADMI NI STRATI ON	SERVICES &	RECORDS &	oub to tu.	Residents Cost	
			SUPPLY	LI BRARY		& Post	
						Stepdown	
						Adjustments	
		13. 00	14. 00	16. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS	T				T	
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 00800 LAUNDRY & LINEN SERVICE						7.00
8. 00 9. 00	00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSING ADMINISTRATION	151, 109					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	280, 775				14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	1, 250				16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	'		· '			
30.00	03000 ADULTS & PEDI ATRI CS	25, 761	10, 503	300, 044	2, 652, 062	0	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	12, 663	11, 478	65, 986	1, 128, 557	0	50. 00
51. 00	05100 RECOVERY ROOM	1, 228	287	0	91, 822	0	51. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	1	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	23, 270	9, 945	79, 893	2, 510, 151	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
60.00	06000 LABORATORY	19, 214	119, 337		2, 214, 733		60.00
65. 00	06500 RESPI RATORY THERAPY	2, 774	1, 055		183, 569		65. 00
66. 00	06600 PHYSI CAL THERAPY	6, 827	1, 386		748, 878		66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	2, 915 313	68 13		330, 806 56, 176		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	3, 111	516		260, 414		69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	3, 111	0		200, 414		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		19, 232		422, 028	1	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	69, 871		135, 705		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	9, 473	4, 354		6, 032, 810		73. 00
	OUTPATIENT SERVICE COST CENTERS	<u> </u>				•	
90.00	09000 CLI NI C	0	11, 445	0	2, 740, 392	0	90. 00
90. 01	09001 SURGI CAL ASSOCI ATES	0	832	0	250, 791	0	90. 01
90. 02	09002 ORTHOPAEDI CS	0	0	0	147, 012	0	90. 02
90. 03	09003 RHEUMATOLOGY	0	720		274, 804	0	90. 03
90. 04	09004 ENDOCRI NOLOGY	0	65		49, 309		90. 04
90. 05	09005 PEDI ATRI CS	0	1, 442		251, 305		90. 05
90.06	09006 WOMEN'S HEALTH	0	830		185, 802		90.06
90. 07	09007 PAIN MANAGEMENT	10 414	880		54, 782		90.07
91.00	09100 EMERGENCY	19, 414	10, 728	250, 924	3, 164, 100	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					0	92. 00
95. 00	09500 AMBULANCE SERVICES	24, 146	4, 538	0	1, 263, 065	0	95. 00
73.00	SPECIAL PURPOSE COST CENTERS	24, 140	4, 330	<u> </u>	1, 203, 003		75.00
118.00		151, 109	280, 775	698, 327	25, 149, 073	0	118. 00
	NONREI MBURSABLE COST CENTERS	1017107	200,770	0,0,02,	20/11//0/0		
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	O	0	0	0	0	192. 00
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	19301 FOUNDATION	0	0	0	143, 420		193. 01
	19302 OCCUPATI ONAL MEDI CI NE	0	0	0	0		193. 02
	07950 OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
200.00					0		200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	151, 109	280, 775	698, 327	25, 292, 493	1 0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS RUSH MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2017	Part
To 12/31/2017	Date/Time Prepared:
5/23/2018 4:25 pm	Provider CCN: 15-1304

			3/2018 4: 25 pm
	Cost Center Description	Total	
		26. 00	
	GENERAL SERVICE COST CENTERS		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL		5. 00
7.00	00700 OPERATION OF PLANT		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE		8. 00
9.00	00900 HOUSEKEEPI NG		9. 00
	01000 DI ETARY		10.00
11.00	01100 CAFETERI A		11.00
13.00	01300 NURSING ADMINISTRATION		13. 00
	01400 CENTRAL SERVICES & SUPPLY		14. 00
16.00	01600 MEDICAL RECORDS & LIBRARY		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000 ADULTS & PEDIATRICS	2, 652, 062	30.00
	ANCILLARY SERVICE COST CENTERS		
	05000 OPERATI NG ROOM	1, 128, 557	50.00
	05100 RECOVERY ROOM	91, 822	51. 00
	05300 ANESTHESI OLOGY	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 510, 151	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	55. 00
	06000 LABORATORY	2, 214, 733	60.00
65. 00	06500 RESPI RATORY THERAPY	183, 569	65. 00
66. 00	06600 PHYSI CAL THERAPY	748, 878	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	330, 806	67. 00
68. 00	06800 SPEECH PATHOLOGY	56, 176	68. 00
69. 00	06900 ELECTROCARDI OLOGY	260, 414	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	422, 028	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	135, 705	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	6, 032, 810	73. 00
	OUTPATIENT SERVICE COST CENTERS		
	09000 CLI NI C	2, 740, 392	90.00
90. 01	09001 SURGI CAL ASSOCI ATES	250, 791	90. 01
	09002 ORTHOPAEDI CS	147, 012	90. 02
	09003 RHEUMATOLOGY	274, 804	90. 03
90. 04	09004 ENDOCRI NOLOGY	49, 309	90. 04
	09005 PEDI ATRI CS	251, 305	90. 05
	09006 WOMEN'S HEALTH	185, 802	90.06
90. 07	09007 PAIN MANAGEMENT	54, 782	90. 07
	09100 EMERGENCY	3, 164, 100	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92. 00
	OTHER REIMBURSABLE COST CENTERS	4 040 045	
95. 00	09500 AMBULANCE SERVI CES	1, 263, 065	95. 00
440.00	SPECIAL PURPOSE COST CENTERS	05 440 070	110.00
118. 00		25, 149, 073	118. 00
100.00	NONREI MBURSABLE COST CENTERS	<u></u>	100.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	192. 00
	19300 NONPAI D WORKERS	0	193. 00
	19301 FOUNDATION	143, 420	193. 01
	19302 OCCUPATI ONAL MEDI CI NE	0	193. 02
	07950 OTHER NON REIMBURSABLE COST CENTERS	0	194. 00
200.00	, , , , , , , , , , , , , , , , , , , ,	0	200. 00
201.00		0	201. 00
202.00	TOTAL (sum lines 118 through 201)	25, 292, 493	202. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part | I | To 12/31/2017 | Date/Time Prepared: | Part | I | Part | Pa Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1304

				To	12/31/2017	Date/Time Prep 5/23/2018 4:2	
			CAPI TAL			3/23/2010 4.2.	J DIII
			RELATED COSTS				
	Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
	·	Assigned New	FLXT		BENEFI TS	& GENERAL	
		Capi tal			DEPARTMENT		
		Related Costs					
	T	0	1. 00	2A	4. 00	5. 00	
	GENERAL SERVI CE COST CENTERS	I		ı		T	4 00
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT		10 7/0	10.7/0	10 7/0		1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	12, 760		12, 760		4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	242, 645		1, 977 284		5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	128, 421 12, 626	128, 421 12, 626	204		8. 00
9. 00	00900 HOUSEKEEPING	0	27, 665		281	5, 929	9. 00
10.00	01000 DI ETARY	0	53, 319		106		10. 00
11. 00	01100 CAFETERI A	0	17, 722		222		11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	11, 783		68		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	37, 877		49		14. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	25, 060		319		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	_				37.132	
30.00	03000 ADULTS & PEDI ATRI CS	0	126, 581	126, 581	817	15, 413	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	103, 993	103, 993	510	8, 167	50.00
51. 00	05100 RECOVERY ROOM	0	12, 032	12, 032	32		51.00
53.00	05300 ANESTHESI OLOGY	0	0	I -	0		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	141, 353		902		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	·	0		55. 00
60.00	06000 LABORATORY	0	39, 869		574		60.00
65. 00	06500 RESPIRATORY THERAPY	0	2, 510		95 241		65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	71, 596 16, 534		165		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	3, 468		27		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	7, 702		136		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö		0	3, 896	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	О	0	0	637	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 820	6, 820	481	57, 980	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	248, 388		2, 769	21, 662	90. 00
90. 01	09001 SURGI CAL ASSOCI ATES	0	30, 079		71		90. 01
90. 02	09002 ORTHOPAEDI CS	0	20, 653		40		90. 02
90. 03	09003 RHEUMATOLOGY	0	27, 569		471	2, 123	90. 03
90. 04	09004 ENDOCRI NOLOGY	0	6, 897		105		90. 04
90.05	09005 PEDI ATRI CS	0	27, 378		274		90. 05
90. 06 90. 07	09006 WOMEN'S HEALTH 09007 PAIN MANAGEMENT	0	20, 596	20, 596 0	275 78		90.06
90.07	09100 EMERGENCY	0	73, 914	I -	786		90. 07 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	73, 714	73, 714	700	20, 349	92. 00
72.00	OTHER REIMBURSABLE COST CENTERS			<u> </u>			72.00
95. 00	09500 AMBULANCE SERVICES	0	71, 424	71, 424	547	10, 478	95. 00
	SPECIAL PURPOSE COST CENTERS		, , ,				
118.00		0	1, 629, 234	1, 629, 234	12, 702	243, 491	118. 00
	NONREI MBURSABLE COST CENTERS			,			
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	19300 NONPAID WORKERS	0	0	-	0		193. 00
	19301 FOUNDATION		16, 285	16, 285	58		193. 01
	2 19302 OCCUPATIONAL MEDICINE 07950 OTHER NON REIMBURSABLE COST CENTERS	0	0		0		193. 02 194. 00
200.00			١		Ü		200. 00
200.00			n		0	n	200.00
202.00		0	1, 645, 519	1, 645, 519	12, 760		
00			., 5.5, 517	., 0.0, 0.7	, . 00		

| Peri od: | Worksheet B | From 01/01/2017 | Part | I | To 12/31/2017 | Date/Time Prepared: | Part | I | Part | Pa Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1304

				Ic	12/31/2017	Date/lime Pre 5/23/2018 4:2	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	J piii
	occi conton boson pri on	PLANT	LINEN SERVICE	I I I I I I I I I I I I I I I I I I I	512171111	57.11 E 1 E 1.11 7 1	
		7. 00	8. 00	9.00	10.00	11. 00	
GEN	IERAL SERVICE COST CENTERS	<u> </u>					
1.00 001	100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 004	100 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	500 ADMINISTRATIVE & GENERAL						5. 00
	700 OPERATION OF PLANT	142, 050					7. 00
8.00 008	300 LAUNDRY & LINEN SERVICE	1, 421	14, 889				8. 00
	POO HOUSEKEEPI NG	3, 115	1, 045	38, 035			9. 00
	000 DI ETARY	6,003	428	1, 660	64, 648		10.00
11. 00 011	100 CAFETERI A	1, 995	0		o	23, 691	11. 00
13. 00 013	BOO NURSING ADMINISTRATION	1, 327	0	367	o	128	13. 00
14.00 014	100 CENTRAL SERVICES & SUPPLY	4, 264	0	1, 179	o	256	14. 00
16. 00 016	600 MEDICAL RECORDS & LIBRARY	2, 821	0	780	o	1, 333	16. 00
	PATIENT ROUTINE SERVICE COST CENTERS		<u> </u>	·		·	1
	000 ADULTS & PEDIATRICS	14, 251	9, 709	3, 942	64, 648	2, 447	30. 00
	CILLARY SERVICE COST CENTERS				· .	·	
50.00 050	000 OPERATING ROOM	11, 708	974	3, 238	0	1, 204	50. 00
51.00 051	100 RECOVERY ROOM	1, 355	0	375	o	115	51.00
	BOO ANESTHESI OLOGY	0	0	o	o	0	53. 00
54. 00 054	100 RADI OLOGY-DI AGNOSTI C	15, 914	630	4, 402	o	2, 217	54.00
55. 00 055	500 RADI OLOGY-THERAPEUTI C	0	0	0	o	0	55. 00
60.00 060	000 LABORATORY	4, 489	0	1, 242	o	1, 832	60.00
65. 00 065	500 RESPIRATORY THERAPY	283	125	78	o	256	65. 00
66. 00 066	600 PHYSI CAL THERAPY	8, 061	293	2, 230	o	641	66.00
67. 00 067	700 OCCUPATI ONAL THERAPY	1, 862	135	515	0	282	67. 00
68. 00 068	BOO SPEECH PATHOLOGY	390	6	108	0	38	68. 00
69. 00 069	POO ELECTROCARDI OLOGY	867	0	240	0	295	69. 00
70.00 070	000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00 072	200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
73. 00 073	BOO DRUGS CHARGED TO PATIENTS	768	0	212	0	897	73. 00
	PATIENT SERVICE COST CENTERS						
	DOO CLINIC	27, 966	0	7, 734	0	5, 612	90. 00
90. 01 090	001 SURGI CAL ASSOCI ATES	3, 387	0	937	0	218	90. 01
	002 ORTHOPAEDI CS	2, 325	0		0	128	90. 02
	003 RHEUMATOLOGY	3, 104	0	859	0	641	90. 03
90. 04 090	004 ENDOCRI NOLOGY	777	0	215	0	26	90. 04
90. 05 090	005 PEDI ATRI CS	3, 082	0	853	0	525	90. 05
	006 WOMEN'S HEALTH	2, 319	0	641	0	256	90. 06
	007 PAIN MANAGEMENT	0	0	1 4	0	205	90. 07
	100 EMERGENCY	8, 322	1, 544	2, 302	0	1, 845	
	200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	HER REIMBURSABLE COST CENTERS						
	500 AMBULANCE SERVICES	8, 041	0	2, 224	0	2, 294	95. 00
	CIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	140, 217	14, 889	37, 528	64, 648	23, 691	118. 00
	IREI MBURSABLE COST CENTERS						
	200 PHYSICIANS' PRIVATE OFFICES	0			0		192. 00
	300 NONPALD WORKERS	0	ļ		0		193. 00
	BO1 FOUNDATION	1, 833	l e		0		193. 01
	302 OCCUPATIONAL MEDICINE	0	0	_	0		193. 02
	OTHER NON REIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	142, 050	14, 889	38, 035	64, 648	23, 691	202. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1304

