This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1304 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/23/2022 12:28 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/23/2022 Time: 12:28 pm Manually prepared cost report use only] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and 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 01/01/2021 and ending 12/31/2021 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Br	ad Smith	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Brad Smith			2
3	Signatory Title	CEO/PRESI DENT			3
4	Date	(Dated when report is electronica			4

			Title	XVLLL			
	Cost Center Description		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	219, 759	-1, 343, 161	0	75, 681	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	23, 524	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		275, 127		0	10.00
200.00	Total	0	243, 283	-1, 068, 034	0	75, 681	200.00

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

Health Financial Systems RUSH MEMORIAL HOSPITAL

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 15-1304

Period: From 01/01/2021 Part I

From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/23/2022 12:28 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1300 NORTH MAIN STREET 1.00 PO Box: 1.00 State: IN 2.00 City: RUSHVILLE Zi p Code: 46173-County: RUSH 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N) Certi fi ed Number Number Type 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 0 3.00 Subprovi der - IPF 4.00 4.00 Subprovi der - IRF 5.00 5.00 Subprovi der - (Other) 6.00 6.00 7.00 Swing Beds - SNF RUSH SWING BEDS 15Z304 99915 08/01/2000 N 0 N 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital -Based Health Clinic - RHC 15.00 RMH HEALTHCARE ASSOC 158539 99915 0 06/12/2019 0 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2021 12/31/2021 20 00 21.00 Type of Control (see instructions) 9 21.00 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 Ν Ν 22.01 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) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 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. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν N 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this 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.

22.04 Did this hospital receive a geographic reclassification from urban to N N Ν 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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 lines 24 and/or 25 23.00 0 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

58.00

59.00

Ν

58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA	Provi der C	1	Period: From 01/01/2021	Worksheet S-2 Part	
				To 12/31/2021	Date/Time Pre 5/23/2022 12:	pared: 28 pm
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qual i fi cati on Cri teri on Code	
			1. 00	2. 00	3. 00	
.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 4' instructions) Enter "Y" for yes or "N" for no in or is "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in company.	13.85? (s column 1. t CR) NAHE	see If column 1	N			60.00
	Y/N	I ME	Direct GME	I ME	Direct GME	
	1.00	2. 00	3. 00	4. 00	5. 00	
 .00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) .01 Enter the average number of unweighted primary care 	, N			0.00	0.00	61.00
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)	5					
.02 Enter the current year total unweighted primary can FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)	re l					61.02
.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)	-					61.03
.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
.05 Enter the difference between the baseline primary 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)	ne					61.05
.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	/					61.06
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3. 00	4. 00	
.10 Of the FTEs in line 61.05, specify each new program 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 GMI FTE unweighted count.				0.00	0.00	61. 10
.20 Of the FTEs in line 61.05, specify each expanded 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 colum 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0. 00	61. 20
			•	·	1.00	
ACA Provisions Affecting the Health Resources and .00 Enter the number of FTE residents that your hospital	al trained			riod for which	0.00	62.00
your hospital received HRSA PCRE funding (see insti-	n a Teachi			o your hospital	0.00	62. 01
during in this cost reporting period of HRSA THC pure Teaching Hospitals that Claim Residents in Nonprov. .00 Has your facility trained residents in nonprovider "Y" for yes or "N" for no in column 1. If yes, compared to the content of the column 1.	der Setti settings	ings during this d	cost reporting		N	63.00

Health Financial Systems	RUSH N	MEMORIAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: rom 01/01/2021	Worksheet S-2 Part I Date/Time Pre 5/23/2022 12:	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	<u> Б</u>
Section 5504 of the ACA Base Yea	ar FTF Residents in No	onnrovider Settinas	1.00 This base year	2.00	3.00	
period that begins on or after of the control of th	July 1, 2009 and before yes, or your facilitable of unweighted nor otations occurring in a number of unweighted	re June 30, 2010. ty trained residents n-primary care all nonprovider d non-primary care	0.00			64. 00
of (column 1 divided by (column		instructions)				
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
(5 00 l5)	1. 00	2. 00	3.00	4. 00	5. 00	15.00
65.00 Enter in column 1, if line 63 is yes, or your facility 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)			0.00	0.00	0.000000 Ratio (col.	65. 00
			FTEs	FTEs in	1/ (col . 1 +	
			Nonprovider Site	Hospi tal	col. 2))	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Current		n Nonprovider Setting	sEffective f	or cost report	ing periods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar occurring in all nonpr unweighted non-primar cal. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0. 00	0. 000000	66.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
(7.00 Fatar in advers 1. the arrange	1. 00	2. 00	3.00	4. 00	5. 00 0. 000000	(7.00
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	07.00

From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/23/2022 12:28 pm 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 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 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75 00 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 0 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) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 80.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 $\S413.40(f)(1)(ii)$? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90 00 N yes or "N" for no in the applicable column. is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Υ 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Ν 92.00 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. 93.00 Ν N 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν N 96.00 applicable column. 97.00 | If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Υ 98.00 stepdown adjustments on Wkst. 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. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 98.01 98.01 C,Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V,and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 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. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) 98.03 Ν reimbursed 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. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and 98.04 N N 98.04 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)

Health Financial Systems RUSH MEMORIAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CN: 15-1304 Pe	In Lie	worksheet S-	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	Fr	om 01/01/2021	Part I	
		To		Date/Time Pr 5/23/2022 12	
			V 1. 00	2. 00	-
108.00 s this a rural hospital qualifying for an exception to the (CRNA fee sch	edul e? See 42	N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2. 00	3. 00	4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 00
110 000 d this best to be sited and in the Dural Community Hearity	D		104	1. 00	110.00
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "'complete Worksheet E, Part A, lines 200 through 218, and Workapplicable.	Y" for yes or	"N" for no. I	f yes,	N	110.00
			1. 00	2. 00	
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	st reporting umn 1 is Y, ticipating in	period? Enter enter the n column 2.	N		111. 00
		1.00	2. 00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting partier "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable.	oeriod? "Y", enter e	N N	2. 00	0.00	112.00
Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			_ 0115.00
in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) 3" percent ncludes				
116.00 s this facility classified as a referral center? Enter "Y" i	for yes or	N			116. 00
117.00 Is this facility legally-required to carry malpractice insura	ance? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00 is the mal practice insurance a claims-made or occurrence poli	cy? Enter 1	2			118. 00
if the policy is claim-made. Enter 2 if the policy is occurre	ence.	Premi ums	Losses	Insurance	
		PI eiiii uiiis	LUSSES	Trisui diice	
110.01		1. 00	2. 00	3.00	0110 01
118.01 List amounts of malpractice premiums and paid losses:		132, 593	(0	0118.01
110 02 Are melaprostice promiume and rold lesses reported in a cost of	aantan athan	than the	1. 00 N	2. 00	118. 02
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 119.00 DO NOT USE THIS LINE			IV		119.00
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "\ alifies for t	/" for yes or the Outpatient	N	N	120. 00
121.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no.	ntable device	es charged to	Υ		121. 00
122.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information			N		122. 00
125.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N'	'for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enterprint of the control of the cont		fication date			126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, ento	er the certi	fication date			127. 00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter		fication date			128. 00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter					129. 00
column 1 and termination date, if applicable, in column 2.					

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLEX	RUSH MEMORIA X IDENTIFICATION DATA	Provi der CO	CN: 15-1304	Peri od	:	worksheet S	
					1/01/2021 2/31/2021	Part I Date/Time P 5/23/2022 1	repared
					1. 00	2. 00	
30.00 f this is a Medicare certified pa			ti fi cati on		11 00	2.00	130.0
date in column 1 and termination d 31.00 f this is a Medicare certified in			erti fi cati d	n l			131. (
date in column 1 and termination d	ate, if applicable, in c	olumn 2.					
32.00 If this is a Medicare certified is in column 1 and termination date,			ication dat	е			132.
33.00 Removed and reserved	• •						133.
84.00 If this is an organ procurement or and termination date, if applicable All Providers		the OPO number	in column 1				134.
40.00 Are there any related organization					N		140.
chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the				its			
1. 00		00	11 0115)		3. 00		
If this facility is part of a chai			ough 143 the	e name ar	nd address	of the home	•
office and enter the home office c 41.00 Name:	Contractor's Name:	actor Humber.	Contrac	ctor's Nu	umber:		141.0
42.00 Street:	PO Box:		7: 0				142.0
43. 00 Ci ty:	State:		Zi p Coc	ie:			143.
44 000	+- :					1. 00 Y	144
44.00 Are provider based physicians' cos	ts included in worksheet	A?				Y	144. (
45 001 5 1			. 6.		1. 00	2. 00	1.45
15.00 If costs for renal services are clain inpatient services only? Enter "Y" no, does the dialysis facility inc	for yes or "N" for no i	n column 1. If	column 1 is	;			145.
period? Enter "Y" for yes or "N"		iii ioi tiiis cost	reporting				
16.00 Has the cost allocation methodolog	y changed from the previ	ously filed cos	t report?		N		146.
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	•	15-2, chapter	40, §4020)	lf			
3	•	15-2, chapter	40, §4020)	lf		1.00	
yes, enter the approval date (mm/d	d/yyyy) in column 2.	•		lf		1. 00 N	147.
yes, enter the approval date (mm/d 47.00Was there a change in the statistic 48.00Was there a change in the order of	d/yyyy) in column 2. cal basis? Enter "Y" for allocation? Enter "Y" f	yes or "N" for for yes or "N" f	no. For no.		·	N N	148.
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Health Financial Systems	RUSH MEMORIAL H	IOSPI TAL	In Lie	In Lieu of Form CMS-2552-		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	FICATION DATA	Peri od:	Worksheet S-2			
			From 01/01/2021 To 12/31/2021	Part Date/Time Pre	narod:	
			10 12/31/2021	5/23/2022 12:		
			Begi nni ng	Endi ng		
			1. 00	2. 00		
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)			170. 00			
			1. 00	2. 00		
171.00 If line 167 is "Y", does this provider hav			N	0	171. 00	
section 1876 Medicare cost plans reported "Y" for yes and "N" for no in column 1. If 1876 Medicare days in column 2. (see instr	column 1 is yes, er		on			

	Financial Systems RUSH MEMORIA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CO	CN: 15-1304	Peri od:	u of Form CMS Worksheet S-	
	LE THE TOOL THE TELETH STATE HE HESTIGENEEM COLON TO THE TELETH COLON TO THE THE TELETH COLON TO THE TELETH COLON TO THE TELETH COLON TO THE THE TELETH COLON TO THE TELETH COLON TO THE TELETH COLON TO THE THE TELETH COLON TO THE TELETH COLON TO THE TELETH COLON TO THE THE TELETH COLON TO THE TELETH COLON TO THE TELETH COLON TO THE THE TELETH COLON TO THE TELETH COLON TO THE TELETH COLON TO THE THE TELETH COLON TO THE TELETH COLON TO THE TELETH COLON TO THE THE TELETH COLON TO THE TELETH COLON TO THE TELETH COLON TO THE T			From 01/01/2021 To 12/31/2021	Part II Date/Time Pr	epared:
				Y/N	5/23/2022 12 Date	2: 28 piii
				1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter	N for all NO re	esponses. Ente			
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation	- h!!	46	N.		1 00
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in			N		1.00
	reporting period: 11 yes, enter the date of the change in	cordiiir 2. (See	Y/N	Date	V/I	
			1.00	2.00	3. 00	
00	Has the provider terminated participation in the Medicare	Program? If	N			2.00
	yes, enter in column 2 the date of termination and in colu	mn 3, "V" for				
	voluntary or "I" for involuntary.					
00	Is the provider involved in business transactions, includi		N			3.00
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provi					
	officers, medical staff, management personnel, or members					
	of directors through ownership, control, or family and oth					
	relationships? (see instructions)					
			Y/N	Type	Date	
			1. 00	2. 00	3. 00	
	Financial Data and Reports			T -		
00	Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C"	tified Public	Y	Α		4.00
	or "R" for Reviewed. Submit complete copy or enter date av					
	column 3. (see instructions) If no, see instructions.	arrabre in				
00	Are the cost report total expenses and total revenues diff	erent from	N			5.00
	those on the filed financial statements? If yes, submit re					
				Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities	0 16				
00	Column 1: Are costs claimed for a nursing program? Column	2: If yes, 15	s the provide	r N		6. 00
00	is the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see i	netructi one		N		7.00
00	Were nursing programs and/or allied health programs approv		wed during the			8.00
	cost reporting period? If yes, see instructions.					1
00	Are costs claimed for Interns and Residents in an approved	graduate medio	cal education	N		9.00
	program in the current cost report? If yes, see instruction					
00	Was an approved Intern and Resident GME program initiated	or renewed in t	the current	N		10.00
. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than	I & Din an And	arayad	N		11.00
. 00	Teaching Program on Worksheet A? If yes, see instructions.	ı akınan app	or oved	IN		11.00
	Teaching Trogram on Norksheet A: Tr yes, see That detrons.				Y/N	
					1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If ye				Y	12.00
.00	If line 12 is yes, did the provider's bad debt collection	policy change o	during this co	ost reporting	N	13.00
00	period? If yes, submit copy.		e !		N.	14.00
	If line 12 is yes, were patient deductibles and/or co-paym Bed Complement	ents warved? I1	yes, see ins	STERICTIONS.	N N	14.00
	вед сошргешент Did total beds available change from the prior cost report	ina period? If	ves. see ins	tructions	N	15.00
	The second secon		t A		t B	10.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data			1	00/5:/:::	
00	Was the cost report prepared using the PS&R Report only?	Y	02/24/2022	Y	02/24/2022	16.00
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see					
	instructions)					
00	Was the cost report prepared using the PS&R Report for	N		N		17.00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
00	Report data for additional claims that have been billed					
00						
00	but are not included on the PS&R Report used to file this					
	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		19 00
00	but are not included on the PS&R Report used to file this	N		N		19. 00

