PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

Contractor use only

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 01/01/2018 and ending 12/31/2018 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	9
Date	
Date	

number of times reopened = 0-9.

			Title	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	274, 228	440, 281	0	206, 662	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	40, 295	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	314, 523	440, 281	0	206, 662	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 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/24/2019 4:59 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 fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal RUSH MEMORIAL HOSPITAL 151304 99915 08/01/2000 Ν 3.00 Subprovider - IPF 4.00 4.00 Subprovi der - IRF 5.00 5 00 Subprovider - (Other) 6.00 6.00 Swing Beds - SNF 7.00 RUSH SWING BEDS 15Z304 99915 08/01/2000 N 0 N 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 12.00 Hospi tal -Based HHA 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 15.00 Hospital - Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 12/31/2018 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 20 00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.

Did this hospital receive interim uncompensated care payments for this 22. 01 22 01 Ν Ν cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care 22.02 Ν N 22 02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas 22.03 Ν Ν N 22.03 adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

	yes or "N" for no.							
23.00	Which method is used to determine Medicaid days on li	ines 24 and	/or 25		o			23.00
	below? In column 1, enter 1 if date of admission, 2 i							
	if date of discharge. Is the method of identifying the							
	reporting period different from the method used in the							
	reporting period? In column 2, enter "Y" for yes or							
		In-State	In-State	Out-of	Out-of	Medicaid	Other	
		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	paid days	eligible			
			days		unpai d			
		1, 00	2. 00	3. 00	4. 00	5. 00	6.00	
24.00	I & this securidas is as I DDC bessital sector the	1.00	2.00	3.00	4.00	3.00	0.00	24.00
24. 00	If this provider is an IPPS hospital, enter the	0	"	1 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.							
	cordinir 5, and other mearcard days in cordinir 6.	1	I	1	I	ı	ı	ı

	Financial Systems RUSH TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	MEMORIAL HO	Provi der CC	N: 15-1304	Peri od:	111 -		ksheet	MS-255 S-2
						31/2018	3 Dat 5/2	e/Ti me 4/2019	Prepar 4:59 p
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medic HMO c	lays	Othe Medica days	ai d
. 00	If this provider is an IDE contact the in state	1.00	2.00	3. 00	4. 00	5. 0		6. 00	
5. 00	If this provider is an IRF, enter the in-state 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.		0	0	Urban/		0	of Co	25
						00	Date	2.00	ogi
7. 00	Enter your standard geographic classification (not woost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not woreporting period. Enter in column 1, "1" for urban center the effective date of the geographic reclassification is a sole community hospital (SCH), enter the	or rural. wage) status or "2" for r fication in	at the end ural. If ap column 2.	l of the cos pplicable,	t		2		27
). 00	effect in the cost reporting period.	ie ridiliber or	perrous 30	ii Status III					30
						ni ng:	E	ndi ng:	
. 00	Enter applicable beginning and ending dates of SCH s	status. Subs	cript line	36 for numb		00		2. 00	36
	of periods in excess of one and enter subsequent date	tes.							
	If this is a Medicare dependent hospital (MDH), ento is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for		•		S		0		37
. 01	accordance with FY 2016 OPPS final rule? Enter "Y" instructions)								
. 00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number center subsequent dates.								38
						/N 00		Y/N 2. 00	-
9. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent	er in colum its in	me n	V		N	36
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octono in column 2, for discharges on or after October 1	ober 1. Ente	r "Y" for y			V		N	40
						1. (00
	Prospective Payment System (PPS)-Capital						, , ,	00 0.	
	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc	·	·			N N			N 45
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	st. L, Pt. I	II and Wkst	L-1, Pt.	I through				
. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymer Teaching Hospitals					N N			N 47 N 48
	Is this a hospital involved in training residents in or "N" for no.		. 0		,	N			56
	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor for yes or "N" for no in column 2. If column 2 is '"N", complete Wkst. D, Parts III & IV and D-2, Pt. If the 56 is yes, did this facility elect restrain	or yes or "N onth of this 'Y", complet I, if appli	" for no in cost report e Worksheet cable.	column 1. ing period? E-4. If co	If column Enter "Y Iumn 2 is				57
	If line 56 is yes, did this facility elect cost rein defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If ye	complete W	kst. D-5.		5 dS	N			58
	,	,		NAHE 413.8 Y/N		neet A le #	Pas Qual	s-Throu ificat erion (ugh i on
				1. 00	2.	00		3. 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 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/24/2019 4:59 pm Y/N IME Direct GME IME Direct GME 5.00 1.00 2.00 3. 00 4.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0 00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA \$5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00 Ν Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal

	Nonpi ovi aci	i ilospi tai	- //	
	Si te			
	1. 00	2.00	3. 00	
Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsT	This base year	is your cost r	eporti ng	
period that begins on or after July 1, 2009 and before June 30, 2010.				l
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents	0.00	0.00	0. 000000	64. 00
in the base year period, the number of unweighted non-primary care				l
resident FTEs attributable to rotations occurring in all nonprovider				l
settings. Enter in column 2 the number of unweighted non-primary care				l
resident FTEs that trained in your hospital. Enter in column 3 the ratio			i	
of (column 1 divided by (column 1 + column 2)). (see instructions)				

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1304 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/24/2019 4:59 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 0.000000 65.00 0. 00 0. 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 ghted Ratio (col. 3/ Program Code Unwei ahted 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)

Long Term Care Mospital PPS 1.00 Is this a long term care hospital (LICH)? Enter "Y" for yes and "N" for no. 1.01 Is this a Life co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes, and "N" for no. 1.02 Is this a new hospital under 42 CFR Section \$413.40(f)(1)(1) TEFRA? Enter "Y" for yes or "N" for no. 1.03 Is this a new hospital under 42 CFR Section \$413.40(f)(1)(1) TEFRA? Enter "Y" for yes or "N" for no. 1.04 Is this a new hospital under 42 CFR Section \$413.40(f)(1)(1) TEFRA? Enter "Y" for yes or "N" for no. 1.05 Is 13.40(f)(1)(1)? Inter "Y" for yes and "N" for no. 1.06 Is this facility establish a new Other subprovider (excluded unit) under 42 CFR Section \$413.40(f)(1)(1)? Inter "Y" for yes or "N" for no. 1.05 Is 13.40(f)(1)(1)? Inter "Y" for yes or "N" for no. 1.06 Is this facility have title V and/or XIX impatient hospital services? Enter "Y" for yes or "N" for no. 1.00 Does this facility have title V and/or XIX impatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 1.00 Does this part? Enter "Y" for yes or "N" for no in the applicable column. 1.01 Or in part? Enter "Y" for yes or "N" for no in the applicable column. 1.00 Does title V or XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 1.00 Does title V or XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 1.00 Does title V or XIX reduce capital cost? Enter "Y" for yes or "N" for no in the applicable column. 1.00 Does title V or XIX reduce the reduction percentage in the applicable column. 1.00 Does title V or XIX reduce the reduction percentage in the applicable column. 1.00 Does title V or XIX reduce the reduction percentage in the applicable column. 1.00 Does title V or XIX reduce the reduction percentage in the applicable column. 1.00 Does title V or XIX reduce the reduction percentage in the applicable column. 1.00 Does title V or XIX reduce the reduction percentage in the applicable colu	epared 59 pm
1.00 s. this a long term care hospital (LTGH)? Enter "Y" for yes and "N" for no. N N St this a LTGK co-located within another hospital for part or all of the cost reporting period? Enter N Y" for yes and "N" for no.	-
1.00 1.	4
5.00 [is this Facility establish a new hospital under 42 CRR Section \$413.40(F)(1)(1) TEFRA? Enter "Y" for yes or "N" for no. \$413.40(F)(1)(1)? Enter "Y" for yes and "N" for no. 10 [is this hospital an extended neopla stic disease care hospital classified under section N N If the V and XIX Services V XIX 1.00 2.00	80. (
Statis hospital an extended neoplastic disease care hospital classified under section N 1886(d)(1)(B)(v)? Enter "Y" for yes or "N" for no. V XIX	85. (86. (
Title V and XIX Services 1.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 1.00 Is this hospital relimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 2.00 Are title XIX NP patients occupying title XVIII SNP beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 3.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 3.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 3.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 3.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 3.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 3.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on West. B. Pt. I. col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.00 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 title XIX. 3.00 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) relimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.01 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) relimbursed 101% of not put the XIX follow Medicare (title XVIII) for a critical access hospital (CAH) relimbursed 101% of not put the XIX follow Medicare (title XVIII) for not in column 1 for title V, and in column 2 for title XIX. 3.00 Does t	87. (
Title V and XIX Services	
0.00 Does this facility have title V and/or XIX Inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column. 1.00 Is this hospital relimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. 2.00 Are title XIX NF patients occupying title XVIII SMF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. 3.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "N" for yes or "N" for no in the applicable column. 3.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column. 3.01 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 3.02 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 3.03 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column. 3.04 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 1, col. 25? Enter "Y" for yes or "N" for no in column 2 for title XIX. 3.04 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. V, C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.03 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 3.04 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of no in a column 1 for title V, and in column 2 for title XIX. 3.04 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of no in column 1 for title V, and in column 2 for title XIX. 3.04 Does title V or XIX follow Medicare (title XVI	
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106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for L&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N 108.00 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory	105. (
07.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for L&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00	106. (
08.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 N CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00	107. (
Physical Occupational Speech Respiratory 1.00 2.00 3.00 4.00	108. (
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	109. 0
1.00	

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

lealth Financial Systems RUSH MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C	^N· 15_13∩4	Peri od:	LIC	u of Form Worksheet	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	JN: 15-1304	From 01/01/ To 12/31/		Part I Date/Time 5/24/2019	Prepared
		1.00		2. 00	
111.00 If this facility qualifies as a CAH, did it participate in the Frontier C Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	period? Enter enter the column 2.	N		2.00	111. (
			1. 00	2.00 3	3. 00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no i is yes, enter the method used (A, B, or E only) in column 2. If column 2 a either "93" percent for short term hospital or "98" percent for long te psychiatric, rehabilitation and long term hospitals providers) based on t Pub. 15-1, chapter 22, §2208.1.	is "E", enter rm care (incl he definition	in column udes	N		0 115. (
l16.00 is this facility classified as a referral center? Enter "Y" for yes or "N l17.00 is this facility legally-required to carry malpractice insurance? Enter " no.		"N" for	N Y		116. (117. (
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 claim-made. Enter 2 if the policy is occurrence.	if the policy	is	1		118. (
granii iliade. Enter 2 11 the porrey 13 decurrence.	Premi ums	Losse	S	Insuran	се
	1. 00	2.00		3. 00	
118.01 List amounts of malpractice premiums and paid losses:	135, 1	09	0		0 118. (
		1. 00		2. 00	
 18.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing c and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro 	ost centers vision in ACA	N N		N	118. (119. (120. (
§3121 and applicable amendments? (see instructions) Enter in column 1, "Y "N" for no. Is this a rural hospital with < 100 beds that qualifies for t Hold Harmless provision in ACA §3121 and applicable amendments? (see inst Enter in column 2, "Y" for yes or "N" for no. 21.00Did this facility incur and report costs for high cost implantable device	he Outpatient ructions)	Y			121. (
patients? Enter "Y" for yes or "N" for no.	Ü				
22.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", ente the Worksheet A line number where these taxes are included. Transplant Center Information					122. (
25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no. If	N			125. (
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter the certiin column 1 and termination date, if applicable, in column 2.		•			126. (
27.00 If this is a Medicare certified heart transplant center, enter the certifing column 1 and termination date, if applicable, in column 2.					127. (
28.00 If this is a Medicare certified liver transplant center, enter the certifing in column 1 and termination date, if applicable, in column 2.					128. (
29.00 f this is a Medicare certified lung transplant center, enter the certificolumn 1 and termination date, if applicable, in column 2.		n			129. (
30.00 olf this is a Medicare certified pancreas transplant center, enter the cer date in column 1 and termination date, if applicable, in column 2. 31.00 of this is a Medicare certified intestinal transplant center, enter the center.					130. (
date in column 1 and termination date, if applicable, in column 2. 32.00 f this is a Medicare certified islet transplant center, enter the certified islet transplant center, enter the certified islet transplant center.					131. (
in column 1 and termination date, if applicable, in column 2. 33.00 f this is a Medicare certified other transplant center, enter the certif					133. (
in column 1 and termination date, if applicable, in column 2. 34.00 of this is an organ procurement organization (OPO), enter the OPO number					134.
and termination date, if applicable, in column 2. All Providers					
140.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home		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 01/01/2018 Part I 12/31/2018 Date/Time Prepared: To 5/24/2019 4:59 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: Contractor's Name: Contractor's Number: 141 00 142.00 Street: PO Box: 142.00 143.00 Ci ty: State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? γ 144. 00 1. 00 2.00 145.00|If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146.00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 147. 00 Ν 148 00 N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N N 155.00 156.00 Subprovi der - 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 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 of this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 1168.00 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	01/01/2018	12/31/2018	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)			

	Financial Systems RUSH MEMORIA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1304	Period: From 01/01/2018 To 12/31/2018		2
					5/24/2019 4:5	59 pm
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	esponses. Ente	1.00 er all dates in t	2.00 :he	
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the		46	N		1
00	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions)	N		1.0
			Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, including	nn 3, "V" for	N N			3. 0
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	der or its of the board				
			Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.0
00	Are the cost report total expenses and total revenues diffe		N			5. 0
	those on the filed financial statements? If yes, submit rec	conciliation.		Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities					٠.,
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider is	S N		6.0
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	N N		7. (8. (
00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. (
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		he current	N		10.0
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. (
	Treaching Trogram on worksheet A: Tr yes, see That detrons.				Y/N	
	E				1. 00	
2. 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s soo instruct	Lone		Y	12. (
3. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	N N	13. (
1. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	structi ons.	N	14. (
5. 00	Did total beds available change from the prior cost reporti	na period? If	ves. see inst	ructions.	N	15. (
	<u> </u>	, , , , , , , , , , , , , , , , , , , ,	t A		t B	
		Y/N	Date	Y/N	Date	
	DC*D Data	1. 00	2. 00	3. 00	4. 00	
5. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	Y	03/27/2019	Y	03/27/2019	16. 0
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. (
. 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. (
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. (

Heal th	Financial Systems RUSH MEMORIA	AL HOSPITAL		In Lie	u of Form CM	S-2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1304	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S Part II Date/Time P 5/24/2019 4	repared:	
		Descr	ipti on	Y/N	Y/N	, , , , , , , , , , , , , , , , , , ,	
		()	1. 00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00	
		Y/N	Date	Y/N	Date		
		1.00	2. 00	3. 00	4. 00		
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00	
				•	1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)		1.00		
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made dur	ing the cost	N	23. 00	
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost re	eporting period?	N	24. 00	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	Plf yes, see	N	25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ne cost reporti	ng period? I	f yes, see	N	26. 00	
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	g period? If	ges, submit	N	27. 00	
28. 00	Interest Expense Were new Loans, mortgage agreements or letters of credit er	ntered into dur	ing the cost	reporting	N	28. 00	
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	•	bt Service F	Reserve Fund)	Υ	29. 00	
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If yes	s, see	N	30. 00	
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new	debt? If yes	s, see	N	31. 00	
	Purchased Services						
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		d through co	ontractual	N	32. 00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 approx, see instructions.		g to competi	tive bidding? If	N	33. 00	
	Provi der-Based Physi ci ans						
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement with	provi der-ba	ased physicians?	Υ	34. 00	
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		its with the	provi der-based	N	35. 00	
	physicians during the cost reporting period. It yes, see it	isti deti ons.		Y/N	Date		
				1. 00	2. 00		
	Home Office Costs						
36. 00 37. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	N N		36. 00 37. 00	
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off			- N		38. 00	
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other			s, N		39. 00	
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00	
	instructions.	1					
	1.00 2.						
	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.	LANDON		HACKETT		41. 00	
42. 00	1	BLUE & CO., LL	С			42. 00	
43. 00		317-713-7929		LHACKETT@BLUEA	NDCO. COM	43. 00	

Heal th	Financial Systems	RUSH MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der		Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Pre 5/24/2019 4:5	pared:
				3. 00			
	Cost Report Preparer Contact Information			3. 00			
41. 00	Enter the first name, last name and the ti held by the cost report preparer in column respectively.		SENI OR MANAG	ER			41. 00
42. 00	Enter the employer/company name of the compreparer.	st report					42. 00
43. 00	Enter the telephone number and email addresserve preparer in columns 1 and 2, respec						43. 00

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Health Financial Systems RUSH MOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1304

						To 12/31/201		
							5/24/2019 4:5 I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
		Line Number		0. 2000	Avai I abl e	0, 11, 11,001, 0		
		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			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	
6. 00	Hospital Adults & Peds. Swing Bed NF						0	
7. 00	Total Adults and Peds. (exclude observation			25	9, 12	30, 432. 0	00 0	7. 00
0.00	beds) (see instructions)							0.00
8.00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)							11. 00 12. 00
13. 00	NURSERY							13.00
14. 00	Total (see instructions)			25	9, 12	30, 432. 0	00	14. 00
15. 00	CAH visits			23	7, 12	.5 50, 452. 0	0	15. 00
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21. 00
22.00	HOME HEALTH AGENCY							22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)			25				27. 00
28. 00	Observation Bed Days						0	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		0		32.00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days							33. 00
	LTCH site neutral days and discharges							33. 00
55.01	TETOTI SI to ricutt ai days and di schal ges				I	I	1	1 33.01

Provider CCN: 15-1304

I/P Days / 0/P VISITS / Trips					'	0 12/31/2010	5/24/2019 4:5	
Note			I/P Days	o / O/P Visits	/ Trips	Full Time		
No. Hospital Adults & Peds. (columns 5, 6, 7 and 8 & Residents Payrol		Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
Nespital 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) No and other (see instructions)								
B exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			6. 00	7. 00	8. 00			
2 00 HM0 and other (see instructions) 0 3 3 3 4	1.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	870	114	1, 268			1.00
4. 00 HMO I RF Subprovider 0 0 58 58 5. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 7. 00 7. 00 6. 00 7.	2.00		o	3				2. 00
5.00	3.00	HMO IPF Subprovider	0	0				3. 00
6. 00 Hospital Adul ts & Peds. Swing Bed NF 7. 00 Total Adul ts and Peds. (exclude observation beds) (see instructions) 8. 00 INTENSIVE CARE UNIT 9. 00 GORONARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 TOTAL (see instructions) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 HOME HEALTH AGENCY 21. 00 HOME HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 00 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 OBSERVATION BED BED BYS 29. 00 Ambulance Trips 30. 00 Labor & delivery room outpatient days (see instructions) 31. 00 Unpatient days (see instructions) 32. 00 Labor & delivery days (see instructions) 33. 00 United into room of the proof outpatient days (see instructions) 33. 00 United into room of the proof outpatient days (see instructions) 33. 00 United into room of the proof outpatient days (see instructions) 33. 00 United into room of the proof outpatient days (see instructions) 33. 00 United into room outpatient days (see instructions) 33. 00 United into room outpatient days (see instructions) 33. 00 United into room outpatient days (see instructions) 33. 00 United into room outpatient days (see instructions) 33. 00 United into room outpatient days (see instructions) 33. 00 United into room outpatient days (see instructions) 33. 00 United into room outpatient days (see instructions) 33. 00 United into room outpatient days (see instructions) 33. 00 United Room outpatient days (see instructions) 33.	4.00		0	0				4. 00
7.00	5.00		58	0	58	1		5. 00
7.00	6.00			0	17	•		6. 00
9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 Total (see instructions) 15.00 CAH visits 0 0 0 0 0 17.00 SUBPROVIDER - IPF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 20.00 HOME HEALTH AGENCY 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.10 HOSPICE (non-distinct part) 26.00 CHMC - CAMP C 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 CBMC - CAMP C 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instructions) 30.00 Employee discount days - IRF 30.00 SUBPROVIDER SURGICAL SETURATIONS) 30.00 Employee discount days - IRF 30.00 SUBPROVIDER O	7. 00	Total Adults and Peds. (exclude observation	928	114	1, 343			7. 00
10. 00 BURN INTENSIVE CARE UNIT 10. 00 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 12. 00 01. 00 01. 00 12. 00 12. 00 13. 00 01. 00 14. 00 15. 00 02. 00 13. 00 02. 00 00 00 00 00 00. 00.	8.00	INTENSIVE CARE UNIT						8. 00
11. 00 SURGICAL INTENSIVE CARE (UNIT 12. 00 12. 00 OTHER SPECIAL CARE (SPECIFY) 12. 00 13. 00 NURSERY 13. 00 NURSERY 13. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 OTHER SPECIAL CARE (SPECIFY) 14. 00 OTHER SPECIAL CARE (SPECIFY) 14. 00 OTHER SPECIAL CARE (SUBPROVIDER - IPF OTHER SPECIAL CARE	9.00	CORONARY CARE UNIT						9. 00
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER - IRF 19. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 33. 00 LTCH non-covered days 33. 00 LTCH non-covered days 4 10 August 2 A	10.00	BURN INTENSIVE CARE UNIT						10.00
13. 00 14. 00 Total (see instructions) 15. 00 CAH visits 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 33. 00 LTOH non-covered days 30. 00 LTOH non-covered days 41. 00 O O O O O O O O O O O O O O O O O O	11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
14.00	12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IPF 18. 00 18. 00 SUBPROVIDER - IRF 18. 00 19. 00 SKILLED NURSING FACILITY 19. 00 NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 33. 00 LTCH non-covered days 30. 00 31. 00 outpatient days (see instructions) 31. 00 LTCH non-covered days 30. 00 LTCH non-covered days	13.00	NURSERY						13. 00
16. 00 SUBPROVIDER - IPF 16. 00 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER 18. 00 17. 00 18. 00 19. 00 SKILLED NURSING FACILITY 19. 00 1	14.00	Total (see instructions)	928	114	1, 343	0.00	272. 77	14.00
17. 00 SUBPROVIDER - IRF 17. 00 18. 00 SUBPROVIDER 18. 00 18. 00 SUBPROVIDER 18. 00	15.00	CAH visits	0	0	0)		15. 00
18.00 SUBPROVI DER 18.00 19.00 SKI LLED NURSI NG FACI LITY 19.00 20.00 NURSI NG FACI LITY 20.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 AMBULATORY SURGI CAL CENTER (D.P.) 23.00 24.00 HOSPI CE (non-distinct part) 24.10 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINI C 26.00 RURAL HEALTH CLINI C 26.00 RURAL HEALTH CLINI C 26.00 Total (sum of lines 14-26) 0.00 272.77 27.00 28.00 Observation Bed Days 364 30.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 0 0 0 0 0 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 CMHC CMHC	16.00	SUBPROVIDER - IPF						16. 00
19.00 SKILLED NURSING FACILITY 19.00 20.00 20.00 21.00 20.00 21.00 21.00 22.00 21.00 22.	17.00	SUBPROVI DER - I RF						17. 00
20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 00 Observation Bed Days 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 20. 00 21. 00 22. 00 21. 00 22. 00 22. 00 24. 10 25. 00 26. 25 27. 00 O O O O O O O O O O O O O O O O O O	18. 00	SUBPROVI DER						18. 00
21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 44. 00 HOSPICE 44. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 28. 00 Observation Bed Days 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 0 HOME HEALTH AGENCY 22. 00 22. 00 22. 00 22. 00 23. 00 24. 10 25. 00 0 0 0 0. 00 0 0. 00 0 0. 00 0 0. 00 272. 77 27. 00 38. 00 39. 00 30. 00 31. 00 32. 01 33. 00 33. 00 33. 00 33. 00	19. 00	SKILLED NURSING FACILITY						19. 00
22.00	20.00	NURSING FACILITY						20. 00
23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 00 Labor & delivery days (see instructions) 30. 00 LTCH non-covered days 30. 00 LTCH non-covered days	21. 00	OTHER LONG TERM CARE						21. 00
24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 00 Labor & days (see instructions) 30. 00 LTCH non-covered days 30. 00 LTCH non-covered days 24. 00 24. 10 24. 10 24. 10 24. 10 24. 10 24. 10 25. 00 26. 00 27. 07 27. 00 28. 00 0	22. 00							22. 00
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 00 LTCH non-covered days 30. 00 LTCH non-covered days 30. 00 CMHC - CMHC 25. 00	23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
25. 00 CMHC - CMHC 25. 00 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 0 0 0 0. 00 0. 00 272. 77 27. 00 28. 00 0bservation Bed Days 0 681 28. 00 29. 00 Ambulance Trips 364 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 0 31. 00 29. 00 32. 00 Labor & delivery days (see instructions) 0 0 0 0 32. 00 33. 00 LTCH non-covered days 0 0 33. 00 33. 00 1TCH non-covered days 0 33. 00	24.00							24. 00
26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 26. 00 0 0 0 0. 00	24. 10	HOSPICE (non-distinct part)			0)		24. 10
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0 0 0 0.00 272. 77 28. 00 Observation Bed Days 0 681 272. 77 29. 00 Ambulance Trips 364 29. 00 30. 00 Employee discount days (see instruction) 0 30. 00 31. 00 Employee discount days - IRF 0 31. 00 32. 00 Labor & delivery days (see instructions) 0 0 0 32. 01 Total ancillary labor & delivery room 0 0 0 LTCH non-covered days 0 0 33. 00 33. 00 LTCH non-covered days 0 33. 00	25. 00	CMHC - CMHC						25. 00
27. 00 Total (sum of lines 14-26) 0. 00 272.77 27. 00 28. 00 0bservation Bed Days 0 681 28. 00 29. 00 Ambulance Trips 364 30. 00 Employee discount days (see instruction) 0 30. 00 31. 00 Employee discount days - IRF 0 31. 00 32. 00 Labor & delivery days (see instructions) 0 0 0 32. 00 32. 01 Total ancillary labor & delivery room 0 0 32. 01 0utpatient days (see instructions) 0 33. 00 LTCH non-covered days 0 33. 00 33. 00	26.00	RURAL HEALTH CLINIC						26. 00
28. 00 Observation Bed Days 28. 00 29. 00 Ambulance Trips 364 29. 00 30. 00 Employee discount days (see instruction) 30. 00 Employee discount days - IRF 0 31. 00 32. 00 Labor & delivery days (see instructions) 0 0 0 32. 00 32. 01 Total ancillary labor & delivery room 0 0 32. 01 outpatient days (see instructions) 33. 00 LTCH non-covered days 0 33. 00 TCH non-covered days 0 33. 00	26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
29. 00 Ambulance Trips 364 29. 00 30. 00 Employee discount days (see instruction) 30. 00 Employee discount days - IRF 0 31. 00 32. 00 Labor & delivery days (see instructions) 0 0 0 32. 00 32. 01 Total ancillary labor & delivery room 0 0 32. 01 outpatient days (see instructions) 0 0 33. 00 LTCH non-covered days 0 33. 00 33. 00 33. 00 33. 00 33. 00 364 0 364 0 30. 00 30. 00 30. 00 31. 00 31. 00 32. 01 32. 01 33. 00 33	27. 00					0.00	272. 77	27. 00
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 30.00 31.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00	Observation Bed Days		0	681			28. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 31.00 32.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			364					29. 00
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00				0)		30. 00
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 32.01					0)		
outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00	32.00	Labor & delivery days (see instructions)	0	0	0)		32. 00
33.00 LTCH non-covered days 0 33.00	32. 01				0			32. 01
33.01 LTCH site neutral days and discharges 0 33.01		1						
	33. 01	LTCH site neutral days and discharges	0					33. 01