				To	12/31/2017	Date/Time Prep 5/23/2018 4: 2	
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	Subtotal	Intern &	J pili
	, , , , , , , , , , , , , , , , , , ,	ADMI NI STRATI ON	SERVICES &	RECORDS &		Residents Cost	
			SUPPLY	LI BRARY		& Post	
						Stepdown	
						Adjustments	
		13.00	14. 00	16. 00	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS						
1.00	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 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE						7. 00 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	14, 930					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	45, 707				14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	204				16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	, -,					
30.00	03000 ADULTS & PEDI ATRI CS	2, 546	1, 710	15, 755	257, 819	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 251	1, 868	3, 465	136, 378	0	50.00
51.00	05100 RECOVERY ROOM	121	47	0	14, 744	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 299	1, 619	4, 195	194, 124	0	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
60.00	06000 LABORATORY	1, 898	19, 426		88, 514	0	60.00
65. 00	06500 RESPI RATORY THERAPY	274	172		5, 510	1	65. 00
66. 00	06600 PHYSI CAL THERAPY	675	226		89, 887	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	288	11	0	22, 652	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	31	2	0	4, 550		68. 00
69. 00	06900 ELECTROCARDI OLOGY	307	84	0	11, 950		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	7 027	0	70. 00 71. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	3, 131	0	7, 027 12, 011	0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	936	11, 374 709	0	68, 803		73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	730	707	U _I	00, 003	0	73.00
90. 00	09000 CLINIC	0	1, 863	o	315, 994	0	90. 00
90. 01	09001 SURGI CAL ASSOCI ATES	0	135		36, 739		90. 01
90. 02	09002 ORTHOPAEDI CS	0	0		24, 867	Ö	90. 02
90. 03	09003 RHEUMATOLOGY	0	117	o	34, 884	Ö	90. 03
90. 04	09004 ENDOCRI NOLOGY	0	11	0	8, 395	0	90. 04
90. 05	09005 PEDI ATRI CS	0	235	0	34, 256	0	90. 05
90.06	09006 WOMEN' S HEALTH	0	135	0	25, 649	0	90. 06
90. 07	09007 PAIN MANAGEMENT	0	143	0	917	0	90. 07
91. 00	09100 EMERGENCY	1, 918	1, 746	13, 176	131, 902	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	2, 386	739	0	98, 133	0	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		14, 930	45, 707	36, 669	1, 625, 705	0	118. 00
400.00	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
	19300 NONPALD WORKERS	0	0	0	10.014		193. 00
	19301 FOUNDATION		0	0	19, 814		193. 01
	19302 OCCUPATIONAL MEDICINE 07950 OTHER NON REIMBURSABLE COST CENTERS		0	0	0		193. 02 194. 00
200.00	1	1	U	۱	0		200. 00
200.00			O	n	0		200.00
202.00		14, 930	45, 707	36, 669	1, 645, 519		202. 00
	, (, , , , , ,	.5, .61	00,007	., 5.5, 517		00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS RUSH MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2017 | Part II |
| To 12/31/2017 | Date/Time Prepared: | 5/23/2018 4:25 pm | Provider CCN: 15-1304

			'2018 4: 25 pm
	Cost Center Description	Total	
	·	26. 00	
	GENERAL SERVICE COST CENTERS		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL		5. 00
7.00	00700 OPERATION OF PLANT		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPI NG		9. 00
10.00	01000 DI ETARY		10.00
11.00	01100 CAFETERI A		11. 00
13.00	01300 NURSING ADMINISTRATION		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY		14. 00
16.00	01600 MEDICAL RECORDS & LIBRARY		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000 ADULTS & PEDIATRICS	257, 819	30.00
	ANCILLARY SERVICE COST CENTERS		
50.00	05000 OPERATING ROOM	136, 378	50.00
51.00	05100 RECOVERY ROOM	14, 744	51. 00
53.00	05300 ANESTHESI OLOGY	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	194, 124	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	55. 00
60.00	06000 LABORATORY	88, 514	60.00
65.00	06500 RESPI RATORY THERAPY	5, 510	65. 00
66.00	06600 PHYSI CAL THERAPY	89, 887	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	22, 652	67. 00
68. 00	06800 SPEECH PATHOLOGY	4, 550	68. 00
69.00	06900 ELECTROCARDI OLOGY	11, 950	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 027	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	12, 011	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	68, 803	73. 00
	OUTPATIENT SERVICE COST CENTERS		
90.00	09000 CLI NI C	315, 994	90. 00
90. 01	09001 SURGI CAL ASSOCI ATES	36, 739	90. 01
90. 02	09002 ORTHOPAEDI CS	24, 867	90. 02
90. 03	09003 RHEUMATOLOGY	34, 884	90. 03
90.04	09004 ENDOCRI NOLOGY	8, 395	90. 04
90. 05	09005 PEDI ATRI CS	34, 256	90. 05
90.06	09006 WOMEN'S HEALTH	25, 649	90. 06
90. 07	09007 PAIN MANAGEMENT	917	90. 07
91.00	09100 EMERGENCY	131, 902	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		92. 00
	OTHER REIMBURSABLE COST CENTERS		
95.00	09500 AMBULANCE SERVI CES	98, 133	95. 00
	SPECIAL PURPOSE COST CENTERS		
118. 00		1, 625, 705	118. 00
	NONREI MBURSABLE COST CENTERS		
	19200 PHYSICIANS' PRIVATE OFFICES	0	192. 00
	19300 NONPALD WORKERS	0	193. 00
	19301 FOUNDATI ON	19, 814	193. 01
	19302 OCCUPATIONAL MEDICINE	0	193. 02
	07950 OTHER NON REIMBURSABLE COST CENTERS	0	194. 00
200.00	1 1	0	200. 00
201. 00	9	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	1, 645, 519	202. 00

Heal th	Financial Systems	RUSH MEMORIAI	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2017 To 12/31/2017	Worksheet B-1 Date/Time Pre 5/23/2018 4:2	pared:
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SOUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)		n ADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4. 00	5A	5. 00	7. 00	
1 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT	85, 889					1 00
1. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	666	13, 878, 044				1. 00 4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	12, 665	2, 150, 727	•	9 20, 903, 644		5. 00
7.00	00700 OPERATION OF PLANT	6, 703	309, 040		1, 140, 362	65, 855	1
8.00	00800 LAUNDRY & LINEN SERVICE	659	C	1	71, 914	659	1
9.00	00900 HOUSEKEEPI NG	1, 444	305, 544	1	506, 653	1, 444	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	2, 783 925	115, 506 241, 981	1	267, 615 273, 454	2, 783 925	
13.00	01300 NURSI NG ADMI NI STRATI ON	615	73, 522	1	0 107, 446	615	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 977	53, 243		177, 935	1, 977	1
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 308	347, 130)	525, 720	1, 308	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1 = [
30. 00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	6, 607	889, 344		0 1, 317, 095	6, 607	30.00
50. 00	05000 OPERATING ROOM	5, 428	554, 717		697, 914	5, 428	50.00
51. 00	05100 RECOVERY ROOM	628	34, 672	1	57, 020	628	1
53.00	05300 ANESTHESI OLOGY	0	C)	0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 378	981, 021	•	1, 759, 797	7, 378	
55. 00 60. 00	05500 RADI OLOGY-THERAPEUTI C 06000 LABORATORY	0	(C) 4 1 4 C		0 1, 639, 344	0	55. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	2, 081 131	624, 149 102, 992		1, 639, 344 140, 037	2, 081 131	1
66. 00	06600 PHYSI CAL THERAPY	3, 737	261, 773		506, 245	3, 737	
67. 00	06700 OCCUPATI ONAL THERAPY	863	180, 027	'	244, 426	863	67. 00
68. 00	06800 SPEECH PATHOLOGY	181	29, 540		0 40, 984	181	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	402	148, 523		0 198, 180 0 0	402 0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		C	1	332, 901	0	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	l o	C	•	54, 410	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	356	523, 485	5	4, 954, 124	356	73. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	12, 965	3, 008, 041	1	1, 851, 175	12, 965	90.00
90. 00	09001 SURGI CAL ASSOCI ATES	1, 570	77, 327	1	1, 851, 175	1, 570	1
90. 02	09002 ORTHOPAEDICS	1, 078	43, 755	1	92, 139	1, 078	1
90. 03	09003 RHEUMATOLOGY	1, 439	512, 081	•	181, 435	1, 439	1
90. 04	09004 ENDOCRI NOLOGY	360	114, 150	1	31, 108 163, 121	360	1
90. 05 90. 06	09005 PEDIATRICS 09006 WOMEN'S HEALTH	1, 429 1, 075	297, 731 299, 095		0 163, 121 0 121, 981	1, 429 1, 075	1
90. 07	09007 PAIN MANAGEMENT	0	84, 908		0 41, 977	0	1
91.00	09100 EMERGENCY	3, 858	855, 010)	2, 251, 634	3, 858	91.00
92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
95 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	3, 728	595, 396		895, 421	3, 728	95. 00
70.00	SPECIAL PURPOSE COST CENTERS	3,720	070, 070	·	0,0,121	0,720	70.00
118.00		85, 039	13, 814, 430	-4, 388, 84	9 20, 806, 996	65, 005	118. 00
400.00	NONREI MBURSABLE COST CENTERS					^	100.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0	C	•	0 0		192. 00 193. 00
	19301 FOUNDATION	850	63, 614	•	96, 648		193. 01
	19302 OCCUPATIONAL MEDICINE	0	C		0 0		193. 02
	07950 OTHER NON REIMBURSABLE COST CENTERS	0	C		0	0	194. 00
200.00							200.00
201. 00 202. 00		1, 645, 519	3, 647, 398		4, 388, 849	1, 379, 788	201. 00
202.00	Part I)	1, 043, 317	3, 047, 370	ή	4, 300, 047	1, 377, 700	202.00
203.00		19. 158670	0. 262818	1	0. 209956	20. 951909	1
204.00			12, 760	9	244, 622	142, 050	204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part		0. 000919	,	0. 011702	2. 157012	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
	1. 3. 5	ı		1	1	l	1

RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1304 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/23/2018 4:25 pm Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG LINEN SERVICE (MEALS ADMI NI STRATI ON (SQUARE (FTE'S) (POUNDS OF FEET) SERVED) LAUNDRY) (DI RECT NRSING HRS) 9.00 10.00 8.00 11.00 13.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 28, 495 8.00 8.00 00900 HOUSEKEEPI NG 2,000 9.00 63, 752 9 00 10.00 01000 DI ETARY 820 2, 783 100 10.00 11.00 01100 CAFETERI A 925 1,849 11.00 0 C 01300 NURSING ADMINISTRATION 0 0 233.589 13 00 615 10 13 00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 1.977 0 20 0 14.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1.308 0 104 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 18, 580 100 191 30 00 03000 ADULTS & PEDLATRICS 39, 820 30 00 6.607 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1,865 5, 428 0 94 19, 575 50.00 1, 899 05100 RECOVERY ROOM 0 9 51 00 628 51 00 53.00 05300 ANESTHESI OLOGY 0 0 Ω 53.00 05400 RADI OLOGY-DI AGNOSTI C 1, 205 7, 378 0 173 35, 972 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 0 0 06000 LABORATORY 0 2 081 29, 702 60 00 0 143 60 00 06500 RESPIRATORY THERAPY 0 65.00 240 131 20 4, 288 65.00 06600 PHYSI CAL THERAPY 50 66.00 561 3.737 10.554 66.00 4, 506 67.00 06700 OCCUPATIONAL THERAPY 258 863 0 22 67.00 0 06800 SPEECH PATHOLOGY 68 00 11 181 484 68 00 06900 ELECTROCARDI OLOGY 0 69.00 0 402 23 4,809 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 70.00 C 0 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 C 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 C 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 356 0 70 14, 643 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 90.00 12.965 438 0 09001 SURGI CAL ASSOCI ATES 0 0 90.01 1,570 17 0 90.01 09002 ORTHOPAEDI CS 0 1,078 10 90.02 90.02 0 0 90.03 09003 RHEUMATOLOGY 1, 439 0 50 O 90.03 09004 ENDOCRI NOLOGY 90.04 0 90.04 360 0 0 0 90.05 09005 PEDI ATRI CS 1, 429 41 Λ 90.05 90.06 09006 WOMEN'S HEALTH 0 1,075 0 20 0 90.06 90.07 09007 PAIN MANAGEMENT 0 90.07 16 09100 EMERGENCY 2.955 n 91.00 3,858 144 30,011 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 3, 728 95.00 0 0 179 37, 326 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 28, 495 62, 902 100 1, 849 233, 589 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192, 00 C 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 193. 01 19301 FOUNDATI ON 0 0 0 0 193. 01 850 193. 02 19302 OCCUPATIONAL MEDICINE 0 ol 0 193.02 0 194.00 07950 OTHER NON REIMBURSABLE COST CENTERS 0 C 0 0 0 194, 00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202 00 Cost to be allocated (per Wkst. B, 100 820 650, 359 413, 402 359 684 151, 109 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 3.538165 10. 201390 4, 134. 020000 194. 528935 0. 646901 203. 00 204.00 Cost to be allocated (per Wkst. B, 14,889 38, 035 64, 648 23, 691 14, 930 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0. 522513 0.596609 646. 480000 12. 812872 0.063916 205.00

206.00

207.00

II)

(per Wkst. B-2)

Parts III and IV)

NAHE adjustment amount to be allocated

NAHE unit cost multiplier (Wkst. D,

206.00

207.00

In Lieu of Form CMS-2552-10 Health Financial Systems RUSH MEMORIAL HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1304 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/23/2018 4:25 pm Cost Center Description CENTRAL MEDI CAL SERVICES & RECORDS & LI BRARY **SUPPLY** (COSTED (TIME REQUIS.) SPENT) 14.00 16.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 1, 178, 008 14.00 14.00 16.00 01600 MEDICAL RECORDS & LIBRARY 5, 246 94, 400 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 44, 065 40, 560 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 48, 157 8, 920 50.00 05100 RECOVERY ROOM 1, 204 51.00 51 00 53.00 05300 ANESTHESI OLOGY 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 41, 726 10, 800 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 06000 LABORATORY 60 00 500, 676 60 00 06500 RESPIRATORY THERAPY 65.00 4, 427 200 65.00 66.00 06600 PHYSI CAL THERAPY 5, 817 66.00 06700 OCCUPATIONAL THERAPY 67.00 286 0 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 54 0 06900 ELECTROCARDI OLOGY 69.00 2, 163 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 80, 689 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 293, 149 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 18, 269 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 48.020 0 90.00 09001 SURGI CAL ASSOCI ATES 90 01 90.01 3, 492 0 90.02 09002 ORTHOPAEDI CS 0 90.02 09003 RHEUMATOLOGY 3,020 0 90. 03 90. 03 09004 ENDOCRI NOLOGY 90.04 90.04 273 0

70. 00 0 7000 1 EDI / (1111 05		0, 0 10	٩	70.00
90.06 09006 WOMEN'S HEAL	LTH	3, 482	0	90.06
90. 07 09007 PAIN MANAGEN	MENT	3, 694	0	90. 07
91.00 09100 EMERGENCY		45, 009	33, 920	91. 00
92. 00 09200 OBSERVATI ON	BEDS (NON-DISTINCT PART)			92. 00
OTHER REIMBURSABL	E COST CENTERS			
95.00 09500 AMBULANCE SE	ERVI CES	19, 041	0	95. 00
SPECIAL PURPOSE C	OST CENTERS			
118.00 SUBTOTALS (S	SUM OF LINES 1 through 117)	1, 178, 007	94, 400	118. 00
NONREI MBURSABLE CO	OST CENTERS			
192. 00 19200 PHYSI CI ANS'	PRIVATE OFFICES	0	0	192. 00
193.00 19300 NONPALD WORK	KERS	0	0	193. 00
193. 01 19301 FOUNDATI ON		1	0	193. 01
193. 02 19302 OCCUPATI ONAL	L MEDICINE	0	0	193. 02
194.00 07950 OTHER NON RE	EIMBURSABLE COST CENTERS	0	0	194. 00
200.00 Cross Foot A	Adjustments			200. 00
201.00 Negative Cos	st Centers			201. 00
	allocated (per Wkst. B,	280, 775	698, 327	202. 00
Part I)				
203.00 Unit cost mu	ultiplier (Wkst. B, Part I)	0. 238347	7. 397532	
	allocated (per Wkst. B,	45, 707	36, 669	204. 00
Part II)				
	ultiplier (Wkst. B, Part	0. 038800	0. 388443	205. 00
	ment amount to be allocated			206. 00
(per Wkst. E				20.7.00
	ost multiplier (Wkst. D,			207. 00
Parts III ar	na iv)			

6,048

0

90.05

90. 05 09005 PEDIATRICS

RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
Provi der CCN: 15-1304	Peri od:	Worksheet C
		Part Date/Time Prenared:
		Provider CCN: 15-1304 Period: From 01/01/2017

					o 12/31/2017	Date/Time Pre 5/23/2018 4:2	
			Title	XVIII	Hospi tal	Cost	
	·				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1				
30. 00	03000 ADULTS & PEDI ATRI CS	2, 652, 062		2, 652, 062	0	0	30.00
	ANCILLARY SERVICE COST CENTERS		ſ		_	_	
50. 00	05000 OPERATING ROOM	1, 128, 557	ł .	1, 128, 557		0	00.00
51. 00	05100 RECOVERY ROOM	91, 822		91, 822	0	_	51. 00
	05300 ANESTHESI OLOGY	0		C	0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 510, 151		2, 510, 151	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	55. 00
60.00	06000 LABORATORY	2, 214, 733		2, 214, 733		0	60.00
65. 00	06500 RESPI RATORY THERAPY	183, 569				0	65. 00
66. 00	06600 PHYSI CAL THERAPY	748, 878		748, 878		0	66. 00
67. 00	06700 OCCUPATIONAL THERAPY	330, 806		330, 806		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	56, 176		56, 176		0	68. 00
	06900 ELECTROCARDI OLOGY	260, 414		260, 414	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0		C	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	422, 028		422, 028		0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	135, 705		135, 705		ľ	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	6, 032, 810		6, 032, 810	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS		ı		_	_	
	09000 CLI NI C	2, 740, 392		2, 740, 392		_	, , , , , ,
	09001 SURGI CAL ASSOCI ATES	250, 791		250, 791	0	Ŭ	,
	09002 ORTHOPAEDI CS	147, 012		147, 012		0	90. 02
	09003 RHEUMATOLOGY	274, 804		274, 804		0	90. 03
	09004 ENDOCRI NOLOGY	49, 309		49, 309		0	90. 04
	09005 PEDI ATRI CS	251, 305		251, 305		0	90. 05
	09006 WOMEN'S HEALTH	185, 802		185, 802		0	90. 06
	09007 PAIN MANAGEMENT	54, 782		54, 782		0	90. 07
91. 00	09100 EMERGENCY	3, 164, 100		3, 164, 100		0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	834, 245		834, 245		0	92.00
	OTHER REIMBURSABLE COST CENTERS		1				ļ
	09500 AMBULANCE SERVICES	1, 263, 065		1, 263, 065		_	
200.00		25, 983, 318		,,			200. 00
201.00		834, 245		834, 245			201. 00
202.00	Total (see instructions)	25, 149, 073	0	25, 149, 073	0	0	202. 00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304	Period: Worksheet C From 01/01/2017 Part I
		To 12/31/2017 Date/Time Prepared

				Ţ	o 12/31/2017	Date/Time Pre 5/23/2018 4:2	
			Title	XVIII	Hospi tal	Cost	
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
			7.00		0.00	Ratio	
	LABATI ENT. DOUTLAGE CERVICES COCT. CENTERS	6.00	7. 00	8. 00	9. 00	10. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2 010 204		2 010 204			20.00
30. 00	03000 ADULTS & PEDI ATRI CS	3, 819, 384		3, 819, 384			30. 00
F0 00	ANCILLARY SERVICE COST CENTERS	100 540	0 470 707	0 574 007	0.400040	0.000000	F0 00
50.00	05000 OPERATI NG ROOM	100, 519	2, 470, 707			0. 000000	
51.00	05100 RECOVERY ROOM	71, 757	651, 494	723, 251		0.000000	
53.00	05300 ANESTHESI OLOGY	702 571	10 202 404	20 004 077	0.000000	0.000000	
54.00	05400 RADI OLOGY THERAPELITIC	792, 571	19, 302, 406			0.000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C 06000 LABORATORY	704 070	0 024 2/1		0. 000000 0. 207971	0.000000	
60. 00 65. 00	06500 RESPI RATORY THERAPY	724, 972	9, 924, 261	10, 649, 233 287, 722		0. 000000 0. 000000	
	06600 PHYSI CAL THERAPY	112, 760	174, 962			0. 000000	
66. 00 67. 00	06700 OCCUPATIONAL THERAPY	240, 916	1, 731, 450			0. 000000	
	06800 SPEECH PATHOLOGY	143, 422	1, 156, 036			0. 000000	
68. 00 69. 00	06900 ELECTROCARDI OLOGY	80, 432	92, 068				
70.00	07000 ELECTROCARDI OLOGY	71, 275	1, 409, 952	1, 481, 227		0. 000000 0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	141 444	2 OEO 421	ľ		0. 000000	
71.00	07200 IMPL. DEV. CHARGED TO PATIENT	141, 464	3, 059, 631	3, 201, 095		0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	56 1, 006, 993	177, 629 11, 211, 810			0. 000000	
73.00	OUTPATIENT SERVICE COST CENTERS	1,000,993	11, 211, 010	12, 210, 603	0.493732	0.000000	73.00
90. 00	09000 CLINIC	15, 336	1, 145, 123	1, 160, 459	2. 361472	0. 000000	90.00
90. 00	09001 SURGI CAL ASSOCI ATES	2, 295	26, 370			0. 000000	
	09002 ORTHOPAEDI CS	2, 273	24, 954			0. 000000	
90. 02	09003 RHEUMATOLOGY		44, 154			0.000000	
90. 04	09004 ENDOCRI NOLOGY		1, 418			0.000000	
90. 05	09005 PEDIATRICS		95, 196			0.000000	
90. 06	09006 WOMEN' S HEALTH		29, 256			0. 000000	
90. 07	09007 PAIN MANAGEMENT		1, 822			0. 000000	
91. 00	09100 EMERGENCY	2, 303	6, 178, 178			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 914	1, 527, 869			0. 000000	
72.00	OTHER REIMBURSABLE COST CENTERS	0, 711	1,027,007	1,001,700	0.011020	0.00000	72.00
95. 00	09500 AMBULANCE SERVICES	O	1, 235, 151	1, 235, 151	1. 022600	0. 000000	95. 00
200.00		7, 330, 369	61, 671, 897				200. 00
201.00	,	,,555,667	0., 0, 0, 1	37, 332, 200			201.00
202.00		7, 330, 369	61, 671, 897	69, 002, 266			202.00
	1 1 (/	.,,,		1 11, 111, 200	1		, .=

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304	Peri od: Worksheet C From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