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1304	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S Part II Date/Time P 5/23/2022 1	repared
		Descr	iption	Y/N	Y/N	2. 20 p
			0	1. 00	3. 00	
0. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.0
		Y/N	Date	Y/N	Date	
1 00	lw. the section of th	1.00	2. 00	3. 00	4. 00	04.0
1. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.0
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHI LDRENS	HOSPI TALS)		1.00	
	Capital Related Cost		,			
2. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22.0
3. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ring the cost	N	23.0		
4. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	N	24.0			
5. 00	Have there been new capitalized leases entered into during instructions.	N	25.0			
5. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	N	26. (
7. 00	Has the provider's capitalization policy changed during the copy.	cost reporti	ng period? I	f yes, submit	N	27.0
3. 00	Interest Expense Were new loans, mortgage agreements or letters of credit en	itered into du	ring the cos	t reporting	N	28. (
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	Υ	29.			
0. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu instructions.		debt? If ye	s, see	N	30.
1. 00	Has debt been recalled before scheduled maturity without is instructions.	suance of new	debt? If ye	s, see	N	31. (
2. 00	Purchased Services Have changes or new agreements occurred in patient care ser		ed through c	ontractual	N	32. (
3. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to compet	itive bidding? If	N	33.
	Provi der-Based Physi ci ans		h			
4.00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement wit	n provider-b	ased physicians?	Υ	34.0
5. 00	If line 34 is yes, were there new agreements or amended exilphysicians during the cost reporting period? If yes, see in		nts with the	provi der-based	N	35. (
	physicians during the cost reporting period: if yes, see in	isti ucti olis.		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs			<u> </u>		
	Were home office costs claimed on the cost report?			N		36.
. 00	If line 36 is yes, has a home office cost statement been pr	epared by the	home office	? N		37.
3. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home off	ice different	from that o	f N		38.
9. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			s, N		39.
0. 00	j ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	home office?	If yes, see	· N		40.
	i nstructi ons.					
		1	00	2	00	
	Cost Report Preparer Contact Information	1.00 2.00				
. 00		_ANDON		HACKETT		41.
2. 00		BLUE & CO., LI	_C			42.0
	preparer. Enter the telephone number and email address of the cost 3	317-713-7929		LHACKETT@BLUEA	NDCO COM	43.

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2						2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEN	ENT QUESTI ONNAI RE	Provi der C		Peri od:	Worksheet S-2	!
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	narodi
				10 12/31/2021	5/23/2022 12:	28 pm
		3.	00			
Cost Report Preparer Contact Informati	on					
41.00 Enter the first name, last name and t		DI RECTOR				41.00
held by the cost report preparer in c	olumns 1, 2, and 3,					
respecti vel y.						
42.00 Enter the employer/company name of the	e cost report					42.00
preparer.						
43.00 Enter the telephone number and email						43.00
report preparer in columns 1 and 2, re	especti vel y.					

 Heal th Fi nancial
 Systems
 RUSH MI

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provi der CCN: 15-1304 Period: Worksheet S-3 From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

						o 12/31/2021	Date/Time Pre 5/23/2022 12:	
							I/P Days /	20 piii
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 125	32, 040. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)							2.00
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, 125	32, 040. 00	0	7.00
7.00	beds) (see instructions)			20	7,120	02,010.00	· ·	,
8.00	INTENSIVE CARE UNIT							8.00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)			25	9, 125	32, 040. 00	0	
15. 00	CAH visits						0	15. 00
16. 00	SUBPROVIDER - IPF							16. 00
17. 00	SUBPROVIDER - IRF							17.00
18. 00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22. 00 23. 00	HOME HEALTH AGENCY							22. 00 23. 00
24.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE							24.00
24. 00	HOSPICE (non-distinct part)	30. 00						24. 00
25. 00	CMHC - CMHC	30.00						25.00
26. 00	RURAL HEALTH CLINIC	88. 00					0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00	l .				0	
27. 00	Total (sum of lines 14-26)	07.00		25			· ·	27. 00
28. 00	Observation Bed Days						0	
29. 00	Ambul ance 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)			0	()		32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges		l					33. 01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-1304

				11	0 12/31/2021	5/23/2022 12:	
		I/P Davs	/ O/P Visits	/ Tri ps	Full Time I	Equi val ents	20 0111
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	792	23	1, 335			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)	440	4.4				0.00
2.00	HMO and other (see instructions)	110	11				2.00
3.00	HMO IPF Subprovi der	0	0				3.00
4. 00 5. 00	HMO IRF Subprovider	25	0				4. 00 5. 00
6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	23	0				6.00
7. 00	Total Adults and Peds. (exclude observation	817	23				7.00
7.00	beds) (see instructions)	017	23	1, 303			7.00
8. 00	INTENSIVE CARE UNIT						8.00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	817	23	1, 365	0.00	258. 77	14.00
15.00	CAH visits	0	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)			0			24. 10
25. 00	CMHC - CMHC	2 002	1 050	11 077	0.00	25.07	25.00
26. 00	RURAL HEALTH CLINIC	2, 993	1, 050		0.00		•
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	U	0	0	0. 00 0. 00	l	•
28. 00	Total (sum of lines 14-26) Observation Bed Days		14	564	0.00	283. 83	28.00
29.00	Ambulance Trips	175	14	304			29.00
30.00	Employee discount days (see instruction)	175		0			30.00
31. 00	Employee discount days (see Fristraction)			0			31.00
32. 00	Labor & delivery days (see instructions)	0	0	_			32.00
32. 01	Total ancillary labor & delivery room	Ĭ	J	Ö			32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	o					33.00
33. 01	LTCH site neutral days and discharges	o					33. 01

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To | 12/31/2021 | Date/Time Prepared: Provider CCN: 15-1304

				To	12/31/2021	Date/Time Prep 5/23/2022 12:3	
		Full Time	_	Di sch	arges	0, 20, 2022 12.	
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	11.00	Pati ents	
	I	11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	246	7	401	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
2 00	for the portion of LDP room available beds)			20	2		2.00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider			28	3		2. 00 3. 00
4. 00					0		3. 00 4. 00
5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				٩		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	246	7	401	14. 00
15. 00	CAH visits						15. 00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC	0. 00					26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31. 00 32. 00
32.00	Labor & delivery days (see instructions)						
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges						33. 00
33.01	Lion of the heath ar days and dround ges			١	ı	ı	55.01

Health Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	u of Form CMS	-2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1304	Peri od: From 01/01/2021	Worksheet S-	8
		Component	CCN: 15-8539	To 12/31/2021	Date/Time Pr 5/23/2022 12	
				RHC I	Cost	. ==
				1	00	4
Clinic Address and Identification					00	
1.00 Street				201 CONRAD HAR		1.00
			00	State 2.00	ZIP Code 3. 00	
2.00 City, State, ZIP Code, County		RUSHVI LLE	00		46173	2.00
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rur	al or "II" for	urban		1.00	0 3.00
3.00 HOSPITAL-BASED FUNCS UNLT. DESIGNATION - EIT	er k for fura	1 01 0 101		nt Award	Date	3.00
				1. 00	2. 00	
Source of Federal Funds			1		T	
4.00 Community Health Center (Section 330(d), PHS 5.00 Migrant Health Center (Section 329(d), PHS A						4. 00 5. 00
6.00 Health Services for the Homeless (Section 34						6.00
7.00 Appal achi an Regi onal Commi ssi on						7.00
8.00 Look-Alikes 9.00 OTHER (SPECIFY)						8. 00 9. 00
7.00 OTHER (SPECITY)						9.00
				1. 00	2. 00	
10.00 Does this facility operate as other than a h yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of o	other operatio	ns in column		1	0 10.00
Tiour 3.)	Sun	day	l N	Monday	Tuesday	
	from	to	from	to	from	
Facility hours of energtions (1)	1.00	2. 00	3. 00	4. 00	5. 00	
Facility hours of operations (1) 11.00 CLINIC			08: 00	05: 00	08: 00	11.00
			•			
12.00 Have you received an approval for an excepti	on to the produ	ictivity stand	and?	1. 00 Y	2. 00	12.00
13.00 ls this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	ed in CMS Pub. 1 umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the		(13.00
numbers below.			1 -		2011	
			Prov	ider name 1.00	CCN number 2.00	
14.00 RHC/FQHC name, CCN number				1. 00	2.00	14.00
	Y/N	V	XVIII	XI X	Total Visits	
15.00 Have you provided all or substantially all	1.00	2. 00	3. 00	4. 00	5. 00	15. 00
GME cost? Enter "Y" for yes or "N" for no in						15.00
column 1. If yes, enter in columns 2, 3 and						
4 the number of program visits performed by Intern & Residents for titles V, XVIII, and						
XIX, as applicable. Enter in column 5 the						
number of total visits for this provider.						
(see instructions)		0	lntv.			
			inty 00			
2.00 City, State, ZIP Code, County		RUSH				2.00
	Tuesday		esday		sday	
	to	from	8. 00	9.00	to	
Facility hours of operations (1)	6. 00	7. 00	8.00	7.00	10.00	

Health Financial Systems	RUSH MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1304	Peri od:	Worksheet S-8	}
		Component	CCN: 15-8539	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/23/2022 12:	pared: 28 pm
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)	_					
11. 00 CLINIC	08: 00	05: 00				11. 00

	Financial Systems RUSH MEMORIAL HOSE TAL UNCOMPENSATED AND INDIGENT CARE DATA Pr	ovi der CCN	: 15-1304	Peri od:	u of Form CMS-2 Worksheet S-1	
0011	THE GROOM ENGINED AND THEIR CENT OF THE BATTA	ovider con	. 10 1001	From 01/01/2021		
				To 12/31/2021	Date/Time Pre 5/23/2022 12:	pared 28 pm
					1. 00	
	Uncompensated and indigent care cost computation				1.00	
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by lin	e 202 colum	n 8)	0. 319408	1.0
	Medicaid (see instructions for each line)					
. 00	Net revenue from Medicaid				1, 232, 173	
00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.
. 00	If line 3 is yes, does line 2 include all DSH and/or supplementa			ai d?	0	4.
. 00 . 00	If line 4 is no, then enter DSH and/or supplemental payments fro Medicaid charges	m wearcard			0 16, 679, 220	
. 00	Medicaid cost (line 1 times line 6)		5, 327, 476			
. 00	Difference between net revenue and costs for Medicaid program (I	nes 2 and 5 if	4, 095, 303			
	<pre>< zero then enter zero)</pre>		o ou o		1,070,000	"
	Children's Health Insurance Program (CHIP) (see instructions for	each line)			
. 00	Net revenue from stand-alone CHIP				0	9. (
	Stand-alone CHIP charges				0	1
1. 00	Stand-alone CHIP cost (line 1 times line 10)		0			
2. 00	Difference between net revenue and costs for stand-alone CHIP (I	if < zero then	0	12.		
	enter zero) Other state or local government indigent care program (see instru	ustions fo	r oach line	1		1
3. 00	Other state or local government indigent care program (see instr Net revenue from state or local indigent care program (Not inclu				0	13.
1. 00					0	
00	10)	program (n	or Therage	111 111163 0 01		' ''
5. 00	State or local indigent care program cost (line 1 times line 14)				0	15.
5. 00	Difference between net revenue and costs for state or local indi	ne 15 minus line	0	16.		
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and state	/local indi	gent care progra	ıms (see	
7. 00	Private grants, donations, or endowment income restricted to fun	iding chari	ty care		0	17.
3. 00	Government grants, appropriations or transfers for support of ho	spital ope	rati ons		0	18.
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent c	are program	s (sum of lines	4, 095, 303	19.
	,		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
	Uncompensated Care (see instructions for each line)	11+1	22.2	7.4 45 510	47.702	20
0. 00	Charity care charges and uninsured discounts for the entire faci (see instructions)	iity	22, 2	74 45, 519	67, 793	20.
1. 00	Cost of patients approved for charity care and uninsured discoun	its (see	7, 1	14 45, 519	52, 633	21.
00	instructions)	(555	.,.		02, 000	
2. 00	Payments received from patients for amounts previously written o	off as		0 0	0	22.
	charity care					
3. 00	Cost of charity care (line 21 minus line 22)		7, 1	14 45, 519	52, 633	23.
					1.00	
1. 00	Does the amount on line 20 column 2, include charges for patient	days bays	nd a Lanath	of stay limit	1. 00 N	24.
1. 00	imposed on patients covered by Medicaid or other indigent care p		nu a rengti	or Stay IIIII t	IN	24.
5. 00	If line 24 is yes, enter the charges for patient days beyond the	-	care progra	m's length of	0	25.
5 00	stay limit Total bad debt expense for the entire hospital complex (see inst	ructions)			3, 893, 024	26
6. 00 7. 00	Medicare reimbursable bad debts for the entire hospital complex (see inst		uctions)		3, 893, 024 579, 467	1
7. 01	Medicare allowable bad debts for the entire hospital complex (se	•			891, 488	1
3. 00	Non-Medicare bad debt expense (see instructions)	.c matruct	1 0113)		3, 001, 536	1
9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	ense (see i	nstructions	(a)	1, 270, 736	
				*		
0.00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 323, 369	30.