Health Financial Systems RUSH MOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1304

				To	12/31/2018	Date/Time Prep 5/24/2019 4:59	
		Full Time		Di sch	arges	7 37 247 2017 4. 3) piii
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospi tal Adul ts & Peds. (columns 5, 6, 7 and		0	269	35	381	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)			0	2		2. 00
3. 00	HMO IPF Subprovider				ol		3. 00
4.00	HMO IRF Subprovider				o		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7. 00
	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 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY						12. 00 13. 00
14. 00	Total (see instructions)	0. 00	0	269	35	381	14. 00
15. 00	CAH visits	0.00	O	207	33	301	15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10 25. 00
25. 00 26. 00	CMHC - CMHC 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	0.00					28. 00
29. 00	Ambulance Trips						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	I	33. 01

	Financial Systems RUSH MEMORIAL HOSP FAL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN: 15-1304		u of Form CMS-2 Worksheet S-10				
HUSPI	TAL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN: 15-1304	Peri od: From 01/01/2018	worksneet 5-10	U			
			To 12/31/2018	Date/Time Pre	pared:			
				5/24/2019 4: 5	9 piii			
	The second secon			1. 00				
	Uncompensated and indigent care cost computation Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ad by Lina 202 calu	mp 0)	0.242252	1 1 0			
1.00	Medicaid (see instructions for each line)	ed by Trie 202 Coru	11111 8)	0. 362252	1.0			
2. 00	Net revenue from Medicaid			2, 640, 797	2.00			
3. 00	Did you receive DSH or supplemental payments from Medicaid?			Υ Υ	3. 0			
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental	payments from Medi	cai d?	Υ	4.0			
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from	Medi cai d		0				
5. 00	Medi cai d charges			11, 618, 177	•			
7.00	Medicaid cost (line 1 times line 6)	no 7 minuo oum of l	inco 2 and E. if	4, 208, 708	•			
3. 00	Difference between net revenue and costs for Medicaid program (li < zero then enter zero)	ne / minus sum oi i	rnes z anu s; rr	1, 567, 911	8.00			
	Children's Health Insurance Program (CHIP) (see instructions for	each line)			1			
9. 00	Net revenue from stand-alone CHIP			0	9.00			
10. 00	Stand-alone CHIP charges			0				
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	1			
12. 00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)							
	Other state or local government indigent care program (see instru	ctions for each lin	e)		1			
13. 00	Net revenue from state or local indigent care program (Not includ			0	13.0			
4.00	Charges for patients covered under state or local indigent care p	rogram (Not include	d in lines 6 or	0	14.0			
	10)			_				
15.00	State or local indigent care program cost (line 1 times line 14)	+ (1	: 15:	0				
16. 00	Difference between net revenue and costs for state or local indig 13; if < zero then enter zero)	ent care program (i	The 15 minus Tine	0	16. 0			
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state/local ind	igent care program	ns (see	1			
	instructions for each line)			·				
	Private grants, donations, or endowment income restricted to fund			0				
18. 00 19. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local i		ma (aum af linaa	295, 037 1, 567, 911				
19.00	8, 12 and 16)	ndrgent care progra	ilis (suili or rifles	1, 507, 711	19.0			
		Uni nsured	d Insured	Total (col. 1				
		pati ents		+ col . 2)				
	Uncompensated Care (see instructions for each line)	1.00	2. 00	3. 00				
20. 00	Charity care charges and uninsured discounts for the entire facil	i ty 127,	247 0	127, 247	20.00			
_0.00	(see instructions)	. 19		1277217	20.0			
21. 00	Cost of patients approved for charity care and uninsured discount	s (see 46,	095 0	46, 095	21.0			
20.00	instructions)				00.00			
22. 00	Payments received from patients for amounts previously written of charity care	t as	0 0	0	22. 00			
23. 00	Cost of charity care (line 21 minus line 22)	46,	095 0	46, 095	23 00			
		,		.57 5.75				
				1.00				
24. 00	Does the amount on line 20 column 2, include charges for patient		h of stay limit	N	24.00			
25. 00	imposed on patients covered by Medicaid or other indigent care pr If line 24 is yes, enter the charges for patient days beyond the		am's Length of	0	25. 00			
26. 00	stay limit Total bad debt expense for the entire hospital complex (see instr	uctions)		4, 071, 164	26.00			
27. 00	Medicare reimbursable bad debts for the entire hospital complex (see Fisti			166, 717	•			
27. 01	Medicare allowable bad debts for the entire hospital complex (see	· ·		256, 487	1			
	Non-Medicare bad debt expense (see instructions)	,		3, 814, 677	1			
28. 00 29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expen	se (see instruction	s)	1, 471, 644	29.00			
28. 00 29. 00 30. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expen Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line	`	s)	1, 471, 644 1, 517, 739 3, 085, 650	30.00			

Heal th	Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der Co	CN: 15-1304 P	eri od:	Worksheet A	
					rom 01/01/2018		
				Τ	o 12/31/2018	Date/Time Pre	pared:
		0.1.1		I = 1	5 1 16 11	5/24/2019 4:5	9 pm
	Cost Center Description	Sal ari es	Other		Reclassi fi cati		
				+ 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, 179, 496	2, 179, 496	0	2, 179, 496	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	403, 556	3, 915, 284	4, 318, 840	5, 553	4, 324, 393	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	2, 401, 999	2, 729, 949			5, 148, 727	5. 00
7. 00	00700 OPERATION OF PLANT	323, 488	879, 986			1, 226, 115	•
8. 00	00800 LAUNDRY & LINEN SERVICE	020, 100	0,7,700	1		68, 908	1
9. 00	00900 HOUSEKEEPING	364, 868	218, 432	1		536, 708	1
				1			1
10.00	01000 DI ETARY	348, 878	202, 377	1		143, 607	1
11.00	01100 CAFETERI A	111 050	0	_	,	429, 791	11.00
13. 00	01300 NURSING ADMINISTRATION	111, 859	380			380	•
14. 00	01400 CENTRAL SERVICES & SUPPLY	63, 494	90, 042			153, 366	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	346, 179	55, 660	401, 839	0	401, 839	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 670, 443	105, 308	1, 775, 751	-710, 675	1, 065, 076	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	817, 174	565, 235	1, 382, 409	-320, 795	1, 061, 614	50.00
51.00	05100 RECOVERY ROOM	0	5, 578	5, 578	25, 079	30, 657	51.00
53.00	05300 ANESTHESI OLOGY	o	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 039, 452	567, 020	1, 606, 472	-9, 275	1, 597, 197	54.00
54. 01	05401 ONCOLOGY	301, 248	443, 331			744, 579	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	00.72.0	0			0	55. 00
60.00	06000 LABORATORY	617, 960	885, 086			1, 503, 025	•
	06500 RESPIRATORY THERAPY			1			•
65. 00	1 1	88, 186	18, 477			106, 663	1
66. 00	06600 PHYSI CAL THERAPY	274, 046	15, 492			319, 319	1
67. 00	06700 OCCUPATI ONAL THERAPY	205, 415	2, 181			237, 466	1
68. 00	06800 SPEECH PATHOLOGY	110, 413	11, 908			62, 533	1
69. 00	06900 ELECTROCARDI OLOGY	124, 927	1, 870	126, 797	-263	126, 534	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	384, 501	384, 501	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	83, 396	83, 396	0	83, 396	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	551, 592	3, 939, 131	4, 490, 723	-3, 159	4, 487, 564	73. 00
	OUTPATIENT SERVICE COST CENTERS	•					ĺ
90.00	09000 CLI NI C	2, 364, 679	148, 399	2, 513, 078	707, 451	3, 220, 529	90.00
90. 01	09001 SURGI CAL ASSOCI ATES	66, 212	554, 290			619, 907	90. 01
90. 02	09002 ORTHOPAEDI CS	12, 848	145, 954			158, 681	90. 02
90. 03	09003 RHEUMATOLOGY	520, 539	10, 891			530, 833	•
90. 04	09004 ENDOCRI NOLOGY	174, 976	168, 087			334, 816	•
90. 05	09005 PEDI ATRI CS	· •		1	·		
		307, 185	13, 937			321, 085	1
90.06	09006 WOMEN'S HEALTH	261, 449	10, 486			266, 793	1
90. 07	09007 PAIN MANAGEMENT	457, 749	9, 578			467, 327	90. 07
91. 00	09100 EMERGENCY	849, 524	1, 206, 973	2, 056, 497	-33, 955	2, 022, 542	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	391, 433	47, 528	438, 961	-1, 415	437, 546	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	15, 571, 771	19, 231, 742	34, 803, 513	0	34, 803, 513	118. 00
192 00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	n	192. 00
	19300 NONPAI D WORKERS	n n	0	1	0		193. 00
	19301 FOUNDATION	64, 630	15		_	64, 645	
	19302 OCCUPATIONAL MEDICINE	04, 030	0		0		193. 01
	07950 OTHER NON REIMBURSABLE		0		0		194. 00
200.00		15, 636, 401	19, 231, 757			34, 868, 158	
200. UC	1 TOTAL (SOM OF LINES 110 LINOUGH 199)	13, 030, 401	17, 231, 131	1 34,000,130	ı U	34,000,130	₁ 200.00

 Health Financial
 Systems
 RUSH MEMORITY

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CCN: 15-1304

				5/24/2019	
	Cost Center Description	Adjustments	Net Expenses		
	·	(See A-8)	or Allocation		
		6.00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	-176, 736	2, 002, 760		1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-211, 902	4, 112, 491		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-1, 254, 381	3, 894, 346		5. 00
7. 00	00700 OPERATION OF PLANT	-762	1, 225, 353		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	68, 908		8. 00
9. 00	00900 HOUSEKEEPI NG	-396	536, 312		9. 00
10.00	01000 DI ETARY	-2, 359	141, 248		10. 00
11. 00	01100 CAFETERI A	-247, 634	182, 157		11. 00
13. 00	01300 NURSING ADMINISTRATION	-380	0		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-520	152, 846		14. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	-5, 965	395, 874		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	4 005	4 0/4 074		—
30. 00	03000 ADULTS & PEDI ATRI CS	-1, 005	1, 064, 071		30. 00
	ANCILLARY SERVICE COST CENTERS		100 010		
50.00	05000 OPERATING ROOM	-571, 595	490, 019		50.00
51.00	05100 RECOVERY ROOM	0	30, 657		51.00
53.00	05300 ANESTHESI OLOGY	704 011	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-704, 811	892, 386		54.00
54. 01	05401 ONCOLOGY	-375, 000	369, 579		54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	2 224	1 500 701		55. 00
60.00	06000 LABORATORY	-2, 324	1, 500, 701		60.00
65. 00	06500 RESPIRATORY THERAPY	0	106, 663		65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	319, 319		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		237, 466 62, 533		68. 00
69. 00	06900 ELECTROCARDI OLOGY	-23	126, 511		69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	-23	120, 511		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-3, 313	381, 188		71.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENT	-3, 313	83, 396		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	-74, 482	4, 413, 082		73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	74,402	4, 415, 002		73.00
90. 00	09000 CLINI C	-2, 704, 392	516, 137		90, 00
90. 01	09001 SURGI CAL ASSOCI ATES	-541, 630	78, 277		90. 01
90. 02	09002 ORTHOPAEDI CS	-126, 963	31, 718		90. 02
90. 03	09003 RHEUMATOLOGY	-529, 323	1, 510		90. 03
90. 04	09004 ENDOCRI NOLOGY	-229, 993	104, 823		90. 04
90. 05	09005 PEDI ATRI CS	-243, 080	78, 005		90. 05
90. 06	09006 WOMEN' S HEALTH	-279, 159	-12, 366		90.06
90. 07	09007 PAIN MANAGEMENT	-466, 087	1, 240		90. 07
91. 00	09100 EMERGENCY	0	2, 022, 542		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		2,022,012		92. 00
	OTHER REIMBURSABLE COST CENTERS	I. I.			
95. 00	09500 AMBULANCE SERVI CES	0	437, 546		95. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>	,		
118.00		-8, 754, 215	26, 049, 298		118. 00
	NONREI MBURSABLE COST CENTERS				
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
	19300 NONPALD WORKERS	l ol	O		193. 00
	19301 FOUNDATION	o	64, 645		193. 01
	19302 OCCUPATIONAL MEDICINE	ol	0		193. 02
	07950 OTHER NON REIMBURSABLE	o	0		194. 00
200.00	1 1	-8, 754, 215	26, 113, 943		200. 00
		•	•		*

Provider CCN: 15-1304

					To 12/31/2018	3 Date/lime Prepared: 5/24/2019 4:59 pm
		Increases				072172017 1.07 piii
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	A - LAUNDRY AND LINEN					
1.00	LAUNDRY & LINEN SERVICE	8. 00	0	68, 908		1. 00
				68, 908		
	B - DIETARY/ CAFETERIA	•	<u>'</u>			
1.00	CAFETERI A	11. 00	272, 006	157, 785		1. 00
			272, 006	157, 785		
	C - MED SUPPLY RECLASS	-	,			
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	384, 501		1.00
	PATIENTS					
2.00		0.00	0	О		2. 00
3.00		0.00	o	Ö		3. 00
4. 00		0.00	o	Ö		4.00
5.00		0.00	o o	o		5. 00
6. 00		0.00	Ö	Ö		6. 00
7. 00		0.00	0	0		7.00
		I	-1			•
8.00		0.00	0	0		8. 00
9. 00		0. 00	0	0		9.00
10.00		0. 00	0	0		10.00
11. 00		0.00	0	0		11.00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0. 00	0	0		14. 00
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17.00		0.00	0	0		17. 00
18.00		0.00	o	0		18. 00
19.00		0.00	O	0		19. 00
20.00		0.00	o	0		20.00
21. 00		0.00	0	O		21. 00
22. 00		0.00	o	O		22. 00
23. 00		0.00	o	0		23. 00
20.00			- — 	384, 501		20.00
	D - AMBULANCE RECLASS		٥	001,001		
1.00	OPERATION OF PLANT	7. 00	269	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	94	Ö		2.00
3. 00	RADI OLOGY-DI AGNOSTI C	54.00	20	Ö		3. 00
4. 00	EMERGENCY	91.00	221			4.00
4.00	n line Robins 1		$- \frac{221}{604}$	0		4.00
	E - SALARY RECLASS		004	<u> </u>		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	5, 592	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	16, 779	Ö		2. 00
3.00	OPERATION OF PLANT	7. 00	22, 372	Ö		3. 00
4. 00	HOUSEKEEPI NG	9. 00	22, 372	0		4.00
	DI ETARY	1	22, 372	0		
5.00		10.00				5. 00
6.00	RECOVERY ROOM	51.00	29, 384	0		6.00
7.00	PHYSI CAL THERAPY	66.00	29, 894	0		7. 00
8.00	OCCUPATI ONAL THERAPY	67.00	29, 894	0		8. 00
9. 00	CLINIC	<u>90.</u> 00	22, 372	0		9. 00
	U PUNGU GUAN PEGUAGO		201, 031	0		
	F - PHYSICIAN RECLASS					
1.00	CLINIC	90.00	689, 692	0		1.00
-05	0		689, 692			
500.00	Grand Total: Increases		1, 163, 333	611, 194		500. 00

RECLASSI FI CATIONS

Provider CCN: 15-1304

Peri od: Worksheet A-6 From 01/01/2018 To 12/31/2018 Date/Ti me Prepared:

500.00

5/24/2019 4:59 pm Decreases Wkst. A-7 Ref. Cost Center Li ne # Sal ary 0ther 6.00 7.00 8.00 9.00 10.00 - LAUNDRY AND LINEN 1.00 HOUSEKEEPI NG 9.00 68, 908 0 1.00 68, 908 B - DIETARY/ CAFETERIA 1.00 DI ETARY 10.00 272,006 157, 785 0 1.00 272, 006 157, 785 C - MED SUPPLY RECLASS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 39 0 1.00 2.00 HOUSEKEEPI NG 9.00 0 56 0 2.00 DI ETARY 10.00 0 229 0 3.00 3.00 4 00 CENTRAL SERVICES & SUPPLY 14.00 0 170 0 4 00 21, 077 ADULTS & PEDIATRICS 0 0 5.00 30.00 5.00 6.00 OPERATING ROOM 50.00 0 291, 411 0 6.00 7.00 RECOVERY ROOM 51.00 0 4, 305 0 7.00 RADI OLOGY-DI AGNOSTI C 0 0 54 00 9, 295 8 00 8 00 0 9.00 LABORATORY 60.00 21 9.00 10.00 PHYSICAL THERAPY 66.00 o 113 0 10.00 OCCUPATIONAL THERAPY 67.00 0 0 11.00 24 11.00 12.00 ELECTROCARDI OLOGY 69.00 12.00 263 0 0 13.00 DRUGS CHARGED TO PATIENTS 73.00 3, 159 13.00 CLINIC 90.00 0 1,847 0 14.00 14.00 0 0 SURGICAL ASSOCIATES 90.01 15.00 595 15.00 ORTHOPAEDI CS 16.00 90.02 0 121 0 16.00 17.00 RHEUMATOLOGY 90.03 0 597 0 17.00 18.00 ENDOCRI NOLOGY 90.04 0 8, 247 0 18.00 0 0 19.00 PEDLATRI CS 90.05 37 19 00 20.00 WOMEN'S HEALTH 90.06 0 5, 142 0 20.00 21.00 CLINIC 90.00 0 2,766 0 21.00 EMERGENCY 91.00 0 34, 176 0 22.00 22.00 23 00 AMBULANCE SERVICES 95.00 0 811 0 23.00 0 384, 501 D - AMBULANCE RECLASS AMBULANCE SERVICES 1.00 95.00 604 0 1.00 0 2.00 0.00 0 0 0 2.00 3.00 0.00 0 0 0 3.00 4.00 0.00 0 4.00 0 0 604 E - SALARY RECLASS 1.00 NURSING ADMINISTRATION 13.00 111, 859 0 1.00 0 2.00 OPERATING ROOM 50.00 29, 384 0 2.00 SPEECH PATHOLOGY 59, 788 0 0 3.00 3.00 68.00 0 4.00 0.00 0 0 4.00 5.00 0.00 0 0 0 5.00 6.00 0.00 0 0 0 6.00 0 0 0 7.00 0.00 7.00 8.00 0.00 o 0 0 8.00 9.00 0.00 0 0 9.00 201, 031 0 - PHYSICIAN RECLASS 1.00 ADULTS & PEDIATRICS 30.00 689, 692 0 1.00 689, 692 O

611, 194

1, 163, 333

500.00 Grand Total: Decreases

RUSH MEMORIAL HOSPITAL

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1304

				أ	Го 12/31/2018	Date/Time Pre 5/24/2019 4:5	pared: 9 pm
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET				_		
1.00	Land	188, 708	0	(0	0	1. 00
2.00	Land Improvements	455, 968	0	(0	0	2. 00
3.00	Buildings and Fixtures	16, 823, 696	1, 659, 095	(1, 659, 095	13, 742	3. 00
4.00	Building Improvements	0	0	(0	0	4. 00
5.00	Fixed Equipment	2, 946, 813	843, 094	(843, 094		5. 00
6.00	Movable Equipment	15, 503, 070	1, 327, 113	(1, 327, 113	465, 136	6. 00
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	35, 918, 255	3, 829, 302	(3, 829, 302	2, 520, 457	8. 00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	35, 918, 255	3, 829, 302	(3, 829, 302	2, 520, 457	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		_				
1.00	Land	188, 708	0				1. 00
2.00	Land Improvements	455, 968	0				2. 00
3.00	Buildings and Fixtures	18, 469, 049	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	1, 748, 328	0				5. 00
6.00	Movable Equipment	16, 365, 047	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	37, 227, 100	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	37, 227, 100	0				10. 00

Heal th	Financial Systems	RUSH MEMORIA	RUSH MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2018 To 12/31/2018		pared:		
			Sl	JMMARY OF CAPI	TAL				
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)			
		9. 00	10.00	11. 00	12. 00	13. 00			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2					
1.00	NEW CAP REL COSTS-BLDG & FLXT	1, 741, 632	0	206, 51	5 231, 348	0	1. 00		
3.00	Total (sum of lines 1-2)	1, 741, 632	0	206, 51	5 231, 348	0	3. 00		
		SUMMARY 0	F CAPITAL						
	Cost Center Description	Other	Total (1) (sum						
		Capi tal -Relate	of cols. 9						
		d Costs (see	through 14)						
		instructions)							
		14. 00	15. 00						
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2					
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	2, 179, 496				1. 00		
3.00	Total (sum of lines 1-2)	0	2, 179, 496				3. 00		

Health Financial Systems	RUSH MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
			1 -	From 01/01/2018 Fo 12/31/2018		pared:
					5/24/2019 4:59	
	COM	PUTATION OF RAT	ALLOCATION OF	OTHER CAPITAL		
Cost Center Description	Gross Assets	Capi tali zed	Gross Assets	Ratio (see	Insurance	
oust contain busin per on	010337133013	Leases	for Ratio	instructions)	Trisur unce	
			(col. 1 - col.	,		
			2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS				_		
1.00 NEW CAP REL COSTS-BLDG & FLXT	37, 227, 100	1	37, 227, 100			1.00
3.00 Total (sum of lines 1-2)	37, 227, 100		37, 227, 100			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)			
	6.00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS	CENTERS	_	1		_	
1.00 NEW CAP REL COSTS-BLDG & FIXT		0	9	1, 724, 188		1. 00
3.00 Total (sum of lines 1-2)	C	0	(1, 724, 188	0	3. 00
		St	JMMARY OF CAPI	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)		
	11. 00	12. 00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS			1			
1.00 NEW CAP REL COSTS-BLDG & FLXT	47, 224			0	2, 002, 760	1. 00
3.00 Total (sum of lines 1-2)	47, 224	231, 348	(0	2, 002, 760	3. 00

| Period: | Worksheet A-8 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-1304