	5/23/2018 4: 25 pm
	Title XVIII Hospital Cost
Cost Center Description PPS Inpati	ent
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	1
51. 00 05100 RECOVERY ROOM	
53. 00 05300 ANESTHESI OLOGY	0000 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 00	0000 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 00	0000 55.00
60. 00 06000 LABORATORY 0. 00	0000 60.00
65. 00 06500 RESPI RATORY THERAPY 0. 00	0000 65.00
66. 00 06600 PHYSI CAL THERAPY 0. 00	0000 66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 00	0000 67.00
68. 00 06800 SPEECH PATHOLOGY 0. 00	0000 68.00
69. 00 06900 ELECTROCARDI OLOGY 0. 00	0000 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 00	0000 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.00	0000 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT 0.00	0000 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 00	0000 73.00
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 0. 00	90.00
90. 01 09001 SURGI CAL ASSOCI ATES 0. 00	0000 90.01
90. 02 09002 ORTHOPAEDI CS	0000 90.02
90. 03 09003 RHEUMATOLOGY 0. 00	0000 90.03
90. 04 09004 ENDOCRI NOLOGY 0. 00	0000 90.04
90. 05 09005 PEDI ATRI CS 0. 00	0000 90.05
90. 06 09006 WOMEN' S HEALTH 0. 00	90.06
90. 07 09007 PAIN MANAGEMENT 0. 00	0000 90. 07
91. 00 09100 EMERGENCY 0. 00	0000 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.00	0000 92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>
95. 00 09500 AMBULANCE SERVICES 0. 00	95. 00
200.00 Subtotal (see instructions)	200. 00
201.00 Less Observation Beds	201. 00
202.00 Total (see instructions)	

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304	Period: Worksheet C From 01/01/2017 Part I
		To 12/31/2017 Part I

				o 12/31/2017	Date/Time Pre 5/23/2018 4:2	pared: 5 pm
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 652, 062		2, 652, 062	2 0	2, 652, 062	30.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 128, 557		1, 128, 557	0	1, 128, 557	50.00
51.00 05100 RECOVERY ROOM	91, 822		91, 822	2 0	91, 822	51.00
53. 00 05300 ANESTHESI OLOGY	0		(0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 510, 151		2, 510, 151	0	2, 510, 151	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		C	0	0	55. 00
60. 00 06000 LABORATORY	2, 214, 733		2, 214, 733	0	2, 214, 733	60.00
65. 00 06500 RESPIRATORY THERAPY	183, 569	0	183, 569	0	183, 569	65. 00
66. 00 06600 PHYSI CAL THERAPY	748, 878	0	748, 878	0	748, 878	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	330, 806	0	330, 806	0	330, 806	67.00
68.00 06800 SPEECH PATHOLOGY	56, 176	0	56, 176	0	56, 176	68. 00
69. 00 06900 ELECTROCARDI OLOGY	260, 414		260, 414	0	260, 414	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			o	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	422, 028		422, 028	o o	422, 028	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	135, 705		135, 705	o o	135, 705	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 032, 810		6, 032, 810	o	6, 032, 810	73. 00
OUTPATIENT SERVICE COST CENTERS			•	<u>'</u>		
90. 00 09000 CLI NI C	2, 740, 392		2, 740, 392	2 0	2, 740, 392	90.00
90. 01 09001 SURGI CAL ASSOCI ATES	250, 791		250, 791	0	250, 791	90. 01
90. 02 09002 ORTHOPAEDI CS	147, 012		147, 012	o	147, 012	90. 02
90. 03 09003 RHEUMATOLOGY	274, 804		274, 804	ı o	274, 804	90. 03
90. 04 09004 ENDOCRI NOLOGY	49, 309		49, 309	o	49, 309	90. 04
90. 05 09005 PEDI ATRI CS	251, 305		251, 305	ol ol	251, 305	90. 05
90. 06 09006 WOMEN'S HEALTH	185, 802		185, 802		185, 802	90.06
90. 07 09007 PALN MANAGEMENT	54, 782		54, 782		54, 782	90. 07
91. 00 09100 EMERGENCY	3, 164, 100		3, 164, 100		3, 164, 100	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	834, 245	l .	834, 245		834, 245	
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	1, 263, 065		1, 263, 065	0	1, 263, 065	95 00
200.00 Subtotal (see instructions)	25, 983, 318		25, 983, 318		25, 983, 318	
201.00 Less Observation Beds	834, 245	l .	834, 245		834, 245	
202.00 Total (see instructions)	25, 149, 073					
	20,, 070	'	20,, 010	٠, ۱	23,, 070	1-32.00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304	Peri od: Worksheet C
		From 01/01/2017 Part I
		To 12/21/2017 Doto/Time Dropared.

					o 12/31/2017	Date/Time Pre 5/23/2018 4:2	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
	[6. 00	7. 00	8. 00	9. 00	10. 00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.010.001					
30. 00	03000 ADULTS & PEDI ATRI CS	3, 819, 384		3, 819, 384	·		30.00
	ANCILLARY SERVICE COST CENTERS	100 540	0 470 707	0.574.007	0.400040		
	05000 OPERATI NG ROOM	100, 519	2, 470, 707			0.000000	
51.00	05100 RECOVERY ROOM	71, 757	651, 494	1		0.000000	
53.00	05300 ANESTHESI OLOGY	0	0			0. 000000	
54.00	05400 RADI OLOGY - DI AGNOSTI C	792, 571	19, 302, 406			0.000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0.00000	0. 000000	
60.00	06000 LABORATORY	724, 972	9, 924, 261			0. 000000	
65.00	06500 RESPI RATORY THERAPY	112, 760	174, 962	·		0. 000000	
66. 00	06600 PHYSI CAL THERAPY	240, 916	1, 731, 450			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	143, 422	1, 156, 036			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	80, 432	92, 068	·		0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	71, 275	1, 409, 952			0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	141, 464	3, 059, 631			0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	56	177, 629	·		0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 006, 993	11, 211, 810	12, 218, 803	0. 493732	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	15, 336	1, 145, 123			0. 000000	
90. 01	09001 SURGI CAL ASSOCI ATES	2, 295	26, 370			0. 000000	
90. 02	09002 ORTHOPAEDI CS	0	24, 954	·		0. 000000	
90. 03	09003 RHEUMATOLOGY	0	44, 154	·		0. 000000	
90. 04	09004 ENDOCRI NOLOGY	0	1, 418			0. 000000	
	09005 PEDI ATRI CS	0	95, 196			0. 000000	
90. 06	09006 WOMEN'S HEALTH	0	29, 256			0. 000000	
90. 07	09007 PAI N MANAGEMENT	0	1, 822			0. 000000	1
91. 00	09100 EMERGENCY	2, 303	6, 178, 178			0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 914	1, 527, 869	1, 531, 783	0. 544623	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES	0	1, 235, 151			0. 000000	
200.00		7, 330, 369	61, 671, 897	69, 002, 266			200. 00
201.00	1 1						201. 00
202.00	Total (see instructions)	7, 330, 369	61, 671, 897	69, 002, 266			202. 00

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-25	52-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1304	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepa 5/23/2018 4:25	
		Title XIX	Hospi tal	Cost	

				5/23/2018 4: 25 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50. 00
51.00 05100 RECOVERY ROOM	0. 000000			51. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 SURGI CAL ASSOCI ATES	0. 000000			90. 01
90. 02 09002 ORTHOPAEDI CS	0. 000000			90. 02
90. 03 09003 RHEUMATOLOGY	0. 000000			90. 03
90. 04 09004 ENDOCRI NOLOGY	0. 000000			90. 04
90. 05 09005 PEDI ATRI CS	0. 000000			90. 05
90. 06 09006 WOMEN'S HEALTH	0. 000000			90.06
90. 07 09007 PAI N MANAGEMENT	0. 000000			90. 07
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS	0.00000			72.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
200.00 Subtotal (see instructions)	1. 222300			200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	ı			1202. 00

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-1304	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/23/2018 4:2	pared: 5 pm
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)		Program	Capital Costs (column 3 x column 4)	
	1.00	2.00	3.00	4. 00	5. 00	

-					072072010 1.2	о р
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal		Ratio of Cost	Inpati ent	Capital Costs	
	Related Cost	(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	T				
50. 00 05000 OPERATI NG ROOM	136, 378			88, 039		
51. 00 05100 RECOVERY ROOM	14, 744			2, 799		51.00
53. 00 05300 ANESTHESI OLOGY	0		0.00000	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	194, 124			577, 387		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0.00000	0	0	55. 00
60. 00 06000 LABORATORY	88, 514			503, 112		60.00
65. 00 06500 RESPI RATORY THERAPY	5, 510			52, 178		
66. 00 06600 PHYSI CAL THERAPY	89, 887			114, 780		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	22, 652	1, 299, 458	0. 017432	59, 517	1, 038	67. 00
68. 00 06800 SPEECH PATHOLOGY	4, 550	172, 500		57, 283		
69. 00 06900 ELECTROCARDI OLOGY	11, 950	1, 481, 227		54, 844	442	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 027	3, 201, 095	0. 002195	54, 852	120	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	12, 011	177, 685	0. 067597	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	68, 803	12, 218, 803	0. 005631	598, 133	3, 368	73. 00
OUTPATIENT SERVICE COST CENTERS	_					
90. 00 09000 CLI NI C	315, 994	1, 160, 459	0. 272301	2, 826	770	90.00
90. 01 09001 SURGI CAL ASSOCI ATES	36, 739	28, 665	1. 281668	0	0	90. 01
90. 02 09002 ORTHOPAEDI CS	24, 867	24, 954	0. 996514	0	0	90. 02
90. 03 09003 RHEUMATOLOGY	34, 884	44, 154	0. 790053	0	0	90. 03
90. 04 09004 ENDOCRI NOLOGY	8, 395	1, 418	5. 920310	0	0	90. 04
90. 05 09005 PEDI ATRI CS	34, 256	95, 196	0. 359847	0	0	90. 05
90. 06 09006 WOMEN'S HEALTH	25, 649	29, 256	0. 876709	0	0	90.06
90. 07 09007 PAIN MANAGEMENT	917	1, 822	0. 503293	0	0	90. 07
91. 00 09100 EMERGENCY	131, 902			2, 303	49	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	81, 101			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50 through 199)	1, 350, 854	63, 947, 731		2, 168, 053	28, 015	200.00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	,		'			

In Lieu of Form CMS-2552-10 Health Financial Systems RUSH MEMORIAL HOSPITAL APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1304 Peri od: Worksheet D From 01/01/2017 THROUGH COSTS Part IV

12/31/2017 Date/Time Prepared: 5/23/2018 4:25 pm Title XVIII Hospi tal Cost Non Physician Nursing School Nursing School Allied Health Allied Health Cost Center Description Anesthetist Post-Stepdown Post-Stepdown Cost Adjustments Adjustments 1.00 2.00 3. 00 2A 3A ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 51.00 05100 RECOVERY ROOM 0 51.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 0 55.00 0 06000 LABORATORY 0 60.00 60.00 0 65.00 06500 RESPIRATORY THERAPY 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 0 0 0 06800 SPEECH PATHOLOGY 0 68.00 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLINIC 0 0 0 90.00 0 0 0 0 0 0 0 90. 01 09001 SURGI CAL ASSOCIATES 0 0 90.01 90. 02 09002 ORTHOPAEDI CS 0 0 90.02 0 0 0 0 0 0 0 0 90.03 09003 RHEUMATOLOGY 0 90.03 0 01 09004 ENDOCRI NOLOGY 0 90.04 90.04 0 0 90.05 09005 PEDI ATRI CS 0 0 90.05 09006 WOMEN'S HEALTH 0 90.06 90.06 0

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0 92.00

91.00

95.00

0 200. 00

0

0

90.07

91.00

95.00

200.00

09007 PAIN MANAGEMENT

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES

09100 EMERGENCY

Health Financial Systems	RUSH MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1304	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2017	

THROUG	n (0313				To 12/31/2017	Date/Time Pre 5/23/2018 4:2	
			Title	XVIII	Hospi tal	Cost	<u>o p</u>
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	'	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,		
		Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
				4)			
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS				_		
	05000 OPERATING ROOM	0	0	(2, 571, 226		1
	05100 RECOVERY ROOM	0	0	(723, 251	0. 000000	1
	05300 ANESTHESI OLOGY	0	0	(0	0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	0	0	(20, 094, 977	0. 000000	
	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0. 000000	1
	06000 LABORATORY	0	0	(10, 649, 233	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0	(287, 722		
66. 00	06600 PHYSI CAL THERAPY	0	0	(1, 972, 366	0. 000000	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	(1, 299, 458	0. 000000	67. 00
	06800 SPEECH PATHOLOGY	0	0	(172, 500		
	06900 ELECTROCARDI OLOGY	0	0	(1, 481, 227	0. 000000	
	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0. 000000	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(3, 201, 095	0. 000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(177, 685	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(12, 218, 803	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	(1, 160, 459		
	09001 SURGI CAL ASSOCI ATES	0	0	(28, 665	0. 000000	
90. 02	09002 ORTHOPAEDI CS	0	0	(24, 954	0. 000000	90. 02
90. 03	09003 RHEUMATOLOGY	0	0	(44, 154	0. 000000	90. 03
	09004 ENDOCRI NOLOGY	0	0	(1, 418		
90. 05	09005 PEDI ATRI CS	0	0	(95, 196	0.000000	90. 05
90.06	09006 WOMEN'S HEALTH	0	0	(29, 256	0.000000	90. 06
90. 07	09007 PAIN MANAGEMENT	0	0	(1, 822	0.000000	90. 07
91.00	09100 EMERGENCY	0	0	(6, 180, 481	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(1, 531, 783	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	(63, 947, 731		200. 00