Health Financial Systems	RUSH MEMORIAL				u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		Period: From 01/01/2021	Worksheet A	
				To 12/31/2021	Date/Time Pre	pared:
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	5/23/2022 12: Recl assi fi ed	28 pm
cost center bescription	Sararres	other	+ col . 2)	i ons (See	Tri al Balance	
			,	A-6)	(col. 3 +-	
					col. 4)	
OFNERAL OFRILLOS COOT OFNERO	1. 00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS		2 140 770	2 140 77	sl ol	2 140 770	1 00
1.00 OO100 NEW CAP REL COSTS-BLDG & FIXT 4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT	451, 202	2, 148, 668 5, 116, 680			2, 148, 668 5, 583, 584	1.00 4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	3, 253, 846	3, 772, 222			6, 900, 450	5.00
7. 00 00700 OPERATION OF PLANT	344, 743	871, 861	1, 216, 604		1, 255, 860	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	106, 652	106, 652	0	106, 652	8. 00
9. 00 00900 HOUSEKEEPI NG	631, 543	219, 736	851, 279	39, 256	890, 535	9. 00
10. 00 01000 DI ETARY	330, 083	117, 254			165, 651	10.00
11. 00 01100 CAFETERI A	0	0	457.000		313, 091	11.00
13. 00 O1300 NURSI NG ADMINI STRATI ON 14. 00 O1400 CENTRAL SERVI CES & SUPPLY	149, 436	8, 403		1	157, 839	13. 00 14. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	108, 791 312, 909	130, 294 192, 013	239, 085 504, 922		258, 144 504, 922	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	312, 707	172,013	304, 722	<u>-</u>	304, 722	10.00
30. 00 03000 ADULTS & PEDIATRICS	2, 036, 814	92, 298	2, 129, 112	-44, 672	2, 084, 440	30.00
ANCILLARY SERVICE COST CENTERS	,	,		,	, ,	
50. 00 05000 OPERATING ROOM	1, 511, 643	754, 396	2, 266, 039		1, 495, 080	50.00
51.00 05100 RECOVERY ROOM	0	25, 282	25, 282	177, 048	202, 330	51.00
53. 00 05300 ANESTHESI OLOGY	0	0	(0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 240, 184	699, 895			1, 877, 316	54.00
54. 01 05401 0NCOLOGY 55. 00 05500 RADI OLOGY-THERAPEUTI C	370, 366 0	260, 144 0	630, 510	I I	625, 641 0	54. 01 55. 00
60. 00 06000 LABORATORY	849, 172	1, 290, 175	,	1 1	2, 060, 544	60.00
65. 00 06500 RESPIRATORY THERAPY	163, 399	36, 754	200, 153		197, 320	65.00
66. 00 06600 PHYSI CAL THERAPY	277, 760	43, 430			357, 337	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	194, 711	2, 542			233, 282	67.00
68. 00 06800 SPEECH PATHOLOGY	147, 155	796	147, 951	-72, 295	75, 656	68. 00
69. 00 06900 ELECTROCARDI OLOGY	104, 637	7, 345			169, 666	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(1	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	0	(24, 200	(24.200	.,	1, 029, 746	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	591, 394	634, 388 4, 922, 646		1	634, 388 5, 507, 857	72. 00 73. 00
OUTPATIENT SERVICE COST CENTERS	371, 374	4, 722, 040	3, 314, 040	ار –0, ۱۵۵ <u>ا</u>	3, 307, 037	73.00
88. 00 08800 RURAL HEALTH CLINIC	1, 545, 411	135, 870	1, 681, 281	-37, 521	1, 643, 760	88. 00
90. 00 09000 CLI NI C	1, 126, 196	135, 339			1, 224, 309	90.00
90. 01 09001 SURGI CAL ASSOCI ATES	64, 236	554, 325			626, 525	
90. 02 09002 ORTHOPAEDI CS	487, 111	389, 666			884, 960	90. 02
90. 03	532, 745	1, 441		1	542, 829	
90. 04 09004 SPECI ALTY CLI NI C 90. 05 09005 PEDI ATRI CS	1, 124, 472	307, 780			1, 193, 163 501, 713	
90. 05 09005 PEDIATRICS 90. 06 09006 WOMEN' S HEALTH	476, 365 0	19, 773	490, 138	1	501, 713	90.05
90. 07 09007 PAI N MANAGEMENT	582, 075	130, 861	712, 936	1 1	721, 562	90.07
90. 08 09008 0NCOLOGY MD	0	0		1	0	90. 08
91. 00 09100 EMERGENCY	1, 026, 992	1, 277, 876	2, 304, 868	-37, 268	2, 267, 600	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	110, 683	24, 797	135, 480	-224	135, 256	95.00
SPECIAL PURPOSE COST CENTERS	20 14/ 074	24 421 (02	44 577 /7/		44 577 /7/	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	20, 146, 074	24, 431, 602	44, 577, 676	5 0	44, 577, 676	JI 18. UU
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	0			n	192. 00
193. 00 19300 NONPALD WORKERS	o	0				193. 00
193. 01 19301 FOUNDATI ON	140, 672	1, 401	142, 073	·	142, 073	1
193. 02 19302 OCCUPATI ONAL MEDICINE	0	0				193. 02
193. 03 19303 GUEST MEALS	0	0	(o		193. 03
194. 00 07950 NON REI MBURSABLE	0	0	(0		194.00
200.00 TOTAL (SUM OF LINES 118 through 199)	20, 286, 746	24, 433, 003	44, 719, 749	이	44, 719, 749	200. 00

 Health Financial
 Systems
 RUSH MEMORE

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

			5/23/2021 Date/Time Pre	
Cost Center Description	Adjustments	Net Expenses		, , , , , , , , , , , , , , , , , , ,
·	(See A-8)	For		
		Allocation		
	6. 00	7.00		
GENERAL SERVICE COST CENTERS				
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT	-108, 453	2, 040, 215		1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-229, 083	5, 354, 501		4.00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT	-1, 771, 440	5, 129, 010	l l	5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	0	1, 255, 860 106, 652	l l	7. 00 8. 00
9. 00 00900 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPI NG	0	890, 535		9.00
10. 00 01000 DI ETARY	-540	165, 111		10.00
11. 00 01100 CAFETERI A	-74, 979	238, 112		11.00
13. 00 01300 NURSING ADMINISTRATION	0	157, 839	l .	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	258, 144	l .	14.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	504, 922		16.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS	-909, 266	1, 175, 174		30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	-616, 447	878, 633		50.00
51.00 05100 RECOVERY ROOM	0	202, 330		51.00
53. 00 05300 ANESTHESI OLOGY	0	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-713, 675	1, 163, 641		54.00
54. 01 05401 ONCOLOGY	-223, 350	402, 291		54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		55.00
60. 00 06000 LABORATORY	0	2, 060, 544	1	60.00
65. 00 06500 RESPI RATORY THERAPY	0	197, 320		65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	357, 337		66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	0	233, 282 75, 656	l l	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	169, 666	l	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	107, 000	·	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-7, 985	1, 021, 761		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	634, 388		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	-155, 228	5, 352, 629	l l	73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	1, 643, 760		88. 00
90. 00 09000 CLI NI C	-626, 714	597, 595		90.00
90. 01 09001 SURGI CAL ASSOCI ATES	-554, 304	72, 221		90. 01
90. 02 09002 ORTHOPAEDI CS	-885, 009	-49		90. 02
90. 03 09003 RHEUMATOLOGY	-558, 620	-15, 791		90. 03
90. 04 09004 SPECI ALTY CLINI C	-948, 950	244, 213	l .	90. 04
90. 05 09005 PEDI ATRI CS	-417, 069	84, 644	l l	90.05
90. 06 09006 WOMEN' S HEALTH	740.043	0		90.06
90. 07 09007 PAI N MANAGEMENT 90. 08 09008 0NCOLOGY MD	-749, 843	-28, 281		90. 07 90. 08
90. 08 09008 0NCOLOGY MD 91. 00 09100 EMERGENCY	0	2 267 600		90.08
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	U	2, 267, 600		91.00
OTHER REIMBURSABLE COST CENTERS				72.00
95. 00 09500 AMBULANCE SERVICES	-1, 980	133, 276		95. 00
SPECIAL PURPOSE COST CENTERS	1, 700	100, 270		70.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-9, 552, 935	35, 024, 741		118. 00
NONREI MBURSABLE COST CENTERS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	337 32 77 7 7		
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	o		193. 00
193. 01 19301 FOUNDATI ON	0	142, 073		193. 01
193. 02 19302 OCCUPATI ONAL MEDI CI NE	0	0		193. 02
193. 03 19303 GUEST MEALS	0	0		193. 03
194.00 07950 NON REIMBURSABLE	0	0		194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-9, 552, 935	35, 166, 814		200. 00

| Peri od: | Worksheet A-6 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-1304

					5/23/2022 12	
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	B - DIETARY/ CAFETERIA					
1. 00	CAFETERI A	1100	23 <u>1, 0</u> 25	8 <u>2, 0</u> 66		1.00
	0		231, 025	82, 066		_
	C - MED SUPPLY RECLASS					
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 029, 746		1.00
	PATI ENTS		_			
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	19, 059		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8. 00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0			11.00
12.00		0.00		0		12.00
13. 00 14. 00		0. 00 0. 00	0	0		13.00
			0			14.00
15. 00 16. 00		0. 00 0. 00	٩	0		15.00
16.00		l I	0	0		16. 00 17. 00
18.00		0. 00 0. 00	0	0		18.00
19. 00		0.00	0	0		19.00
20.00		0.00	o	0		20.00
20.00		— — " • • • • • • • • • • • • • • • • • • •		1, 048, 805		20.00
	E - SALARY RECLASS		<u> </u>	1,046,603		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	15, 702	0		1.00
2.00	OPERATION OF PLANT	7. 00	39, 256	Ö		2.00
3. 00	HOUSEKEEPI NG	9. 00	39, 256	Ö		3.00
4. 00	DI ETARY	10.00	31, 405	0		4.00
5. 00	RECOVERY ROOM	51.00	189, 466	Ö		5.00
6. 00	PHYSI CAL THERAPY	66.00	36, 148	Ö		6.00
7. 00	OCCUPATI ONAL THERAPY	67. 00	36, 148			7.00
7.00	0		387, 381	0		7.00
	G - PHYSICIAN PRACTICE ADMIN	RECLASS	20.722.1	-		
1.00	CLI NI C	90.00	6, 013	0		1.00
2.00	SURGI CAL ASSOCI ATES	90. 01	8, 643	0		2.00
3.00	ORTHOPAEDI CS	90. 02	8, 643	0		3.00
4.00	RHEUMATOLOGY	90. 03	8, 643	0		4.00
5.00	SPECIALTY CLINIC	90. 04	17, 287	0		5.00
6.00	PEDI ATRI CS	90. 05	8, 643	0		6.00
7.00	PAIN MANAGEMENT	90. 07	8, 643	0		7.00
	0		66, 515	0		
	H - RECLASS RHC EXPENSE					
1.00	RURAL HEALTH CLINIC	88.00	30, 050	<u>0</u>		1.00
	TOTALS		30, 050	0		
	I - ECHO EXPENSE RECLASS					
1.00	ELECTROCARDI OLOGY	69.00	0	<u>57, 8</u> 82		1.00
	ITOTAL C	i l	٥	E7 000		1
	TOTALS Grand Total: Increases		714, 971	57, 882 1, 188, 753		500.00