REL COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL COSTS-MMBLE EQUIP (chapter 2) 3.00 Investment income - other (chapter 2) 4.00 Trade, quantity, and time (chapter 2) 4.00 Trade, quantity, and time (chapter 2) 5.00 Refunds and rebates of expenses (chapter 8) 6.00 Refunds and rebates of expenses (chapter 8) 7.00 Television exercises (pay stations excluded) (chapter 2) 8.00 Television and radio service (chapter 21) 9.00 Provider -based physician and pushing to the provider space of the provi	red:
Cost Center Description	JIII
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT	
REL COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL (COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other (chapter 2) 4.00 Trade, quantity, and time (chapter 2) 5.00 Refunds and rebates of expenses (chapter 8) 6.00 Refunds and rebates of expenses (chapter 8) 7.00 Tel ephone services (pay stations excluded) (chapter 2) 8.00 Tel ephone services (pay stations excluded) (chapter 2) 8.00 Tel evision and radio service (chapter 21) 9.00 Provider-based physician and patients and patients 11.00 Sale of Scrap, waste, etc. (chapter 23) 12.00 Rel ated organization and transactions (chapter 10) 13.00 Laundry and lines service 0 0 0.00 0.00 0.00 14.00 Cafeteria -employees and guests 0 0.00 0.00 0.00 15.00 Sale of force of the stations excluded of th	1. 00
2.00	1.00
COSTS-MWLE EQUIP (chapter 2) Investment income - other (chapter 2) Investment income - other (chapter 2) (chapter 2) (chapter 2) (chapter 2) (chapter 2) (chapter 8) (chapter 21) (chapter 23) (chapter 24) (chapter 24) (chapter 25) (chapter 26) (chapter 27) (chapter 28) (chapter 29) (c	2. 00
(chapter 2) 4.00 Trade, quantity, and time discounts (chapter 8) 0 0.00 0 5.00 Refunds and rebates of expenses (chapter 8) 0 0.00 0 6.00 Rental of provider space by suppliers (chapter 8) 0 0.00 0 7.00 Telephone services (pay stations excluded) (chapter 21) 0 0.00 0 8.00 Television and radio service (chapter 21) 0 0.00 0 9.00 Parking lot (chapter 21) 0 0.00 0 10.00 Provider-based physician adjustment 0 0.00 0 11.00 Sale of scrap, waste, etc. (chapter 23) 0 0.00 0 12.00 Related organization (chapter 10) 0 0 0 0 13.00 Laundry and linen service and guests 0 0 0 0 0 15.00 Rental of quarters to employee and others 0 0 0 0 0 16.00 Sale of medical and surgical supplies to other than patients 0 0 0 0 0 0 17.00 Sale of drugs to other tha	2.00
4.00 Trade, quantity, and time discounts (chapter 8) 5.00 Refunds and rebates of expenses (chapter 8) 6.00 Refunds and rebates of expenses (chapter 8) 7.00 Refunds excluded (chapter 8) 7.00 Telephone services (pay stations excluded) (chapter 21) 8.00 Telephone services (pay stations excluded) (chapter 21) 9.00 Provider-based physician adjustment 7.00 Sale of scrap, waste, etc. (chapter 23) 7.00 Related organization (chapter 24) 7.00 Related organization (chapter 10) 7.00	3. 00
5.00 Refunds and rebates of expenses (chapter 8) 0 0.00 0 6.00 Rental of provider space by suppliers (chapter 8) 0 0 0 7.00 Tel ephone services (pay stations excluded) (chapter 21) 0 0 0 8.00 Tel evision and radio service (chapter 21) 0 0 0 9.00 Parking Lot (chapter 21) 0 0 0 10.00 Provider-based physician adjustment 0 0 0 11.00 Sale of scrap, waste, etc. (chapter 23) 0 0 0 12.00 Related organization Atlant (chapter 10) 0 0 0 13.00 Laundry and Linen service 0 0 0 0 14.00 Cafeteria-employees and guests 0 0 0 0 15.00 Sale of medical and surgical supplies to other than patients 0 0 0 0 17.00 Sale of drugs to other than patients 0 0 0 0 18.00 Sale of medical records and 0 0 0 0	4. 00
expenses (chapter 8)	5. 00
Suppliers (chapter 8) 7.00 Telephone services (pay stations excluded) (chapter 21) 8.00 Television and radio service (chapter 21) 9.00 Parking lot (chapter 21) 0 0.00 0 0 0 0 0 0 0	
7. 00 Telephone services (pay stations excluded) (chapter 21) 0<	6. 00
21)	7. 00
8.00 Tel evision and radio service (chapter 21) 9.00 Parking Lot (chapter 21) 10.00 Provider-based physician adjustment 11.00 Sale of scrap, waste, etc. (chapter 23) 12.00 Related organization transactions (chapter 10) 13.00 Laundry and Linen service 14.00 Cafeteria-employees and guests 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 medical records and 18.00 Sale of medical records and Tel evision and radio service 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0	
9.00 Parking Lot (chapter 21) 10.00 Provider-based physician adjustment 11.00 Sale of scrap, waste, etc. (chapter 23) 12.00 Related organization transactions (chapter 10) 13.00 Laundry and Linen service 0 14.00 Cafeteria-employees and guests 0 15.00 Rental of quarters to employee and others 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and 9.00 0 10	8. 00
10.00 Provider-based physician adjustment 11.00 Sale of scrap, waste, etc. (chapter 23) 12.00 Related organization A-8-1 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	9. 00
11.00 Sale of scrap, waste, etc. (chapter 23) 12.00 Related organization transactions (chapter 10) 13.00 Laundry and linen service 14.00 Cafeteria-employees and guests 15.00 Rental of quarters to employee and others 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and 10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0. 00
12.00 Related organization transactions (chapter 10) 13.00 Laundry and linen service 0 0.00 0 1 14.00 Cafeteria-employees and guests 0 0.00 0 1 15.00 Rental of quarters to employee and others 0.00 0 1 16.00 Sale of medical and surgical supplies to other than patients 0.00 0 0 1 17.00 Sale of drugs to other than patients 0.00 0 0 0 1 18.00 Sale of medical records and 0 0.00 0 0 1	1. 00
transactions (chapter 10) Laundry and linen service 14.00 Cafeteria-employees and guests 15.00 Rental of quarters to employee and others 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and	2. 00
14.00 Cafeteria-employees and guests 15.00 Rental of quarters to employee and others 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and 0 0.00 0 1 0.00 0 1 0.00 0 1 0.00 0 1	2.00
15.00 Rental of quarters to employee and others 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and 0 0.00 0 1 0.00 0 1 0.00 0 1	3. 00 4. 00
16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and 0 0.00 0 1 0.00 0 1	5. 00
supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of medical records and 0 0.00 0 1	6. 00
17. 00 Sale of drugs to other than patients 0 0.00 0 1 18. 00 Sale of medical records and 0 0.00 0 0	0. 00
patients 18.00 Sale of medical records and 0 0.00 0 1	7. 00
abstracts	8. 00
19.00 Nursing and allied health 0 0.00 0 1 education (tuition, fees,	9. 00
books, etc.)	
	0. 00 1. 00
21.00 Income from imposition of 0 0.00 0 2	1.00
charges (chapter 21) 22.00 Interest expense on Medicare 0 0.00 0.2	2. 00
overpayments and borrowings to	2.00
repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 2	3. 00
therapy costs in excess of	
Iimitation (chapter 14)	4. 00
therapy costs in excess of	
limitation (chapter 14) 25.00 Utilization review - 0 *** Cost Center Deleted *** 114.00 2	5. 00
physicians' compensation (chapter 21)	
	6. 00
COSTS-BLDG & FIXT	7. 00
COSTS-MVBLE EQUIP	
	8. 00 9. 00
30.00 Adjustment for occupational A-8-3 0 OCCUPATIONAL THERAPY 67.00 3	0. 00
therapy costs in excess of limitation (chapter 14)	
30.99 Hospice (non-distinct) (see 0 ADULTS & PEDLATRICS 30.00 3	0. 99
instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 3	1. 00
pathology costs in excess of	
	2. 00
Depreciation and Interest FIXT	

Provider CCN: 15-1304

Peri od: Worksheet A-8 From 01/01/2018 | To 12/31/2018 | Date/Time Prepared:

				To	12/31/2018	Date/Time Prep 5/24/2019 4:59	
				Expense Classification on	Workshoot A	5/24/2019 4:5	9 DIII
				To/From Which the Amount is			
				TO/FI OIII WITCH THE AMOUNT IS	to be Aujusteu		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	cost center bescription	1. 00	2.00	3.00	4. 00	5. 00	
33. 00	CAFETERI A	1.00 B		CAFETERI A	11. 00	0.00	33. 00
33. 00	JAIL MEALS	В		CAFETERI A	11. 00	0	33. 00
	I Total Control of the Control of th	В		l e e e e e e e e e e e e e e e e e e e		0	
33. 02	VENDING MACHINES			ADMINISTRATIVE & GENERAL	5.00		33. 02
34.00	SALE OF DRUGS	В		DRUGS CHARGED TO PATIENTS	73.00	0	34.00
35. 00	SALE OF SUPPLIES	В		MEDICAL SUPPLIES CHARGED TO	71. 00	0	35. 00
	BUNGA OLAM, BEORIU THENTO			PATI ENTS			
37. 00	PHYSICIAN RECRUITMENTS	В		ADMINISTRATIVE & GENERAL	5. 00	0	37. 00
37. 01	NSF FEES	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	37. 01
38. 00	MEDICAL RECORDS TRANSCRIPTION	В	-5, 965	MEDICAL RECORDS & LIBRARY	16. 00	0	38. 00
	FEES						
41. 00	COPI ER FEES	В		ADMINISTRATIVE & GENERAL	5. 00	0	41. 00
42.00	ATHLETIC TRAINER - SCHOOL REV	В	-9, 025	ADMINISTRATIVE & GENERAL	5. 00	0	42.00
42.01	SALE OF PODIATRY SUPPLIES	В	-2, 870	MEDICAL SUPPLIES CHARGED TO	71.00	0	42. 01
				PATI ENTS			
45.00	OCCUPATI ONAL HEALTH	В	-75, 190	CLINIC	90.00	0	45.00
45. 01	MISC. INCOME	В	-207	ADMINISTRATIVE & GENERAL	5.00	0	45. 01
45.02	MISC. INCOME	В	-20	DI ETARY	10.00	0	45. 02
45.03	MISC. INCOME	В	-1, 998	LABORATORY	60.00	0	45. 03
45.04	MISC. INCOME	В		RHEUMATOLOGY	90. 03	0	45. 04
45. 08	INTEREST INCOME	В	-159, 292	NEW CAP REL COSTS-BLDG &	1.00	11	45. 08
			·	FLXT			
45. 09	TELEPHONE SALARY	В	-5, 086	ADMINISTRATIVE & GENERAL	5. 00	0	45. 09
45. 10	TELEPHONE OTHER	A		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		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	45. 12
45. 13	I HA & AHA LOBBYI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	45. 13
45. 14	REBATES	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	9	45. 14
45. 15	REBATES	В		ADMINISTRATIVE & GENERAL	5. 00	Ó	45. 15
45. 16	REBATES	B	· ·	OPERATION OF PLANT	7. 00	0	45. 16
45. 17	REBATES	В		HOUSEKEEPI NG	9. 00	0	45. 10
45. 17	REBATES	В		DI ETARY	10. 00	0	45. 17
45. 19		В	· ·	l .			
	REBATES	В		NURSING ADMINISTRATION	13.00	0	45. 19
45. 20	REBATES			CENTRAL SERVICES & SUPPLY	14.00	, and the second	45. 20
45. 25	REBATES	В		ADULTS & PEDIATRICS	30.00	0	45. 25
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. 01
46. 02	REBATES	В		ELECTROCARDI OLOGY	69. 00	0	46. 02
46. 03	REBATES	В		DRUGS CHARGED TO PATIENTS	73. 00	0	46. 03
46. 04	REBATES	В		RHEUMATOLOGY	90. 03	0	46. 04
46. 05	HAF EXPENSE	В	-1, 180, 982	ADMINISTRATIVE & GENERAL	5. 00	0	46. 05
46. 07	SAFE SITTER CLASS FEES	A	-721	ADMINISTRATIVE & GENERAL	5. 00	0	46. 07
50.00	TOTAL (sum of lines 1 thru 49)		-8, 754, 215				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) Do	scription all chapter referen			CMC Dub 1E 1			

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Provider CCN: 15-1304

Peri od: Worksheet A-8-2 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

								5/24/2019 4:5	9 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi or	nal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Componen	t	Component		ider Component	
								Hours	
	1. 00	2, 00	3.00	4.00		5. 00	6. 00	7. 00	
1.00	50, 00	OPERATI NG ROOM	594, 343	571,	011	23, 332	0	0	1. 00
2. 00		RADI OLOGY-DI AGNOSTI C	729, 887		576		0		
3. 00		LABORATORY	37, 200		0				
4. 00		CLI NI C	2, 723, 193	1	-		ĺ		
5. 00		SURGI CAL ASSOCI ATES	550, 000		630		l o		
6. 00		ORTHOPAEDI CS	140, 499		963			-	
		RHEUMATOLOGY							
7.00			506, 587		910	·	0		
8.00		ENDOCRI NOLOGY	290, 378		993	·	0	_	
9. 00		PEDI ATRI CS	253, 166		080		0	0	9. 00
10.00		WOMEN'S HEALTH	294, 136		159		0	0	10. 00
11. 00		PAIN MANAGEMENT	480, 104			14, 017	0	0	11. 00
12. 00		EMERGENCY	1, 118, 839		0	.,	0	0	12. 00
13.00	54. 01	ONCOLOGY	400, 000	375,	000	25, 000	0	0	13.00
200.00			8, 118, 332	6, 649,	611	1, 468, 721		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent	of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadj usted	RCE	Memberships &	Component	of Mal practice	
				Limit		Continuing	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	OPERATI NG ROOM	0		0	0			1. 00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	0		0	0	0	0	2. 00
3. 00		LABORATORY	0	i	0	0	l e		3. 00
4. 00		CLI NI C	0	i	0	0		0	
5. 00		SURGI CAL ASSOCI ATES	l o		0	0	1	o o	
6. 00		ORTHOPAEDI CS		1	0	0		o o	
7. 00		RHEUMATOLOGY			0	0		0	
8. 00		ENDOCRI NOLOGY			0	0		0	
					0	0		0	9. 00
9.00		PEDI ATRI CS			0	_		1	
10.00		WOMEN'S HEALTH	_		0	0	0	0	
11. 00		PAIN MANAGEMENT	0		0	0	0	0	11.00
12. 00		EMERGENCY	0		0	0	0	0	12. 00
13. 00	54. 01	ONCOLOGY	0		0	0	0		
200.00			0		0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted F	RCE	RCE	Adjustment		
		l denti fi er	Component	Limit		Di sal I owance			
			Share of col.						
	1.00		14	1		17.00	10.00		
1 00	1. 00	2.00	15. 00	16. 00		17. 00	18.00		4 00
1.00		OPERATING ROOM	0		0				1. 00
2. 00		RADI OLOGY-DI AGNOSTI C	0	1	0	_			2. 00
3.00		LABORATORY	0		0				3. 00
4.00		CLI NI C	0		0				4. 00
5.00		SURGI CAL ASSOCI ATES	0		0	0	541, 630		5. 00
6.00	90. 02	ORTHOPAEDI CS	0		0	0	126, 963		6. 00
7.00	90. 03	RHEUMATOLOGY	0		0	0	482, 910		7. 00
8.00	90. 04	ENDOCRI NOLOGY	0		0	0	229, 993		8. 00
9.00		PEDI ATRI CS	0		0	0			9. 00
10. 00		WOMEN'S HEALTH	l o	1	0	0	l		10.00
11. 00		PAIN MANAGEMENT		1	0				11. 00
12. 00		EMERGENCY		1	0	0			12. 00
13. 00		ONCOLOGY		1	0	0	1		13. 00
200.00	34.01	ONGOLOG I		1	0				200.00
200.00	1		1	1	U	1	0,047,011	I	200.00

	Financial Systems	RUSH MEMORIAL				u of Form CMS-2	
	IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provi der CC	N: 15-1304	Peri od: From 01/01/2018 To 12/31/2018		pared:
					Speech Pathology		
						1. 00	
	PART I - GENERAL INFORMATION						
1. 00 2. 00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instructi	ons)			0	1. 00 2. 00
3.00	Number of unduplicated days in which supervis	sor or therapist	was on provid	der site (see	e instructions)	0	3.00
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor						
5. 00	nor therapist was on provider site (see instructions) Number of unduplicated offsite visits - supervisors or therapists (see instructions)						
6.00							5. 00 6. 00
	assistant and on which supervisor and/or the	apist was not pr	esent during	the visit(s)) (see		
7. 00	instructions) Standard travel expense rate						
8.00	Optional travel expense rate per mile					0. 00 0. 00	7. 00 8. 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	203. 25	<u> </u>			9. 00
	AHSEA (see instructions)	0. 00	75. 55	0.0		0.00	
11. 00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	37. 78	37. 78	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		12. 01 13. 00
	Number of miles driven (offsite)	0	Ō		0		13. 01
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
	Supervisors (column 1, line 9 times column 1,					0	
	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					15, 356 0	15. 00 16. 00
17. 00	Subtotal allowance amount (sum of lines 14 ar		tory therapy	or lines 14-	16 for all	15, 356	•
10 00	others)	10)				o	18. 00
	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li					0	19.00
19.00	0 Trainees (column 5, line 9 times column 5, line 10) 0 1						
	Total allowance amount (sum of lines 17-19 for	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 15,356 20 If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or					
	Total allowance amount (sum of lines 17-19 for lf the sum of columns 1 and 2 for respiratory	therapy or colu	ımns 1-3 for p	hysical ther			20.00
	Total allowance amount (sum of lines 17-19 for	therapy or colu line 2, make no	ımns 1-3 for p	hysical ther			20.00
20. 00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra	therapy or colu line 2, make no lines 21-23. hinees (line 17 c	mns 1-3 for positive and livided by sur	hysical ther ines 21 and	22 and enter on	line 23	21. 00
20. 00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete	therapy or colu lline 2, make no lines 21-23. ainees (line 17 o line 9 for all o	mns 1-3 for positive entries on livided by sur bithers)	hysical ther ines 21 and	22 and enter on	line 23	21. 00
20. 0021. 0022. 00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained Total salary equivalency (see instructions)	therapy or colu lline 2, make no lines 21-23. minees (line 17 o line 9 for all o ees (line 2 times	mns 1-3 for pentries on la divided by surothers)	ohysical ther ines 21 and n of columns	22 and enter on 1 and 2, line 9	0.00	21. 00 22. 00
20. 0021. 0022. 00	Total allowance amount (sum of lines 17-19 for lifthe sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	therapy or colu lline 2, make no lines 21-23. minees (line 17 o line 9 for all o ees (line 2 times	mns 1-3 for pentries on la divided by surothers)	ohysical ther ines 21 and n of columns	22 and enter on 1 and 2, line 9	0.00 0	21. 00 22. 00
20. 00 21. 00 22. 00 23. 00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained Total salary equivalency (see instructions)	therapy or colu lline 2, make no lines 21-23. minees (line 17 o line 9 for all o ees (line 2 times	mns 1-3 for pentries on la divided by surothers)	ohysical ther ines 21 and n of columns	22 and enter on 1 and 2, line 9	0.00 0	21. 00 22. 00 23. 00
20. 00 21. 00 22. 00 23. 00 24. 00 25. 00	Total allowance amount (sum of lines 17-19 for lifthe sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, 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)	therapy or coluitine 2, make no lines 21-23. ainees (line 17 d line 9 for all d ees (line 2 times	mns 1-3 for positive ded by surporthers) Soline 21) EXPENSE COMPL	obysical ther ines 21 and n of columns	22 and enter on 1 and 2, line 9	0.00 0 15,356	21. 00 22. 00 23. 00 24. 00 25. 00
20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00	Total allowance amount (sum of lines 17-19 for lifthe sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, 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	therapy or columning the state of the state	mns 1-3 for positive entries on I divided by surthers) in EXPENSE COMPLEARED and 25 for all	obysical ther ines 21 and on of columns UTATION - PRO	22 and enter on 1 and 2, line 9 OVIDER SITE	0.00 0 15,356 0 0	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00
20. 00 21. 00 22. 00 23. 00 24. 00 25. 00	Total allowance amount (sum of lines 17-19 for lifthe sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, 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)	therapy or columnine 2, make no lines 21-23. ainees (line 17 cline 9 for all cles (line 2 times ANCE AND TRAVEL sum of lines 24	mns 1-3 for positive entries on I divided by surthers) in EXPENSE COMPLEARED and 25 for all	obysical ther ines 21 and on of columns UTATION - PRO	22 and enter on 1 and 2, line 9 OVIDER SITE	0.00 0 15,356	21. 00 22. 00 23. 00 24. 00 25. 00
20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	Total allowance amount (sum of lines 17-19 for lift the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trained for respiratory therapy or columns 1 thru 3, 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	therapy or columning the state of the state	mns 1-3 for positive ded by surpthers) soline 21) EXPENSE COMPLE and 25 for all therapy or su	obysical ther ines 21 and on of columns ITATION - PRO I others) Im of lines 3	22 and enter on 1 and 2, line 9 WIDER SITE B and 4 for all	0.00 0 15,356 0 0	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00
20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	Total allowance amount (sum of lines 17-19 for lifthe sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, 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)	therapy or columning the set of t	mns 1-3 for positive ded by surpthers) soline 21) EXPENSE COMPLE and 25 for all therapy or su	obysical ther ines 21 and on of columns ITATION - PRO I others) Im of lines 3	22 and enter on 1 and 2, line 9 WIDER SITE B and 4 for all	0.00 0.15,356	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00	Total allowance amount (sum of lines 17-19 for lift the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trained for respiratory therapy or columns 1 thru 3, 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	therapy or columning the state of the state	mns 1-3 for potential the provided and 25 for all the provided the pro	obysical ther ines 21 and on of columns ITATION - PRO I others) Im of lines 3	22 and enter on 1 and 2, line 9 WIDER SITE B and 4 for all	0.00 0.15,356	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00	Total allowance amount (sum of lines 17-19 for lift the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, 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,	therapy or column therapy or column the series of the seri	mns 1-3 for positive ded by surpthers) s line 21) EXPENSE COMPL and 25 for all therapy or surptherapy or surptherapy or surptherapy (2, line 12)	obysical ther ines 21 and on of columns ITATION - PRO I others) um of lines 3 er site (sum	22 and enter on 1 and 2, line 9 WIDER SITE B and 4 for all	0.00 0.15,356 0 0 0 0 0 0	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00
20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00	Total allowance amount (sum of lines 17-19 for lift the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, 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	therapy or column therapy or column the state of the stat	mns 1-3 for positive ded by surpthers) soline 21) EXPENSE COMPLE and 25 for all therapy or surptherapy or surptherapy or surptherapy and 25 for all therapy or surptherapy or surptherap	Dhysical ther ines 21 and on of columns DTATION - PRO I others) Let site (sum of lines (sum of lines)	22 and enter on 1 and 2, line 9 WIDER SITE 3 and 4 for all of lines 26 and	0.00 0 0 15,356 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21. 00 22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00
20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	Total allowance amount (sum of lines 17-19 for lifthe sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trafor respiratory therapy or columns 1 thru 3, 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)	therapy or column therapy or c	mns 1-3 for positive ded by surpthers) is line 21) EXPENSE COMPL and 25 for all therapy or surptherapy or surptherapy or surptherapy and 30 for all 3 for respirations.	Dhysical ther ines 21 and on of columns DTATION - PRO I others) Let site (sum of lines (sum of lines)	22 and enter on 1 and 2, line 9 WIDER SITE 3 and 4 for all of lines 26 and	0.00 0 0 15,356	21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00
20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00	Total allowance amount (sum of lines 17-19 for lif the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trainer for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trainer 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)	therapy or columnia therapy or columnia the set of the	mns 1-3 for potential entries on I divided by surpthers) and 25 for all therapy or surptherapy o	Dhysical ther ines 21 and on of columns ITATION - PRO I others) Jum of lines 3 Per site (sum I others) atory therapy	22 and enter on 1 and 2, line 9 WIDER SITE 3 and 4 for all of lines 26 and	0.00 0 0 15,356 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21. 00 22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00

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

36. 00 37. 00

38.00

40.00

0

0

0 39.00

0

0 41.00

38.00

39.00

40.00

41.00

Standard Travel Expense

Therapists (line 5 times column 2, line 11)

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

Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)

Optional Travel Allowance and Optional Travel Expense

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

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

Subtotal (sum of lines 36 and 37)

KEASUN	Financial Systems HABLE COST DETERMINATION FOR THERAPY SERVICES I	RUSH MEMORIAL	HOSPI TAL Provi der CO	CN: 1E 1204	In Lie Period:	worksheet A-8	
	E SUPPLIERS	-UKNI SHED BY	Provider CC		From 01/01/2018 To 12/31/2018	Parts I-VI	pared:
				9	Speech Pathology		, piii
						1.00	
46. 00	Optional travel allowance and optional travel	expense (sum o	f lines 42 an	d 43 – see in	structions)		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	
47. 00	Overtime hours worked during reporting	0. 00	0.00	0.0	0.00	0.00	47. 00
	period (if column 5, line 47, is zero or						
	equal to or greater than 2,080, do not						
	complete lines 48-55 and enter zero in each						
48. 00	column of line 56) Overtime rate (see instructions)	0. 00	0. 00	0. 0	0.00		48. 00
49.00		0.00	0.00	0.0			49.00
17.00	allowance) (multiply line 47 times line 48)	0.00	0.00	0.0	0.00		17.00
	CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category	0. 00	0. 00	0. 0	0.00	0.00	50.00
	(divide the hours in each column on line 47						
	by the total overtime worked - column 5, line 47)						
51. 00	1 1	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	a					
52. 00	Adjusted hourly salary equivalency amount (see instructions)	75. 55	0. 00	0. 0	0.00		52. 00
53. 00	Overtime cost limitation (line 51 times line	o	0		0		53. 00
00.00	52)		J				00.00
54.00	Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
	line 49 or line 53)		_				
55. 00	Portion of overtime already included in	O	0		0		55. 00
	hourly computation at the AHSEA (multiply line 47 times line 52)						
56. 00	Overtime allowance (line 54 minus line 55 -	o	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.)						
						1. 00	
	D+ VI COMPLITATION OF THE DADY LIMITATION A					11.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST /	ADJUSIMENI				
	Salary equivalency amount (from line 23)					15, 356	57. 00
58. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 33,	34, or 35))			0	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)))		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 servic Overtime allowance (from column 5, line 56)	(from lines 33,	34, or 35)))		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 servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions)	(from lines 33,	34, or 35)))		0 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)))		0 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, es (from lines	34, or 35)))		0 0 0 0 0 15, 356	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 servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions)	(from lines 33, ses (from lines a	34, or 35)) 44, 45, or 46)		0 0 0 0 0 15, 356 10, 834	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	(from lines 33, ces (from lines as a your records)	34, or 35)) 44, 45, or 46 enter zero)			0 0 0 0 0 15, 356 10, 834	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 Line 26 = line 24 for respiratory therapy or	(from lines 33, ses (from lines a your records) 3 - if negative, sum of lines 24	34, or 35)) 44, 45, or 46 enter zero) and 25 for a	 II others		0 0 0 0 0 15, 356 10, 834 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	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 27 = line 7 times line 3 for respiratory	(from lines 33, ses (from lines a your records) 3 - if negative, sum of lines 24	34, or 35)) 44, 45, or 46 enter zero) and 25 for a	 II others	others	0 0 0 0 0 15, 356 10, 834 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	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 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27	(from lines 33, ses (from lines a your records) 3 - if negative, sum of lines 24	34, or 35)) 44, 45, or 46 enter zero) and 25 for a	 II others	others	0 0 0 0 0 15, 356 10, 834 0	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 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 63 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 33, ses (from lines 33, ses (from lines 34, ses (from 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 (0 0 0 0 15, 356 10, 834 0	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 100. 00 100. 01
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 27 = line 7 times line 3 for respiratory LINE 34 CALCULATION LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	(from lines 33, es (from lines 33, es (from lines 33, es (from lines 34, es (from lines 24, es (from lines 33, es (from lines 4, es (from l	34, or 35)) 44, 45, or 46 enter zero) and 25 for a of lines 3 a	II others nd 4 for all o		0 0 0 0 15, 356 10, 834 0	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 100. 00 100. 01 100. 02
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 100. 00 100. 02 101. 00 101. 01	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 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	(from lines 33, es (from lines 33, es (from lines 33, es (from lines 34, es (from lines 24, es (from lines 33, es (from lines 4, es (from l	34, or 35)) 44, 45, or 46 enter zero) and 25 for a of lines 3 a	II others nd 4 for all o		0 0 0 0 15, 356 10, 834 0 0	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 100. 00 100. 02 101. 00 101. 01
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 100. 01 100. 02 101. 00 101. 01 101. 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 28 = sum of lines 26 and 27 LINE 34 CALCULATION 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	(from lines 33, ses (from lines 33, ses (from lines 34, ses (from lines 24, ses (from	and 25 for a of lines 3 a and 30 for a	II others nd 4 for all o nd 4 for all o II others		0 0 0 0 15, 356 10, 834 0 0	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 100. 00 100. 01 100. 02
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 100. 00 100. 01 101. 00 101. 01 101. 02 102. 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 Line 37 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 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 Line 31 = line 29 for respiratory therapy or	(from lines 33, ses (from lines 34, ses (from lines 34, ses (from lines 24, ses (from	and 25 for a of lines 3 a and 30 for a	II others nd 4 for all others	others	0 0 0 0 15, 356 10, 834 0 0 0 0	58. 00 59. 00 60. 00 61. 00 62. 00 64. 00 65. 00 100. 00 100. 01 101. 01 101. 01 101. 02 102. 00
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 100. 00 100. 01 101. 00 101. 01 101. 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 28 = sum of lines 26 and 27 LINE 34 CALCULATION 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	(from lines 33, ses (from lines 34, ses (from lines 34, ses (from lines 24, ses (from	and 25 for a of lines 3 a and 30 for a	II others nd 4 for all others	others	0 0 0 0 15, 356 10, 834 0 0 0 0	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00

| Period: | Worksheet B | From 01/01/2018 | Part | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1304