Health Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AND THROUGH COSTS	ILLARY SERVICE OTHER PASS		<u> </u>	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre 5/23/2018 4:2	
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)		Outpati ent Program Pass-Through Costs (col. 9 x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	88, 039	(0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	2, 799	(0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0	(0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	577, 387	(0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	(0	0	55. 00
60. 00 06000 LABORATORY	0. 000000	503, 112	(0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	52, 178	(0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	114, 780	(0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	59, 517	(0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	57, 283	(0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	54, 844	(0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	(0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO P	ATI ENTS 0. 000000	54, 852	(0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	598, 133	(0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	2, 826	(0	0	90.00
90. 01 09001 SURGI CAL ASSOCI ATES	0. 000000	0	(0	0	90. 01
90. 02 09002 ORTHOPAEDI CS	0. 000000	0	(0	0	90. 02
90. 03 09003 RHEUMATOLOGY	0. 000000	0	(0	0	90. 03
90. 04 09004 ENDOCRI NOLOGY	0. 000000	0	(0	0	90. 04
90. 05 09005 PEDI ATRI CS	0. 000000	0	(0	0	90. 05
90.06 09006 WOMEN'S HEALTH	0. 000000	0	(0	0	90. 06
90. 07 09007 PAIN MANAGEMENT	0. 000000	0	(0	0	90. 07
91.00 09100 EMERGENCY	0. 000000	2, 303	(0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTING	T PART) 0. 000000	0	(0	0	92. 00

2, 168, 053

0 92.00 95.00

0

0 200. 00

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVICES

Total (lines 50 through 199)

200.00

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1304 Peri od: Worksheet D From 01/01/2017 Part V Date/Time Prepared: 12/31/2017 5/23/2018 4:25 pm Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 438918 1, 275, 806 0 50.00 51.00 05100 RECOVERY ROOM 0.126957 160, 912 0 0 0 51.00 0 05300 ANESTHESI OLOGY 0.000000 53 00 0 53 00 C 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.124914 0 6, 502, 367 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55.00 60.00 06000 LABORATORY 0.207971 0 3, 759, 051 0 0 60.00 06500 RESPIRATORY THERAPY 0.638008 65.00 64, 670 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.379685 750, 826 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0. 254572 412, 607 0 0 67.00 06800 SPEECH PATHOLOGY 0.325658 24 061 68 00 68 00 0 69.00 06900 ELECTROCARDI OLOGY 0.175810 0 588, 974 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 70.00 ol 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.131839 0 142, 923 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 0 72 00 0.763739 60.354 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.493732 0 4, 874, 577 51, 895 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2. 361472 0 316, 091 21, 090 0 90.00 09001 SURGI CAL ASSOCI ATES 90.01 8.749032 0 14, 594 90.01 0 0 90.02 09002 ORTHOPAEDI CS 5.891320 6,018 0 0 90.02 09003 RHEUMATOLOGY 6. 223762 15, 323 0 90.03 90.03 0 0 09004 ENDOCRI NOLOGY 90.04 90.04 34. 773625 0 509 0 09005 PEDI ATRI CS 90.05 90.05 2.639869 Ω 39 0 90.06 09006 WOMEN'S HEALTH 6. 350902 0 2,082 0 0 90.06 09007 PAIN MANAGEMENT 0 90.07 30.066959 90.07 68 1, 419, 525 0 09100 EMERGENCY 0. 511950 0 91.00 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 159, 509 92.00 0.544623 0 Ω 92.00 OTHER REIMBURSABLE COST CENTERS

1. 022600

Λ

21, 550, 886

21, 550, 886

72, 985

72, 985

95.00

0 200. 00

0 202.00

201.00

95.00

200.00

201.00

202.00

09500 AMBULANCE SERVICES

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

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

From 01/01/2017 Part V
To 12/31/2017 Date/Time Prepared: 5/23/2018 4:25 pm Titl<u>e XVIII</u> Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 559, 974 50.00 51.00 05100 RECOVERY ROOM 20, 429 0 51.00 53.00 05300 ANESTHESI OLOGY 0 53 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 812, 237 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 60.00 06000 LABORATORY 781.774 0 60.00 06500 RESPIRATORY THERAPY 0 65.00 41, 260 65.00 66.00 06600 PHYSI CAL THERAPY 285, 077 66.00 06700 OCCUPATIONAL THERAPY 105, 038 0 67.00 67.00 06800 SPEECH PATHOLOGY 68 00 68 00 7 836 69.00 06900 ELECTROCARDI OLOGY 103, 548 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 18,843 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 46, 095 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 406, 735 25, 622 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 746, 440 49, 803 90.00 09001 SURGI CAL ASSOCI ATES 90.01 127, 683 90.01 0 90.02 09002 ORTHOPAEDI CS 35, 454 90.02 09003 RHEUMATOLOGY 95, 367 0 90.03 90.03 17, 700 09004 ENDOCRI NOLOGY 90.04 0 90.04 09005 PEDI ATRI CS 0 90.05 103 90.05 90.06 09006 WOMEN'S HEALTH 13, 223 0 90.06 09007 PAIN MANAGEMENT 90.07 2,045 90.07 09100 EMERGENCY 91.00 91.00 726, 726 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 631, 495 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 200.00 Subtotal (see instructions) 7, 585, 082 75, 425 200.00 Less PBP Clinic Lab. Services-Program 201.00 201. 00 Only Charges

7, 585, 082

75, 425

202.00

202.00

Net Charges (line 200 - line 201)

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

From 01/01/2017 Part V Component CCN: 15-Z304 12/31/2017 Date/Time Prepared: 5/23/2018 4:25 pm Title XVIII Swing Beds - SNF Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 438918 0 50.00 51.00 05100 RECOVERY ROOM 0.126957 0 0 0 0 0 0 0 0 0 0 0 0 51.00 05300 ANESTHESI OLOGY 0.000000 0 53 00 0 53 00 0 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.124914 0 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55.00 0 60.00 06000 LABORATORY 0.207971 0 60.00 0 06500 RESPIRATORY THERAPY 0 0.638008 0 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.379685 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0. 254572 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 0.325658 68 00 0 06900 ELECTROCARDI OLOGY 69.00 0.175810 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.131839 0 0 71.00 0 0 07200 IMPL. DEV. CHARGED TO PATIENT Ω 72 00 0.763739 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.493732 0 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2. 361472 0 0 0 90.00 0 0 0 0 0 0 0 09001 SURGI CAL ASSOCI ATES 0 90.01 8.749032 0 90.01 0 90.02 09002 ORTHOPAEDI CS 5.891320 0 90.02 09003 RHEUMATOLOGY 6. 223762 0 90.03 90.03 0 09004 ENDOCRI NOLOGY 34. 773625 90.04 90.04 0 0 09005 PEDI ATRI CS 2.639869 0 90.05 90.05 0 0 90.06 09006 WOMEN'S HEALTH 6. 350902 0 0 90.06 09007 PAIN MANAGEMENT 0 90. 07 90.07 30.066959 0 91.00 09100 EMERGENCY 0. 511950 0 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0.544623 0 0 Ω 92.00 OTHER REIMBURSABLE COST CENTERS 0 95.00 09500 AMBULANCE SERVICES 1. 022600 95.00 0 0 200.00 Subtotal (see instructions) Λ 0 0 200. 00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 0 0 202.00

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1304 Component CCN: 15-2304 Period: From 01/01/2017 To 12/31/2017 Part V Date/Time Prepared: 5/23/2018 4: 25 pm

Cost Center Description Cost Cost

		'			5/23/2018 4:25 pm	n
		Title	XVIII	Swing Beds - SNF	Cost	
	Cos	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				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				. 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 RESPIRATORY 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				. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0				. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>				75.	
90. 00 09000 CLINIC	0	0			90	. 00
90. 01 09001 SURGI CAL ASSOCI ATES	0	0				. 01
90. 02 09002 ORTHOPAEDI CS	0	0				. 02
90. 03 09003 RHEUMATOLOGY	0	0				. 03
90. 04 09004 ENDOCRI NOLOGY	0	0				. 04
90. 05 09005 PEDI ATRI CS	0	0				. 05
90. 06 09006 WOMEN' S HEALTH	0	0				. 06
90. 07 09007 PAI N MANAGEMENT	0	0				. 07
91. 00 09100 EMERGENCY		0				. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0				. 00
OTHER REIMBURSABLE COST CENTERS					72.	. 00
95. 00 09500 AMBULANCE SERVICES					O.E.	. 00
200.00 Subtotal (see instructions)		0			95. 200.	
201.00 Less PBP Clinic Lab. Services-Program					201.	. 00
Only Charges 202.00 Net Charges (line 200 - line 201)		_			202.	
202.00 Net Charges (Title 200 - Title 201)	1	0	Ί		J202.	. 00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1304	Peri od: From 01/01/2017	Worksheet D-1
			Date/Time Prepared:
-	Title YVIII	Hospi tal	5/23/2018 4: 25 pm

-				5/23/2018 4: 2	5 pm
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	cost center bescription			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
4 00	I NPATI ENT DAYS			0.4/5	4 00
1.00	Inpatient days (including private room days and swing-bed days			2, 465	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-le Private room days (excluding swing-bed and observation bed day		vate room days	2, 248 0	2. 00 3. 00
3.00	do not complete this line.	73). IT you have only pr	vate room days,	١	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		1, 477	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	203	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private room	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	days) through December	31 of the cost	14	7. 00
7.00	reporting period	adys) through beechber	or or the cost	, -,	7.00
8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 037	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including privato r	oom dave)	203	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		Joili days)	203	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en		,		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	(only (including privat	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	/ only (including privat	n room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ve			1	13.00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
17.00	reporting period	23 thi dagii becember 31 0	the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
	reporting period			'	
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 001	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	155. 02	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			2, 652, 062	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	n period (line 6	0	23. 00
20.00	x line 18)	or or the boot roper trin	g po ou (o		20.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25 00	7 x line 19) Swing-bed cost applicable to NF type services after December (of the cost reporting	nominal (line O	0	25 00
25. 00	x line 20)	of the cost reporting	perrod (Title 8	ا ا	25. 00
26.00	Total swing-bed cost (see instructions)			219, 652	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 432, 410	27. 00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	•		0.00	32. 00
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 mir		tions)	0.00	34. 00
35.00	Average per diem private room cost differential (line 34 x line 35)	ne 31)		0.00	35.00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 2, 432, 410	36. 00 37. 00
37.00	27 minus line 36)	and private room cost ur	Transmittan (Title	2, 432, 410	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see	*		1, 082. 03	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line	•		1, 122, 065 0	39. 00 40. 00
	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			1, 122, 065	
11.00	1.0ta ogram gonerar impatront routine service cost (Tine 37		ı	1, 122, 003	