RECLASSI FI CATI ONS

Provider CCN: 15-1304

Peri od: Worksheet A-6 From 01/01/2021

12/31/2021 Date/Time Prepared: 5/23/2022 12:28 pm Decreases Cost Center 0ther Sal ary Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 B - DIETARY/ CAFETERIA 1.00 DI ETARY 10.00 231, 025 82, 066 0 1.00 231, 025 82, 066 MED SUPPLY RECLASS 1.00 ADULTS & PEDIATRICS 30.00 14,622 0 1.00 2.00 OPERATING ROOM 50.00 0 581, 491 0 2.00 0 0 3.00 RECOVERY ROOM 51.00 12, 418 3.00 0 RADI OLOGY-DI AGNOSTI C 0 4, 881 4.00 54.00 4.00 5.00 ONCOLOGY 54.01 0 4,869 0 5.00 LABORATORY 0 6.00 60.00 78,803 0 6.00 0 7.00 RESPIRATORY THERAPY 65.00 2,833 7.00 PHYSI CAL THERAPY 8.00 66.00 8.00 0 9.00 OCCUPATIONAL THERAPY 67.00 119 0 9.00 10.00 ELECTROCARDI OLOGY 69.00 0 198 0 10.00 DRUGS CHARGED TO PATIENTS 73.00 11 00 6.183 11 00 12.00 RURAL HEALTH CLINIC 88.00 1,056 12.00 13.00 CLI NI C 90.00 o 43, 239 0 13.00 14.00 SURGICAL ASSOCIATES 0 0 90.01 679 14.00 ORTHOPAEDI CS 15.00 90.02 15.00 460 0 0 16.00 SPECIALTY CLINIC 90.04 256, 376 16.00 PEDI ATRI CS 90.05 0 0 17.00 17.00 3,068 0 PAIN MANAGEMENT 0 18 00 90 07 18 00 17 19.00 EMERGENCY 91.00 0 37, 268 0 19.00 20.00 AMBULANCE SERVICES 95.00 224 0 20.00 1, 048, 805 E - SALARY RECLASS 1.00 ADMINISTRATIVE & GENERAL 5.00 125, 618 0 1.00 2.00 OPERATING ROOM 50.00 189, 468 0 0 2.00 0 3.00 SPEECH PATHOLOGY 68.00 72, 295 0 3.00 4.00 0 00 Ω 0 4 00 5.00 0.00 0 0 0 5.00 6.00 0.00 o 0 0 6.00 0 0. 00 7.00 0 7.00 387, 381 0 - PHYSICIAN PRACTICE ADMIN RECLASS RURAL HEALTH CLINIC 0 0 1.00 88. 00 66, 515 1.00 0 0 2.00 0.00 0 2.00 0 3.00 0.00 0 3.00 4.00 0.00 0 0 0 4.00 0 5.00 0.00 0 0 5.00 6.00 0 0.00 0 0 6.00 7.00 0.00 0 0 7.00 66, 515 Ō H - RECLASS RHC EXPENSE 1.00 ADULTS & PEDIATRICS 30, 050 30.00 0 0 1.00 30, 050 I - ECHO EXPENSE RECLASS

57,882

57,882

1, 188, 753

0

1.00

500.00

54.00

714, 971

RADI OLOGY-DI AGNOSTI C

500.00 Grand Total: Decreases

TOTALS

1.00

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

| Peri od: | Worksheet A-7 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared:

				10	12/31/2021	Date/lime Pre 5/23/2022 12:	
				Acqui si ti ons		0, 20, 2022 121	20 р
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	188, 708	0	0	0	0	1.00
2.00	Land Improvements	486, 548	62, 884		62, 884		2.00
3.00	Buildings and Fixtures	19, 120, 333	2, 978, 831	0	2, 978, 831	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fi xed Equi pment	4, 071, 057	0	0	0	428, 077	5.00
6.00	Movable Equipment	18, 331, 669	1, 307, 445	0	1, 307, 445	0	6.00
7. 00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	42, 198, 315	4, 349, 160	0	4, 349, 160		8. 00
9. 00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	42, 198, 315	4, 349, 160	0	4, 349, 160	428, 077	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00	Land	188, 708	0				1. 00
2.00	Land Improvements	549, 432	0				2.00
3. 00	Buildings and Fixtures	22, 099, 164	0				3.00
4. 00	Building Improvements	0	0				4. 00
5. 00	Fi xed Equi pment	3, 642, 980	0				5.00
6. 00	Movable Equipment	19, 639, 114	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	46, 119, 398	0				8. 00
9.00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	46, 119, 398	0				10.00

Heal th	Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2021 To 12/31/2021		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 WOR	· · · · · · · · · · · · · · · · · · ·		and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 751, 562	0	129, 24	1 267, 865	0	1.00
3.00	Total (sum of lines 1-2)	1, 751, 562	0	129, 24	1 267, 865	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	0ther	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2, 148, 668				1.00
3. 00	Total (sum of lines 1-2)	0	2, 148, 668	s			3.00

Heal th	Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od:	Worksheet A-7	
					From 01/01/2021 o 12/31/2021	Part III Date/Time Pre	pared:
						5/23/2022 12:	28 pm_
		COMF	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
	'		Leases	for Ratio	instructions)		
				(col. 1 -			
				col . 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	NEW CAP REL COSTS-BLDG & FIXT	46, 119, 398		46, 119, 398			1.00
3. 00	Total (sum of lines 1-2)	46, 119, 398		46, 119, 398			3. 00
		ALLOCAT	FION OF OTHER (CAPITAL	SUMMARY O	F CAPI TAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		1		_	
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0		1, 750, 700		1.00
3.00	Total (sum of lines 1-2)	0	0	(1, 750, 700	0	3. 00
			St	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			1			
1.00	NEW CAP REL COSTS-BLDG & FIXT	21, 650	· ·	1		2, 040, 215	1.00
3.00	Total (sum of lines 1-2)	21, 650	267, 865	(0	2, 040, 215	3.00

Cost Domier Description Bests/Code Amount Cost Denter Line # Bissl. A-7					Ic	12/31/2021	Date/lime Pre 5/23/2022 12:	
Cost Center Description								
1.00					To/From Which the Amount is t	to be Adjusted		
1.00								
1.00								
1.00								
1.00								
1.00 Investment Income - NEW CAP 1.00 2.00 3.00 4.00 5.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00		Cost Center Description		Amount	Cost Center	Li ne #		
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27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 0 *** Cost Center Deleted *** 2.00 0 27.00 28. 00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 29. 00 Physicians' assistant 0 0.00 0 29.00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 0 OCCUPATIONAL THERAPY 67.00 30.00 30. 99 Hospice (non-distinct) (see 0 ADULTS & PEDIATRICS 30.00 30.99	26. 00	Depreciation - NEW CAP REL		0		1. 00	0	26. 00
COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist O *** Cost Center Deleted *** 19.00 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.0	27 ∩∩	1		0		2 00	0	27 00
28.00 Non-physician Anesthetist 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see	۷۱.00				Jost Jenter Dereteu	2.00	O	27.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.00		Non-physician Anesthetist		0	*** Cost Center Deleted ***	l l	ļ	1
therapy costs in excess of i mitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99			۸_٥ ء	0	DOCCUBATIONAL THEDARY	1	0	
I i mi tati on (chapter 14) 30.99 Hospi ce (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99	30.00		V-0-2		JOSSOI ATTOMAL THERAPT	37.00	ļ	30.00
		limitation (chapter 14)					ļ	
	30. 99			0	DIADULTS & PEDIATRICS	30. 00	ļ	30. 99
				ı	1	1		I

From 01/01/2021

				Fi	rom 01/01/2021 o 12/31/2021	Date/Time Pre	
				Expense Classification on	Worksheet A	5/23/2022 12:	ZO PIII
				To/From Which the Amount is			
					,		
	Cost Contar Doscription	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	Cost Center Description	(2)	Amount	Cost Center	LITIE #	Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00	0.00	31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for	А	-862	NEW CAP REL COSTS-BLDG &	1. 00	9	32.00
	Depreciation and Interest			FLXT			
33. 00	CAFETERI A	В		CAFETERI A	11. 00	0	33.00
33. 01	JAIL MEALS	В		CAFETERIA	11. 00	0	33. 01
33. 02	VENDING MACHINES	В		ADMI NI STRATI VE & GENERAL	5. 00	0	33. 02
33. 03	SALE OF DRUGS	В		DRUGS CHARGED TO PATIENTS	73.00	0	33. 03
33. 04	SALE OF SUPPLIES	В	0	MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 04
33. 05	SALE OF PODIATRY SUPPLIES	В	7 005	PATIENTS MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 05
33. 03	SALE OF PODIATRY SUPPLIES	D	-1, 900	PATIENTS	71.00	U	33.03
33. 06	PHYSICIAN APPLICATION FEES	В	-315	ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 07	NSF FEES	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 07
33. 08	MEDICAL RECORDS TRANSCRIPTION	В		MEDICAL RECORDS & LIBRARY	16. 00	0	33. 08
	FEES	_				_	
33.09	COPI ER FEES	В	-2, 688	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	ATHLETIC TRAINER - SCHOOL REV	В	-9, 025	ADMINISTRATIVE & GENERAL	5. 00	0	33. 10
33. 11	OCCUPATI ONAL HEALTH	В	-81, 959	CLI NI C	90. 00	0	33. 11
33. 12	SALE OF SCRAP	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 13	SHUTTLE BUS SERVICES	В	-1, 980	AMBULANCE SERVICES	95. 00	0	33. 13
33. 14	MISC. INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 14
33. 15	MISC. INCOME	В		RHEUMATOLOGY	90. 03	0	33. 15
33. 16	INTEREST INCOME	В	-107, 591	NEW CAP REL COSTS-BLDG &	1. 00	11	33. 16
00 47	TEL EDUCATE CALABY		5 007	FIXT	5 00		00.47
33. 17	TELEPHONE SALARY	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	TELEPHONE OTHER	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19 33. 20	TELEPHONE BENEFITS ADVERTISING	A A		ADMINISTRATIVE & GENERAL EMPLOYEE BENEFITS DEPARTMENT	5. 00 4. 00	0	33. 19 33. 20
33. 21	I HA & AHA LOBBYI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 20
33. 21	REBATES	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 21
33. 23	REBATES	В		OPERATION OF PLANT	7. 00	0	33. 23
33. 24	REBATES	В		HOUSEKEEPI NG	9. 00	0	33. 24
33. 25	REBATES	В		DI ETARY	10. 00	0	33. 25
33. 26	REBATES	В		NURSING ADMINISTRATION	13. 00	0	33. 26
33. 27	REBATES	В	-2, 281	OPERATING ROOM	50.00	0	33. 27
33. 28	REBATES	В	0	RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 28
33. 29	REBATES	В	0	LABORATORY	60.00	0	33. 29
33. 30	REBATES	В	0	ELECTROCARDI OLOGY	69. 00	0	33. 30
33. 31	REBATES	В	-135, 217	DRUGS CHARGED TO PATIENTS	73. 00	0	
33. 32	HAF EXPENSE	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 32
33. 33	PHYSICIAN RECRUITMENTS	A	-	ADMI NI STRATI VE & GENERAL	5. 00	0	33. 33
33. 34	BAD DEBTS	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 35	MI SC. I NCOME	A		OPERATION OF PLANT	7. 00	0	33. 35
33. 36	MISC. INCOME	A		ADULTS & PEDIATRICS	30.00	0	
33. 37	ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 37
33. 38	REBATES	A		EMERGENCY	91. 00	0	33. 38
50. 00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		-9, 552, 935				50.00
	column 6, line 200.)						
(1) Do	escription - all chapter referen	nces in this co	lumn nertain t	o CMS Pub 15_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