CAPITIAL SERVICE COST CENTERS Subtotal SPACE SERVICE COST CENTERS SUBTOTAL						Ť	o 12/31/2018		
Cost Center Description					CAPLTAL			5/24/2019 4:5	9 pm
SEMERAL SERVICE COST CENTERS									
CALL DOCATION COLUMN COL			Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
					FLXT			& GENERAL	
ENERAL SERVICE COST CENTERS						DEPARTMENT			
GRIPRIAL SERVICE COST CHATES 1.00 00100 (DNIC LAR PERL COSTS-BLDG & F1XT 2,002,760 2,002,760 4.00 0.000 0.000 FURL LYPE FIRSTEFITS (FFFRATURENT 4,112,491 15,530 4,128,021 4,845,385 4,845,385 5.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0					1 00	4 00	ΛΔ	5.00	
0.00 0.000 NEW CAR PEL COSTS-BIG & FIXT 2,002,760 4,128,007 4,128,007 4,108,007 4,00		GENER	AL SERVICE COST CENTERS		1.00	1 4.00	7/1	3.00	
0.0000 OBMON DISTATTIVE & GENERAL 3,894, 346 295, 323 655, 716 4,845,385 4,845,385 5,00 0.0000 OPERATION OF PILANT 1,225,353 156,301 39,883 136,301 39,883 30,848 336,144 7.00 0.0000 OPERATION OF PILANT 1,225,353 156,301 39,883 136,301 39,883 30,801 10,000 0.000 0.0000 DETARY 141,248 64,894 26,904 233,046 53,002 10.000 10.000 DETARY 141,248 64,894 26,904 233,046 53,002 10.000 13,000 0.000 DETARY 141,248 64,894 26,904 233,046 53,002 10.000 13,000 0.000 DETARY 141,000 141,341 3,267 33,000 141,341 3,267 33,000 141,341 3,267 33,000 141,341 3,267 33,000 141,341 3,267 33,000 141,341 3,267 33,000 141,341 3,267 33,000 141,341 3,267 33,000 141,341 3,267 33,000 30,000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.	1.00			2, 002, 760	2, 002, 760				1. 00
7,00 00700 (DREATION OF PLANT 1,225, 353 156, 301 93,833 1,475, 487 336, 144 7,00 9,00 00900 (HOUSKEKEPING 536, 312 33, 671 104, 778 674, 961 153, 769 9,00 11,00 01000 (DICOLAR CREENING 141, 248 44, 894 26,904 233, 041 53, 092 10.00 11,00 01000 (DICAL CREENIA 182, 157 21, 569 73, 739 227, 465 63, 212 11.00 14,00 014300 (CHENTRAL SERVICES & SURGEY) 152, 844 46, 100 17, 213 216, 159 49, 265 14, 04 10,00 01000 (MISH SA AGAIM INSTRATION) 0 14, 341 0 14, 341 33, 614 18, 21 15, 00 14, 0100 (MISH SA SAMIN ISTRATION) 0 14, 341 0 14, 341 33, 214 18, 02 11, 04, 91 11, 04, 91 14, 341 33, 814 18, 02 14, 24, 14 14, 24, 14 14, 24, 14 10, 24, 24 14, 24, 24 14, 24, 24 14, 24, 24 14, 24, 24 14, 24, 24 14, 24, 24	4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4, 112, 491	15, 530	4, 128, 021			4. 00
B.OO OBSOOL LANDRY & LINEN SERVICE 68, 908 15, 367 04, 978 647, 961 153, 769 9, 00 0000 HOUSEKEEPING 153, 769 9, 00 10.00 10 COOL DIETARY 141, 248 64, 894 26, 904 233, 046 53, 092 10.00 10.00 10 COC GAFTERIA 182, 157 21, 569 73, 739 277, 465 63, 272 11.00 13.00 01300 NURSI NG ADMINISTRATION 182, 157 21, 569 73, 739 277, 465 63, 272 11.00 13.00 01300 CURTRAL SERVICES & SUPPLY 152, 846 46, 100 17, 273 216, 159 49, 245 14.00 140, 01400 CURTRAL SERVICES & SUPPLY 152, 846 46, 100 17, 721 216, 159 49, 245 14.00 140, 01400 CURTRAL SERVICES & SUPPLY 152, 846 46, 100 17, 760 1						655, 716	4, 845, 385	4, 845, 385	
9.00 000000 HOUSEKEEPING 536, 312 33, 671 104, 978 674, 961 153, 769 9.00 11.00 01000 DIETARY 1412, 248 64, 844 26, 90 233, 046 53, 079 10.00 11.00 011000 CAFETERI A 182, 157 21, 569 73, 739 277, 465 63, 212 11.00 14. 030 01300 UNISSI MG ADMINISTRATION 0 14, 341 0 143, 341 3, 267 13.00 14. 00 01400 CENTRAL SERVICES & SUPPLY 152, 846 46, 100 17, 213 216, 159 49, 245 14.00 14. 00 1400 CENTRAL SERVICES & SUPPLY 152, 846 46, 100 17, 213 216, 159 49, 245 14.00 14. 00 01400 CENTRAL SERVICES & SUPPLY 152, 846 46, 100 17, 213 216, 159 49, 245 14.00 14. 00 01400 CENTRAL SERVICE COST CENTERS 395, 874 30, 500 93, 874 50.0 221 118, 816 16.00 14. 00 000 OUTLARY SERVICE COST CENTERS 390, 874 30, 500 30, 500 15. 00 03000 OUTLARY SERVICE COST CENTERS 395, 874 30, 500 30, 50								l	
10.00 0 1000 DIETRY 141,246		1	•						
11.00 01100 CAFETERIA 182, 157 21, 569 73, 739 277, 465 63, 272 11.00 14.00 14.31 3.267 13.00 13.00 01300 NURSI NG ADMINISTRATION 0 14.341 3.267 13.00 13.00 01300 MEDICAL RECROSOS & LIBRARY 395, 874 30.500 93, 847 520, 221 118, 151 16.00 10.00 MEDICAL RECROSOS & LIBRARY 395, 874 30.500 93, 847 520, 221 118, 151 16.00 10.00 MEDICAL RECROSOS & LIBRARY 395, 874 30.500 93, 847 520, 221 118, 151 16.00 10.00 MEDICAL RECROSOS & LIBRARY 395, 874 30.500 93.00 03000 MULTS & PEDIA IRTIC S 1.064, 071 154, 062 265, 901 1, 484, 034 336, 091 30.00 30.00 03000 MULTS & PEDIA IRTIC S 1.064, 071 154, 062 265, 901 1, 484, 034 336, 091 30.00 30.00 03000 MURTS & PEDIA IRTIC S 1.064, 071 154, 062 265, 901 1, 484, 034 336, 091 30.00 30.00 05000 MERATI NER ROW 490, 019 126, 570 213, 565 830, 154 189, 125 50.00 30.00 30.00 MESTINESI OLGY 0 0 0 0 0 0 0 0 0 0 35.00 30.00 30.00 MESTINESI OLGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								1	
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50.00	30. 00			1, 064, 071	154, 062	265, 901	1, 484, 034	338, 091	30. 00
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53.00 06300 ABISTHESI OLOGY 0 0 0 0 0 0 0 0 0								l	
54.00 05400 RADIOLOGY-DIAGNOSTIC 892, 386 123, 422 281, 795 1, 297, 603 295, 619 54.00		1	•					1	
54 01 05401 05COLOCY 369,579 48,618 81,667 499,864 113,879 54,01				_	,	1	_		
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60.00 0.0000 LABIORATORY 1.500, 701 48, 525 1.67, 525 1,716, 751 391, 108 60. 00				0				1	
66.00 06600 PHYSI CAL THERAPY 319, 319 87, 139 82, 396 488, 854 111, 370 66.00 67.00 06700 OCCUPATI ONAL THERAPY 237, 466 20, 123 63, 791 321, 380 73, 216 67. 00 68.00 06800 SPEECH PATHOLOGY 62, 533 4, 221 13, 724 80, 478 18, 334 68. 00 69.00 06800 SPEECH PATHOLOGY 126, 511 9, 374 33, 867 169, 752 38, 673 69. 00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 70. 00 71.00 07000 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 381, 188 0 0 0 381, 188 86, 842 71. 00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 381, 188 0 0 0 833, 366 18, 999 72. 00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 4, 413, 082 8, 301 149, 533 4, 570, 916 1, 041, 347 73.00 07300 DRUGS CHARGED TO PATI ENTS 4, 413, 082 8, 301 149, 533 4, 570, 916 1, 041, 347 74.00 07300 DRUGS CHARGED TO PATI ENTS 4, 413, 082 8, 301 149, 533 4, 570, 916 1, 041, 347 75.00 07300 DRUGS CHARGED TO PATI ENTS 4, 413, 082 8, 301 149, 533 4, 570, 916 1, 041, 347 75.00 07300 DRUGS CHARGED TO PATI ENTS 78, 277 36, 609 17, 950 132, 836 30, 263 90, 01 76.00 09001 SURGI CAL ASSOCI ATES 78, 277 36, 609 17, 950 132, 836 30, 263 90, 01 76.00 09002 ORTHOPAEDI CS 31, 718 25, 137 3, 483 60, 338 13, 746 90, 02 76.00 09003 RHEUMATOLOGY 1, 510 33, 555 141, 115 176, 180 40, 137 90, 02 76.00 09004 ENDOCRI NOLOGY 1, 510 33, 555 141, 115 176, 180 40, 137 90, 04 76.00 09005 PEDI ATRI CS 78, 005 33, 321 83, 276 194, 602 44, 334 90, 05 76.00 09006 WOMEN'S HEALTH -12, 366 25, 667 70, 877 83, 578 19, 041 90, 06 76.00 09006 WOMEN'S HEALTH -12, 366 25, 667 70, 877 83, 578 19, 041 90, 06 76.00 09006 WOMEN'S HEALTH -12, 266 25, 667 70, 877 83, 578 19, 041 90, 06 76.00 09006 AMBULANCE SERVI CES 437, 546 86, 930 105, 951 630, 427 143, 623 77.00 07000 07000	60.00	06000	LABORATORY	1, 500, 701	48, 525	167, 525	1, 716, 751	391, 108	60.00
67:00 06700 OCCUPATI ONAL THERAPY 237, 466 20, 123 63, 791 321, 380 73, 216 67. 00 68:00 06800 SPEECH PATHOLOGY 62,533 4, 221 13, 724 80, 478 18, 334 68. 00 69:00 06900 ELECTROCARDI OLOGY 126, 511 9, 374 33, 867 169, 752 38, 673 69. 00 70:00 07000 ELECTROCARDI OLOGY 126, 511 9, 374 33, 867 169, 752 38, 673 69. 00 70:00 07000 ELECTROCARDI OLOGY 126, 511 9, 374 33, 867 169, 752 38, 673 69. 00 70:00 07000 ELECTROCARDI OLOGY 17. 00 0 0 0 0 70:00 07000 MIPL DEV. CHARGED TO PATIENT 38, 396 0 0 83, 396 18, 999 72. 00 73:00 07300 DRUGS CHARGED TO PATIENT 4, 413, 082 8, 301 149, 533 4, 570, 916 1, 041, 347 73:00 07900 SURGI CAL ASSOCI ATES 78, 277 36, 609 17, 950 132, 836 30, 263 90. 01 79:00 09000 SURGI CAL ASSOCI ATES 78, 277 36, 609 17, 950 132, 836 30, 263 90. 01 79:00 09000 SURGI CAL ASSOCI ATES 78, 277 36, 609 17, 950 132, 836 30, 263 90. 01 79:00 09000 SURGI CAL ASSOCI ATES 78, 277 36, 609 17, 950 132, 836 30, 263 90. 01 79:00 09000 SURGI CAL ASSOCI ATES 78, 277 36, 609 17, 950 132, 836 30, 263 90. 01 79:00 09000 SURGI CAL ASSOCI ATES 78, 277 36, 609 17, 950 132, 836 30, 263 90. 01 79:00 09000 SURGI CAL ASSOCI ATES 78, 277 36, 609 17, 950 132, 836 30, 263 90. 01 79:00 09000 SURGI CAL ASSOCI ATES 78, 277 36, 609 17, 950 132, 836 30, 263 90. 01 79:00 09000 SURGI CAL ASSOCI ATES 78, 277 36, 609 17, 950 132, 836 30, 263 90. 01 79:00 09000 SURGI CAL ASSOCI ATES 78, 277 36, 609 17, 950 132, 836 30, 263 90. 01 79:00 09000 SURGI CAL ASSOCI ATES 78, 205 33, 321 83, 376 194, 602 44, 334 79:00 09000 SURGI CAL ASSOCI ATES 78, 205 33, 321 83, 276 194, 602 44, 334 79:00 09000 SURGI CAL ASSOCI ATES 78, 205 33, 321 83, 276 194, 602 44, 334 79:00 09000 O9000 O900	65.00			106, 663	3, 055	23, 907	133, 625	30, 442	65. 00
68.00 06800 SPEECH PATHOLOGY 62,533 4,221 13,724 80,478 18,334 68.00 69.00 06900 ELECTROCARDIOLOGY 126,511 9,374 33,867 169,752 38,673 69.00 69.00 07000 ELECTROCENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0 0 0 70.00 71.00 07000 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 381,188 0 0 0 381,188 86,842 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 381,188 0 0 0 83,396 18,999 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 4,413,082 8,301 149,533 4,570,916 1,041,347 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 4,413,082 8,301 149,533 4,570,916 1,041,347 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 78,277 36,609 17,950 132,836 30,263 90.01 79.01 09001 SURGI CAL ASSOCI ATES 78,277 36,609 17,950 132,836 30,263 90.01 79.02 09002 ORTHOPAEDI CS 31,718 25,137 3,483 60,338 13,746 90.02 79.03 09003 RHEUMATOLOGY 1,510 33,555 141,115 176,180 40,137 90.03 79.04 09004 ENDOCRI NOLOGY 104,823 8,394 47,435 160,652 36,600 90.04 79.05 09005 PEDI ATRI ICS 78,005 33,321 83,276 194,602 44,334 90.05 79.06 09006 WOMEN' S HEALTH -12,366 25,067 70,877 83,578 19,041 90.06 79.07 09007 PAIN MANAGEMENT 1,240 0 124,093 125,333 28,553 90.07 79.00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 79.00 79.00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 79.00 79.00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 79.00 79.00 79.00 09000 MBURNSABLE COST CENTERS 1,982,940 4,110,500 26,011,957 4,822,151 79.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 0 793.01 193.01 19301 FOUNDATI ON 64,645 19,820 17,521 101,986 23,241 193.01 793.01 19301 19301 FOUNDATI ON 64,645 19,820 17,521 101,986 23,241 193.01 793.01 19301 FOUNDATI ON 64,645 19,820 17,521 101,986 23,241 193.01 794.00 07950 OTHER NON REI MBURSABLE 0								l	
69.00 06900 ELECTROCARDI OLOGY 126,511 9,374 33,867 169,752 38,673 69.00 70.								l	
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 381, 188 86, 842 71.00 72.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 381, 188 0 0 0 833, 396 18, 999 72.00 73.00 07200 IMPL. DEV. CHARGED TO PATIENTS 4, 413, 082 8, 301 149, 533 4, 570, 916 1, 041, 347 73.00 73.00 DRUGS CHARGED TO PATIENTS 4, 413, 082 8, 301 149, 533 4, 570, 916 1, 041, 347 73.00 73.00 DRUGS CHARGED TO PATIENTS 4, 413, 082 8, 301 149, 533 4, 570, 916 1, 041, 347 73.00 73.00 DRUGS CHARGED TO PATIENTS 73.00 73.00 DRUGS CHARGED TO PATIENTS 73.00 73.00 DRUGS CHARGED TO PATIENTS T3.00 DRUGS CHARGED TO PATIENTS 73.00 DRUGS CHARGED TO PATIENTS T3.00 DRUGS CHARGED TO PATIENTS D								l	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 381, 188 0 0 381, 188 86, 842 71. 00 72. 00 7200 MPL. DEV. CHARGED TO PATIENT 83, 396 0 0 381, 188 86, 842 71. 00 72. 00 7200 MPL. DEV. CHARGED TO PATIENT 83, 396 0 0 381, 188 86, 842 71. 00 72.		1	l e e e e e e e e e e e e e e e e e e e					l	
72. 00 07200 MPL. DEV. CHARGED TO PATIENT 83, 396 0 0 83, 396 18, 999 72. 00 73. 00 07300 DRIGS CHARGED TO PATIENTS 4, 413, 082 8, 301 149, 533 4, 570, 916 1, 041, 347 73. 00 0000 DRIGS CHARGED TO PATIENTS 73. 00 00000 00000 0000 00000 00000 00000 00000 00000 00000 00000 00000 0				_			U		
73. 00 07300 DRUGS CHARGED TO PATIENTS 4, 413, 082 8, 301 149, 533 4, 570, 916 1, 041, 347 73. 00 00700 CLI NI C 516, 137 302, 316 834, 092 1, 652, 545 376, 481 90. 00 90. 01 90. 01 90. 01 SURGI CAL ASSOCI ATES 78, 277 36, 609 17, 950 132, 836 30, 263 90. 01 90. 02 09002 ORTHOPABUI CS 31, 718 25, 137 3, 483 60, 338 13, 746 90. 02 90. 02 09002 ORTHOPABUI CS 1, 510 33, 555 141, 115 176, 180 40, 137 90. 03 90. 04 09004 ENDOCRI NOLOGY 104, 823 8, 394 47, 435 160, 652 36, 600 90. 04 90. 05 09005 PEDI ATRI CS 78, 005 33, 321 83, 276 194, 602 44, 334 90. 05 90. 05 90. 06 09004 OWNEN' S HEALTH -12, 366 25, 067 70, 877 83, 578 19, 041 90. 06 90. 07 09007 PAI N MANAGEMENT 1, 240 0 124, 093 125, 333 28, 553 90. 07 91. 00 09000 OBERGENCY 2, 022, 542 89, 961 230, 361 2, 342, 864 533, 749 91. 00 92. 00 09200 OBERGENCY 09									
OUTPATIENT SERVICE COST CENTERS 00 00900C CLINIC 516, 137 302, 316 834, 092 1, 652, 545 376, 481 90. 00 90. 00 9000T SURGI CAL ASSOCIATES 78, 277 36, 609 17, 950 132, 836 30, 263 90. 01 90. 02 90002 ORTHOPAEDI CS 31, 718 25, 137 3, 483 60, 338 13, 746 90. 02 90. 03 90903 RHEUMATOLOGY 1, 510 33, 555 141, 115 176, 180 40, 137 90. 03 90. 03 90. 03 90. 04 90. 04 90. 04 90. 05 90. 04 90. 06 90. 05 90. 05 90. 06 90. 06 90. 06 90. 06 90. 06 90. 06 90. 06 90. 06 90. 06 90. 06 90. 06 90. 06 90. 06 90. 06 90. 07 9							•		
90. 01 09001 SURGI CAL ASSOCI ATES 78, 277 36, 609 17, 950 132, 836 30, 263 90. 01 90. 02 09002 0RTHOPAEDI CS 31, 718 25, 137 3, 483 60, 338 13, 746 90. 02 90. 03 09003 RHEUMATOLOGY 1, 510 33, 555 141, 115 176, 180 40, 137 90. 03 90. 04 09004 ENDOCRI NOLOGY 104, 823 8, 394 47, 435 160, 652 36, 600 90. 04 90. 05 09005 PEDI ATRI CS 78, 005 33, 321 83, 276 194, 602 44, 334 90. 05 90. 07 9									
90. 02		1	•						90. 00
90. 03 09003 RHEUMATOLOGY									
90. 04 09004 ENDOCRI NOLOGY 104, 823 8, 394 47, 435 160, 652 36, 600 90. 04 90. 05 90. 05 PEDI ATRI CS 78, 005 33, 321 83, 276 194, 602 44, 334 90. 05 90. 06 90. 06 90. 06 90. 06 90. 06 90. 06 90. 06 90. 06 90. 07 90. 0								l	
90. 05 09005 PEDI ATRI CS 78, 005 33, 321 83, 276 194, 602 44, 334 90. 05 90. 06 09006 WOMEN'S HEALTH -12, 366 25, 067 70, 877 83, 578 19, 041 90. 06 90. 07 09007 PAIN MANAGEMENT 1, 240 0 124, 093 125, 333 28, 553 90. 07 91. 00 09100 EMERGENCY 2, 022, 542 89, 961 230, 361 2, 342, 864 533, 749 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 07HER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES 437, 546 86, 930 105, 951 630, 427 143, 623 95. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 26, 049, 298 1, 982, 940 4, 110, 500 26, 011, 957 4, 822, 151 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 193. 01 19301 FOUNDATI ON 64, 645 19, 820 17, 521 101, 986 23, 234 193. 01 194. 00 07950 OTHER NON REI MBURSABLE 0 0 0 0 0 0 194. 00 07950 OTHER NON REI MBURSABLE 0 0 0 0 0 194. 00 000 0 0 0 0 194. 00 000 0 0 0 194. 00 000 0 0 0 195. 00 0 0 0 0 196. 00 0 0 0 197. 00 0 0 197. 00 0 0 197. 00 0 0 197. 00 0 0 197. 00 0 0 197. 00 0 0 197. 00 0 197. 00 0 0 197. 00 0 197. 00 0 197. 00 0 197. 00 0 197. 00 197. 00 0 197. 0								l	
90. 06							•		
90. 07 09007 PAI N MANAGEMENT 1, 240 0 124, 093 125, 333 28, 553 90. 07 91. 00 09100 EMERGENCY 2, 022, 542 89, 961 230, 361 2, 342, 864 533, 749 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0								l	
91. 00								l	
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0THER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVI CES 437,546 86,930 105,951 630,427 143,623 95.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 26,049,298 1,982,940 4,110,500 26,011,957 4,822,151 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 192.00 193.00 19300 NONPAID WORKERS 0 0 0 0 0 0 193.00 193.00 19300 NONPAID WORKERS 0 0 0 0 0 0 193.00 193.01 19301 FOUNDATI ON 64,645 19,820 17,521 101,986 23,234 193.01 193.02 19302 OCCUPATI ONAL MEDI CINE 0 0 0 0 194.00 200.00 00 0 0 0 0 0 0 0								l	
95. 00	92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			·			
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 26,049,298 1,982,940 4,110,500 26,011,957 4,822,151 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 192.00 193.00 19300 NONPAID WORKERS 0 0 0 0 0 0 0 0 193.00 19300 NONPAID WORKERS 0 0 0 0 0 0 0 0 193.00 19300		OTHER	REIMBURSABLE COST CENTERS						
18. 00 SUBTOTALS (SUM OF LINES 1 through 117) 26, 049, 298 1, 982, 940 4, 110, 500 26, 011, 957 4, 822, 151 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 192. 00 193. 00 193. 00 193. 00 193. 00 193. 01 193. 01 193. 01 193. 01 193. 01 193. 01 193. 01 193. 01 193. 02 193. 02 193. 02 193. 02 193. 02 193. 02 193. 02 193. 03 193. 04 193. 05 193. 05 193. 06 193. 07 193. 07 193. 08 193.	95. 00			437, 546	86, 930	105, 951	630, 427	143, 623	95. 00
NONREI MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.00	110 00			24 040 200	1 000 040	4 110 F00	24 011 057	4 000 151	110 00
192. 00	118.00			26, 049, 298	1, 982, 940	4, 110, 500	26, 011, 957	4, 822, 151	118.00
193. 00	192.00			0	0		n	0	192, 00
193. 01 19301 FOUNDATION 64, 645 19, 820 17, 521 101, 986 23, 234 193. 01 193. 02 19302 OCCUPATIONAL MEDICINE 0 0 0 0 0 193. 02 194. 00 07950 OTHER NON REIMBURSABLE 0 0 0 0 0 194. 00 200. 00 0 0 0 194. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00		1	•	0	•		o o		
193. 02 19302 OCCUPATIONAL MEDICINE 0 0 0 0 193. 02 194. 00 07950 OTHER NON REIMBURSABLE 0 0 0 0 0 194. 00 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00				64, 645	19, 820	17, 521	101, 986		
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 0				0	0	0	0	0	193. 02
201.00 Negative Cost Centers 0 0 0 0 201.00		1	l e e e e e e e e e e e e e e e e e e e	0	0	0	0	0	
							0		
202.00		1		2/ 442 6:2	0	4 400 633	0 440 610		
	202.00	기	IUTAL (SUM TIMES TIX THROUGH 201)	26, 113, 943	2,002,760	4, 128, 021	26, 113, 943	4, 845, 385	J202. 00