Private CRE 15-1304	Heal th	Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-2	2552-10
Cost Center Description					CN: 15-1304	Peri od:		
Cost Center Description								
Total Average Per Program Days				Title	e XVIII	Hospi tal		5 pm
2.00 BMSERP (citie v 8 xiz orly)		Cost Center Description		Total	Average Per	Program Days	Program Cost	
1.00 2.00 3.00 4.00 5.00 4.00 5.00 4.00 5.00 4.2.00 5.00 4.2.00 5.00 4.2.00 5.00 4.2.00 5.00			Inpatient Cost	Inpatient Days		÷		
Interestive Care Type Inpartient Dispital Units			1.00	2. 00		4. 00		
	42. 00							42. 00
45.00 BURNEL INTENSIVE CARE UNIT	43. 00							43. 00
64.00								
47.00 OTHER SPECIAL CASE (SPECIFY)								1
1.00		OTHER SPECIAL CARE (SPECIFY)						
Program Inpatient and Illary service cost (Wikst: D-3, col. 3, Illne 200) Formal Inpatient costs (come of Illness 4, 140, 00 Total Program Inpatient costs (come of Illness 4, 140, 00 Total Program Inpatient costs (some of Illness 4, 140, 00 Total Program inpatient and Illary services (from Wikst: D, sum of Parts II and 19) School Pass through costs applicable to Program inpatient and Illary services (from Wikst: D, sum of Parts II and 19) School Pass through costs applicable to Program inpatient and Illary services (from Wikst: D, sum of Parts III and 19) School Sc		Cost Center Description					1 00	
PASS_THROUGH_COST_ADUISTNEMTS 0.00								48. 00
50.00 Pass through costs applicable to Program Inpatient routine services (From West. D., sum of Parts II and III 151.00 111.01 151.00	49. 00		41 through 48)(see instructio	ons)		1, 768, 539	49. 00
51.00 and IV) 10.10 Pass through costs applicable to Program Inpatient ancillarly services (from Wkst. D. sum of Parts II on 10 S1.00 and IV) 10.10 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and page 10.50.00 total Program inpatient operating cost excluding capital related, non-physician anesthetist, and page 10.50.00 total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and page 10.50.00 total page 10.50.00 tot	50. 00		atient routine	services (from	n Wkst. D, sur	m of Parts I and	0	50. 00
and IV) 2	F1 00	,			Wi+ D			F1 00
	51.00		atient anciliar	y services (fr	OM WKSt. D, S	sum or Parts II	0	51.00
medical education costs (line 49 in nus line 52)								
TARKET ANDUNT AND LIMIT COMPUTATION	53. 00		9 1	lated, non-phy	sician anestl	netist, and	0	53. 00
1.00 Target amount per discharge 0.00 55.00 0.00		TARGET AMOUNT AND LIMIT COMPUTATION	02)					
1.0 1.7 1.0 1.7 1.0 1.7 1.0 1.7 1.0 1.7 1.0 1.7 1.0 1.7 1.0 1.7 1.0 1.7 1.0 1.7 1.0 1.7 1.0								
88.00 Bonus payment (see instructions) 9.00 Losser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 Losser of lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 Losser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.00 Losser of lines 63/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.00 Losser of lines 63/54 or 155 lines 63 are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 0.00 Losser of lines 63/54 or 155 lines 14 lines 63/54 lines 64/54 lin							l	1
Design of Liesser of Lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 60.00 Lesser of Lines 53/54 or 55 from prior year cost report, updated by the market basket 0.00 60.00 fol.00 line 53/54 is less than the lower of Lines 55/5 by or 60 enter the lesser of 50% of the amount by which operating costs (Line 53) are less than expected costs (Lines 54 x 60), or 1% of the target amount (Line 56), otherwise enter zero (see instructions) 0.63.00 Relief payment (see instructions) 1.00 fol.00 lines 100 fol.00 fol.00 lines 100 fol.00 fol.00 lines 100 fol.00 fol.00 fol.00 lines 100 fol.00 fol.			ing cost and ta	rget amount (I	ine 56 minus	line 53)		
market basket 0.00 60.00			porting period	endi ng 1996, u	updated and co	ompounded by the		
61.00 If line 53/54 is less than the lower of lines 55, 50 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medic are swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) (see instructions) (title XVIII only) (fine care swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) (fine 12 x line 19) (see instructions) (title XVIII only) (see instructions) (see	(0.00			J-4-J b., 4b-			0.00	(0.00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient costs plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 (Intel 2 X III in 19) 68.00 (Intel 2 X III in 19) 68.00 (Intel 2 X III in 19) 69.00 Total Hitle V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See Instructions) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See Instructions) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (See Instructions) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PARTIII - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID DNLY 70.00 Skilled nursing facility/other nursing facility/ICE/IID routine service cost (line 37) 71.00 Algusted general inpatient routine service costs (line 70 + line 2) 72.00 Program routine service cost (line 9 x Iine 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x Iine 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital-related cost (line 9 x Iine 76) 76.00 Per diem capital-related costs (line 9 x Iine 77) 77.00 Program capital-related costs (line 9 x Iine 77) 78.00 Med						the amount by	1	1
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine service costs (line 67 + line 68) 69.00 Total trough special spe				s (lines 54 x	60), or 1% or	f the target		
63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see Instructions) 67.00 Title Vor XIX Swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see Instructions) 68.00 Total Medicare swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see Instructions) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 plus line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 plus line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 plus line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 plus line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 plus line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 plus line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 plus line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 plus line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 plus line 68) 69.00 Total program inpatient routine service cost per diem (line 70 plus line 68) 69.00 Total Program patient routine service cost (line 70 plus line 72 plus line 73) 69.00 Total Program general inpatient routine service costs (line 72 plus line 73) 69.00 Porgram capital-related costs (line 74 minus line 77) 69.00 Porgram capital-related costs (line 74 minus line 77) 69.00 Porgram capital-related costs (line 74 minus line 77) 69.00 Porgram capital-related costs (line 74 minus line 77) 69.00 Reasonabl	62. 00		instructions)				0	62. 00
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (See Instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service costs (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Program capital related costs (line 75 + line 2) 77.00 Program capital related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost (see instructions) 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Inpatient routine service cost (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient routine service cost (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient routine service cost (see instructions) 87.01 Total Progr	63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63. 00
Instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) For COAM (See Instructions)	64. 00		ts through Dece	mber 31 of the	e cost reporti	na period (See	219, 652	64.00
instructions) (title XVIII only) Cotal Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For 219,652 66.00 CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY. OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital-related cost (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 76 x line 77) 78.00 Total Program routine service costs (from provider records) 80.00 Total Program routine service costs (from provider records) 81.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient accillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient routine cost per diem (line 27 + line 27) 87.00 Total Program inpatient routine cost per diem (line 27 + line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (lin		instructions)(title XVIII only)	Ü		·			
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	89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				834, 245	89. 00

Health Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/23/2018 4:2	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	257, 819	2, 652, 062	0. 09721	5 834, 245	81, 101	90. 00
91.00 Nursing School cost	0	2, 652, 062	0.00000	0 834, 245	0	91.00
92.00 Allied health cost	0	2, 652, 062	0.00000	0 834, 245	0	92.00
93.00 All other Medical Education	0	2, 652, 062	0. 00000	0 834, 245	0	93. 00

Health Financial Systems	RUSH MEMORIAL H	OSPI TAL		In Lieu	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERA	TING COST	Provider CCN		Peri od: From 01/01/2017	Worksheet D-1
					Date/Time Prepared: 5/23/2018 4:25 pm
		Title	XIX	Hospi tal	Cost

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Proof of Cock 13-1301 Proo	Heal th	Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	eu of Form CMS-:	2552-10
Cost Center Description					CN: 15-1304	Peri od:		
Title 10								
Total Abstrage Port Program Boys Program Boys Cost Co				Ti +I	e XIX	Hospi tal		5 pm
Col. 20 MINSER** (Little V 8 XIX orly)		Cost Center Description	Total					
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Table Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 44 minus line 52)	52 00	1 '	50 and 51)				0	52.00
TARCET ANOUNT AND LIMIT COMPUTATION 0 54				elated, non-phy	ysician anestl	netist, and		
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1.55	54. 00						0	54. 00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57.00		Target amount per discharge					0.00	55. 00
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76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 771 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 78.00 Inpatient routine service costs (see instructions) 771 87.00 Resonable inpatient routine cost per diem (line 27 ÷ line 2) 78.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						Part II, column		
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78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		· · · · · · · · · · · · · · · · · · ·						
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 81) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 81) 89.00 Reasonable inpatient routine service cost limitation		Inpatient routine service cost (line 74 minu	s line 77)					78. 00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Pogram inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		33 3 3	, ,		· .	nus line 70)		1
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 Post Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00				ost militati ()	. (11116-76 IIII)	143 TTHE 77)		
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Recomplete instructions (see instructions) 88.00 Recomplete instructions (see instructions) 88.00 Recomplete instructions (see instructions) 89.00 Rec		Inpatient routine service cost limitation (I	ine 9 x line 81	* .				1
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Route description of the cost per diem (line 27 ÷ line 2) 88.00 Route description of the cost per diem (line 27 ÷ line 2) 88.00 Route description of the cost per diem (line 27 ÷ line 2)		1 .		ıs)				
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 87.00 Total observation bed days (see instructions) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Total observation bed days (see instructions)				ons)				1
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 771 87.00 88.00 88.00		Total Program inpatient operating costs (sum	of lines 83 th					
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,082.03 88.00	87 ∩∩						771	87 00
89.00 Observation bed cost (line 87 x line 88) (see instructions) 834,245 89.00	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				1, 082. 03	88. 00
	89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				834, 245	89.00

Health Financial Systems	RUSH MEMORIAL	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017	D-+- /T: D	
				To 12/31/2017	Date/Time Prep 5/23/2018 4: 2	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	257, 819	2, 652, 062	0. 09721	5 834, 245	81, 101	90.00
91.00 Nursing School cost	0	2, 652, 062	0.00000	0 834, 245	0	91.00
92.00 Allied health cost	0	2, 652, 062	0.00000	0 834, 245	0	92.00
93.00 All other Medical Education	0	2, 652, 062	0.00000	0 834, 245	0	93. 00

	ncial Systems RUSH MEMORIAL NCILLARY SERVICE COST APPORTIONMENT		CN: 15-1304	Peri od:	eu of Form CMS-: Worksheet D-3	
				From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/23/2018 4:2	
		Ti tl e	e XVIII	Hospi tal	Cost	.с р
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
I NDAT	TENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	ADULTS & PEDIATRICS			1, 846, 490		30.00
	LARY SERVICE COST CENTERS		1	1,040,470	l	30.00
	OPERATI NG ROOM		0. 4389	18 88, 039	38, 642	50.00
	RECOVERY ROOM		0. 1269	· ·		1
53.00 05300	ANESTHESI OLOGY		0.0000	00 0	0	53.00
54.00 05400	RADI OLOGY-DI AGNOSTI C		0. 1249	14 577, 387	72, 124	54.00
1	RADI OLOGY-THERAPEUTI C		0.0000		0	55.00
	LABORATORY		0. 2079			
	RESPI RATORY THERAPY		0. 6380			
	PHYSI CAL THERAPY		0. 3796			1
	OCCUPATIONAL THERAPY SPEECH PATHOLOGY		0. 2545 0. 3256			
	SPEECH PATHOLOGY ELECTROCARDI OLOGY		0. 3256			
	ELECTROCARDI OLOGI ELECTROENCEPHALOGRAPHY		0. 1738		1	
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1318			
	IMPL. DEV. CHARGED TO PATIENT		0. 7637			
	DRUGS CHARGED TO PATIENTS		0. 4937		295, 317	73.0
	TIENT SERVICE COST CENTERS					
	CLI NI C		2. 3614	72 2, 826	6, 674	
	SURGI CAL ASSOCI ATES		8. 7490		1	
	ORTHOPAEDI CS		5. 8913		0	
	RHEUMATOLOGY		6. 2237		0	1
	ENDOCRI NOLOGY		34. 7736		0	
	PEDIATRICS		2. 6398		0	1
	WOMEN'S HEALTH PAIN MANAGEMENT		6. 3509 30. 0669			
	PALIN MANAGEMENT		0.5119			
	OBSERVATION BEDS (NON-DISTINCT PART)		0.5119		1, 1/9	
	REIMBURSABLE COST CENTERS		0.5440			1 /2.00
	AMBULANCE SERVICES					95.00
200. 00	Total (sum of lines 50 through 94 and 96 through 98)			2, 168, 053	646, 474	
201. 00	Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.00
202. 00	Net charges (line 200 minus line 201)			2, 168, 053		202. 00