Period: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/23/2022 12: 28 pm

								5/23/2022 12:	28 pm_
	Wkst. A Line #	Cost Center/Physician	Total	Professi ona	al	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	-	Component		ider Component	
		1 401121 11 01	110	00p0011		oomponone.		Hours	
	1 00	2.00	2.00	4.00		Г 00	/ 00	7. 00	
1 00	1. 00		3. 00	4. 00	0.4.4	5. 00	6. 00		1.00
1. 00		ADULTS & PEDIATRICS	952, 261	909, 2		42, 995			
2.00		OPERATING ROOM	619, 982			5, 816	0		
3.00	54.00	RADI OLOGY-DI AGNOSTI C	728, 573	713, 6	675	14, 898	0	0	3.00
4.00	54. 01	ONCOLOGY	223, 350	223, 3	350	0	0	l 0	4.00
5. 00	60.00	LABORATORY	38, 400		0	38, 400	0	0	5.00
6. 00		CLINIC	560, 397		755	15, 642	Ö	_	
7. 00		SURGICAL ASSOCIATES	560, 236			5, 932	0	1	
8. 00	90. 02	ORTHOPAEDI CS	903, 729	885, (009	18, 720	0	0	8. 00
9.00	90. 03	RHEUMATOLOGY	535, 900	501, 1	164	34, 736	0	0	9. 00
10.00	90. 04	SPECIALTY CLINIC	967, 671	948, 9	950	18, 721	0	0	10.00
11.00	90.05	PEDI ATRI CS	443, 332	417, (069	26, 263	0	0	11.00
12. 00		PAIN MANAGEMENT	761, 718			11, 875	ĺ	1	12.00
13.00	91.00	EMERGENCY	1, 148, 050		0	1, 148, 050	0	0	13.00
200.00			8, 443, 599			1, 382, 048		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent o	of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadiusted F	RCE N	Memberships &	Component	of Mal practice	
				Limit		Conti nui ng	Share of col.	Insurance	
						Education	12		
	1.00	2.00	8. 00	9. 00		12. 00	13. 00	14.00	
1. 00		ADULTS & PEDIATRICS	0.00		0	12.00	13.00		1. 00
2. 00		OPERATING ROOM	0		0	0	0		
3.00	54. 00	RADI OLOGY-DI AGNOSTI C	0		0	0	0	0	3.00
4.00	54. 01	ONCOLOGY	0		0	0	0	0	4.00
5.00	60, 00	LABORATORY	0		0	0	0	0	5. 00
6. 00		CLINIC	0		0	0	Ö	1	1
		SURGICAL ASSOCIATES			0	0		0	
7.00			1		0	-	U	1	
8. 00		ORTHOPAEDI CS	0		0	0	U	0	
9. 00		RHEUMATOLOGY	0		0	0	0	0	9. 00
10.00	90. 04	SPECIALTY CLINIC	0		0	0	0	0	10.00
11.00	90. 05	PEDI ATRI CS	l o		0	0	0	l 0	11.00
12.00		PAIN MANAGEMENT	0		0	0	0	0	12.00
13. 00		EMERGENCY	0		0	0		0	
	71.00	LWENGLINGT			-	0		_	
200.00		0 1 0 1 (8)	0		0		0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RO		RCE	Adjustment		
		l denti fi er	Component	Limit		Di sal I owance			
			Share of col.						
			14						
	1. 00	2.00	15. 00	16. 00		17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	0		0	0	909, 266		1.00
2. 00		OPERATING ROOM			0	0	614, 166	•	2.00
				1			·		
3. 00		RADI OLOGY-DI AGNOSTI C	0	1	0	0	713, 675		3.00
4.00		ONCOLOGY	0		0	0	223, 350		4. 00
5.00	60.00	LABORATORY	0		0	0	0		5.00
6.00	90.00	CLINIC	l o	1	0	0	544, 755		6. 00
7. 00		SURGI CAL ASSOCI ATES	l o		0	0	554, 304		7. 00
8. 00		ORTHOPAEDI CS			0	0	885, 009		8.00
			-		0	-			
9. 00		RHEUMATOLOGY	0		0	0	501, 164		9. 00
10.00		SPECIALTY CLINIC	0		0	0	948, 950		10.00
11.00	90. 05	PEDI ATRI CS	0		0	0	417, 069		11.00
12.00	90. 07	PAIN MANAGEMENT	0		0	0	749, 843		12.00
13. 00		EMERGENCY	0		0	0	0		13. 00
200.00	,1.00		Ö		0	0	7, 061, 551		200.00
200.00	l	I	ı	I	U	U	1,001,001	I	200.00

Period: Worksheet B From 01/01/2021 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-1304

						o 12/31/2021	Date/Time Pre 5/23/2022 12:	pared:
				CAPI TAL			3/23/2022 12.	26 piii
				RELATED COSTS				
		Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMINISTRATIV	
			for Cost Allocation	FLXT	BENEFITS DEPARTMENT		E & GENERAL	
			(from Wkst A		DELYAKTMENT			
			col. 7)					
	OFNED	AL CERVACE COCT OFFITERS	0	1. 00	4. 00	4A	5. 00	
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT	2, 040, 215	2, 040, 215				1.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	5, 354, 501	77, 542				4.00
5. 00		ADMINISTRATIVE & GENERAL	5, 129, 010	153, 317			6, 139, 682	5.00
7.00	00700	OPERATION OF PLANT	1, 255, 860	239, 301				7. 00
8.00		LAUNDRY & LINEN SERVICE	106, 652	12, 257			l .	8. 00
9.00	1	HOUSEKEEPI NG	890, 535	48, 805			l .	9.00
10.00		DI ETARY CAFETERI A	165, 111	71, 702 17, 205				1
11. 00 13. 00		NURSING ADMINISTRATION	238, 112 157, 839	2, 269			1	1
14. 00		CENTRAL SERVICES & SUPPLY	258, 144	45, 253			1	14.00
16.00		MEDICAL RECORDS & LIBRARY	504, 922	78, 900			141, 626	•
		IENT ROUTINE SERVICE COST CENTERS				,		
30.00		ADULTS & PEDIATRICS	1, 175, 174	153, 001	549, 996	1, 878, 171	397, 261	30.00
FO 00		LARY SERVICE COST CENTERS OPERATING ROOM	070 (22	127 001	242.270	1 240 004	200 272	FO 00
50. 00 51. 00		RECOVERY ROOM	878, 633 202, 330	127, 091 10, 955	362, 370 51, 927		289, 372 56, 096	50.00 51.00
53. 00		ANESTHESI OLOGY	202, 330	10, 755			0	53.00
54. 00	1	RADI OLOGY-DI AGNOSTI C	1, 163, 641	74, 864		-	333, 856	•
54. 01		ONCOLOGY	402, 291	72, 260			121, 845	1
55.00		RADI OLOGY-THERAPEUTI C	0	0			0	55.00
60.00		LABORATORY	2, 060, 544	52, 284			496, 121	60.00
65.00		RESPIRATORY THERAPY	197, 320	2, 604			51, 759	1
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	357, 337 233, 282	36, 753 16, 052			l	1
68. 00		SPEECH PATHOLOGY	75, 656	3, 367				•
69. 00		ELECTROCARDI OLOGY	169, 666	20, 404			l	1
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	O	0	0	70.00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 021, 761	0			216, 118	1
72.00		I MPL. DEV. CHARGED TO PATIENT	634, 388	0		,	i .	1
73. 00		DRUGS CHARGED TO PATIENTS TIENT SERVICE COST CENTERS	5, 352, 629	39, 896	162, 084	5, 554, 609	1, 174, 893	73.00
88. 00		RURAL HEALTH CLINIC	1, 643, 760	120, 954	413, 558	2, 178, 272	460, 737	88. 00
90.00		CLINIC	597, 595	179, 282		· · ·	1	1
90. 01	09001	SURGI CAL ASSOCI ATES	72, 221	30, 801	19, 974	122, 996	26, 015	
90. 02	1	ORTHOPAEDI CS	-49	19, 158			32, 781	90.02
90.03		RHEUMATOLOGY	-15, 791	42, 147		·		1
90. 04 90. 05	1	SPECIALTY CLINIC PEDIATRICS	244, 213 84, 644	59, 277 62, 476		·	130, 381 59, 234	90. 04 90. 05
90.06		WOMEN'S HEALTH	04, 044	02, 470			0 0	90.06
90. 07		PAIN MANAGEMENT	-28, 281	28, 625	161, 899	162, 243		90. 07
90.08	09008	ONCOLOGY MD	0	0				
	1	EMERGENCY	2, 267, 600	74, 399	281, 469	2, 623, 468	554, 903	
92.00		OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
05 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	133, 276	31, 396	30, 335	195, 007	41 247	95.00
95.00		AL PURPOSE COST CENTERS	133, 270	31, 390	30, 330	195,007	41, 247	95.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	35, 024, 741	2, 004, 597	5, 393, 489	34, 950, 569	6, 093, 943	118. 00
	NONRE	IMBURSABLE COST CENTERS		, ,				
		PHYSICIANS' PRIVATE OFFICES	0	0				192. 00
		NONPAI D WORKERS	0	0		_		193.00
		FOUNDATION OCCUPATIONAL MEDICINE	142, 073	35, 618	38, 554	216, 245	45, 739	193. 01 193. 02
		GUEST MEALS		0	i o	0		193. 02
	1	NON REIMBURSABLE	0	0		0		194. 00
200.00		Cross Foot Adjustments]	0		200.00
201.00		Negative Cost Centers		0	0	0		201.00
202.00)	TOTAL (sum lines 118 through 201)	35, 166, 814	2, 040, 215	5, 432, 043	35, 166, 814	6, 139, 682	202. 00

Provider CCN: 15-1304

Peri od: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Ti me Prepared: 5/23/2022 12:28 pm

				12/31/2021	5/23/2022 12:	
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	
GENERAL SERVICE COST CENTERS						
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 00700 OPERATION OF PLANT	1, 938, 913					7.00
8. 00 00800 LAUNDRY & LINEN SERVICE	15, 137	159, 197				8.00
9. 00 00900 HOUSEKEEPI NG	60, 272	11, 174				9.00
10. 00 01000 DI ETARY	88, 547	4, 581	68, 053	491, 402		10.00
11. 00 01100 CAFETERI A	21, 247	4, 361	16, 329	471, 402	423, 606	1
				0		1
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	2, 802	0	_,	0	2, 157	1
	55, 884	0		U O	6, 450	1
16. 00 01600 MEDI CAL RECORDS & LI BRARY	97, 436	0	74, 885	0	16, 719	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	100.04/	400.005	145.045	404 400	4/ //0	00.00
30. 00 03000 ADULTS & PEDIATRICS	188, 946	103, 805	145, 215	491, 402	46, 662	30.00
ANCILLARY SERVICE COST CENTERS	457.050	40.440	100 (04	ما	0/ 700	
50. 00 05000 OPERATING ROOM	156, 950	10, 419		0	26, 729	
51. 00 05100 RECOVERY ROOM	13, 529	0		0	8, 823	1
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	92, 452	6, 732		0	30, 396	
54. 01 05401 0NC0L0GY	89, 236	0	68, 583	0	13, 785	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	
60. 00 06000 LAB0RAT0RY	64, 567	0	49, 623	0	32, 122	60.00
65. 00 06500 RESPI RATORY THERAPY	3, 216	1, 341	2, 471	0	5, 242	65.00
66. 00 06600 PHYSI CAL THERAPY	45, 387	3, 134	34, 883	0	10, 743	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	19, 823	1, 441	15, 235	0	6, 493	67.00
68. 00 06800 SPEECH PATHOLOGY	4, 157	61	3, 195	0	2, 136	68.00
69. 00 06900 ELECTROCARDI OLOGY	25, 197	0	19, 366	0	4, 293	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	ol	0	l o	o	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	49, 269	0		o	14, 497	
OUTPATIENT SERVICE COST CENTERS			, , , , , , , ,			
88. 00 08800 RURAL HEALTH CLINIC	149, 370	0	114, 799	0	54, 064	88.00
90. 00 09000 CLI NI C	221, 403	0		o	40, 039	1
90. 01 09001 SURGI CAL ASSOCI ATES	38, 037	0		0	4, 120	1
90. 02 09002 ORTHOPAEDI CS	23, 658	0		0	4, 703	1
90. 03 09003 RHEUMATOLOGY	52, 049	0	40, 002	0	7, 594	1
90. 04 09004 SPECI ALTY CLINI C	73, 203	0	56, 261	0	24, 421	1
90. 05 09005 PEDI ATRI CS	77, 154	0	59, 297	0	11, 498	
90. 06 09006 WOMEN' S HEALTH	0	0	0,,2,,	0	0	1
90. 07 09007 PAI N MANAGEMENT	35, 350	0	27, 168	0	8, 047	
90. 08 09008 0NCOLOGY MD	00,000	0	27,100	o o	0, 017	1
91. 00 09100 EMERGENCY	91, 877	16, 509	70, 613	0	35, 919	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	71,077	10, 309	70,013		33, 717	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
95. 00 09500 AMBULANCE SERVI CES	38, 772	0	29, 799	0	1, 963	95. 00
SPECIAL PURPOSE COST CENTERS	30, 112	0	27, 177	U _I	1, 703	75.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 894, 927	159, 197	1, 398, 398	491, 402	419, 615	110 00
	1, 094, 927	139, 197	1, 390, 390	491, 402	419, 013	1110.00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES		0		0	0	192.00
	0	0		0		
193. 00 19300 NONPALD WORKERS	0	0	-	0		193.00
193. 01 19301 FOUNDATI ON	43, 986	0	33, 806	0		193. 01
193. 02 19302 OCCUPATI ONAL MEDI CI NE	0	0	0	0		193. 02
193. 03 19303 GUEST MEALS	0	0	0	0		193. 03
194. 00 07950 NON REI MBURSABLE	0	0	0	0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	1, 938, 913	159, 197	1, 432, 204	491, 402	423, 606	202.00

RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1304 Peri od: Worksheet B From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/23/2022 12:28 pm Cost Center Description NURSI NG CENTRAL MEDI CAL Subtotal Intern & ADMI NI STRATI O RECORDS & SERVICES & Resi dents **SUPPLY** LI BRARY Cost & Post Ν Stepdown Adjustments 13.00 14.00 16.00 24.00 25.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 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 13.00 250, 705 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 508, 977 14.00 16.00 01600 MEDICAL RECORDS & LIBRARY 485 1,000,732 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 429, 975 30.00 48, 777 8, 461 3, 738, 675 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 27, 952 120, 719 2, 120, 859 0 50.00 0 05100 RECOVERY ROOM 9, 219 51 00 2, 217 94, 561 460,055 0 51.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 2, 268, 691 54.00 54.00 31, 778 9, 529 114, 491 0 05401 ONCOLOGY 14, 401 54.01 887, 058 0 54.01 3, 150 0 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 55.00 60.00 06000 LABORATORY 33, 580 120, 215 0 3, 141, 789 0 60.00 06500 RESPIRATORY THERAPY 65.00 5, 487 1, 309 2, 120 317, 652 0 65.00 66 00 06600 PHYSI CAL THERAPY 11, 240 783 O 687, 846 66 00 0 06700 OCCUPATIONAL THERAPY 67.00 6,777 431 0 428, 927 0 67.00 68.00 06800 SPEECH PATHOLOGY 2, 233 124 0 132, 500 0 68.00 06900 ELECTROCARDI OLOGY 69.00 4, 477 1,576 0 319, 925 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70 00 0 70 00 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 81,060 1, 318, 939 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 114, 719 0 883, 290 0 72.00 07300 DRUGS CHARGED TO PATIENTS 15, 164 73.00 4.201 0 6, 850, 499 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 5, 969 0 2, 963, 211 0 88.00 09000 CLI NI C 0 0 1, 759, 404 90.00 90.00 10,665 0 0 90.01 09001 SURGI CAL ASSOCI ATES 246 0 220, 648 0 90.01 0 90.02 90.02 09002 ORTHOPAEDI CS 82 234, 388 0 90.03 09003 RHEUMATOLOGY 0 50 0 311, 389 0 90.03 90 04 09004 SPECIALTY CLINIC 0 6, 798 0 907, 477 0 90.04 09005 PEDI ATRI CS 0 0 90.05 90.05 2,059 489, 289 0 09006 WOMEN'S HEALTH 0 O 90.06 0 0 90.06 90.07 09007 PAIN MANAGEMENT 0 307 0 267, 432 0 90.07 09008 ONCOLOGY MD 90.08 90.08 0 0 0 3, 804, 002 91.00 91.00 09100 EMERGENCY 37.558 13, 570 359, 585 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 2,062 0 309, 102 252 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 250, 705 508, 977 1,000,732 34, 823, 047 0 118.00 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 0 193. 00 19300 NONPALD WORKERS 0 C 0 0 193.00 193. 01 19301 FOUNDATI ON 0 0 0 343, 767 0 193. 01 0 193. 02 19302 OCCUPATIONAL MEDICINE 0 0 193.02 0 0 193. 03 19303 GUEST MEALS 0 0 193.03 0 C 0

0

250, 705

C

508, 977

0

1, 000, 732

0

0

35, 166, 814

0 194.00 0 200.00

0 201.00

0 202.00

194.00 07950 NON REI MBURSABLE

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

202.00

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

Provider CCN: 15-1304 Period: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

			То		
	Cost Center Description	Total		5/23/2022 12:	. 20 piii
		26. 00			
	GENERAL SERVICE COST CENTERS				
1	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
1	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
1	00500 ADMINISTRATIVE & GENERAL				5.00
1	00700 OPERATION OF PLANT				7. 00
1	00800 LAUNDRY & LINEN SERVICE				8. 00
	00900 HOUSEKEEPI NG				9.00
1	01000 DI ETARY				10.00
1	O1100 CAFETERI A				11.00
	01300 NURSI NG ADMI NI STRATI ON				13.00
1	01400 CENTRAL SERVICES & SUPPLY				14.00
-	01600 MEDI CAL RECORDS & LI BRARY				16. 00
-	NPATIENT ROUTINE SERVICE COST CENTERS	0.700.475			
	03000 ADULTS & PEDIATRICS	3, 738, 675			30.00
	ANCILLARY SERVICE COST CENTERS	2 120 050			
1	05000 OPERATING ROOM	2, 120, 859			50.00
	05100 RECOVERY ROOM	460, 055			51.00
1	05300 ANESTHESI OLOGY	0			53.00
1	05400 RADI OLOGY - DI AGNOSTI C	2, 268, 691			54.00
	05401 ONCOLOGY	887, 058			54. 01
1	05500 RADI OLOGY-THERAPEUTI C	0			55.00
1	06000 LABORATORY	3, 141, 789			60.00
1	06500 RESPI RATORY THERAPY	317, 652			65.00
1	06600 PHYSI CAL THERAPY	687, 846			66.00
1	06700 OCCUPATI ONAL THERAPY	428, 927 132, 500			67.00
1	06800 SPEECH PATHOLOGY				68. 00 69. 00
1	D6900 ELECTROCARDI OLOGY D7000 ELECTROENCEPHALOGRAPHY	319, 925 0			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 318, 939			71.00
1	07200 IMPL. DEV. CHARGED TO PATIENT	883, 290			71.00
1	07300 DRUGS CHARGED TO PATIENTS	6, 850, 499			73.00
	DUTPATIENT SERVICE COST CENTERS	0, 030, 477			73.00
	D8800 RURAL HEALTH CLINIC	2, 963, 211			88. 00
1	09000 CLI NI C	1, 759, 404			90.00
1	09001 SURGI CAL ASSOCI ATES	220, 648			90. 01
1	09002 ORTHOPAEDI CS	234, 388			90. 02
	09003 RHEUMATOLOGY	311, 389			90. 03
90. 04	09004 SPECIALTY CLINIC	907, 477			90. 04
1	09005 PEDI ATRI CS	489, 289			90. 05
90.06	09006 WOMEN'S HEALTH	O			90.06
90. 07	09007 PAIN MANAGEMENT	267, 432			90. 07
90.08	09008 ONCOLOGY MD	0			90.08
91.00	09100 EMERGENCY	3, 804, 002			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
-	OTHER REIMBURSABLE COST CENTERS				
	09500 AMBULANCE SERVICES	309, 102			95.00
S	SPECIAL PURPOSE COST CENTERS				
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	34, 823, 047			118. 00
	NONREI MBURSABLE COST CENTERS				-
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.00
	19300 NONPAL ON THE STATE OF TH	0			193.00
	19301 FOUNDATION	343, 767			193. 01
	19302 OCCUPATI ONAL MEDI CI NE	0			193. 02
1	19303 GUEST MEALS	0			193. 03
	07950 NON REI MBURSABLE	0			194.00
200.00	Cross Foot Adjustments	0			200. 00 201. 00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118 through 201)	- 1			201.00
202.00	TOTAL (Sum Titles 118 through 201)	35, 166, 814			1202.00

| Period: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1304

					Ť	0 12/31/2021	Date/Time Pre 5/23/2022 12:	pared:
				CAPI TAL			5/23/2022 12:	28 piii
				RELATED COSTS				
		Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI V	
			Assigned New	FI XT		BENEFI TS	E & GENERAL	
			Capi tal			DEPARTMENT		
			Related Costs 0	1. 00	2A	4. 00	5. 00	
	GENER	AL SERVICE COST CENTERS	U	1.00	I ZA	4.00	5.00	
1.00		NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	77, 542	77, 542	77, 542		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	153, 317	153, 317	12, 245	165, 562	5.00
7.00	4	OPERATION OF PLANT	0	239, 301		1, 502	9, 129	7.00
8. 00	4	LAUNDRY & LINEN SERVICE	0	12, 257		0	678	8. 00
9.00		HOUSEKEEPI NG	0	48, 805		2, 624	6, 407	9.00
10.00	4	DI ETARY	0	71, 702		510	1, 555	10.00
11. 00 13. 00	1	CAFETERIA NURSI NG ADMI NI STRATI ON	0	17, 205 2, 269		904 585	1, 817	11. 00 13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY	0	45, 253		426	1, 147 1, 901	14.00
16. 00		MEDICAL RECORDS & LIBRARY	0			1, 224	3, 819	16.00
		ENT ROUTINE SERVICE COST CENTERS		707700	707700	.,	0,017	
30.00		ADULTS & PEDIATRICS	0	153, 001	153, 001	7, 850	10, 713	30.00
		LARY SERVICE COST CENTERS				,		
50.00		OPERATI NG ROOM	0	127, 091		5, 172	7, 804	50.00
51.00		RECOVERY ROOM	0	10, 955		741	1, 513	51.00
53.00	4	ANESTHESI OLOGY	0	74 944	1	4 953	0 003	53.00
54. 00 54. 01		RADI OLOGY-DI AGNOSTI C ONCOLOGY	0	74, 864 72, 260		4, 852 1, 449	9, 003 3, 286	54. 00 54. 01
55. 00	4	RADI OLOGY-THERAPEUTI C	0	72, 260		1, 449	3, 200	55. 00
60.00		LABORATORY	0	52, 284		3, 322	13, 379	60.00
65. 00		RESPI RATORY THERAPY	0	2, 604		639	1, 396	
66.00		PHYSI CAL THERAPY	0	36, 753		1, 228	2, 739	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16, 052	16, 052	903	1, 783	67.00
68.00	1	SPEECH PATHOLOGY	0	3, 367		293	568	68.00
69. 00		ELECTROCARDI OLOGY	0	20, 404		409	1, 248	
70.00	1	ELECTROENCEPHALOGRAPHY	0	0	1	0	0	70.00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	5, 828	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	0	0 39, 896	1	0 2, 314	3, 619 31, 674	72. 00 73. 00
73.00		TIENT SERVICE COST CENTERS	0	37, 070	37, 070	2,314	31,074	73.00
88. 00		RURAL HEALTH CLINIC	0	120, 954	120, 954	5, 903	12, 425	88. 00
90.00	09000	CLINIC	0	179, 282	179, 282	4, 429	6, 201	90.00
90. 01		SURGI CAL ASSOCI ATES	0	30, 801	30, 801	285	702	90. 01
90. 02		ORTHOPAEDI CS	0	19, 158		1, 939	884	90. 02
90. 03	1	RHEUMATOLOGY	0	42, 147		2, 118	997	90.03
90. 04 90. 05		SPECI ALTY CLINI C PEDI ATRI CS	0	59, 277		4, 467	3, 516	90. 04 90. 05
90.03	1	WOMEN' S HEALTH	0	62, 476 0	62, 476	1, 897 0	1, 597 0	90.03
90. 07		PAIN MANAGEMENT	0	28, 625	28, 625	2, 311	925	90.07
90. 08	1	ONCOLOGY MD	0	0	0	0	0	90. 08
91.00		EMERGENCY	0	74, 399	74, 399	4, 018	14, 964	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
		REIMBURSABLE COST CENTERS						
95. 00		AMBULANCE SERVICES	0	31, 396	31, 396	433	1, 112	95. 00
118.00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 004, 597	2, 004, 597	76, 992	164, 329	118 00
110.00		IMBURSABLE COST CENTERS	0	2,004,377	2,004,377	70, 772	104, 327	110.00
192.00		PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
		NONPALD WORKERS	0	0	0	0		193. 00
		FOUNDATI ON	0	35, 618	35, 618	550		193. 01
		OCCUPATIONAL MEDICINE	0	0	0	0		193. 02
		GUEST MEALS	0	0		0		193. 03
		NON REIMBURSABLE	0	0	0	0		194.00
200.00		Cross Foot Adjustments		_				200. 00 201. 00
201. 00 202. 00		Negative Cost Centers TOTAL (sum lines 118 through 201)	0	2, 040, 215	2, 040, 215	77, 542	165, 562	
202.00	7	TOTAL (Sum TITIES TTO LITTOUGH 201)	ı	2,040,213	2,040,213	11, 542	100, 502	202.00