Provider CCN: 15-1304

						5/24/2019 4:5	9 pm
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	·	PLANT	LINEN SERVICE				
		7. 00	8. 00	9.00	10.00	11. 00	
GEN	NERAL SERVICE COST CENTERS				,		
	100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	500 ADMINISTRATIVE & GENERAL						5. 00
	700 OPERATION OF PLANT	1, 811, 631					7. 00
			101 (00				
	800 LAUNDRY & LINEN SERVICE	18, 129	121, 603				8. 00
	900 HOUSEKEEPI NG	39, 724	8, 535	· ·			9. 00
	000 DI ETARY	76, 559	3, 499		404, 480		10. 00
	100 CAFETERI A	25, 446	0		0	378, 848	11. 00
	300 NURSING ADMINISTRATION	16, 918	0	-,	0	2, 031	13. 00
14. 00 014	400 CENTRAL SERVICES & SUPPLY	54, 386	0	27, 196	0	4, 469	14. 00
16. 00 016	600 MEDICAL RECORDS & LIBRARY	35, 982	0	17, 993	0	23, 157	16. 00
INF	PATIENT ROUTINE SERVICE COST CENTERS						
30.00 030	000 ADULTS & PEDIATRICS	181, 755	79, 291	90, 888	404, 480	41, 237	30.00
	CILLARY SERVICE COST CENTERS					·	
	OOO OPERATING ROOM	149, 321	7, 959	74, 669	0	18, 282	50.00
	100 RECOVERY ROOM	17, 276	0	8, 639	o	1, 625	51.00
	300 ANESTHESI OLOGY	17,270	0	0,007	ol	0	53.00
	400 RADI OLOGY-DI AGNOSTI C	145, 607	5, 142	١	0	25, 392	54.00
	401 ONCOLOGY	57, 357	5, 142	28, 682	0	15, 032	54. 00
		37, 337	0	20, 002	0		55. 00
	500 RADI OLOGY-THERAPEUTI C	F7 047	0		٩	0	1
	000 LABORATORY	57, 247	0	28, 627	0	27, 220	60.00
	500 RESPI RATORY THERAPY	3, 604	1, 024		0	3, 656	65. 00
	600 PHYSI CAL THERAPY	102, 803	2, 394		0	10, 360	66. 00
	700 OCCUPATI ONAL THERAPY	23, 741	1, 101	11, 872	0	5, 688	67. 00
	800 SPEECH PATHOLOGY	4, 979	47		0	2, 438	68. 00
	900 ELECTROCARDI OLOGY	11, 059	0	5, 530	0	6, 297	69. 00
70.00 070	000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00 07	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	o	0	72. 00
73. 00 073	300 DRUGS CHARGED TO PATIENTS	9, 793	0	4, 897	o	15, 438	73. 00
OUT	TPATIENT SERVICE COST CENTERS				,		
	000 CLI NI C	356, 658	0	178, 349	0	80, 442	90.00
	001 SURGI CAL ASSOCI ATES	43, 190	Ö		o	5, 688	90. 01
	002 ORTHOPAEDI CS	29, 655	0	14, 829	0	1, 219	90. 02
	003 RHEUMATOLOGY	39, 586	0		0	9, 954	90. 03
	004 ENDOCRI NOLOGY	9, 903	0	4, 952	0	8, 938	90.03
	005 PEDI ATRI CS	39, 311	0	19, 658	0	6, 094	90. 05
	l .	· ·	0	· ·	0		
	006 WOMEN'S HEALTH	29, 573	0	14, 788	0	4, 063	90.06
	007 PAIN MANAGEMENT	0	0	0	0	6, 094	90. 07
	100 EMERGENCY	106, 131	12, 611	53, 072	O	40, 627	91.00
92. 00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	HER REIMBURSABLE COST CENTERS						
	500 AMBULANCE SERVICES	102, 555	0	51, 283	0	11, 782	95. 00
SPE	ECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 788, 248	121, 603	865, 296	404, 480	377, 223	118. 00
NON	NREIMBURSABLE COST CENTERS						
192. 00 192	200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
	300 NONPALD WORKERS	0	0	l o	o	0	193. 00
	301 FOUNDATION	23, 383	l n	11, 693	ol		193. 01
	302 OCCUPATIONAL MEDICINE	25, 500	l n	1, 5,0	ol O		193. 02
	950 OTHER NON REIMBURSABLE	0	١		0		194. 00
200.00	Cross Foot Adjustments			١	ď	U	200. 00
200.00	Negative Cost Centers	_	^			^	201. 00
		1 011 421	121 402	876, 989	404, 480		
202. 00	TOTAL (sum lines 118 through 201)	1, 811, 631	121, 603	J 870, 989	404, 480	3/8, 848	1202.00

| Period: | Worksheet B | From 01/01/2018 | Part | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1304

				-	o 12/31/2018		
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	Subtotal	5/24/2019 4:59 Intern &	9 pm
	oost conten bescriptron	ADMI NI STRATI ON	SERVICES &	RECORDS &	Subtotui	Residents Cost	
			SUPPLY	LI BRARY		& Post	
						Stepdown	
		10.00	11.00	44.00	0.4.00	Adjustments	
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	16. 00	24. 00	25. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	45, 017					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	351, 455				14. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	363		2		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	7, 485	16, 280	307, 73	2, 951, 278	0	30. 00
F0 00	ANCI LLARY SERVI CE COST CENTERS	2 400	04.405		4 0/4 047		F0 00
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	3, 402 331	91, 135 319	1		0	50. 00 51. 00
53.00	05300 ANESTHESI OLOGY	0	319	· ·		1	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 223	8, 792				54. 00
54. 01	05401 ONCOLOGY	3, 111	3, 307	(54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(55. 00
60.00	06000 LABORATORY	5, 602	136, 081		2, 362, 636		60.00
65.00	06500 RESPI RATORY THERAPY	774	961	1, 51	· ·		65. 00
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	2, 281	1, 062				66.00
67. 00 68. 00	06800 SPEECH PATHOLOGY	1, 309 231	231 175	(438, 538 109, 172		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 292	391				69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	23, 338	(491, 368	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	20, 908		123, 303		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 168	5, 153	(5, 650, 712	0	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS		17 207	·	2 ((0 701	1 0	00.00
90. 00 90. 01	09000 CLI NI C 09001 SURGI CAL ASSOCI ATES		16, 306 605	1	2, 660, 781 234, 179	0	90. 00 90. 01
90. 01	09002 ORTHOPAEDI CS	0	149				90.01
90. 03	09003 RHEUMATOLOGY	o	753				90. 03
90.04	09004 ENDOCRI NOLOGY	0	7, 058	(228, 103	0	90. 04
90. 05	09005 PEDI ATRI CS	0	2, 139				90. 05
90.06	09006 WOMEN'S HEALTH	0	646		,		90.06
90. 07	09007 PAIN MANAGEMENT	0 200	707	257.25			90. 07 91. 00
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 399	11, 049	257, 358	3, 365, 860	0	91.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00	09500 AMBULANCE SERVICES	2, 409	3, 547	(945, 626	0	95. 00
	SPECIAL PURPOSE COST CENTERS		·				
118.00	7	45, 017	351, 455	716, 232	25, 952, 022	0	118. 00
40-	NONREI MBURSABLE COST CENTERS	,					
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192. 00 193. 00
	19300 NONPALD WORKERS 19301 FOUNDATION		0		0 161, 921		193. 00 193. 01
	19302 OCCUPATIONAL MEDICINE		0		01, 721		193. 01
	07950 OTHER NON REIMBURSABLE		0		o o		194. 00
200.00					0	0	200. 00
201.00		0	0		0		201. 00
202.00	TOTAL (sum lines 118 through 201)	45, 017	351, 455	716, 232	26, 113, 943	0	202. 00

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

Provider CCN: 15-1304

			5/24/2019 4:	
	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 INPATIENT ROUTINE SERVICE COST CENTERS			16. 00
30. 00	03000 ADULTS & PEDIATRICS	2, 951, 278		30.00
30.00	ANCILLARY SERVICE COST CENTERS	2, 951, 278		30.00
50. 00	05000 OPERATING ROOM	1, 364, 047		50.00
51. 00	05100 RECOVERY ROOM	161, 270		51.00
53. 00	05300 ANESTHESI OLOGY	101, 270		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 938, 132		54.00
54. 01	05401 ONCOLOGY	721, 232		54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		55. 00
60. 00	06000 LABORATORY	2, 362, 636		60.00
65. 00	06500 RESPIRATORY THERAPY	177, 405		65. 00
66. 00	06600 PHYSI CAL THERAPY	770, 531		66, 00
67. 00	06700 OCCUPATI ONAL THERAPY	438, 538		67. 00
68. 00	06800 SPEECH PATHOLOGY	109, 172		68. 00
69.00	06900 ELECTROCARDI OLOGY	232, 994		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	491, 368		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	123, 303		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	5, 650, 712		73. 00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLI NI C	2, 660, 781		90. 00
90. 01	09001 SURGI CAL ASSOCI ATES	234, 179		90. 01
90. 02	09002 ORTHOPAEDI CS	119, 936		90. 02
90. 03	09003 RHEUMATOLOGY	286, 405		90. 03
90. 04	09004 ENDOCRI NOLOGY	228, 103		90. 04
90. 05	09005 PEDI ATRI CS	306, 138		90. 05
90.06	09006 WOMEN'S HEALTH	151, 689		90.06
90. 07	09007 PAIN MANAGEMENT	160, 687		90. 07
91.00	09100 EMERGENCY	3, 365, 860		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
05 00	OTHER REIMBURSABLE COST CENTERS	045 (2)		05.00
95. 00	09500 AMBULANCE SERVICES	945, 626		95. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	25, 952, 022		118. 00
110.00	NONREI MBURSABLE COST CENTERS	20, 702, 022		110.00
192 00	19200 PHYSICIANS' PRIVATE OFFICES	0		192. 00
	19300 NONPALD WORKERS	0		193. 00
	19301 FOUNDATION	161, 921		193. 00
	2 19302 OCCUPATIONAL MEDICINE	101, 921		193. 01
	07950 OTHER NON REIMBURSABLE	0		194. 00
200.00		o o		200.00
201.00		O		201. 00
202.00	9	26, 113, 943		202. 00
	1.1 (34 113 1 4 349.1 201)	20, , , 10		1-02.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | Period: | Peri Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1304

				To	12/31/2018	Date/Time Prep 5/24/2019 4:5	
			CAPI TAL			072172017 1.0) piii
			RELATED COSTS				
	Cost Center Description	Directly	NEW BLDG &	Subtotal		ADMI NI STRATI VE	
		Assigned New	FLXT		BENEFI TS	& GENERAL	
		Capi tal			DEPARTMENT		
		Related Costs 0	1. 00	2A	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	0	1.00	ZA	4.00	3.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	15, 530	15, 530	15, 530		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	295, 323	295, 323	2, 467	297, 790	5. 00
7.00	00700 OPERATION OF PLANT	0	156, 301		353	20, 658	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	15, 367		0	1, 180	•
9.00	00900 HOUSEKEEPI NG	0	33, 671		395	9, 450	9.00
10.00		0	64, 894		101	3, 263	ı
11.00		0	21, 569		277	3, 885	1
13. 00 14. 00		0	14, 341 46, 100		0 65	201 3, 026	13. 00 14. 00
16. 00		0	30, 500		353	7, 284	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		00,000	00,000		7,201	10.00
30.00		0	154, 062	154, 062	1, 000	20, 778	30. 00
	ANCILLARY SERVICE COST CENTERS			,	,		
50.00	05000 OPERATING ROOM	0	126, 570	126, 570	804	11, 623	50. 00
51.00		0	14, 644	14, 644	30	746	
53.00		0	0		0	0	53. 00
54. 00	l	0	123, 422	1	1, 060	18, 168	1
54. 01		0	48, 618	1	307	6, 999	1
55.00		0	0		0	0	55. 00
60. 00 65. 00	1	0	48, 525 3, 055	1	630 90	24, 036 1, 871	60. 00 65. 00
66. 00	1	0	87, 139	1	310		•
67. 00	1	0	20, 123		240		
68. 00		0	4, 221		52	1, 127	1
69.00	1	0	9, 374		127	2, 377	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00		0	0	0	0	5, 337	71. 00
72. 00		0	0		0	1, 168	•
73. 00		0	8, 301	8, 301	563	64, 004	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS		202 217	202 21/	2 127	22 127	00.00
90. 00 90. 01		0	,		3, 137	23, 137	90.00
90.01	09001 SURGI CAL ASSOCI ATES 09002 ORTHOPAEDI CS	0	36, 609 25, 137		68 13	1, 860 845	90. 01 90. 02
90. 02		0	33, 555		531	2, 467	90.02
90. 04		0	8, 394		178		•
90. 05		0	33, 321	1	313		1
90.06	09006 WOMEN' S HEALTH	0	25, 067		267	1, 170	1
90. 07	09007 PAIN MANAGEMENT	0	0	0	467	1, 755	90. 07
91.00	1	0	89, 961	89, 961	867	32, 802	91.00
92. 00				0			92. 00
	OTHER REIMBURSABLE COST CENTERS	1	0, 000	0.000		0.007	
95. 00	09500 AMBULANCE SERVICES	0	86, 930	86, 930	399	8, 827	95. 00
110 00	SPECIAL PURPOSE COST CENTERS	0	1 002 040	1 000 040	15, 464	207. 27.2	110 00
118. 00	O SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	1, 982, 940	1, 982, 940	15, 464	296, 362	1118.00
192 00	0 19200 PHYSI CLANS' PRI VATE OFFI CES	n	0	O	0	n	192. 00
	0 19300 NONPALD WORKERS	0	0	Ö	0		193. 00
	1 19301 FOUNDATION	0	19, 820	19, 820	66		193. 01
	2 19302 OCCUPATIONAL MEDICINE	0	0	o	0		193. 02
	0 07950 OTHER NON REIMBURSABLE	0	0	0	0		194. 00
200.00				0			200. 00
201.00			0	0	0		201. 00
202.00	0 TOTAL (sum lines 118 through 201)	0	2, 002, 760	2, 002, 760	15, 530	297, 790	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1304

				To	12/31/2018	Date/Time Pre 5/24/2019 4:5	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	7 DIII
	5551 551161 25551 Pt. 511	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 Z 1 Z 1.17.1	
		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	177, 312					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 774	18, 321				8. 00
9.00	00900 HOUSEKEEPI NG	3, 888			70 400		9.00
10.00	01000 DI ETARY	7, 493	527		78, 403	20,020	10.00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	2, 491	0		0	28, 928 155	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 656 5, 323			0	341	14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 523		,	0	1, 768	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	3, 522		777	<u> </u>	1, 700	10.00
30. 00	03000 ADULTS & PEDIATRICS	17, 789	11, 946	5, 046	78, 403	3, 149	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	17,707	11, 740	3, 040	70, 403	5, 147	30.00
50.00	05000 OPERATING ROOM	14, 615	1, 199	4, 146	0	1, 396	50.00
51. 00	05100 RECOVERY ROOM	1, 691	0		ol	124	51.00
53. 00	05300 ANESTHESI OLOGY	0	0		o	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	14, 251	775	4, 042	o	1, 939	54.00
54.01	05401 ONCOLOGY	5, 614	0	1, 592	o	1, 148	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
60.00	06000 LABORATORY	5, 603	0	1, 589	0	2, 078	1
65.00	06500 RESPI RATORY THERAPY	353	154		0	279	1
66.00	06600 PHYSI CAL THERAPY	10, 062	361		0	791	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 324	166		0	434	1
68.00	06800 SPEECH PATHOLOGY	487	7	138	0	186	1
69. 00	06900 ELECTROCARDI OLOGY	1, 082	0		0	481	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	- 1	0	0	
71.00	07200 I MPL. DEV. CHARGED TO PATIENT	0		- 1	0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	959			0	1, 179	1
73.00	OUTPATIENT SERVICE COST CENTERS	757		2/2	<u> </u>	1, 177	73.00
90. 00	09000 CLINI C	34, 907	0	9, 904	o	6, 145	90.00
90. 01	09001 SURGI CAL ASSOCI ATES	4, 227	ĺ		ol	434	1
90. 02	09002 ORTHOPAEDI CS	2, 902	l o	'	ol	93	1
90. 03	09003 RHEUMATOLOGY	3, 874	0		o	760	1
90.04	09004 ENDOCRI NOLOGY	969	0	275	О	682	1
90. 05	09005 PEDI ATRI CS	3, 848	0	1, 091	o	465	90. 05
90.06	09006 WOMEN' S HEALTH	2, 894	0	821	o	310	90.06
90. 07	09007 PAI N MANAGEMENT	0	0	0	0	465	90. 07
91. 00	09100 EMERGENCY	10, 388	1, 900	2, 947	0	3, 102	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	10, 037	0	2, 847	0	900	95. 00
	SPECIAL PURPOSE COST CENTERS			1			
118.00	1	175, 023	18, 321	48, 041	78, 403	28, 804	118. 00
100.00	NONREI MBURSABLE COST CENTERS		1 0	l ol	٥	0	100 00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0	0	- 1	0		192. 00 193. 00
	19300 NONPALD WORKERS 19301 FOUNDATION	2, 289		- 1	0		193. 00
	19301 FOUNDATION 19302 OCCUPATIONAL MEDICINE	2, 289			0		193. 01
	07950 OTHER NON REIMBURSABLE				0		194. 00
200.00	1 1		١		٩	0	200. 00
201.00	J	0	l .		n	n	201. 00
202.00	1 1 3	177, 312	18, 321	48, 690	78, 403		202. 00
		=	,		-,		

| Period: | Worksheet B | From 01/01/2018 | Part II | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1304

				j	o 12/31/2018		
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	Subtotal	5/24/2019 4:5	9 pm
	oost conten bescriptron	ADMI NI STRATI ON	SERVICES &	RECORDS &	Subtotui	Residents Cost	
			SUPPLY	LI BRARY		& Post	
						Stepdown	
		10.00	11.00	44.00	0.4.00	Adjustments	
	CENEDAL CEDVICE COST CENTEDS	13. 00	14. 00	16. 00	24. 00	25.00	
1. 00	GENERAL SERVICE COST CENTERS OO100 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 13. 00	01100 CAFETERI A	14 022					11. 00 13. 00
14. 00	O1300 NURSI NG ADMI NI STRATI ON O1400 CENTRAL SERVI CES & SUPPLY	16, 823	56, 365				14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	50, 503		ı		16. 00
.0.00	INPATIENT ROUTINE SERVICE COST CENTERS	91		11, 10	·I	l .	10.00
30.00	03000 ADULTS & PEDI ATRI CS	2, 797	2, 611	19, 114	316, 695	0	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	1, 271	14, 616			l .	50. 00
51. 00	05100 RECOVERY ROOM	124	51	4, 203		l .	51. 00
53.00	05300 ANESTHESI OLOGY	0	0	(53. 00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 ONCOLOGY	1, 952	1, 410 530	5, 089 (1	54. 00 54. 01
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 162	0	(l	55. 00
60. 00	06000 LABORATORY	2, 094	21, 825			_	60.00
65. 00	06500 RESPI RATORY THERAPY	289	154	94		l	65. 00
66. 00	06600 PHYSI CAL THERAPY	852	170	(l .	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	489	37	(28, 972	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	86	28	(-,	l .	68. 00
69.00	06900 ELECTROCARDI OLOGY	483	63	(l	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2 742	(_	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT		3, 743 3, 353	(· ·	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 184	826	(•		73. 00
	OUTPATIENT SERVICE COST CENTERS	., ., .,	*=*)				
90.00	09000 CLI NI C	0	2, 615	(382, 161	0	90. 00
90. 01	09001 SURGI CAL ASSOCI ATES	0	97	(44, 494	0	90. 01
90. 02	09002 ORTHOPAEDI CS	0	24	(l .	90. 02
90. 03	09003 RHEUMATOLOGY	0	121	(90. 03
90. 04	09004 ENDOCRI NOLOGY	0	1, 132	(90. 04
90. 05 90. 06	09005 PEDIATRICS 09006 WOMEN'S HEALTH		343 104	(90. 05 90. 06
90. 07	09007 PAIN MANAGEMENT	0	113	(90.00
91. 00	09100 EMERGENCY	3, 140	1, 772		,		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		,	,	, , , , , , , , , , , , , , , , , , , ,	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	900	569	(111, 409	0	95. 00
	SPECIAL PURPOSE COST CENTERS					1	
118.00	3 /	16, 823	56, 365	44, 484	1, 978, 384	0	118. 00
102.00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES	O	O	() 0		192. 00
	19200 PHTSICIANS PRIVATE OFFICES		0				193. 00
	19301 FOUNDATION		ol	(193. 00
	19302 OCCUPATIONAL MEDICINE	o	Ö	(0	193. 02
	07950 OTHER NON REIMBURSABLE	0	O	(0	0	194. 00
200.00	1 1				0	0	200. 00
201.00		0	0	(-		201. 00
202.00	TOTAL (sum lines 118 through 201)	16, 823	56, 365	44, 484	2, 002, 760	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS RUSH MEMORIAL HOSPITAL

Provider CCN: 15-1304

			5/24/2019 4:5	
	Cost Center Description	Total	0,21,201,11	J
	'	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
	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			
	03000 ADULTS & PEDIATRICS	316, 695		30.00
	ANCILLARY SERVICE COST CENTERS			
	05000 OPERATING ROOM	176, 240		50. 00
	05100 RECOVERY ROOM	22, 093		51. 00
	05300 ANESTHESI OLOGY	0		53. 00
	05400 RADI OLOGY-DI AGNOSTI C	172, 108		54. 00
	05401 ONCOLOGY	65, 970		54. 01
	05500 RADI OLOGY-THERAPEUTI C	0		55. 00
	06000 LABORATORY	106, 380		60.00
	06500 RESPI RATORY THERAPY	6, 439		65. 00
	06600 PHYSI CAL THERAPY	109, 383		66. 00
	06700 OCCUPATI ONAL THERAPY	28, 972		67. 00
	06800 SPEECH PATHOLOGY	6, 332		68. 00
	06900 ELECTROCARDI OLOGY	14, 294		69. 00
	07000 ELECTROENCEPHALOGRAPHY	0		70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 080		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENT	4, 521		72. 00
	07300 DRUGS CHARGED TO PATIENTS	77, 288		73. 00
	OUTPATIENT SERVICE COST CENTERS	202 1/1		- 00 00
	09000 CLINIC	382, 161		90.00
	09001 SURGI CAL ASSOCI ATES	44, 494		90. 01
	09002 ORTHOPAEDI CS 09003 RHEUMATOLOGY	29, 837 42, 407		90. 02
	09003 RHEDWATOLOGY	13, 879		90.03
	09005 PEDI ATRI CS	42, 106		90.04
	09006 WOMEN' S HEALTH	30, 633		90.05
	09007 PAIN MANAGEMENT	2, 800		90.00
	09100 EMERGENCY	162, 863		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	102, 603		92.00
	OTHER REIMBURSABLE COST CENTERS			72.00
	09500 AMBULANCE SERVICES	111, 409		95. 00
	SPECIAL PURPOSE COST CENTERS	111, 409		35.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 978, 384		118.00
	NONREI MBURSABLE COST CENTERS	1, 770, 304		1 10.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0		192. 00
	19300 NONPALD WORKERS	0		193. 00
	19301 FOUNDATION	24, 376		193. 00
	19302 OCCUPATIONAL MEDICINE	24, 370		193. 01
	07950 OTHER NON REIMBURSABLE	0		194. 00
200.00	Cross Foot Adjustments	0		200. 00
201.00	Negative Cost Centers	0		201.00
202.00	TOTAL (sum lines 118 through 201)	2, 002, 760		202. 00
_02.00	1:37.12 (34 1:1.33 110 till 34gil 201)	2,302,700		1-02.00