AITH FINANCIAL SYSTEMS RUSH MEN PATIENT ANCILLARY SERVICE COST APPORTIONMENT	ORIAL HOSPITAL Provider C	CN: 15-1304	Peri od:	eu of Form CMS Worksheet D-3	
			From 01/01/2017		
	Component	CCN: 15-Z304	To 12/31/2017	Date/Time Pre 5/23/2018 4:2	
	Title	e XVIII	Swing Beds - SNF	Cost	O PIII
Cost Center Description	-	Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	1
LANDATI FAIT DOUTLAND OFFICE COOT OFFITTING		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				.1	4
.00 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS			0	1	30.
. OO O5000 OPERATING ROOM		0. 4389	18 0	0	50.
. 00 05100 RECOVERY ROOM		0. 4369		1	
. 00 05100 RECOVERT ROOM . 00 05300 ANESTHESI OLOGY		0. 0000		1	
. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 1249			
. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000			
. 00 06000 LABORATORY		0. 2079			
. 00 06500 RESPIRATORY THERAPY		0. 6380			
. 00 06600 PHYSI CAL THERAPY		0. 3796			
. 00 06700 OCCUPATI ONAL THERAPY		0. 2545		14, 130	67
.00 06800 SPEECH PATHOLOGY		0. 3256	58 8, 594	2, 799	68
. 00 06900 ELECTROCARDI OLOGY		0. 1758		217	69
. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		1	
.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1318			
.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 7637		1	1
.00 07300 DRUGS CHARGED TO PATIENTS		0. 4937	32 49, 389	24, 385	73
OUTPATIENT SERVICE COST CENTERS				_	4
. 00 09000 CLINIC		2. 3614		1	
. 01 09001 SURGI CAL ASSOCI ATES		8. 7490			
02 09002 ORTHOPAEDI CS		5. 8913		1	1
03 09003 RHEUMATOLOGY 04 09004 ENDOCRI NOLOGY		6. 2237 34. 7736		1	1
. 04 09004 ENDOCRI NOLOGY . 05 09005 PEDI ATRI CS		2. 6398		1	
. 05 09005 PEDIATRICS . 06 09006 WOMEN' S HEALTH		6. 3509		1	
. 07 09007 PALN MANAGEMENT		30. 0669		1	
00 09100 EMERGENCY		0. 5119		1	
.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5446		1	
OTHER REIMBURSABLE COST CENTERS		1 0.0140.	,		1 ′′
00 09500 AMBULANCE SERVI CES					95
0.00 Total (sum of lines 50 through 94 and 96 through	98)		233, 307	80, 339	
1.00 Less PBP Clinic Laboratory Services-Program only			0	1	201
2.00 Net charges (line 200 minus line 201)	3 ,		233, 307	,	202

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1304	Peri od:	wof Form CMS-3 Worksheet D-3	
			From 01/01/2017		
			To 12/31/2017	Date/Time Pre 5/23/2018 4:2	
	Ti tl	e XIX	Hospi tal	Cost	<u> </u>
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3. 00	_
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
00 03000 ADULTS & PEDI ATRI CS			187, 799		30.
ANCI LLARY SERVI CE COST CENTERS		1	1017177		1 00.
00 05000 OPERATING ROOM		0. 4389	18 4, 289	1, 883	50.
00 05100 RECOVERY ROOM		0. 1269	57 0	0	51.
00 05300 ANESTHESI OLOGY		0.00000	00	0	53
00 05400 RADI OLOGY-DI AGNOSTI C		0. 1249		7, 634	54
00 05500 RADI OLOGY-THERAPEUTI C		0.00000		ı	
00 06000 LABORATORY		0. 2079			
00 06500 RESPI RATORY THERAPY		0. 63800			
00 06600 PHYSI CAL THERAPY		0. 37968			
00 06700 OCCUPATI ONAL THERAPY 00 06800 SPEECH PATHOLOGY		0. 2545 0. 3256			
00 06800 SPEECH PATHOLOGY 00 06900 ELECTROCARDI OLOGY		0. 3256	· ·	730 352	
00 07000 ELECTROCARDI OLOGI 00 07000 ELECTROENCEPHALOGRAPHY		0. 1738		l	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1318		381	
00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 7637			1
00 07300 DRUGS CHARGED TO PATIENTS		0. 4937		34, 981	
OUTPATIENT SERVICE COST CENTERS					
00 09000 CLI NI C		2. 3614		1, 256	90
01 09001 SURGI CAL ASSOCI ATES		8. 7490			
02 09002 ORTHOPAEDI CS		5. 8913		0	
03 09003 RHEUMATOLOGY		6. 2237			
04 09004 ENDOCRI NOLOGY		34. 7736		1	
05 09005 PEDI ATRI CS 06 09006 WOMEN' S HEALTH		2. 63986		1	1
06 09006 WOMEN' S HEALTH 07 09007 PAI N MANAGEMENT		6. 35090 30. 06699			
00 09100 EMERGENCY		0. 5119			
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5446			
OTHER REIMBURSABLE COST CENTERS		0. 5440.		·	1 ′′
00 09500 AMBULANCE SERVI CES					95
Total (sum of lines 50 through 94 and 96 through 98)			213, 366	67, 215	
1.00 Less PBP Clinic Laboratory Services-Program only chai	ges (line 61)		0		201
2.00 Net charges (line 200 minus line 201)	- ,		213, 366		202

			10 12/01/201/	5/23/2018 4: 2	5 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1. 00	Medical and other services (see instructions)			7, 660, 507	1.00
2. 00	Medical and other services reimbursed under OPPS (see instruc-	ti ons)		0	2. 00
3.00	OPPS payments			0	
4.00	Outlier payment (see instructions)			0	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	•
6.00	Line 2 times line 5			0	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	1
8.00	Transitional corridor payment (see instructions)	IV and 12 line 200		0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	IV, Col. 13, Time 200		0	
10. 00 11. 00				7 440 507	10. 00 11. 00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			7, 660, 507	11.00
12. 00	Reasonable charges Ancillary service charges			0	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ina 60)		0	ı
	Total reasonable charges (sum of lines 12 and 13)	1116 07)		0	•
14.00	Customary charges				14.00
15. 00	Aggregate amount actually collected from patients liable for p	navment for services on	charge hasis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(. a ona gozaoi o	ĺ	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	-,		0. 000000	17. 00
	Total customary charges (see instructions)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	ly if line 18 exceeds li	ne 11) (see	0	19. 00
	instructions)		, ,		
20.00	Excess of reasonable cost over customary charges (complete only	ly if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)				
21. 00	Lesser of cost or charges (see instructions)			7, 737, 112	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance (for CAH, see instructions)			87, 387	1
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			3, 478, 722	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	and 23] (see	4, 171, 003	27. 00
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ine 50)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			4, 171, 003	1
	Primary payer payments			1, 306 4, 169, 697	1
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIO	rec)		4, 109, 097	32.00
33 00	Composite rate ESRD (from Wkst. I-5, line 11)	JL3)		0	33. 00
	Allowable bad debts (see instructions)			449, 136	1
	Adjusted reimbursable bad debts (see instructions)			291, 938	1
36. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		297, 543	1
37. 00		1 40 11 0113)		4, 461, 635	1
	MSP-LCC reconciliation amount from PS&R			0	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	•
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration	,		0	1
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	1
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	39. 99
	Subtotal (see instructions)			4, 461, 635	•
40. 01	Sequestration adjustment (see instructions)			89, 233	1
40. 02	Demonstration payment adjustment amount after sequestration			0	1
	Interim payments			4, 799, 399	41.00
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			-426, 997	43.00
44.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
	The rate used to calculate the Time Value of Money			0.00	•
93. 00	,			0	
94. 00	Total (sum of lines 91 and 93)			0	94. 00

| Period: | Worksheet E-1 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | 5/23/2018 4:25 pm Health Financial Systems RU-ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1304

					5/23/2018 4: 25	5 pm
			XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		1, 159, 42	3	4, 041, 999	1. 00
2.00	Interim payments payable on individual bills, either				0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			07/12/2017	535, 600	3. 01
3.02				08/15/2017	221, 800	3. 02
3.03				D	0	3. 03
3.04					0	3. 04
3.05			(0	3. 05
	Provider to Program	1	1	1		
3.50	ADJUSTMENTS TO PROGRAM			O .	0	3. 50
3. 51					0	3. 51
3. 52					0	3. 52
3. 53				O O	0	3. 53
3.54				O O	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				757, 400	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 159, 42	3	4, 799, 399	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after	I	Ι			5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		I (1 0	5. 01
5. 02	TENTATI VE TO TROVIDER				0	5. 02
5. 03					0	5. 03
0.00	Provider to Program			<u>- 1</u>		0.00
5. 50	TENTATI VE TO PROGRAM				0	5. 50
5. 51					o	5. 51
5. 52					o	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				o	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		330, 00	5	0	6. 01
6.02	SETTLEMENT TO PROGRAM				426, 997	6. 02
7.00	Total Medicare program liability (see instructions)		1, 489, 42	3	4, 372, 402	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

 OSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 15-1304
 Period: From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared: 5/23/2018 4:25 pm
 Health Financial Systems RU-ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		'			5/23/2018 4: 2	5 pm
				ving Beds - SNF		
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		254, 749		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					ļ
2 01	Program to Provider ADJUSTMENTS TO PROVIDER		Ιο		0	2 01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER				0	3. 01 3. 02
3.02					0	3. 02
3. 03					0	3.03
3.04					0	3.04
3.05	Provider to Program				0	3.05
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	ADSOSTIMENTS TO TROOKAM				0	3. 51
3. 52					0	3. 52
3. 53			ĺ		Ö	3. 53
3. 54			ĺ		Ö	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		l o		0	3. 99
0. 77	3. 50-3. 98)					0. //
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		254, 749		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider		T	T	ı	
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Describer to Describe		0		0	5. 03
г го	Provi der to Program		1 0			0
5. 50 5. 51	TENTATI VE TO PROGRAM		0		0	5. 50 5. 51
5. 51					0	5.51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
3. 77	5. 50-5. 98)				0	3. 77
6. 00	Determined net settlement amount (balance due) based on					6.00
5.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		41, 053		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		295, 802		l ő	7. 00
				Contractor	NPR Date	1
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Heal th	Financial Systems RUSH MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1304 Period: From 01/01/2017 To 12/31/2017				epared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	l			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1. 00
2.00	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				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	certified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	I NPATIENT HOSPITAL SERVICES UNDER THE I PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
22 00	De Delance due provident (Specify)				

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

30. 00 31. 00 32. 00

Health Financial Systems	RUSH MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1304	Peri od:	Worksheet E-2
			From 01/01/2017	
		Component CCN: 15-Z304	To 12/31/2017	Date/Time Prepared:
				5/23/2018 4: 25 pm
				_

		·		5/23/2018 4: 2	5 pm
		Title XVIII S	wing Beds - SNF	Cost	
			Part A	Part B	
	COMPLITATION OF NET COST OF COVERED SERVICES		1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		221, 849	0	1.
	Inpatient routine services - swing bed-NF (see instructions)		221,049	Ü	2.
4	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	Δ and sum of Wkst D	81, 142	0	1
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins		01, 142	O	5.
	Per diem cost for interns and residents not in approved teachi			0.00	4.
	instructions)	L3 (
- 1	Program days		203	0	5.
1	Interns and residents not in approved teaching program (see in	structions)		0	6
00	Utilization review - physician compensation - SNF optional met	hod only	0		7
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		302, 991	0	8
00	Primary payer payments (see instructions)		0	0	9
0.00	Subtotal (line 8 minus line 9)		302, 991	0	10
	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	11
	professional services)				
1	Subtotal (line 10 minus line 11)		302, 991	0	
	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	1, 152	0	13
	for physician professional services)			0	111
	80% of Part B costs (line 12 x 80%)	4)	301, 839	0	
1	Subtotal (enter the lesser of line 12 minus line 13, or line 1 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	4)	301, 639	0	
	Pioneer ACO demonstration payment adjustment (see instructions)		Ü	16
	Rural community hospital demonstration project (§410A Demonstr		0		16
	adjustment (see instructions)	attion) payment			'
	Demonstration payment adjustment amount before sequestration		0	0	16
	Allowable bad debts (see instructions)		0	0	1
	Adjusted reimbursable bad debts (see instructions)		0	0	17
3. 00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)	0	0	18
9. 00 ·	Total (see instructions)		301, 839	0	19
9. 01	Sequestration adjustment (see instructions)		6, 037	0	1
	Demonstration payment adjustment amount after sequestration)		0	0	
	Interim payments		254, 749	0	1
	Tentative settlement (for contractor use only)		0	0	1 -
	Balance due provider/program (line 19 minus lines 19.01, 20, a		41, 053	0	1
	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2,	O	0	23
	chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstra	ation) Adjustment			1
	Is this the first year of the current 5-year demonstration per				200
	Century Cures Act? Enter "Y" for yes or "N" for no.	Tod dilder the 21st			200
	Cost Reimbursement				
	Medicare swing-bed SNF inpatient routine service costs (from W	kst. D-1, Pt. II, line			201
	66 (title XVIII hospital))				
2.00	Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, line			202
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)] 20₄
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the current	: 5-year demonstr	rati on	
	peri od)				120
	Medicare swing-bed SNF target amount	maa lina 204)			205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs Program reimbursement under the §410A Demonstration (see instr				20
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2				208
	and 3)	, cor. I, suil of fiftes i			200
- 1	and 3) Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209
	Reserved for future use	,			210
	Comparision of PPS versus Cost Reimbursement				1
	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	09 plus line 210) (see			215
	instructions)				1

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1304	From 01/01/2017	Worksheet E-3 Part V Date/Time Prepared: 5/23/2018 4:25 pm
	Title XVIII	Hospi tal	Cost