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1304

COST CENTER DESCRIPTION PREMATI IN INTERS SERVICE DICTARY CAPETERIA					To	12/31/2021	Date/Time Pre 5/23/2022 12:	
SERVERAL SERVICE COST CENTERS		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DLETARY		ZO pili
GERERAL SERVICE COST CENTERS		555 55 TELEVISION 5555 TELEVIS			I I I I I I I I I I I I I I I I I I I	51217	07.11 2.12.11.71	
1.00			7. 00		9.00	10.00	11. 00	
0.0000 DIPLOYER BENEFITS DEPARTMENT	GE	ENERAL SERVICE COST CENTERS						
5.00 00500 ADM INSTRATIVE & GENERAL 249, 932 14, 986 27, 700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 00700 007000 00700 00700 00700 00700 00700 00700 00700 00	1.00 00	D100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00 0.0700 DEPARTION OF PLANT 249, 932								
B. 00								5.00
0.000 0.0000 HOUSEKEEPING			· ·					
10.00 01000 DIETARY 11, 414 428 3, 167 88, 776 0.00 22, 42 11.00 13.00 0350 CAFETERIA 2, 739 0.0 760 0.0 23, 425 11.00 13.00 0350 NURSING ADMINISTRATION 361 0.0 1.00 0.0 1.19 13.00 0.0 0.0 3.57 14.00 14.00 14.00 0100 CENTRAL SERVICES & SUPPLY 7, 704 0.0 1.099 0.0 3.57 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00			· ·					1
11.00 01100 CAFETERIA 2,739 0 760 0 23,425 11.00 14.00 119 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.	1		1					1
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90. 05		l e e e e e e e e e e e e e e e e e e e		0		- 1		1
90. 06		l e e e e e e e e e e e e e e e e e e e		0		- 1		1
90. 07		l e e e e e e e e e e e e e e e e e e e	0	Ö		o		1
91. 00 09100 EMERGENCY 11, 843 1, 544 3, 286 0 1, 986 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 95. 00 OTHER REI MBURSABLE COST CENTERS 095.00 AMBULANCE SERVI CES 4, 998 0 1, 387 0 109 95. 00 OSPECI AL PURPOSE COST CENTERS 0 109 OSPECI AL PURPOSE COST CENTERS 0 0 0 0 0 0 0 0 0			4, 557	0	1, 264	0		1
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 4, 998 0 1, 387 0 109 95. 00 0 0 0 0 0 0 0 0 0	90. 08 09	9008 ONCOLOGY MD	0	0		0	0	90. 08
OTHER REI MBURSABLE COST CENTERS 4,998 0 1,387 0 109 95.00	91.00 09	9100 EMERGENCY	11, 843	1, 544	3, 286	0	1, 986	91.00
95. 00 09500 AMBULANCE SERVI CES 4, 998 0 1, 387 0 109 95. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 244, 262 14, 886 65, 077 88, 776 23, 204 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 193. 01 19301 FOUNDATI ON 5, 670 0 1, 573 0 221 193. 01 193. 02 19302 OCCUPATI ONAL MEDICI NE 0 0 0 0 193. 02 193. 03 19303 GUEST MEALS 0 0 0 0 0 193. 03 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 0 194. 00 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 0 0 0								92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 244, 262 14,886 65,077 88,776 23,204 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 192.00 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 193.00 193.01 19301 FOUNDATI ON 5,670 0 1,573 0 221 193.01 193.01 193.02 193.02 193.02 193.02 193.02 193.03 193.03 193.03 193.03 193.03 GUEST MEALS 0 0 0 0 0 0 0 193.03 194.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00 195.00								
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 244, 262 14, 886 65, 077 88, 776 23, 204 118.00			4, 998	0	1, 387	0	109	95. 00
NONREI MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 192.00	-			11.00/	l (5.000)	00.77/	20.004	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES			244, 262	14, 886	65,077	88, 776	23, 204	1118.00
193.00 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 193.00 193.01 19301 FOUNDATI ON 5, 670 0 1, 573 0 221 193.01 193.02 193.02 OCCUPATI ONAL MEDI CI NE 0 0 0 0 0 0 193.02 193.03 19303 GUST MEALS 0 0 0 0 0 0 193.03 194.00 07950 NON REI MBURSABLE 0 0 0 0 0 0 194.00 200.00 Cross Foot Adjustments 200.00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 201.00			0			ما	0	102.00
193. 01 19301 FOUNDATION 5, 670 0 1, 573 0 221 193. 01 193. 02 19302 OCCUPATIONAL MEDICINE 0 0 0 0 0 193. 02 193. 03 19303 GUEST MEALS 0 0 0 0 0 0 193. 03 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 0 194. 00 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00			0	0	_	- 1		1
193.02 19302 OCCUPATIONAL MEDICINE 0 0 0 0 193.02 193.03 19303 GUEST MEALS 0 0 0 0 0 193.03 194.00 07950 NON REI MBURSABLE 0 0 0 0 0 194.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00			5 670			0		
193. 03 19303 GUEST MEALS 0 0 0 0 193. 03 194. 00 07950 NON REI MBURSABLE 0 0 0 0 0 194. 00 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 0			3,070	0	_	0		
194.00 07950 NON REIMBURSABLE 0 0 0 0 194.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 0					1	- 1		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 0 0 0			o			ol Ol		
201.00 Negative Cost Centers 0 0 0 0 0 201.00						٩	O	
			0	О	o	ol	0	
		9	249, 932	14, 886	66, 650	88, 776		

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2021 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1304

					To	om 01/01/2021 12/31/2021	Part II Date/Time Pre 5/23/2022 12:	
		Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	20 pm
			13. 00	14. 00	16. 00	24.00	25. 00	
4 00		AL SERVICE COST CENTERS				T		4 00
1. 00 4. 00	1	NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5. 00	1	ADMINISTRATIVE & GENERAL						5. 00
7.00	1	OPERATION OF PLANT						7. 00
8. 00	1	LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY						9. 00 10. 00
11. 00	1	CAFETERI A						11. 00
13.00	1	NURSING ADMINISTRATION	4, 581					13.00
14. 00 16. 00	1	CENTRAL SERVICES & SUPPLY MEDICAL RECORDS & LIBRARY	0	57, 140 54	100, 967			14. 00 16. 00
10.00		I ENT ROUTINE SERVICE COST CENTERS	<u> </u>	54	100, 707			10.00
30.00	03000	ADULTS & PEDIATRICS	891	950	43, 381	348, 962	0	30. 00
		LARY SERVICE COST CENTERS			_		_	
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	511 168	13, 553 249	0 9, 541	182, 427 25, 883	0	50.00 51.00
53.00		ANESTHESI OLOGY	0	0	9, 541	25, 863	0	53.00
54.00		RADI OLOGY-DI AGNOSTI C	581	1, 070	11, 551	119, 456	0	54.00
54. 01		ONCOLOGY	263	354	0	93, 069	0	54. 01
55. 00 60. 00	1	RADI OLOGY-THERAPEUTI C LABORATORY	0 614	0 13, 496	0	95, 503	0	55. 00 60. 00
65.00	1	RESPI RATORY THERAPY	100	13, 470	214	6, 045	0	65.00
66.00		PHYSI CAL THERAPY	205	88	0	49, 374	0	66. 00
67.00		OCCUPATIONAL THERAPY	124	48	0	22, 668	0	67.00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	41 82	14 177	0	5, 092 26, 706	0	68. 00 69. 00
70.00	1	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 100	0	14, 928	0	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	0 277	12, 879 472	0	16, 498 83, 548	0	72. 00 73. 00
73.00		TIENT SERVICE COST CENTERS	211	472	U	03, 340	0	/3.00
88.00		RURAL HEALTH CLINIC	0	670	0	167, 538	0	88. 00
90.00		CLINIC	0	1, 197	0	229, 782	0	90.00
90. 01 90. 02		SURGI CAL ASSOCI ATES ORTHOPAEDI CS	0	28 9	0	38, 307 26, 146	0	90. 01 90. 02
90. 02	1	RHEUMATOLOGY		6	0	54, 259	0	90.02
90. 04	1	SPECIALTY CLINIC	О	763	0	81, 427	0	90. 04
90.05	1	PEDI ATRI CS	0	231	0	79, 541	0	90.05
90. 06 90. 07	1	WOMEN'S HEALTH PAIN MANAGEMENT		0 34	0	0 38, 161	0	90. 06 90. 07
90. 08		ONCOLOGY MD	o	0	0	0	0	90.08
91.00		EMERGENCY	686	1, 523	36, 280	150, 529	0	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS					0	92.00
95. 00		AMBULANCE SERVICES	38	28	0	39, 501	0	95. 00
		AL PURPOSE COST CENTERS				31, 331,	_	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4, 581	57, 140	100, 967	1, 995, 350	0	118. 00
192 00		IMBURSABLE COST CENTERS PHYSICIANS' PRIVATE OFFICES	ol	0	0	0	0	192. 00
		NONPALD WORKERS	Ö	0	0	ő	0	193. 00
		FOUNDATI ON	o	0	0	44, 865		193. 01
		OCCUPATIONAL MEDICINE GUEST MEALS	0	0	0	0		193. 02 193. 03
		NON REIMBURSABLE		0	0	0		193. 03
200.00		Cross Foot Adjustments				Ö	0	200. 00
201.00		Negative Cost Centers	0	0	100.07	0 040 045	0	201.00
202.00	기	TOTAL (sum lines 118 through 201)	4, 581	57, 140	100, 967	2, 040, 215	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-1304 | Peri od: | Worksheet B | From 01/01/2021 | Part I I | To 12/31/2021 | Date/Time Prepared:

		To 12/31/2021 Date/Time Pre	
Cost Center Description	Total	5/23/2022 12.	ZO PIII
0001 001101 20001 1 211 011	26. 00		
GENERAL SERVICE COST CENTERS			
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT			1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 00 00500 ADMINI STRATI VE & GENERAL			5.00
7.00 00700 OPERATION OF PLANT			7. 00
8.00 00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00 00900 HOUSEKEEPI NG			9. 00
10. 00 01000 DI ETARY			10.00
11. 00 01100 CAFETERI A			11.00
13.00 O1300 NURSING ADMINISTRATION			13.00
14.00 01400 CENTRAL SERVICES & SUPPLY			14.00
16.00 01600 MEDICAL RECORDS & LIBRARY			16. 00
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 03000 ADULTS & PEDIATRICS	348, 962		30.00
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	182, 427		50.00
51. 00 05100 RECOVERY ROOM	25, 883		51.00
53. 00 05300 ANESTHESI OLOGY	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	119, 456		54.00
54. 01 05401 0NC0L0GY	93, 069		54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		55. 00
60. 00 06000 LABORATORY	95, 503		60.00
65. 00 06500 RESPI RATORY THERAPY	6, 045		65. 00
66. 00 06600 PHYSI CAL THERAPY	49, 374		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	22, 668		67.00
68. 00 06800 SPEECH PATHOLOGY	5, 092		68. 00
69. 00 06900 ELECTROCARDI OLOGY	26, 706		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 928		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	16, 498		72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	83, 548		73. 00
OUTPATIENT SERVICE COST CENTERS	1/7 520		00.00
88. 00 08800 RURAL HEALTH CLINIC	167, 538		88.00
90. 00 09000 CLINIC	229, 782		90.00
90. 01 09001 SURGI CAL ASSOCI ATES	38, 307		90. 01
90. 02 09002 0RTHOPAEDI CS 90. 03 09003 RHEUMATOLOGY	26, 146		90. 02
	54, 259		90.03
90. 04 09004 SPECI ALTY CLI NI C 90. 05 09005 PEDI ATRI CS	81, 427		90. 04 90. 05
90. 05 09005 PEDI ATRI CS 90. 06 09006 WOMEN' S HEALTH	79, 541 0		90.05
90. 07 09007 PALN MANAGEMENT	-1		90.00
90. 07 09007 PATN WANAGEMENT 90. 08 09008 0NCOLOGY MD	38, 161		90.07
91. 00 09100 EMERGENCY	150, 529		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	150, 524		92.00
OTHER REIMBURSABLE COST CENTERS			72.00
95. 00 09500 AMBULANCE SERVICES	39, 501		95. 00
SPECIAL PURPOSE COST CENTERS	07,001		70.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 995, 350		118. 00
NONREI MBURSABLE COST CENTERS	, ,		
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0		192. 00
193. 00 19300 NONPALD WORKERS	0		193.00
193. 01 19301 FOUNDATI ON	44, 865		193. 01
193. 02 19302 OCCUPATI ONAL MEDI CI NE	0		193. 02
193. 03 19303 GUEST MEALS	0		193. 03
194.00 07950 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, 040, 215		202. 00
· · · · · · · · · · · · · · · · · · ·			