	FINANCIAL SYSTEMS	RUSH WEWORIA		ON 15 1204 D		Wardington 1	
COST P	LLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2018	Worksheet B-1	
				To			
						5/24/2019 4:5	9 pm
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliation			
		FLXT	BENEFITS		& GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
		FEET)	(GROSS		COST)	FEET)	
			SALARI ES)				
		1.00	4. 00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT	85, 889				I	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	666	15, 227, 253	3		I	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	12, 665	2, 418, 778	-4, 845, 385	21, 268, 558	I	5. 00
7.00	00700 OPERATION OF PLANT	6, 703	346, 129	9 0	1, 475, 487	65, 855	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	659	(0	84, 275	659	8. 00
9.00	00900 HOUSEKEEPI NG	1, 444	387, 240	0	674, 961	1, 444	9. 00
10.00	01000 DI ETARY	2, 783	99, 244	4 0	233, 046	2, 783	10.00
11.00	01100 CAFETERI A	925	272, 006	6 0	277, 465	925	11. 00
13.00	01300 NURSING ADMINISTRATION	615	. (14, 341	615	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 977	63, 494	4	216, 159		1
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 308	346, 179	1	520, 221	1, 308	1
	INPATIENT ROUTINE SERVICE COST CENTERS	.,	2.127	-1		.,, .,,	1
30.00	03000 ADULTS & PEDIATRICS	6, 607	980, 845	5 0	1, 484, 034	6, 607	30.00
	ANCILLARY SERVICE COST CENTERS			-1	, , , , , , , ,		1
50.00	05000 OPERATI NG ROOM	5, 428	787, 790	0 0	830, 154	5, 428	50.00
51. 00	05100 RECOVERY ROOM	628	29, 384		53, 267	628	1
53. 00	05300 ANESTHESI OLOGY	0	27,00		0	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 293	1, 039, 472	1	1, 297, 603	5, 293	
54. 01	05401 ONCOLOGY	2, 085	301, 248	1	499, 864	2, 085	•
55. 00	05500 RADI OLOGY-THERAPEUTI C	2,083	301, 240		477, 804	2,083	1
60.00	06000 LABORATORY	1	417 040		ĭ		1
		2, 081	617, 960	1	1, 716, 751	2, 081	
65. 00	06500 RESPIRATORY THERAPY	131	88, 186		133, 625	131	•
66.00	06600 PHYSI CAL THERAPY	3, 737	303, 940		488, 854	3, 737	•
67.00	06700 OCCUPATI ONAL THERAPY	863	235, 309		321, 380		
68. 00	06800 SPEECH PATHOLOGY	181	50, 625		80, 478		1
69. 00	06900 ELECTROCARDI OLOGY	402	124, 927		169, 752	402	•
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	(0	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0	381, 188		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	(0	83, 396	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	356	551, 592	2 0	4, 570, 916	356	73. 00
	OUTPATIENT SERVICE COST CENTERS						1
90. 00	09000 CLI NI C	12, 965	3, 076, 743	1		12, 965	1
90. 01	09001 SURGI CAL ASSOCI ATES	1, 570	66, 212		132, 836		1
90. 02	09002 ORTHOPAEDI CS	1, 078	12, 848		60, 338		1
90. 03	09003 RHEUMATOLOGY	1, 439	520, 539		176, 180	1, 439	
90. 04	09004 ENDOCRI NOLOGY	360	174, 97 <i>6</i>		160, 652	360	
90. 05	09005 PEDI ATRI CS	1, 429	307, 185	5 0	194, 602	1, 429	90. 05
90.06	09006 WOMEN' S HEALTH	1, 075	261, 449	9 0	83, 578	1, 075	90. 06
90. 07	09007 PAIN MANAGEMENT	0	457, 749	9 0	125, 333	0	90. 07
91.00	09100 EMERGENCY	3, 858	849, 745	5 0	2, 342, 864	3, 858	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					I	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	3, 728	390, 829	9 0	630, 427	3, 728	95. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	, ,	85, 039	15, 162, 623	-4, 845, 385	21, 166, 572	65, 005	118. 00
	NONREI MBURSABLE COST CENTERS						
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	(0	0	0	192. 00
193.00	19300 NONPALD WORKERS	0	(0	0	0	193. 00
193. 01	19301 FOUNDATI ON	850	64, 630	0	101, 986	850	193. 01
193. 02	19302 OCCUPATIONAL MEDICINE	0	(0	0	0	193. 02
194.00	07950 OTHER NON REIMBURSABLE	0	(ol o	o	0	194. 00
200.00	Cross Foot Adjustments					I	200.00
201.00	Negative Cost Centers					I	201.00
202.00	Cost to be allocated (per Wkst. B,	2, 002, 760	4, 128, 021	1	4, 845, 385	1, 811, 631	202. 00
	Part I)					I	
203.00	Unit cost multiplier (Wkst. B, Part I)	23. 318003	0. 271094	4	0. 227819	27. 509392	203. 00
204.00			15, 530	1	297, 790		•
	Part II)					I	
205.00			0. 001020	o	0. 014001	2. 692461	205. 00
						I	1
206.00						I	206. 00
207.00	(per Wkst. B-2)					I	207.00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)					I	207. 00
		1		1	ı		I

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1304 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/24/2019 4:59 pm Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG LINEN SERVICE (MEALS (SQUARE (FTE'S) ADMI NI STRATI ON (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, 865 11.00 0 C 01300 NURSING ADMINISTRATION 0 0 223. 544 13 00 615 10 13 00 01400 CENTRAL SERVICES & SUPPLY 14.00 0 1.977 0 22 0 14.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1.308 114 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 18, 580 100 30 00 03000 ADULTS & PEDLATRICS 203 37, 171 30.00 6, 607 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1,865 5, 428 0 90 16, 894 50.00 05100 RECOVERY ROOM 0 51 00 628 8 1, 646 51 00 0 53.00 05300 ANESTHESI OLOGY 0 Λ 53.00 05400 RADI OLOGY-DI AGNOSTI C 1, 205 5, 293 0 125 25, 934 54.00 54.00 15, 447 54.01 05401 ONCOLOGY 2,085 0 74 54.01 0 05500 RADI OLOGY-THERAPEUTI C 0 55 00 0 0 0 55 00 0 60.00 06000 LABORATORY 0 2,081 134 27,820 60.00 06500 RESPIRATORY THERAPY 65.00 240 13 18 3, 844 65.00 66.00 06600 PHYSI CAL THERAPY 561 3.737 0 51 11, 328 66, 00 06700 OCCUPATIONAL THERAPY 0 28 67 00 258 863 6, 500 67.00 0 68.00 06800 SPEECH PATHOLOGY 11 181 12 1, 146 68.00 06900 ELECTROCARDI OLOGY 0 0 31 69.00 402 6, 415 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 0 70.00 C 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 C 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 356 76 15, 732 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 0 90 00 09000 CLI NI C 12, 965 0 396 0 90. 01 09001 SURGI CAL ASSOCI ATES 0 1,570 0 90.01 28 09002 ORTHOPAEDI CS 0 90.02 0 0 1, 078 6 0 90.02 0 09003 RHFUMATOLOGY 1, 439 90.03 49 90.03 0 09004 ENDOCRI NOLOGY 90.04 360 44 Λ 90.04 90.05 09005 PEDI ATRI CS 0 1, 429 0 30 0 90.05 09006 WOMEN'S HEALTH 0 1, 075 0 20 90.06 90.06 09007 PALN MANAGEMENT 0 90.07 90.07 30 Λ 91.00 09100 EMERGENCY 2,955 3, 858 0 200 41, 702 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 95.00 3, 728 58 11, 965 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 28, 495 62, 902 100 1, 857 223, 544 118. 00 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192, 00 0 0 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 0 8 193. 01 19301 FOUNDATION 0 0 193.01 850 0 193. 02 19302 OCCUPATIONAL MEDICINE 0 0 0 193, 02 194. 00 07950 OTHER NON REIMBURSABLE 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, 121,603 876, 989 404, 480 378, 848 45, 017 202. 00 Part I) Unit cost multiplier (Wkst. B, Part I) 4. 267521 13. 756259 4, 044. 800000 203. 135657 0. 201379 203. 00 203.00 16, 823 204. 00 204.00 Cost to be allocated (per Wkst. B, 18, 321 48, 690 78, 403 28, 928 Part II) Unit cost multiplier (Wkst. B, Part 784.030000 0. 075256 205. 00 205.00 0.642955 0.763741 15.510992 II) 206.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1304 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/24/2019 4:59 pm Cost Center Description CENTRAL MEDI CAL SERVICES & RECORDS & **SUPPLY** LI BRARY (COSTED (GROSS REQUIS.) REVENUE) 14.00 16.00 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 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 01400 CENTRAL SERVICES & SUPPLY 14.00 1, 401, 873 14.00 16.00 01600 MEDICAL RECORDS & LIBRARY 1,447 94, 400 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30 00 64, 936 40, 560 30 00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 363, 515 50.00 8, 920 05100 RECOVERY ROOM 1, 273 51 00 51 00 53.00 05300 ANESTHESI OLOGY 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 35, 069 10, 800 54.00 13, 192 54.01 05401 ONCOLOGY 54.01 05500 RADI OLOGY-THERAPEUTI C 55 00 55 00 0 60.00 06000 LABORATORY 542, 795 0 60.00 06500 RESPIRATORY THERAPY 3,832 65.00 200 65.00 66.00 06600 PHYSI CAL THERAPY 4, 235 0 66.00 06700 OCCUPATI ONAL THERAPY 67 00 67.00 921 0 68.00 06800 SPEECH PATHOLOGY 697 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 1,561 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 93.090 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 83, 396 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 20, 555 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 65.041 0 90.01 09001 SURGI CAL ASSOCI ATES 2, 415 0 90.01 09002 ORTHOPAEDI CS 0 90.02 594 90.02 09003 RHEUMATOLOGY 3,005 90.03 0 90.03 09004 ENDOCRI NOLOGY 90.04 28, 152 0 90.04 90.05 09005 PEDI ATRI CS 8,532 0 90.05 09006 WOMEN'S HEALTH 2,578 90.06 90.06 0 90.07 09007 PAIN MANAGEMENT 2, 822 90.07 Ω 91.00 09100 EMERGENCY 44,070 33, 920 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 95.00 14, 150 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 1, 401, 873 94, 400 118. 00 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192.00 0 193. 00 19300 NONPALD WORKERS 0 193. 00 0 193. 01 19301 FOUNDATION 193. 01 0 193. 02 19302 OCCUPATIONAL MEDICINE 0 0 193. 02 194. 00 07950 OTHER NON REIMBURSABLE 0 Ω 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, 351, 455 716, 232 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 250704 7.587203 203.00 204.00 Cost to be allocated (per Wkst. B, 56, 365 44, 484 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.040207 205. 00 0.471229 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304	Peri od: From 01/01/2018	Worksheet C Part I

12/31/2018 Date/Time Prepared: To 5/24/2019 4:59 pm Title XVIII Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 4. 00 5. 00 1.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 951, 278 0 30.00 2, 951, 278 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 364, 047 1, 364, 047 0 50.00 05100 RECOVERY ROOM 0 51.00 51.00 161, 270 161, 270 0 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 938, 132 1, 938, 132 0 0 0 0 0 0 0 0 0 0 0 54.00 05401 ONCOLOGY 721, 232 721, 232 54.01 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 Λ 60.00 06000 LABORATORY 2, 362, 636 2, 362, 636 0 60.00 65.00 06500 RESPIRATORY THERAPY 177, 405 177, 405 65.00 06600 PHYSI CAL THERAPY 770, 531 0 770, 531 66.00 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 438, 538 438, 538 0 67.00 68.00 06800 SPEECH PATHOLOGY 109, 172 109, 172 0 68.00 06900 ELECTROCARDI OLOGY 232, 994 232, 994 69.00 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70 00 O 0 491, 368 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 491, 368 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 123, 303 123, 303 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 5, 650, 712 5, 650, 712 0 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2, 660, 781 2, 660, 781 0 0 90.00 09001 SURGI CAL ASSOCI ATES 90. 01 234, 179 234, 179 0 0 0 0 0 0 0 90.01 119, 936 90 02 09002 ORTHOPAEDI CS 119, 936 90.02 0 90.03 09003 RHEUMATOLOGY 286, 405 286, 405 0 90.03 90.04 09004 ENDOCRI NOLOGY 228, 103 228, 103 0 90.04 90.05 09005 PEDI ATRI CS 306, 138 306, 138 0 90.05 90.06 09006 WOMEN'S HEALTH 151, 689 151, 689 90.06 0 90.07 09007 PAIN MANAGEMENT 160, 687 160, 687 0 90.07 09100 EMERGENCY 3, 365, 860 3, 365, 860 0 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,000,512 1,000,512 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 945, 626 945, 626 0 0 95.00 200.00 Subtotal (see instructions) 26, 952, 534 26, 952, 534 0 0 200. 00 201.00 Less Observation Beds 1,000,512 1, 000, 512 0 201. 00 25, 952, 022 0 0 202, 00 202.00 Total (see instructions) 25, 952, 022

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/24/2019 4:59 pm

					o 12/31/2018	Date/Time Prep 5/24/2019 4:59	pared: 9 pm
			Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Rati o	
		6.00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	3, 242, 241		3, 242, 241			30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	110, 553	2, 862, 495			0.000000	
51.00	05100 RECOVERY ROOM	17, 628	803, 674	821, 302		0.000000	
53.00	05300 ANESTHESI OLOGY	0	0		0.00000	0.000000	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	692, 314	20, 249, 561			0.000000	1
54. 01	05401 ONCOLOGY	0	546, 546	546, 546		0.000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0.00000	0.000000	
60.00	06000 LABORATORY	685, 139	9, 783, 802	10, 468, 941		0.000000	
65.00	06500 RESPI RATORY THERAPY	113, 111	197, 049	310, 160	0. 571979	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	176, 537	2, 120, 171	2, 296, 708	0. 335494	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	127, 989	1, 672, 630	1, 800, 619	0. 243548	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	57, 363	187, 519	244, 882	0. 445815	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	262, 020	2, 378, 707	2, 640, 727	0. 088231	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0.000000	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	150, 737	3, 688, 378	3, 839, 115	0. 127990	0.000000	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	572, 508	572, 508	0. 215373	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	886, 123	10, 682, 608	11, 568, 731	0. 488447	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	20, 080	822, 148	842, 228	3. 159217	0.000000	90. 00
90. 01	09001 SURGI CAL ASSOCI ATES	0	31, 295	31, 295	7. 482953	0.000000	90. 01
90. 02	09002 ORTHOPAEDI CS	0	20, 664	20, 664	5. 804104	0.000000	90. 02
90. 03	09003 RHEUMATOLOGY	0	129, 368	129, 368	2. 213878	0.000000	90. 03
90.04	09004 ENDOCRI NOLOGY	0	47, 599	47, 599	4. 792181	0.000000	90. 04
90.05	09005 PEDI ATRI CS	0	165, 727	165, 727	1. 847243	0.000000	90. 05
90.06	09006 WOMEN'S HEALTH	0	39, 387	39, 387	3. 851245	0.000000	90.06
90. 07	09007 PAIN MANAGEMENT	o	103, 807	103, 807	1. 547940	0.000000	90. 07
91.00	09100 EMERGENCY	10, 646	6, 058, 962	6, 069, 608	0. 554543	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 934	1, 055, 369	1, 060, 303	0. 943610	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0	863, 457	863, 457	1. 095163	0.000000	95. 00
200.00	Subtotal (see instructions)	6, 557, 415	65, 083, 431	71, 640, 846			200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	6, 557, 415	65, 083, 431	71, 640, 846	, l		202. 00
						'	

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304		Worksheet C Part I Date/Time Prepared: 5/24/2019 4:59 nm

	9 4:59 pm
Title XVIII Hospital C	ost
Cost Center Description PPS Inpatient	
Rati o	
11.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS	30.00
ANCI LLARY SERVI CE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 0. 000000	50. 00
51. 00 05100 RECOVERY ROOM 0. 000000	51. 00
53. 00 05300 ANESTHESI OLOGY	53.00
54. 00 05400 RADI 0L0GY-DI AGNOSTI C 0. 000000	54.00
54. 01 05401 0NC0L0GY 0. 000000	54. 01
55. 00 05500 RADI 0LOGY-THERAPEUTI C 0. 000000	55. 00
60. 00 06000 LABORATORY	60. 00
65. 00 06500 RESPI RATORY THERAPY 0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY 0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY 0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 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	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	
95. 00 09500 AMBULANCE SERVI CES 0. 000000	95. 00
200.00 Subtotal (see instructions)	200. 00
201.00 Less Observation Beds	201. 00
202.00 Total (see instructions)	202. 00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304	Period: Worksheet C From 01/01/2018 Part I

12/31/2018 Date/Time Prepared: To 5/24/2019 4:59 pm Hospi tal Title XIX Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 4. 00 1.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 0 30.00 03000 ADULTS & PEDIATRICS 2, 951, 278 2, 951, 278 2, 951, 278 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 364, 047 1, 364, 047 0 1, 364, 047 50.00 05100 RECOVERY ROOM 51.00 0 51.00 161, 270 161, 270 161, 270 0 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 938, 132 1, 938, 132 0 1, 938, 132 54.00 05401 ONCOLOGY 721, 232 721, 232 0 721, 232 54.01 54.01 55 00 05500 RADI OLOGY-THERAPEUTI C Ω 55 00 60.00 06000 LABORATORY 2, 362, 636 2, 362, 636 2, 362, 636 60.00 65.00 06500 RESPIRATORY THERAPY 177, 405 177, 405 0 0 0 177, 405 65.00 06600 PHYSI CAL THERAPY 770, 531 0 770, 531 770, 531 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 438, 538 C 438, 538 438, 538 67.00 68.00 06800 SPEECH PATHOLOGY 109, 172 109, 172 109, 172 68.00 06900 ELECTROCARDI OLOGY 232, 994 69.00 232, 994 0 232, 994 69.00 07000 ELECTROENCEPHALOGRAPHY 70 00 0 O 70 00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 491, 368 491, 368 491, 368 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 123, 303 123, 303 0 123, 303 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 5, 650, 712 5, 650, 712 0 5, 650, 712 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2, 660, 781 2, 660, 781 0 2, 660, 781 90.00 90. 01 09001 SURGI CAL ASSOCI ATES 234, 179 234, 179 0 234, 179 90.01 119, 936 90 02 09002 ORTHOPAEDI CS 119, 936 119 936 90 02 90.03 09003 RHEUMATOLOGY 286, 405 286, 405 286, 405 90.03 0 90.04 09004 ENDOCRI NOLOGY 228, 103 228, 103 228, 103 90.04 0 90.05 09005 PEDI ATRI CS 306, 138 306, 138 306, 138 90.05 90.06 09006 WOMEN'S HEALTH 151, 689 151, 689 90.06 151, 689 0 90.07 09007 PAIN MANAGEMENT 160, 687 160, 687 160, 687 90.07 09100 EMERGENCY 3, 365, 860 3, 365, 860 3, 365, 860 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,000,512 1,000,512 1,000,512 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 945, 626 945, 626 0 945, 626 95.00 200.00 26, 952, 534 26, 952, 534 0 26, 952, 534 200. 00 Subtotal (see instructions) 0 201.00 Less Observation Beds 1,000,512 1, 000, 512 1, 000, 512 201. 00 0 0 202.00 Total (see instructions) 25, 952, 022 25, 952, 022 25, 952, 022 202. 00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304		Worksheet C Part I Date/Time Prepared: 5/24/2019 4:59 nm

				Т	o 12/31/2018	Date/Time Pre 5/24/2019 4:5	
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
				<u> </u>		Rati o	
		6.00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				1		4
30.00	03000 ADULTS & PEDI ATRI CS	3, 242, 241		3, 242, 241			30.00
	ANCILLARY SERVICE COST CENTERS				1		
50. 00	05000 OPERATING ROOM	110, 553	2, 862, 495			0. 000000	
51. 00	05100 RECOVERY ROOM	17, 628	803, 674			0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	692, 314	20, 249, 561			0. 000000	
54. 01	05401 ONCOLOGY	0	546, 546	1		0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0			0. 000000	
60.00	06000 LABORATORY	685, 139	9, 783, 802			0. 000000	
65. 00	06500 RESPI RATORY THERAPY	113, 111	197, 049	·		0. 000000	
66. 00	06600 PHYSI CAL THERAPY	176, 537	2, 120, 171		1	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	127, 989	1, 672, 630			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	57, 363	187, 519	·		0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	262, 020	2, 378, 707			0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	150, 737	3, 688, 378			0. 000000	
	07200 I MPL. DEV. CHARGED TO PATIENT	0	572, 508	·		0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	886, 123	10, 682, 608	11, 568, 731	0. 488447	0. 000000	73. 00
	OUTPATIENT SERVICE COST CENTERS				1		
	09000 CLI NI C	20, 080	822, 148			0. 000000	
90. 01	09001 SURGI CAL ASSOCI ATES	0	31, 295			0. 000000	
90. 02	09002 ORTHOPAEDI CS	0	20, 664	·		0. 000000	
90. 03	09003 RHEUMATOLOGY	0	129, 368	·		0. 000000	
90. 04	09004 ENDOCRI NOLOGY	0	47, 599	·		0. 000000	
	09005 PEDI ATRI CS	0	165, 727			0. 000000	
	09006 WOMEN'S HEALTH	0	39, 387			0. 000000	
90. 07	09007 PAIN MANAGEMENT	0	103, 807	·		0. 000000	
91. 00	09100 EMERGENCY	10, 646	6, 058, 962			0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 934	1, 055, 369	1, 060, 303	0. 943610	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						1
		0	863, 457	·		0. 000000	
200.00	1 /	6, 557, 415	65, 083, 431	71, 640, 846)		200. 00
201.00	I I						201. 00
202.00	Total (see instructions)	6, 557, 415	65, 083, 431	71, 640, 846			202. 00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304		Worksheet C Part I Date/Time Prepared: 5/24/2019 4:59 pm

Title XIX Hospital Correct	t
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	
11.00	
INPATI ENT ROUTI NE SERVI CE COST CENTERS	
30. 00 03000 ADULTS & PEDIATRICS	
ANCI LLARY SERVI CE COST CENTERS 50. 00	
50. 00 05000 OPERATI NG ROOM 0. 000000 51. 00 05100 RECOVERY ROOM 0. 000000 53. 00 05300 ANESTHESI OLOGY 0. 000000 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 000000 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 60. 00 06000 LABORATORY 0. 000000 65. 00 06500 RESPI RATORY THERAPY 0. 000000 66. 00 06600 PHYSI CAL THERAPY 0. 000000 67. 00 06700 OCCUPATI ONAL THERAPY 0. 000000 68. 00 06800 SPEECH PATHOLOGY 0. 000000	30. 00
51. 00	
53. 00 05300 ANESTHESI OLOGY 0. 000000 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 000000 54. 01 05401 ONCOLOGY 0. 000000 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 60. 00 06000 LABORATORY 0. 000000 65. 00 06500 RESPI RATORY THERAPY 0. 000000 66. 00 06600 PHYSI CAL THERAPY 0. 000000 67. 00 06700 OCCUPATI ONAL THERAPY 0. 000000 68. 00 06800 SPEECH PATHOLOGY 0. 000000	50. 00
54. 00	51.00
54. 01	53.00
55. 00	54.00
60. 00 06000 LABORATORY 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	54. 01
60. 00 06000 LABORATORY 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	55. 00
65. 00	60.00
66. 00 06600 PHYSI CAL THERAPY 0. 000000 06700 0CCUPATI ONAL THERAPY 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000	65. 00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 00000000	66. 00
68. 00 06800 SPEECH PATHOLOGY 0. 0000000	67. 00
	68. 00
07. 00 00700 ELECTROCARDI 0E001 0. 000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0. 000000	71.00
72. 00 07200 MPL. DEV. CHARGED TO PATIENT 0. 000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	73.00
OUTPATIENT SERVICE COST CENTERS	/3.00
90. 00 09000 CLINIC 0. 000000	90, 00
90. 01 09001 SURGI CAL ASSOCI ATES	90.00
	90. 02
90. 03 09003 RHEUMATOLOGY	90. 03
90. 04 09004 ENDOCRI NOLOGY	90. 04
90. 05 09005 PEDI ATRI CS	90. 05
90. 06 09006 WOMEN' S HEALTH 0. 000000	90.06
90. 07 09007 PAI N MANAGEMENT	90. 07
91. 00 09100 EMERGENCY	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 0000000	92. 00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVICES 0. 000000	95. 00
200.00 Subtotal (see instructions)	200. 00
201.00 Less Observation Beds	201. 00
202.00 Total (see instructions)	201.00

Health Financial Systems	RUSH MEMORIAL H	OSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY S	SERVICE CAPITAL COSTS	Provider CCN: 15-1304	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Prepared: 5/24/2019 4:59 pm
•		Ti +L \ YVIII	Hospi tal	Cost

	TOWNENT OF TWEATTENT ANOTELANT SERVICE CALLE	AE 00313	11 ovi dei C		From 01/01/2018 To 12/31/2018	Date/Time Pre 5/24/2019 4:5	
				XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	ANGLILARY CERVICE COCT CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS	17/ 2/0	2 072 040	0.05027	0 57.770	2.2/5	FO 00
50.00	05000 OPERATI NG ROOM	176, 240		•			1
51.00	05100 RECOVERY ROOM	22, 093				l	
53.00	05300 ANESTHESI OLOGY	0		1 0.0000			
54.00	05400 RADI OLOGY - DI AGNOSTI C	172, 108		l l		3, 591	
54. 01	05401 ONCOLOGY	65, 970	546, 546			0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	10 4/0 044	0.00000		1 400	55. 00
60.00	06000 LABORATORY	106, 380					1
65. 00	06500 RESPIRATORY THERAPY	6, 439					
66.00	06600 PHYSI CAL THERAPY	109, 383					1
67. 00	06700 OCCUPATI ONAL THERAPY	28, 972					1
68. 00	06800 SPEECH PATHOLOGY	6, 332				l .	68. 00
69. 00	06900 ELECTROCARDI OLOGY	14, 294				1, 003	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	1	1 0.0000		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 080		III		l	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	4, 521		•			
73. 00	07300 DRUGS CHARGED TO PATIENTS	77, 288	11, 568, 731	0. 00668	1 502, 044	3, 354	73. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	382, 161	842, 228			l	
90. 01	09001 SURGI CAL ASSOCI ATES	44, 494					70.0.
90. 02	09002 ORTHOPAEDI CS	29, 837		•		0	
90. 03	09003 RHEUMATOLOGY	42, 407		1		0	
90. 04	09004 ENDOCRI NOLOGY	13, 879		•		0	90. 04
90. 05	09005 PEDI ATRI CS	42, 106				0	90. 05
90. 06	09006 WOMEN'S HEALTH	30, 633		1		0	90.06
90. 07	09007 PAIN MANAGEMENT	2, 800				0	1 , 0 . 0 ,
91. 00	09100 EMERGENCY	162, 863					
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	107, 363	1, 060, 303	0. 10125	7 0	0	92. 00
0= 6-	OTHER REIMBURSABLE COST CENTERS		ı				
	09500 AMBULANCE SERVICES	4 (57 (10	/7 505 110		4 054 070	05.01.	95. 00
200.00	Total (lines 50 through 199)	1, 657, 643	67, 535, 148	5	1, 954, 860	25, 014	J200. 00