				5/23/2018 4: 2	5 pm
		Title XVIII	Hospi tal	Cost	
	<u> </u>				
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpati ent servi ces			1, 768, 539	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2. 00
3. 00	Organ acqui si ti on	,		0	3. 00
4. 00	Subtotal (sum of lines 1 through 3)			1, 768, 539	4. 00
5. 00	Primary payer payments			979	
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 785, 245	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			1,700,210	0.00
	Reasonable charges				
7. 00	Routine service charges			0	7. 00
8. 00	Ancillary service charges			Ö	8. 00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	
10.00				U	10.00
11 00	Customary charges	normant for comit and an	a ahanga basi s	0	11 00
11.00	Aggregate amount actually collected from patients liable for particular that would be a been realized from patients liable for			0	
12. 00	Amounts that would have been realized from patients liable for		n a charge basis	U	12. 00
12 00	had such payment been made in accordance with 42 CFR 413.13(e))		0.000000	12 00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
14.00	Total customary charges (see instructions)		() (0	14. 00
15. 00	Excess of customary charges over reasonable cost (complete only	y it line 14 exceeds II	ne 6) (see	0	15. 00
1/ 00	instructions)		- 14) (0	1/ 00
16. 00					16. 00
17 00	instructions)				17 00
17. 00	Cost of physicians' services in a teaching hospital (see insti	ructions)		U	17. 00
40.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	4 1 40		0	10.00
18.00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			1, 785, 245	
20. 00	Deductibles (exclude professional component)			349, 944	
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 435, 301	
23. 00	Coinsurance			1, 974	
24. 00	Subtotal (line 22 minus line 23)			1, 433, 327	
25. 00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		133, 074	
26. 00	Adjusted reimbursable bad debts (see instructions)			86, 498	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		117, 341	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 519, 825	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	29. 50
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			1, 519, 825	30.00
30. 01	Sequestration adjustment (see instructions)			30, 397	30. 01
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
31.00	Interim payments			1, 159, 423	31.00
32.00	Tentative settlement (for contractor use only)			0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0)	2, 31, and 32)		330, 005	33. 00
34.00	Protested amounts (nonallowable cost report items) in accordan		chapter 1,	0	34.00
	§115. 2	•	•		
			'	'	

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1304	Peri od: Worksheet E-3 From 01/01/2017 Part VII To 12/31/2017 Date/Time Prepared: 5/23/2018 4:25 pm

			lo 12/31/2017	Date/lime Pre 5/23/2018 4:2	
		Title XIX	Hospi tal	Cost	o piii
		2 12	Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI)	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		182, 992		1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		182, 992	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		182, 992	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		187, 799		8. 00
9.00	Ancillary service charges		213, 366	0	9. 00
10. 00	Organ acquisition charges, net of revenue		0		10. 00
11. 00	Incentive from target amount computation		0	_	11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		401, 165	0	12. 00
40.00	CUSTOMARY CHARGES	 	1		40.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14. 00	basis	normant for comitoes on	0	0	14. 00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 4			Ü	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CFR 9413. 13(e)	0.000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		401, 165	0.000000	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	218, 173	0	17. 00
17.00	line 4) (see instructions)	y II IIIIc To exceeds	210, 173	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	0	0	18. 00
	16) (see instructions)	,		_	
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1	6)	182, 992	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	ers.		
22. 00	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		182, 992	0	29. 00
00.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				00.00
30.00	Excess of reasonable cost (from line 18)		0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		182, 992	0	31.00
32.00	Deducti bl es		0	-	32.00
33. 00	Coinsurance		0	0	33.00
34. 00 35. 00	Allowable bad debts (see instructions) Utilization review		0	Ü	34. 00 35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 22)	182, 992	0	36. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	1 33)	102, 992	0	37. 00
	Subtotal (line 36 ± line 37)		182, 992	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		102, 772	O	39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		182, 992	0	40.00
41. 00	Interim payments		102, 772	0	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		182, 992	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2	102, 772	0	43. 00
	chapter 1, §115.2			· ·	10.00
	· · · · · · · · · · · · · · · · · · ·		'		•

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

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

Provider CCN: 15-1304

Peri od: Worksheet G From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/23/2018 4:25 pm

oni y)					5/23/2018 4: 2	5 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2. 00	3. 00	4. 00	
1 00	CURRENT ASSETS	2 700 112	, ,		0	1 00
1.00	Cash on hand in banks	3, 799, 112	1		0	1.00
2. 00 3. 00	Temporary investments Notes receivable	4, 631, 264) (0	2. 00 3. 00
4.00	Accounts recei vable	11, 858, 355	1		0	
5.00	Other receivable	730, 040	1		0	
6.00	Allowances for uncollectible notes and accounts receivable	-7, 400, 398	1		0	
7. 00	Inventory	945, 094	•		0	7. 00
8. 00	Prepai d expenses	446, 991			0	
9. 00	Other current assets	110, 771			0	9. 00
10.00	Due from other funds	0		0	0	10.00
11.00	Total current assets (sum of lines 1-10)	15, 010, 458		0		11. 00
	FIXED ASSETS					1
12.00	Land	0) (0	0	12. 00
13.00	Land improvements	0		0	0	13. 00
14.00	Accumulated depreciation	0) (0	0	14. 00
15.00	Bui I di ngs	35, 918, 255	5	0	0	15. 00
16.00	Accumulated depreciation	-20, 622, 001		0	0	16. 00
17.00	Leasehold improvements	0) (0	0	17. 00
18.00	Accumulated depreciation	0)	0	0	18. 00
19. 00	Fi xed equi pment	0) (0	0	19. 00
20. 00	Accumulated depreciation	0)	0	0	20. 00
21. 00	Automobiles and trucks	0	1	0	0	21. 00
22. 00	Accumul ated depreciation	0	1	0	0	22. 00
23. 00	Major movable equipment	0		0	0	23. 00
24. 00	Accumulated depreciation	0		0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0		0	0	25. 00
26. 00	Accumulated depreciation	0		0	0	26. 00
27. 00	HIT designated Assets	0		0	0	27. 00
28. 00	Accumulated depreciation	0	1	0	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable	15 204 254	1	0 0		29. 00 30. 00
30.00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	15, 296, 254	1	<u>J</u>	U	30.00
31. 00	Investments			0	0	31. 00
32. 00	Deposits on Leases				0	32. 00
33. 00	Due from owners/officers	0		0	0	33.00
34. 00	Other assets	0		0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	l o		0	Ö	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	30, 306, 712		0		36. 00
	CURRENT LIABILITIES					
37.00	Accounts payable	2, 913, 523	3	0	0	37. 00
38.00	Salaries, wages, and fees payable	0) (0	0	38. 00
39.00	Payroll taxes payable	0)	0	0	39. 00
40.00	Notes and Loans payable (short term)	1, 059, 511		0	0	40. 00
41.00	Deferred income	0) (0	0	41. 00
42.00	Accel erated payments	0)			42. 00
43.00	Due to other funds	0) (0	0	1
44. 00	Other current liabilities	7, 544, 247		0	Ĭ	
45. 00	Total current liabilities (sum of lines 37 thru 44)	11, 517, 281		0	0	45. 00
	LONG TERM LIABILITIES	1	.1			
46. 00	Mortgage payable	0		٥ -	0	
47. 00	Notes payable	5, 366, 511	1	0		1
48. 00	Unsecured Loans	0			0	48. 00
49. 00	Other long term liabilities	U F 2// F11	1	0	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	5, 366, 511		0 0		
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	16, 883, 792		J 0	U	
52. 00	General fund balance	13, 422, 920				52. 00
53. 00	Specific purpose fund					53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	13, 422, 920	,	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	30, 306, 712			0	60.00
55. 50	[59]	30, 300, 712				55.50
	1. /	1	1	1	1	

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

Provider CCN: 15-1304

					To 12/31/2017	Date/Time Prep 5/23/2018 4:29	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	•
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		12, 399, 919 1, 023, 001		0		1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)		13, 422, 920		0		3. 00
4. 00	Additions (credit adjustments) (specify)	o	.0, .22, ,20		0	0	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6. 00
7. 00 8. 00					0	0	7. 00 8. 00
9. 00		O			0	Ö	9. 00
10.00	Total additions (sum of line 4-9)		0		0		10. 00
11.00	Subtotal (line 3 plus line 10)		13, 422, 920		0		11. 00
12. 00 13. 00	Deductions (debit adjustments) (specify)	0			0	0	12. 00 13. 00
14. 00					0	0	14. 00
15. 00		o			Ö	0	15. 00
16. 00		0			0	0	16. 00
17. 00 18. 00	Total deductions (sum of lines 12-17)	0	0		0	0	17. 00 18. 00
19. 00	Fund balance at end of period per balance		13, 422, 920		0		19. 00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00	_		
1. 00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)		0		0		3. 00 4. 00
5. 00	(Spectry)		0				5. 00
6.00			0				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)	o	J		0		10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13. 00 14. 00			0				13. 00 14. 00
15. 00			0				15. 00
16.00			0				16. 00
17. 00			0				17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0		18. 00 19. 00
17.00	sheet (line 11 minus line 18)						17.00
	•			•	•		•

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

			10) 12/31/201/	Date/IIme Prep 5/23/2018 4:2	
	Cost Center Description	Inpatien	t	Outpati ent	Total	
		1, 00		2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	3, 819,	384		3, 819, 384	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY		_		-	7. 00
8.00	NURSING FACILITY					8. 00
9. 00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	3, 819,	384		3, 819, 384	10.00
10.00	Intensive Care Type Inpatient Hospital Services	0,017,	001		0,017,001	10.00
11. 00	INTENSIVE CARE UNIT					11. 00
12. 00	CORONARY CARE UNIT					12. 00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of li	nes	0		0	16. 00
10.00	11-15)	103	Ü		J	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	3, 819,	384		3, 819, 384	17. 00
18. 00	Ancillary services	3, 431,		51, 418, 419	54, 849, 546	18. 00
19. 00	Outpati ent servi ces		848	9, 074, 340	9, 098, 188	19. 00
20. 00	RURAL HEALTH CLINIC	23,	0	7, 074, 340	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	o	0	21. 00
22. 00	HOME HEALTH AGENCY		U	ď	U	22. 00
23. 00	AMBULANCE SERVICES		0	1, 235, 151	1, 235, 151	23. 00
24. 00	CMHC		U	1, 233, 131	1, 233, 131	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPICE					26. 00
27. 00	PROFESSIONAL FEES	120	969	7, 765, 603	8, 205, 572	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to			69, 493, 513	77, 207, 841	28. 00
20.00	G-3, line 1)	WKSt. 7,714,	320	07, 473, 513	77, 207, 641	20.00
	PART II - OPERATING EXPENSES	L		l		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			32, 425, 178		29. 00
30.00	ADD (SPECIFY)		0	32, 423, 170		30.00
31. 00	(SI ESTITY)		0			31. 00
32. 00			0			32. 00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		U	0		36. 00
37. 00	DEDUCT (SPECIFY)		0	ď		37. 00
38. 00	DEDUCT (SI ECITI)		0			38. 00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			0			41. 00
41.00	Total deductions (sum of lines 37-41)		U	۸		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfor		32, 425, 178		43. 00
43.00	to Wkst. G-3, line 4)	LI GIISI CI		32, 423, 170		43.00
	TO MICST. 0-3, TITIE 4)	I	I	I		

Heal th	Financial Systems RUSH MEMORIAL	HOSPI TAI	In lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1304	Peri od:	Worksheet G-3	
	From 01/01/2017				
			To 12/31/2017	Date/Time Prep 5/23/2018 4:29	
	· · · · · · · · · · · · · · · · · · ·			3/23/2010 4.2	o piii
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	ne 28)		77, 207, 841	1. 00
2.00	Less contractual allowances and discounts on patients' accour			46, 077, 743	2. 00
3.00	Net patient revenues (line 1 minus line 2)			31, 130, 098	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		32, 425, 178	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			-1, 295, 080	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			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	
15.00	Revenue from rental of living quarters			0	
16.00	Revenue from sale of medical and surgical supplies to other t	tnan patients		0	16.00
17. 00	Revenue from sale of drugs to other than patients Revenue from sale of medical records and abstracts			0	17. 00 18. 00
18. 00 19. 00				0	19.00
20. 00	Tuition (fees, sale of textbooks, uniforms, etc.) 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			1, 231, 108	
24. 00	NON-OPERATING EXPENSES/INCOME			1, 086, 973	
25. 00	Total other income (sum of lines 6-24)			2, 318, 081	
26. 00	Total (line 5 plus line 25)			1, 023, 001	
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
	Net income (or loss) for the period (line 26 minus line 28)			1, 023, 001	
			'	, ,	