Health Financial Systems	RUSH MEMORIAL I	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1304	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared:

					0 12/31/2018	5/24/2019 4:5	pared: 9 pm
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	(0	0	50. 00
	05100 RECOVERY ROOM	0	0	(0	0	51. 00
	05300 ANESTHESI OLOGY	0	0	(0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54. 00
	05401 ONCOLOGY	0	0	(0	0	54. 01
	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	55. 00
	06000 LABORATORY	0	0	(0	0	60.00
	06500 RESPI RATORY THERAPY	0	0	(0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	(0	0	90. 00
	09001 SURGI CAL ASSOCI ATES	0	0	(0	0	90. 01
	09002 ORTHOPAEDI CS	0	0	(0	0	90. 02
	09003 RHEUMATOLOGY	0	0	(0	0	90. 03
	09004 ENDOCRI NOLOGY	0	0	(0	0	90. 04
	09005 PEDI ATRI CS	0	0	(0	0	90. 05
	09006 WOMEN'S HEALTH	0	0	(0	0	90. 06
	09007 PAIN MANAGEMENT	0	0	(0	0	90. 07
	09100 EMERGENCY	0	0	(0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		()	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1304	Period: Worksheet D
THROUGH COSTS		From 01/01/2018 Part IV

inkoodi	1 (0313				To 12/31/2018	Date/Time Pre 5/24/2019 4:5	
			Title	xVIII	Hospi tal	Cost	<i>y</i> p
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	F	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)	·		
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	(2, 973, 048	0. 000000	
	05100 RECOVERY ROOM	0	0	(821, 302	0. 000000	
	05300 ANESTHESI OLOGY	0	0	(0	0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	0	0	(20, 941, 875	0. 000000	
	05401 ONCOLOGY	0	0	(546, 546	0. 000000	
	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0. 000000	
	06000 LABORATORY	0	0	(10, 468, 941	0. 000000	
	06500 RESPI RATORY THERAPY	0	0	(310, 160	0. 000000	
	06600 PHYSI CAL THERAPY	0	0	(2, 296, 708	0. 000000	
	06700 OCCUPATI ONAL THERAPY	0	0	(1, 800, 619		
	06800 SPEECH PATHOLOGY	0	0	(244, 882		
69. 00	06900 ELECTROCARDI OLOGY	0	0	(2, 640, 727	0. 000000	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0. 000000	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0) c	3, 839, 115	0.000000	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0) c	572, 508	0.000000	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	(11, 568, 731	0. 000000	73. 00
	OUTPAȚI ENT SERVI CE COST CENTERS						
	09000 CLI NI C	0	0	(0. 000000	
	09001 SURGI CAL ASSOCI ATES	0	0	(31, 295	0. 000000	
	09002 ORTHOPAEDI CS	0	0	(20, 664	0. 000000	
	09003 RHEUMATOLOGY	0	0	(129, 368	0. 000000	
	09004 ENDOCRI NOLOGY	0	0	(47, 599	0. 000000	90. 04
90. 05	09005 PEDI ATRI CS	0	0	(165, 727	0.000000	90. 05
90. 06	09006 WOMEN'S HEALTH	0	0	(39, 387	0.000000	90. 06
90. 07	09007 PAIN MANAGEMENT	0	0	(103, 807	0.000000	90. 07
91. 00	09100 EMERGENCY	0	0) c	6, 069, 608	0. 000000	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(1, 060, 303	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0	(67, 535, 148		200. 00

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCI THROUGH COSTS	ILLARY SERVICE OTHER PASS	Provi der C	CN: 15-1304	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Pre 5/24/2019 4:5	pared: 9 pm
		Ti tl e	e 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. x col. 10)	8	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						

	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	505t 5011tol 55551 pt on	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.	g	Costs (col. 8	5	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11.00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS	'					
50.00	05000 OPERATING ROOM	0. 000000	56, 770	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	11, 164	0	0	0	51.00
53.00	05300 ANESTHESI OLOGY	0.000000	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0.000000	436, 951	0	0	0	54. 00
54. 01	05401 ONCOLOGY	0.000000	0	0	0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	0	0	0	55. 00
60.00	06000 LABORATORY	0.000000	442, 777	0	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0.000000	78, 057	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	107, 764	0	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0.000000	74, 689	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0.000000	31, 095	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	185, 381	0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	0	ol	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	27, 996	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	502, 044	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	172	0	0	0	90. 00
90. 01	09001 SURGI CAL ASSOCI ATES	0. 000000	0	0	0	0	90. 01
90. 02	09002 ORTHOPAEDI CS	0. 000000	0	0	0	0	90. 02
90. 03	09003 RHEUMATOLOGY	0. 000000	0	0	0	0	90. 03
	09004 ENDOCRI NOLOGY	0. 000000	0	0	0	0	90. 04
90. 05	09005 PEDI ATRI CS	0. 000000	0	0	0	0	90. 05
	09006 WOMEN'S HEALTH	0. 000000	0	0	0	0	90. 06
	09007 PAIN MANAGEMENT	0. 000000	0	0	0	0	90. 07
	09100 EMERGENCY	0. 000000	0	0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	0	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)		1, 954, 860	0	0	0	200. 00

Heal th	Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od:	Worksheet D	
					From 01/01/2018	Part V	
					To 12/31/2018	Date/Time Pre 5/24/2019 4:5	pared:
			Ti tl e	e XVIII	Hospi tal	Cost	у рін
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	'		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	`	
		Part I, col. 9	,	Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 458804	0	1, 686, 62	2 0	0	50.00
51.00	05100 RECOVERY ROOM	0. 196359	0	260, 389	9 0	0	51.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0)	lo lo	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 092548	0	6, 458, 63	5 0	0	54.00
54. 01	05401 ONCOLOGY	1. 319618	Ö	370, 95	1 0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	. (ol ol	0	55. 00
60.00	06000 LABORATORY	0. 225681	0	3, 464, 69	4 0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0. 571979	0	77, 16		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 335494	Ö	827, 64		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 243548	Ô	585, 69		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 445815	Ô	32, 95		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 088231	Ö	967, 53		0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000	Ö	1		0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 127990	Ö	86, 88		0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0. 215373	Ö	1		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 488447	Ö			0	73. 00
73.00	OUTPATIENT SERVICE COST CENTERS	0. 400447		0, 204, 41.	5 47,250		73.00
90.00	09000 CLINI C	3. 159217	0	246, 70	5 16, 814	0	90.00
	09001 SURGI CAL ASSOCI ATES	7. 482953	Ö	1		0	90. 01
	09002 ORTHOPAEDI CS	5. 804104	Ô	10, 89		0	90. 02
90. 03	09003 RHEUMATOLOGY	2. 213878	Ö	1		0	90. 03
	09004 ENDOCRI NOLOGY	4. 792181	Ö	26, 63		0	90. 04
90. 05	09005 PEDI ATRI CS	1. 847243	Ô	10:		0	90. 05
	09006 WOMEN'S HEALTH	3. 851245	Ö	4, 25		0	90.06
90. 07	09007 PAIN MANAGEMENT	1. 547940	Ö	23, 80		0	90. 07
	09100 EMERGENCY	0. 554543	Ö	1		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 943610	0	1		0	
	OTHER REIMBURSABLE COST CENTERS	0. 743010		337, 23.	<u> </u>		72.00
	09500 AMBULANCE SERVI CES	1. 095163					95. 00
200.00	l	1. 373100	Ō		-	Λ	200. 00
201.00				23,377,12	0 01, 0, 2	· ·	201.00
201.00	Only Charges			1	<u> </u>		201.00
202.00			O	23, 597, 42	1 64, 072	0	202. 00
50	, , , , , , , , , , , , , , , , , , , ,	ı				Ü	

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

From 01/01/2018 Part V
To 12/31/2018 Part V
Date/Time Prepared: 5/24/2019 4:59 pm Titl<u>e XVIII</u> Hospi tal Cost Costs Cost Center Description Cost Cost Reimbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 773, 829 50.00 51.00 05100 RECOVERY ROOM 51, 130 0 51.00 53.00 05300 ANESTHESI OLOGY 0 53 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 597, 734 54.00 54.01 05401 ONCOLOGY 489, 514 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 06000 LABORATORY 781, 916 0 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 44, 137 65.00 06600 PHYSI CAL THERAPY 0 66.00 277, 669 66.00 06700 OCCUPATIONAL THERAPY 142, 645 67 00 67 00 68.00 06800 SPEECH PATHOLOGY 14,691 0 68.00 69.00 06900 ELECTROCARDI OLOGY 85, 366 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 11, 120 71.00 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 43, 781 0 72.00 07300 DRUGS CHARGED TO PATIENTS 3, 069, 604 23, 083 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 779, 395 53, 119 90.00 90.01 09001 SURGI CAL ASSOCI ATES 116,001 90.01 90.02 09002 ORTHOPAEDI CS 63, 207 90.02 0 09003 RHEUMATOLOGY 90.03 131, 522 0 90.03 09004 FNDOCRI NOLOGY 0 90.04 127, 654 90.04 90.05 09005 PEDI ATRI CS 190 0 90.05 09006 WOMEN'S HEALTH 90.06 16, 383 0 90.06 09007 PAIN MANAGEMENT 36, 841 0 90.07 90.07 91.00 09100 EMERGENCY 745, 311 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 527, 717 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 200.00 Subtotal (see instructions) 8, 927, 357 76, 202 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

8, 927, 357

76, 202

202. 00

202.00

Net Charges (line 200 - line 201)

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

Component CCN: 15-Z304 5/24/2019 4:59 pm Title XVIII Swing Beds - SNF 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.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 458804 0 50.00 51.00 05100 RECOVERY ROOM 0. 196359 0 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 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.092548 0 0 54.00 54.01 05401 ONCOLOGY 1. 319618 0 54.01 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55.00 0 0 06000 LABORATORY 0 60.00 0. 225681 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.571979 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 0. 335494 0 66.00 06700 OCCUPATIONAL THERAPY 0 243548 0 67 00 67 00 0 68.00 06800 SPEECH PATHOLOGY 0.445815 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.088231 0 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0.127990 Ω 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 0. 215373 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 488447 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 3. 159217 0 0 90.00 0 0 0 0 0 0 0 0 90.01 09001 SURGI CAL ASSOCI ATES 7. 482953 0 90.01 09002 ORTHOPAEDI CS 5. 804104 0 90.02 90.02 0 09003 RHEUMATOLOGY 90.03 90.03 2. 213878 0 0 0 09004 ENDOCRI NOLOGY 90.04 90.04 4. 792181 0 90.05 09005 PEDI ATRI CS 1.847243 0 0 0 90.05 09006 WOMEN'S HEALTH 0 90.06 3.851245 90.06 0 09007 PAIN MANAGEMENT 0 90.07 90.07 1.547940 0 0 91.00 09100 EMERGENCY 0. 554543 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.943610 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1. 095163 0 0 95.00 200.00 Subtotal (see instructions) 0 0 0 200. 00 Less PBP Clinic Lab. Services-Program 0 0 201.00 201.00

0

0 202.00

Only Charges

Net Charges (line 200 - line 201)

Health Financial Systems	RUSH MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1304 Component CCN: 15-Z304	From 01/01/2018	
		T: +1 a V/// / /	Cui na Dada CNE	Coot

		Component (CCN: 15-Z304	То	12/31/	2018	Date/Time Pre 5/24/2019 4:5	
		Title	XVIII	Swi no	Beds -	- SNF	Cost	-
	Cost	ts			,			
Cost Center Description	Cost	Cost						
·	Rei mbursed	Rei mbursed						
	Servi ces	Services Not						
	Subject To	Subject To						
	Ded. & Coins. [Ded. & Coins.						
	(see inst.)	(see inst.)						
	6.00	7. 00						
ANCILLARY SERVICE COST CENTERS								
50. 00 05000 OPERATING ROOM	0	0						50. 00
51. 00 05100 RECOVERY ROOM	0	0						51.00
53. 00 05300 ANESTHESI OLOGY	0	0						53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0						54.00
54. 01 05401 0NCOLOGY	0	0						54. 01
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	O	0						66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	O	0						67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0						68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	0						69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	0						70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0						71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	0						72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0						73. 00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>		·					1
90. 00 09000 CLI NI C	0	0						90.00
90. 01 09001 SURGI CAL ASSOCI ATES	0	0						90. 01
90. 02 09002 ORTHOPAEDI CS	O	0						90. 02
90. 03 09003 RHEUMATOLOGY	o	0						90. 03
90. 04 09004 ENDOCRI NOLOGY	0	0						90. 04
90. 05 09005 PEDI ATRI CS	0	0						90. 05
90. 06 09006 WOMEN'S HEALTH	0	0						90.06
90. 07 09007 PAI N MANAGEMENT	O	0						90. 07
91. 00 09100 EMERGENCY	O	0						91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	O	0						92.00
OTHER REIMBURSABLE COST CENTERS								1
95. 00 09500 AMBULANCE SERVI CES	0							95. 00
200.00 Subtotal (see instructions)	O	0						200. 00
201.00 Less PBP Clinic Lab. Services-Program	o							201. 00
Only Charges								
202.00 Net Charges (line 200 - line 201)	0	0						202. 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	Period: From 01/01/2018	Worksheet D-1
		To 12/31/2018	Date/Time Prepared: 5/24/2019 4:59 pm
	Title XVIII	Hospi tal	Cost

		Title XVIII	Hospi tal	5/24/2019 4:5 Cost	9 pm
	Cost Center Description	THE AVITE	nospi tui	'	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			2, 024	
2.00	Inpatient days (including private room days, excluding swing-			1, 949	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		1, 268	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	58	5. 00
	reporting period	om daya) after December	01 of the cost	0	/ 00
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) arter becember :	31 OF the Cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	17	7. 00
0.00	reporting period		1 -6 +1+	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after becember 3	or the cost	0	8. 00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	870	9. 00
40.00	newborn days)				40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instructions)		oom days)	58	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er			_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	Conly (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
10.00	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
10.00	reporting period	23 ditter becember 31 di	the cost		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	155. 02	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	155. 02	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions			2, 951, 278	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	131 of the cost reportion	ng period (line	2, 635	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
07.00	x line 20)			07.047	0, 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		87, 847 2, 863, 431	•
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Trine 21 mirrius Trine 20)		2,003,431	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	1
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11116 20)		0.00	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34. 00	Average per diem private room charge differential (line 32 min		tions)	0.00	1
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	le 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	2, 863, 431	37. 00
	27 minus line 36)	·	•		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 469. 18	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		1, 278, 187	39. 00
40.00	Medically necessary private room cost applicable to the Progra	,		1 270 107	
41.00	Total Program general inpatient routine service cost (line 39)	+ IINE 40)		1, 278, 187	41.00

Heal th	Financial Systems	RUSH MEMORIAI	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CN: 15-1304	Peri od: From 01/01/2018	Worksheet D-1	
					To 12/31/2018	Date/Time Pre	pared:
			Ti tl e	e XVIII	Hospi tal	5/24/2019 4:5 Cost	9 pm
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	inpatient bays	col. 2)	÷	(col. 3 x col. 4)	
42.00	MUDCEDY (+: +1 a V & VI V and v)	1.00	2. 00	3.00	4. 00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
43.00	INTENSIVE CARE UNIT						43.00
44. 00 45. 00							44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1.00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		547, 161 1, 825, 348	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sur	n of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52. 00
53. 00	Total Program inpatient operating cost exclu	ding capital re	lated, non-phy	sician anesth	netist, and	0	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting poriod	onding 1006 u	indated and co	ampounded by the	0	58. 00 59. 00
34.00	market basket	portring perrou	ending 1990, c	ipuateu anu co	inpounded by the		
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0. 00 0	60. 00 61. 00
01.00	which operating costs (line 53) are less that					0	01.00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	85, 212	64 00
	instructions)(title XVIII only)	· ·		•			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the d	cost reportino	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only). For	85, 212	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after N	ecember 31 of	the cost ren	orting period	n	68. 00
	(line 13 x line 20)			•	or tring period		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service d	cost (line 37))		70. 00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic	able to Program					73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•	,		Part II column		74. 00 75. 00
73.00	26, line 45)		COSTS (TION V	orksneet b, i	art II, cordiiii		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu						78. 00
79. 00	Aggregate charges to beneficiaries for exces			*.	ous line 70)		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost iimitatiOl	. (11116 10 IIIII	ius IIIIc /9)		80. 00 81. 00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 81	•				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		S)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		rough 85)				86. 00
87. 00	Total observation bed days (see instructions)				681	1
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	line 2)			1, 469. 18 1, 000, 512	
07.00	1222 220 000 000 (11110 07 X 11110 00) (30					.,000,012	, 57. 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 01/01/2018 To 12/31/2018		
		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	316, 695	2, 951, 278	0. 10730	1, 000, 512	107, 363	90.00
91.00 Nursing School cost	0	2, 951, 278	0.00000	1, 000, 512	0	91.00
92.00 Allied health cost	0	2, 951, 278	0.00000	1, 000, 512	0	92.00
93.00 All other Medical Education	0	2, 951, 278	0. 000000	1, 000, 512	0	93. 00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	eu of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1304	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Prepared: 5/24/2019 4:59 pm
	Title XIX	Hospi tal	Cost
		,	

		Title XIX	Hospi tal	5/24/2019 4:5 Cost	9 pm
	Cost Center Description	TI LIE XIX	nospi tai	Cost	
	DART A ALL DROWNERS COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		2, 024	1. 00
2.00	Inpatient days (including private room days, excluding swing-			1, 949	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
4 00	do not complete this line.	ad daya)		1 2/0	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room		21 of the cost	1, 268 58	4. 00 5. 00
3.00	reporting period	om days) trii ough becember	31 of the cost	30	3.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December :	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	17	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	arter becember 3	i or the cost		0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	114	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		nom davs) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		Join days) arter	· ·	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year)			0	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)	am (exertaining eming zea)	adjo)	0	15. 00
16.00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
10.00	reporting period	as arter becomber or or	the cost		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20.00	reporting period	 D 21 - 		0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of th	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		2, 951, 278	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportion	na period (line	0	24. 00
2 00	7 x line 19)	or or the edet report.	.g po ou (· ·	2 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
27 00	x line 20)			05 200	27.00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		85, 288 2, 865, 990	
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(TITIC 21 IIITIGS TITIC 20)		2,000,770	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27	: Tine 28)		0. 000000 0. 00	
33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mi)	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin		11 0113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	/		0.00	36. 00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	2, 865, 990	
	27 minus line 36)	·	•		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 470 40	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 470. 49 167, 636	
40. 00	Medically necessary private room cost applicable to the Program	-		167, 636	40.00
	Total Program general inpatient routine service cost (line 39	,		167, 636	
			!		

Heal th	Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TATION OF INPATIENT OPERATING COST			CN: 15-1304	Peri od:	Worksheet D-1	
					From 01/01/2018 To 12/31/2018	Date/Time Pre	
			Ti +I	e XIX	Hospi tal	5/24/2019 4:5 Cost	9 pm
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col.	
		1.00	2. 00	3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	1						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description	•		•			
48. 00	Program inpatient ancillary service cost (Wk	st D2 col 2	Lino 200)			1. 00 156, 299	48. 00
	Total Program inpatient costs (sum of lines			ons)		323, 935	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sur	n of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52. 00
53. 00	Total Program inpatient operating cost exclu	,	lated, non-phy	ysician anesth	netist, and	ő	
	medical education costs (line 49 minus line	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge					0.00	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing coot and to	wast smallet (1	ino E/ minuo	line E2)	0	
58. 00	Bonus payment (see instructions)	ing cost and ta	irget allibuitt (i	THE 50 IIITHUS	111le 55)	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, u	updated and co	ompounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	ndated by the m	narket hasket		0.00	60. 00
61.00					the amount by	0.00	61.00
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	f the target		
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)							63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31 of the	cost renorti	na period (See	0	64. 00
	instructions)(title XVIII only)	Ü		·			
65. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts after Decemb	er 31 of the d	cost reportino	g period (See	0	65. 00
66. 00		ne costs (line	64 plus line 6	55)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	a costs through	Necember 31 c	of the cost re	enorting period	0	67. 00
07.00	(line 12 x line 19)	e costs till ough	i becember 31 c	of the cost re	eporting perrod		07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	e 68)		0	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY			70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	-)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	71)		ŕ			72. 00
73.00	Medically necessary private room cost applic						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•	,		Part II, column		74. 00 75. 00
7/ 00	26, line 45)	2)	•				7, 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu						78. 00
79. 00	Aggregate charges to beneficiaries for exces			· ·	aug ling 70)		79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost iimi tati or	i (iine /8 Mit	ius IIIIe /9)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (ine 9 x line 81	* .				82. 00
83.00	Reasonable inpatient routine service costs (ıs)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					681	87. 00
88. 00	3 .	•	line 2)			1, 470. 49	1
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				1, 001, 404	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 01/01/2018 To 12/31/2018		
		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	316, 695	2, 951, 278	0. 10730	8 1, 001, 404	107, 459	90.00
91.00 Nursing School cost	0	2, 951, 278	0.00000	0 1, 001, 404	0	91.00
92.00 Allied health cost	0	2, 951, 278	0.00000	0 1, 001, 404	0	92.00
93.00 All other Medical Education	0	2, 951, 278	0. 00000	1, 001, 404	0	93. 00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1304	Peri od:	worksheet D-3	
FAITENT ANCIELART SERVICE COST AFFORTIONWENT	Frovider C	CN. 13-1304	From 01/01/2018	WOLKSHEET D-3	'
			To 12/31/2018	Date/Time Pre 5/24/2019 4:5	
	Title	e XVIII	Hospi tal	Cost	9 рііі
Cost Center Description	<u> </u>	Ratio of Cos	st Inpatient	Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
. 00 03000 ADULTS & PEDI ATRI CS			1, 330, 803		30.
ANCI LLARY SERVI CE COST CENTERS			1,000,000		00.
. 00 05000 OPERATING ROOM		0. 4588	04 56, 770	26, 046	50.
.00 05100 RECOVERY ROOM		0. 1963		2, 192	51.
. 00 05300 ANESTHESI OLOGY		0.0000	00 0	0	53.
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0925		40, 439	
. 01 05401 ONCOLOGY		1. 3196		1	
. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000		0	
. 00 06000 LABORATORY		0. 2256		1	1
. 00 06500 RESPI RATORY THERAPY		0. 5719		44, 647	
. 00 06600 PHYSI CAL THERAPY		0. 3354		36, 154	
. 00 06700 OCCUPATI ONAL THERAPY . 00 06800 SPEECH PATHOLOGY		0. 2435 0. 4458			1
. 00 06800 SPEECH PATHOLOGY . 00 06900 ELECTROCARDI OLOGY		0. 4458			
. 00 07000 ELECTROCARDI OLOGI . 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		10, 330	1
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1279			
. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 2153		0,000	1
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 4884		245, 222	1
OUTPATIENT SERVICE COST CENTERS					
. 00 09000 CLI NI C		3. 1592	17 172	543	90.
. 01 09001 SURGI CAL ASSOCI ATES		7. 4829	53 0	0	90.
. 02 09002 ORTHOPAEDI CS		5. 8041		0	
03 09003 RHEUMATOLOGY		2. 2138			
. 04 09004 ENDOCRI NOLOGY		4. 7921			
. 05 09005 PEDI ATRI CS		1.8472		1	
06 09006 WOMEN'S HEALTH		3. 8512			
. 07 09007 PAI N MANAGEMENT		1. 5479			
. 00 09100 EMERGENCY		0. 5545			
. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0. 9436	10 0	1 0	92.
. 00 O9500 AMBULANCE SERVICES					95.
0.00 Total (sum of lines 50 through 94 and 96 through 98	1)		1, 954, 860	547, 161	
1.00 Less PBP Clinic Laboratory Services-Program only ch			1, 754, 800	347, 101	200.
2.00 Net charges (line 200 minus line 201)	iai gos (i i iic 01)		1, 954, 860		202.

		USH MEMORIAL HOSPITAL			eu of Form CMS-	
INPATIE	NT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
		Component (CCN: 15-Z304	From 01/01/2018 To 12/31/2018	Date/Time Pre	
		T: +1 -	VV/I I I	Cuit and David	5/24/2019 4: 5	9 pm
	Cost Center Description	IIITIE	XVIII Ratio of Cos	Swing Beds - SNF t Inpatient	Cost Inpatient	
	cost center bescription		To Charges	Program	Program Costs	
			10 onar ges	Charges	(col. 1 x col.	
				Charges	2)	
			1.00	2. 00	3.00	
I	NPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			0		30.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 45880	04 0	0	50.00
51.00	05100 RECOVERY ROOM		0. 19635	69 0	0	51.00
53.00	D5300 ANESTHESI OLOGY		0. 00000	0 0	0	53. 00
54.00	D5400 RADI OLOGY-DI AGNOSTI C		0. 09254	8 7, 880	729	54. 00
54. 01	05401 ONCOLOGY		1. 31961	8 0	0	54. 01
	D5500 RADI OLOGY-THERAPEUTI C		0. 00000		0	55. 00
	D6000 LABORATORY		0. 22568			
	06500 RESPIRATORY THERAPY		0. 57197	79 5, 460	3, 123	65. 00
	06600 PHYSI CAL THERAPY		0. 33549			
	06700 OCCUPATI ONAL THERAPY		0. 24354		3, 161	
	D6800 SPEECH PATHOLOGY		0. 44581			
	06900 ELECTROCARDI OLOGY		0. 08823		95	69. 00
	07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 12799		161	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT		0. 21537			
	07300 DRUGS CHARGED TO PATIENTS		0. 48844	7 28, 955	14, 143	73. 00
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C		3. 15921			
	09001 SURGI CAL ASSOCI ATES		7. 48295		· -	70.0.
	09002 ORTHOPAEDI CS		5. 80410		1	90. 02
	09003 RHEUMATOLOGY		2. 21387		· -	90. 03
	09004 ENDOCRI NOLOGY		4. 79218			90. 04
	09005 PEDI ATRI CS		1. 84724		0	90. 05
	09006 WOMEN'S HEALTH		3. 85124		0	
	09007 PAIN MANAGEMENT		1. 54794		0	90. 07
	09100 EMERGENCY		0. 55454		-	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 94361	0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				I	05 00
200 00	O9500 AMBULANCE SERVICES Total (sum of lines 50 through 94 and 96 th	arough 00)		84 136	20 402	95.00

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

29, 603 200. 00 201. 00 202. 00

84, 136

84, 136

200. 00 201. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der 0		Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Pre 5/24/2019 4:5	pared:
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			184, 588		30.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 45880	4 44, 593	20, 459	50.00
51. 00 05100 RECOVERY ROOM		0. 19635		1, 269	
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 09254		4, 042	54.00
54. 01 05401 0NCOLOGY		1. 31961		0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000		0	
60. 00 06000 LABORATORY		0. 22568		13, 887	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 57197		4, 096	
66. 00 06600 PHYSI CAL THERAPY		0. 33549			1
67. 00 06700 OCCUPATI ONAL THERAPY		0. 24354		1, 517	
68. 00 06800 SPEECH PATHOLOGY		0. 44581		1, 532	
69. 00 06900 ELECTROCARDI OLOGY		0. 08823		305	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 12799		3, 702	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 21537		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 48844	7 108, 581	53, 036	73.00
OUTPATIENT SERVICE COST CENTERS		1 0 15001	=	17.011	
90. 00 09000 CLINIC		3. 15921		47, 214	
90. 01 09001 SURGI CAL ASSOCI ATES		7. 48295		0	1 ,0,0,
90. 02 09002 0RTHOPAEDI CS		5. 80410		0	
90. 03 09003 RHEUMATOLOGY		2. 21387		0	
90. 04 09004 ENDOCRI NOLOGY		4. 79218		0	90.04
90. 05 09005 PEDI ATRI CS		1.84724		0	1 /0.00
90. 06 09006 WOMEN' S HEALTH		3. 85124		0	1 ,0.00
90. 07 09007 PAI N MANAGEMENT		1. 54794		0	90.07
91. 00 09100 EMERGENCY		0. 55454		642	
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 94361	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS					05 00
95.00 09500 AMBULANCE SERVICES 200.00 Total (sum of lines 50 through 94 and 96 through 98)			3/13 857	156 200	95.00
ZOO DOL - LIGIAL (SUM OF LINES SO ENFOUGN 94 AND 96 ENFOLIAN 98)		1	1 44 85 /		

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

202. 00

156, 299 200. 00 201. 00

343, 857

343, 857

200. 00 201. 00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1304		Worksheet E Part B Date/Time Prepared: 5/24/2019 4:59 pm

PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS payments 4.00 Outlier payment (see instructions) 4.01 Outlier reconciliation amount (see instructions)	5/24/2019 4:5 Cost	
1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS payments 4.00 Outlier payment (see instructions)		
1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS payments 4.00 Outlier payment (see instructions)		
1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS payments 4.00 Outlier payment (see instructions)	0.003 FE0	
2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS payments 4.00 Outlier payment (see instructions)	0 002 550	
3.00 OPPS payments 4.00 Outlier payment (see instructions)	9, 003, 559	1.00
4.00 Outlier payment (see instructions)	0	2.00
	0	
4.01 Outlier reconciliation amount (see instructions)	0	4. 00
	0	4. 01
5.00 Enter the hospital specific payment to cost ratio (see instructions)	0.000	5. 00
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)	0	
9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	
10.00 Organ acqui si ti ons	0 000 550	10.00
11.00 Total cost (sum of lines 1 and 10) (see instructions)	9, 003, 559	11. 00
COMPUTATION OF LESSER OF COST OR CHARGES		
Reasonable charges 12.00 Ancillary service charges	0	12.00
13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	1
14.00 Total reasonable charges (sum of lines 12 and 13)	0	ı
Customary charges	1 0	14.00
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15. 00
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16.00
had such payment been made in accordance with 42 CFR §413.13(e)		10.00
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17. 00
18.00 Total customary charges (see instructions)	0	18. 00
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	1
instructions)		İ
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
instructions)		İ
21.00 Lesser of cost or charges (see instructions)	9, 093, 595	21.00
22.00 Interns and residents (see instructions)	0	22. 00
23.00 Cost of physicians' services in a teaching hospital (see instructions)	0	23. 00
24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00 Deductibles and coinsurance amounts (for CAH, see instructions)	70, 196	ı
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3, 984, 487	
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	5, 038, 912	27. 00
instructions) 29 00 Direct graduate medical education nauments (from Wkst. E. 4. Line E0)	0	20 00
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36)	0	28. 00 29. 00
30.00 Subtotal (sum of lines 27 through 29)	5, 038, 912	ı
31.00 Primary payer payments	5, 022	•
32.00 Subtotal (line 30 minus line 31)	5, 033, 890	•
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	3,033,070	32.00
33.00 Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00 Allowable bad debts (see instructions)	241, 307	ı
35.00 Adjusted reimbursable bad debts (see instructions)	156, 850	
36.00 Allowable bad debts for dual eligible beneficiaries (see instructions)	162, 562	
37.00 Subtotal (see instructions)	5, 190, 740	37.00
38.00 MSP-LCC reconciliation amount from PS&R	0	38.00
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39. 00
39.50 Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39.97 Demonstration payment adjustment amount before sequestration	0	39. 97
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
39.99 RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
40.00 Subtotal (see instructions)	5, 190, 740	40.00
40.01 Sequestration adjustment (see instructions)	103, 815	•
40.02 Demonstration payment adjustment amount after sequestration	0	
41.00 Interim payments	4, 646, 644	•
42.00 Tentative settlement (for contractors use only)	0	
43.00 Balance due provider/program (see instructions)	440, 281	1
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44. 00
§115. 2		
TO BE COMPLETED BY CONTRACTOR		00.00
90.00 Original outlier amount (see instructions)	0	
91.00 Outlier reconciliation adjustment amount (see instructions)	0	
92.00 The rate used to calculate the Time Value of Money	0.00	•
93.00 Time Value of Money (see instructions)	0	93. 00 94. 00
94.00 Total (sum of lines 91 and 93)	1	74.00

Health Financial Systems RU-ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1304

				.0 .2,01,2010	5/24/2019 4:59	9 pm
			XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 033, 73	7	4, 646, 644	1. 00
2.00	Interim payments payable on individual bills, either		(O	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	09/14/2018	214, 300)	0	3. 01
3. 02	THE STATE OF THE TREET OF THE STATE OF THE S	0771172010		Ď	0	3. 02
3. 03				o l	0	3. 03
3. 04					l ol	3. 04
3. 05					l ol	3. 05
	Provider to Program			-1	_	
3.50	ADJUSTMENTS TO PROGRAM		(o l	0	3. 50
3.51				O	0	3. 51
3.52			(O	0	3. 52
3.53			()	0	3. 53
3.54				O	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		214, 300	D	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 248, 03	7	4, 646, 644	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider	!		'		
5. 01	TENTATI VE TO PROVI DER		(O O	0	5. 01
5.02				O	0	5. 02
5.03			()	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			O	0	5. 50
5. 51				D	0	5. 51
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		'	O	0	5. 99
4 00	5. 50-5. 98)					4 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		274, 228	3	440, 281	6. 01
6. 02	SETTLEMENT TO PROGRAM				1440, 201	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 522, 26!		5, 086, 925	
7.50	1.22a. man dar o program readerity (300 motivations)		., 522, 20.	Contractor	NPR Date	7.50
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	

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

		'			5/24/2019 4:5	9 pm
		Title	XVIII S	wing Beds - SNF	Cost	
		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		73, 349)	0	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)					ļ
0.04	Program to Provider			<u> </u>		0.01
3. 01	ADJUSTMENTS TO PROVIDER				0	
3. 02 3. 03					0	3. 02 3. 03
3. 03						
3. 04						
3.03	Provider to Program			<u>' </u>		3.03
3. 50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51	THE STATE OF THE S					
3. 52					0	
3. 53			1		0	
3.54			ĺ		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		1 0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		73, 349		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)				L	
	TO BE COMPLETED BY CONTRACTOR		T			
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER)	0	5. 01
5. 02	TENTITY E TO TROVIDER					
5. 03			1		0	
	Provider to Program			1		
5.50	TENTATI VE TO PROGRAM		()	0	5. 50
5. 51			(0	5. 51
5. 52			()	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		()	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)		40.00			/ 05
6. 01	SETTLEMENT TO PROVIDER		40, 295		0	
6. 02	SETTLEMENT TO PROGRAM		112 (4)	1	0	
7. 00	Total Medicare program liability (see instructions)		113, 644		NPR Date	7. 00
				Contractor Number	(Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor		~	1.00	2.00	8. 00
				1	1	

Heal th	Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu			u of Form CMS-	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1304 Period:			Worksheet E-1 Part II		
	From 01/01/2018 F To 12/31/2018 [
		Title XVIII	Hospi tal	Cost		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	2 14		1. 00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	1-12			2. 00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	1-12			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 c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00	
0.00	line 168				0.00	
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00	
9.00	Sequestration adjustment amount (see instructions)				9. 00	
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00	
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH					
	Initial/interim HIT payment adjustment (see instructions)				30. 00	
	Other Adjustment (specify)				31. 00	
22 00	Dalamas dus providor (line 0 (or line 10) minus line 20 and l	ina 21) (aaa inatmuatian	·~ \		1 22 00	

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

30. 00 31. 00 32. 00

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	- SWING BEDS	Provider CCN: 15-1304	Peri od:	Worksheet E-2
			From 01/01/2018	
		Component CCN: 15-Z304	To 12/31/2018	Date/Time Prepared:
		·		5/24/2019 4:59 pm
				_

		•		5/24/2019 4:5	9 pr
		Title XVIII S	Swing Beds - SNF	Cost	
			Part A	Part B	
(COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2. 00	-
	Inpatient routine services - swing bed-SNF (see instructions)		86, 064	0	1
	Inpatient routine services - swing bed-NF (see instructions)		00,001	· ·	2
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A	, and sum of Wkst. D.	29, 899	0	1
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instr			_	
	Per diem cost for interns and residents not in approved teaching			0.00	4
1	instructions)				
1	Program days		58	0	1
	Interns and residents not in approved teaching program (see inst			0	
	Jtilization review - physician compensation - SNF optional metho	a oni y	115 0/3	0	
1	Subtotal (sum of lines 1 through 3 plus lines 6 and 7) Primary payer payments (see instructions)		115, 963	0	
	Subtotal (line 8 minus line 9)		115, 963	0	1
1	Deductibles billed to program patients (exclude amounts applicab	Le to physician	113, 703	0	
	professional services)	re to physician		O	'
1 '	Subtotal (line 10 minus line 11)		115, 963	0	1:
1	Coinsurance billed to program patients (from provider records) (excl ude coi nsurance	0	0	1
-	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		115, 963	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	1 '
	Pioneer ACO demonstration payment adjustment (see instructions)				1
	Rural community hospital demonstration project (§410A Demonstrat	ion) payment	O		1
1	adjustment (see instructions)			0	1
	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)			0	1
	Adjusted reimbursable bad debts (see instructions)		0	0	1
1	Allowable bad debts for dual eligible beneficiaries (see instruc	tions)	Ö	0	1
	Total (see instructions)		115, 963	0	1
. 01	Sequestration adjustment (see instructions)		2, 319	0	1
. 02	Demonstration payment adjustment amount after sequestration)		0	0	1
. 00	Interim payments		73, 349	0	2
	Tentative settlement (for contractor use only)		0	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, and		40, 295	0	1 -
	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0	0	2
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstrat Is this the first year of the current 5-year demonstration perio				20
	Century Cures Act? Enter "Y" for yes or "N" for no.	d dilder the 21st			20
	Cost Reimbursement				
	Medicare swing-bed SNF inpatient routine service costs (from Wks	t. D-1. Pt. II. line			20
	66 (title XVIII hospital))	,			
	Medicare swing-bed SNF inpatient ancillary service costs (from W	kst. D-3, col. 3, line			20:
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				20
	Medicare swing-bed SNF discharges (see instructions)				20
	Computation of Demonstration Target Amount Limitation (N/A in fi	rst year of the current	t 5-year demonstr	rati on	
	period)				20
	Medicare swing-bed SNF target amount Medicare swing-bed SNF inpatient routine cost cap (line 205 time	s lino 204)			20
	adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursem				120
	Program reimbursement under the §410A Demonstration (see instruc				20
1	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	•			20
	and 3)				
1	Adjustment to Medicare swing-bed SNF PPS payments (see instructi	ons)			20
	Reserved for future use	·	<u> </u>		210
	Comparision of PPS versus Cost Reimbursement		<u>'</u>		
	Total adjustment to Medicare swing-bed SNF PPS payment (line 209				

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1304	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Pre 5/24/2019 4:5	pared:
	Title XVIII	Hospi tal	Cost	
			•	

				5/24/2019 4:5	9 pm
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	RELMBURSEMENT		
1.00	Inpatient services			1, 825, 348	1.00
2. 00	Nursing and Allied Health Managed Care payment (see instruction	one)		0	2. 00
3.00	Organ acquisition	0113)		0	3. 00
4.00	Subtotal (sum of lines 1 through 3)				
	9 /			1, 825, 348	
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 843, 601	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routine service charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9.00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	11. 00
12. 00	Amounts that would have been realized from patients liable for			0	
12.00	had such payment been made in accordance with 42 CFR 413.13(e)		ii a charge basi s		12.00
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	,		0. 000000	13 00
14. 00	Total customary charges (see instructions)			0.000000	14. 00
		lu if lima 14 ayasada li	no () (ooo	0	15. 00
15. 00	Excess of customary charges over reasonable cost (complete on	ry ir irne 14 exceeds ir	ne o) (see	U	15.00
1/ 00	instructions)	l : £ l! == / ====== l!=	- 14) /	_	1/ 00
16. 00	Excess of reasonable cost over customary charges (complete on	ry it line 6 exceeds lin	e 14) (See	0	16. 00
47.00	instructions)				17. 00
17. 00					
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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, 843, 601	•
20.00	Deductibles (exclude professional component)			300, 136	20. 00
21. 00	Excess reasonable cost (from line 16)			0	21. 00
22.00	Subtotal (line 19 minus line 20 and 21)			1, 543, 465	22. 00
23.00	Coi nsurance			0	23. 00
24.00	Subtotal (line 22 minus line 23)			1, 543, 465	24.00
25.00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		15, 180	25. 00
26. 00	Adjusted reimbursable bad debts (see instructions)	, , ,		9, 867	26. 00
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	. 401. 05)		1, 553, 332	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			1, 333, 332	
29. 50	Pioneer ACO demonstration payment adjustment (see instructions	2)		0	29. 50
		5)		_	
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			1, 553, 332	
30. 01	Sequestration adjustment (see instructions)			31, 067 0	
30. 02					
31. 00	Interim payments			1, 248, 037	
32.00	Tentative settlement (for contractor use only)			0	
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0)	2, 31, and 32)		274, 228	33. 00
34.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	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 01/01/2018 Part VII To 12/31/2018 Date/Time Prepared:

			lo 12/31/2018	Date/lime Pre 5/24/2019 4:5	
		Title XIX	Hospi tal	Cost	7 piii
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		323, 935		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		323, 935	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)		323, 935	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		184, 588		8.00
9.00	Ancillary service charges		343, 857	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)		528, 445	0	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basi s				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
45.00	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			45.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	1
16.00	Total customary charges (see instructions)	! € ! 1/	528, 445	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete onl	y IT line 16 exceeds	204, 510	0	17. 00
18. 00	line 4) (see instructions)	vifling 4 avecade line	0	0	10 00
18.00	Excess of reasonable cost over customary charges (complete onl 16) (see instructions)	y II IIIle 4 exceeds IIIle	U	U	18. 00
19. 00	Interns and Residents (see instructions)		0	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see instr	suctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		323, 935	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.00
22. 00	Other than outlier payments	compreted for 113 provide	0	0	22.00
	Outlier payments		o	0	
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	
27. 00	Subtotal (sum of lines 22 through 26)		0	0	1
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		323, 935	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		323, 935	0	31. 00
32.00	Deducti bl es		0	0	32. 00
33.00	Coi nsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		323, 935	0	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		323, 935	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		323, 935	0	40. 00
41. 00	Interim payments		117, 273	0	
42.00	Balance due provider/program (line 40 minus line 41)		206, 662	0	
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				

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

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

Provider CCN: 15-1304

Peri od: Worksheet G From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/24/2019 4:59 pm

oni y)					5/24/2019 4:5	9 pm
		General Fund	Specific Purpose Fund	Endowment Fund		
	lauparum taarma	1. 00	2.00	3. 00	4. 00	
1 00	CURRENT ASSETS	2 222 020	N C		0	1 00
1. 00 2. 00	Cash on hand in banks Temporary investments	2, 232, 830 1, 999, 687		0	0	1. 00 2. 00
3. 00	Notes receivable	1, 999, 007		-	0	3.00
4. 00	Accounts receivable	17, 683, 089	1	1	0	
5. 00	Other recei vable	490, 885	1	o o	0	
6. 00	Allowances for uncollectible notes and accounts receivable	-10, 998, 085		0	0	
7.00	Inventory	1, 059, 632	2	0	0	7. 00
8.00	Prepai d expenses	472, 346) (0	0	8. 00
9.00	Other current assets	0) (0	0	9. 00
10. 00	Due from other funds	0) (_	0	10.00
11. 00	Total current assets (sum of lines 1-10)	12, 940, 384		0	0	11. 00
40.00	FI XED ASSETS					40.00
12.00	Land	0			0	12.00
13. 00 14. 00	Land improvements			_	0	13. 00 14. 00
15. 00	Accumulated depreciation Buildings	37, 292, 857		-	0	15. 00
16. 00	Accumulated depreciation	-21, 844, 657	1	_	0	16.00
17. 00	Leasehold improvements	21,044,037		_	0	17. 00
18. 00	Accumulated depreciation			0	0	18. 00
19. 00	Fi xed equipment	0		0	0	19. 00
20.00	Accumulated depreciation	0		0	0	20.00
21. 00	Automobiles and trucks	0) (0	0	21. 00
22.00	Accumul ated depreciation	0) (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	Minor equipment depreciable	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		_	0	28. 00
29. 00	Minor equipment-nondepreciable	15 440 200		_	0	29. 00 30. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	15, 448, 200) () 0	U	30.00
31. 00	Investments	1 0		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)	0) (0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	28, 388, 584		0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	2, 335, 028	1	-	0	37. 00
38. 00	Salaries, wages, and fees payable	0) (_	0	38. 00
39. 00	Payroll taxes payable	0		0	0	39. 00
40.00	Notes and Loans payable (short term)	1, 032, 523		0	0	40.00
41. 00	Deferred income	0		0	0	41. 00
42. 00 43. 00	Accel erated payments	0	,		0	42. 00 43. 00
44. 00	Due to other funds Other current liabilities	8, 279, 052		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	11, 646, 603	1	1		
43.00	LONG TERM LIABILITIES	11,040,003	,	, 0	0	43.00
46. 00	Mortgage payable	1 0) (0	0	46. 00
47. 00	Notes payable	4, 289, 792		0	0	
48. 00	Unsecured Loans	0		0	0	48. 00
49.00	Other long term liabilities	0) (0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	4, 289, 792	.l	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	15, 936, 395	i (0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	12, 452, 189				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		1		0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	12, 452, 189	,	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	28, 388, 584		, 0	0	60.00
55.00	59)	25, 555, 564				55.55
		I	1	I	ı	1

RUSH MEMORIAL HOSPITAL

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-1304

					To		Date/Time Pro 5/24/2019 4:5	
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	
		1.00	2.00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		13, 571, 382			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	1	-1, 119, 193 12, 452, 189			0		2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	0	12, 432, 107		0	O		1
5.00		O			0		C	
6.00		0			0		C	
7. 00 8. 00		0			0			
9. 00					0			
10.00	Total additions (sum of line 4-9)		0			0		10.00
11. 00	Subtotal (line 3 plus line 10)		12, 452, 189			0	l	11. 00
12. 00 13. 00	Deductions (debit adjustments) (specify)	0			0			
14. 00					0			
15. 00		o			0		ď	
16. 00		0			0		C	
17. 00	T-t-1 d-dti (6 li 12 17)	0	0		0	0	C	
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		12, 452, 189			0	ł	18. 00 19. 00
	sheet (line 11 minus line 18)		12, 102, 107					17.00
		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)	O	0		0			3. 00 4. 00
5. 00	Additions (credit adjustments) (specify)		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)	0	O		0			10.00
11. 00	Subtotal (line 3 plus line 10)	o			0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0					12. 00
13.00			0					13.00
14. 00 15. 00		1	0					14. 00 15. 00
16. 00			0					16. 00
17. 00			0					17. 00
18.00	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)				0			19. 00

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

			To 12/31/2018	Date/Time Pre 5/24/2019 4:5	
	Cost Center Description	Inpatient	Outpati ent	Total) piii
	555 C 5511 C 55551 1 P C 511	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES			2. 22	
	General Inpatient Routine Services				
1.00	Hospi tal	3, 242, 24	1	3, 242, 241	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, 242, 24	1	3, 242, 241	10. 00
	Intensive Care Type Inpatient Hospital Services	·			
11.00	INTENSIVE CARE UNIT				11. 00
12.00	CORONARY CARE UNIT				12. 00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of line	es	0	0	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	3, 242, 24	1	3, 242, 241	17. 00
18.00	Ancillary services	3, 279, 51	4 55, 745, 647	59, 025, 161	18. 00
19. 00	Outpati ent servi ces	35, 66	1 8, 474, 325	8, 509, 986	19. 00
20.00	RURAL HEALTH CLINIC		0 0	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23.00	AMBULANCE SERVI CES		0 863, 457	863, 457	23. 00
24.00	CMHC				24. 00
25.00	AMBULATORY SURGI CAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26. 00
27. 00	PROFESSI ONAL FEES	407, 49		9, 083, 602	27. 00
27. 01	PRI OR PERI OD OBSERVATI ON REVENUE		0 -141, 030	-141, 030	27. 01
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to V	Wkst. 6, 964, 91	5 73, 618, 502	80, 583, 417	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		34, 868, 158		29. 00
30.00	ADD (SPECIFY)		0		30. 00
31. 00			0		31. 00
32.00			0		32. 00
33. 00			0		33. 00
34. 00			0		34.00
35. 00	T + 1 - 1 1 1 1 1 1 1 1 1		0		35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39. 00			0		39. 00
40.00			0		40.00
41. 00	Total deductions (sum of lines 27 41)		0		41.00
42. 00	Total deductions (sum of lines 37-41)	-anofor	24 040 150		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tr to Wkst. G-3, line 4)	anster	34, 868, 158		43. 00
	10 WKSt. 0-3, TINE 4)	I	1		I

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu o					2552-10
	TATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1304 Period:		Peri od:	Worksheet G-3	
			From 01/01/2018 To 12/31/2018	Date/Time Prepared: 5/24/2019 4:59 pm	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			80, 583, 417	1.00
2.00	Less contractual allowances and discounts on patients' accounts			48, 580, 053	
3.00	Net patient revenues (line 1 minus line 2)			32, 003, 364	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			34, 868, 158	
5.00	Net income from service to patients (line 3 minus line 4)			-2, 864, 794	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication services			0	
9.00				0	
10.00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			-	
	Parking lot receipts			0	
	Revenue from laundry and linen service			0	
14. 00	5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			0	
	Revenue from sale of medical and surgical supplies to other than patients			0	
	3 11				16.00
	Revenue from sale of drugs to other than patients Revenue from sale of medical records and abstracts			-	17. 00 18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20. 00				0	
21. 00				0	
				0	
23. 00				0	
24. 00	Governmental appropriations OTHER OPERATING EXPENSES/INCOME			926, 498	
24. 00	NON-OPERATING EXPENSES/INCOME			· ·	
24. 01	CONTRACT PHARMACY			442, 006	
25. 00	Total other income (sum of lines 6-24)			1, 745, 601	
	Total (line 5 plus line 25)			-1, 119, 193	
	OTHER EXPENSES (SPECIFY)			-1, 119, 193	
28. 00	Total other expenses (sum of line 27 and subscripts)			0	
	Net income (or loss) for the period (line 26 minus line 28)			-1, 119, 193	
∠7. UU	pret income (or 1055) for the period (fine 20 IIII lius fille 20)		ļ	-1, 117, 193	∠7.00