		ICIAI SYSTEMS	RUSH MEMORIAL		ON 45 4004 5		u or Form CMS-2	
COST A	ILLUCA	FION - STATISTICAL BASIS		Provider C		Period: From 01/01/2021	Worksheet B-1	
						o 12/31/2021	Date/Time Pre	pared:
							5/23/2022 12:	
			CAPI TAL					
			RELATED COSTS					
		Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
			FI XT	BENEFI TS	n	E & GENERAL	PLANT	
			(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE	
			FEET)	(GROSS		COST)	FEET)	
				SALARI ES)				
			1. 00	4. 00	5A	5. 00	7. 00	
		AL SERVICE COST CENTERS				T		4
1. 00	1	NEW CAP REL COSTS-BLDG & FIXT	109, 691				I	1.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	4, 169	19, 819, 842	1		I	4.00
5. 00	1	ADMINISTRATIVE & GENERAL	8, 243	3, 128, 228				5.00
7. 00		OPERATION OF PLANT	12, 866	383, 999	1	1,,	84, 413	
8. 00		LAUNDRY & LINEN SERVICE	659		1		659	1
9.00	1	HOUSEKEEPI NG	2, 624	670, 799	1	1,,,	2, 624	1
10.00	1	DI ETARY	3, 855	130, 463	1	,	3, 855	1
11.00		CAFETERI A	925	231, 025	1		925	
13.00		NURSI NG ADMI NI STRATI ON	122	149, 436	1		122	1
14.00		CENTRAL SERVICES & SUPPLY	2, 433	108, 791			2, 433	
16. 00		MEDICAL RECORDS & LIBRARY	4, 242	312, 909) (669, 581	4, 242	16. 00
		IENT ROUTINE SERVICE COST CENTERS	0.00/	0.004.744			0.007	
30. 00		ADULTS & PEDIATRICS	8, 226	2, 006, 764	:	1, 878, 171	8, 226	30.00
F0 00		LARY SERVICE COST CENTERS		4 000 475	·I	1 2/2 224		
50.00		OPERATI NG ROOM	6, 833	1, 322, 175			6, 833	1
51.00	1	RECOVERY ROOM	589	189, 466	1		589	
53.00		ANESTHESI OLOGY	0	0			0	
54.00	1	RADI OLOGY-DI AGNOSTI C	4, 025	1, 240, 184	1	,	4, 025	
54. 01		ONCOLOGY	3, 885	370, 366	1		3, 885	
55.00	1	RADI OLOGY-THERAPEUTI C	0	0	1		0	
60.00		LABORATORY	2, 811	849, 172	1		2, 811	1
65.00		RESPI RATORY THERAPY	140	163, 399			140	
66.00		PHYSI CAL THERAPY	1, 976	313, 908			1, 976	1
67.00		OCCUPATIONAL THERAPY	863	230, 859	1		863	
68. 00		SPEECH PATHOLOGY	181	74, 860	1			1
69.00		ELECTROCARDI OLOGY	1, 097	104, 637	1		1, 097	1
70.00	1	ELECTROENCEPHALOGRAPHY	0	Ü			0	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	
72.00	07200	IMPL. DEV. CHARGED TO PATIENT	0	504 004			0	
73. 00	0/300	DRUGS CHARGED TO PATIENTS	2, 145	591, 394	C	5, 554, 609	2, 145	73.00
00 00	001PA	TIENT SERVICE COST CENTERS	(500	1 500 04/		2 470 272	(502	1 00 00
		RURAL HEALTH CLINIC	6, 503	1, 508, 946			6, 503	
90.00		CLINIC	9, 639	1, 132, 209	1		9, 639	1
90. 01 90. 02	1	SURGI CAL ASSOCI ATES ORTHOPAEDI CS	1, 656	72, 879	1	, , , ,	1, 656	1
90. 02		RHEUMATOLOGY	1, 030 2, 266	495, 754 541, 388			1, 030 2, 266	
90. 03		SPECIALTY CLINIC	3, 187	1, 141, 759	1		3, 187	
90.04		PEDI ATRI CS	3, 359	485, 008	1		3, 167	
	1	WOMEN' S HEALTH	3, 339	465, 006	1		3, 339	1
		PAIN MANAGEMENT	1, 539	590, 718			1, 539	
	1	ONCOLOGY MD	1, 337	590,710			1, 537	1
91.00		EMERGENCY	4, 000	1, 026, 992				
92.00		OBSERVATION BEDS (NON-DISTINCT PART)	4,000	1,020,772		2,023,400	4,000	92.00
72.00		REIMBURSABLE COST CENTERS						72.00
95 00		AMBULANCE SERVICES	1, 688	110, 683	1	195, 007	1, 688	95.00
70.00		AL PURPOSE COST CENTERS	1,000	110,000	1	170,007	1,000	70.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	107, 776	19, 679, 170	-6, 139, 682	28, 810, 887	82 498	118.00
. 10.00		IMBURSABLE COST CENTERS	107,770	. , , , , , , , , , , ,	., 5, 157, 002		52, 470	1 . 5. 66
192.00		PHYSICIANS' PRIVATE OFFICES	0	0		0	0	192. 00
		NONPALD WORKERS		n				193.00
		FOUNDATI ON	1, 915	140, 672				193. 01
	1	OCCUPATIONAL MEDICINE	0	0.10,072				193. 02
		GUEST MEALS	0	0		1		193. 03
		NON REIMBURSABLE	o	0		o		194.00
200.00		Cross Foot Adjustments		_				200.00
201.00	1	Negative Cost Centers						201.00
202.00	1	Cost to be allocated (per Wkst. B,	2, 040, 215	5, 432, 043	8	6, 139, 682		
		Part I)	, ,	.,,		., ., , ,	1	
203.00		Unit cost multiplier (Wkst. B, Part I)	18. 599657	0. 274071		0. 211515	22. 969365	203.00
204.00		Cost to be allocated (per Wkst. B,		77, 542	1	165, 562	249, 932	1
		Part II)		,			1	
205.00	o	Unit cost multiplier (Wkst. B, Part	1	0. 003912	2	0. 005704	2. 960824	205.00
		[11)					I	
206.00)	NAHE adjustment amount to be allocated					I	206.00
		(per Wkst. B-2)						
207.00)	NAHE unit cost multiplier (Wkst. D,					I	207. 00
		Parts III and IV)					I	

	FINANCIAL SYSTEMS	KUSH WEWUKI A				u or Form CMS	
COSTA	LLOCATION - STATISTICAL BASIS		Provi der CC	:N: 15-1304 P F T	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B-1 Date/Time Pre 5/23/2022 12:	pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI O N	
		LAUNDRY)				(DI RECT NRSI NG HRS)	
		8. 00	9. 00	10.00	11. 00	13. 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 ADMI NI STRATI VE & GENERAL						5.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	28, 495					7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	2, 000					9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	820		100 0	10 (2)		10.00
13.00	01300 NURSI NG ADMI NI STRATI ON		925 122	0	19, 636 100	231, 235	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	2, 433	0	299	0	14. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	4, 242	0	775	0	16.00
30.00	03000 ADULTS & PEDIATRICS	18, 580	8, 226	100	2, 163	44, 989	30.00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	1, 865 0		0	•	25, 781 8, 503	
53.00	05300 ANESTHESI OLOGY	0	0	0		0, 303	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 205		0		29, 310	1
54. 01 55. 00	05401 ONCOLOGY 05500 RADI OLOGY-THERAPEUTI C	0	-,	0	639 0	13, 283 0	1
60.00	06000 LABORATORY	0	-1	0	_	30, 972	
65.00	06500 RESPIRATORY THERAPY	240		0	243	5, 061	
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	561 258		0	498 301	10, 367 6, 251	
68.00	06800 SPEECH PATHOLOGY	11	181	0	99	2, 060	
69.00	06900 ELECTROCARDI OLOGY	0	.,	0	199	4, 129	
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0 0	-1	0	0	0	70.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	1	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	2, 145	0	672	13, 986	73.00
88. 00	08800 RURAL HEALTH CLINIC	0	6, 503	0	2, 506	0	88. 00
90.00	09000 CLINIC	0	.,1	0	,	0	90.00
90. 01 90. 02	09001 SURGI CAL ASSOCI ATES 09002 ORTHOPAEDI CS	0	,	0		0	90. 01 90. 02
90. 03	09003 RHEUMATOLOGY	0	2, 266	0	352	0	90. 03
90. 04 90. 05	09004 SPECIALTY CLINIC 09005 PEDIATRICS	0		0	, -	0	90. 04 90. 05
90.03	09006 WOMEN'S HEALTH			0	533 0	0	
90. 07	09007 PAIN MANAGEMENT	0	1, 539	0	373	0	90. 07
90.08	O9008 ONCOLOGY MD O9100 EMERGENCY	0 2, 955		0	_		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 755	4,000	0	1, 003	34, 041	92.00
05.00	OTHER REIMBURSABLE COST CENTERS	1	1 (00		01	1 000	05.00
95.00	09500 AMBULANCE SERVI CES SPECI AL PURPOSE COST CENTERS	0	1, 688	0	91	1, 902	95.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	28, 495	79, 215	100	19, 451	231, 235	118. 00
192 00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	O	0	0	0	192. 00
	19300 NONPALD WORKERS	Ö	1	0			193.00
	19301 FOUNDATION	0		0			193. 01
	19302 OCCUPATIONAL MEDICINE 19303 GUEST MEALS	0	-1	0	0		193. 02 193. 03
194.00	07950 NON REIMBURSABLE	0	0	0	0		194. 00
200. 00 201. 00	1 1						200. 00 201. 00
201.00		159, 197	1, 432, 204	491, 402	423, 606	250, 705	
	Part I)	5 50/0/0	17 (50100		04 570007		
203. 00 204. 00	1 1	5. 586840 14, 886	1	4, 914. 020000 88, 776		1. 084200 4 581	203.00
204.00	Part II)	14,000	00,030	00,770	25, 425	4, 301	204.00
205. 00		0. 522407	0. 821521	887. 760000	1. 192962	0. 019811	205. 00
206.00							206. 00
207. 00							207. 00
	Parts III and IV)	l	l l				l

Health FinancialSystemsRUSH MEMORIAL HOSPITALIn Lieu of Form CMS-2552-10COST ALLOCATION - STATISTICAL BASISProvider CCN: 15-1304Period:Worksheet B-1

From 01/01/2021 12/31/2021 Date/Time Prepared: 5/23/2022 12:28 pm Cost Center Description CENTRAL MEDI CAL SERVICES & RECORDS & **SUPPLY** LI BRARY (COSTED (GROSS REVENUE) REQUIS.) 14.00 16.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 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 14.00 01400 CENTRAL SERVICES & SUPPLY 2, 814, 614 14.00 16.00 01600 MEDICAL RECORDS & LIBRARY 2,683 94, 400 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 46, 790 30.00 40, 560 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 667, 573 50.00 05100 RECOVERY ROOM 51 00 12, 258 8, 920 51.00 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 52, 697 54.00 10,800 54.00 05401 ONCOLOGY 54.01 17, 417 54.01 C 05500 RADI OLOGY-THERAPEUTI C 55.00 Λ 55.00 60.00 06000 LABORATORY 664, 781 C 60.00 06500 RESPIRATORY THERAPY 65.00 7, 236 200 65.00 06600 PHYSI CAL THERAPY 66 00 4 331 66 00 Ω 06700 OCCUPATI ONAL THERAPY 67.00 2, 382 0 67.00 68.00 06800 SPEECH PATHOLOGY 686 68.00 0 06900 ELECTROCARDI OLOGY 69.00 8,714 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70 00 0 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 448, 255 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 634, 388 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 23, 233 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 33, 009 0 88.00 58, 976 09000 CLI NI C 90.00 0 90.00 90.01 09001 SURGI CAL ASSOCI ATES 1, 363 0 90.01 09002 ORTHOPAEDI CS 90.02 454 0 90.02 90.03 09003 RHEUMATOLOGY 279 0 90.03 90 04 09004 SPECIALTY CLINIC 37, 594 0 90.04 09005 PEDI ATRI CS 11, 384 90.05 90.05 0 09006 WOMEN'S HEALTH 90.06 \cap Ω 90.06 90.07 09007 PAIN MANAGEMENT 1,695 0 90.07 09008 ONCOLOGY MD 90.08 90.08 n 91.00 09100 EMERGENCY 75.041 33, 920 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 1, 395 0 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2, 814, 614 94, 400 118.00 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192.00 193. 00 19300 NONPALD WORKERS 0 0 193.00 193. 01 19301 FOUNDATI ON 0 0 193.01 0 193. 02 19302 OCCUPATIONAL MEDICINE 193.02 0 193. 03 19303 GUEST MEALS 0 0 l193. 03 194.00 07950 NON REIMBURSABLE 0 C 194.00 200.00 Cross Foot Adjustments 200.00 201. 00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, 508, 977 1,000,732 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.180834 10.600975 203.00 Cost to be allocated (per Wkst. B, 204.00 57.140 100.967 204.00 Part II) 0.020301 205.00 205.00 Unit cost multiplier (Wkst. B, Part 1.069566 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 207 00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)

Health Financial Systems	RUSH MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-1304		Worksheet C Part I Date/Time Pre 5/23/2022 12:	pared: 28 pm
		Title	XVIII	Hospi tal	Cost	
·				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 738, 675		3, 738, 675	0	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 120, 859		2, 120, 859	0	0	50.00
51.00	05100 RECOVERY ROOM	460, 055		460, 055	0	0	51.00
53.00	05300 ANESTHESI OLOGY	0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 268, 691		2, 268, 691	0	0	54.00
54.01	05401 ONCOLOGY	887, 058		887, 058	0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	55.00
60.00	06000 LABORATORY	3, 141, 789		3, 141, 789	0	0	60.00
65.00	06500 RESPIRATORY THERAPY	317, 652	0	317, 652	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	687, 846	0	687, 846	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	428, 927	0	428, 927	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	132, 500	0	132, 500	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	319, 925		319, 925	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 318, 939		1, 318, 939	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	883, 290		883, 290	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 850, 499		6, 850, 499	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	2, 963, 211		2, 963, 211	0	0	88. 00
90.00	09000 CLI NI C	1, 759, 404		1, 759, 404	0	0	90.00
90. 01	09001 SURGI CAL ASSOCI ATES	220, 648		220, 648	0	0	90. 01
90. 02	09002 ORTHOPAEDI CS	234, 388		234, 388	0	0	90. 02
90. 03	09003 RHEUMATOLOGY	311, 389		311, 389	0	0	90. 03
90. 04	09004 SPECIALTY CLINIC	907, 477		907, 477	0	0	90.04
90.05	09005 PEDI ATRI CS	489, 289		489, 289	0	0	90.05
90.06	09006 WOMEN' S HEALTH	0		0	0	0	90.06
90. 07	09007 PAIN MANAGEMENT	267, 432		267, 432	0	0	90. 07
90. 08	09008 ONCOLOGY MD	0		0	0	0	90.08
91.00	09100 EMERGENCY	3, 804, 002		3, 804, 002	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 095, 649		1, 095, 649		0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	309, 102		309, 102	0	0	95.00
200.00	Subtotal (see instructions)	35, 918, 696	0	35, 918, 696	0		200.00
201.00		1, 095, 649		1, 095, 649			201.00
202.00	Total (see instructions)	34, 823, 047	0	34, 823, 047	0	0	202. 00

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 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/23/2022 12:28 pm
	Title XVIII	Hospi tal	Cost

				-	Γο 12/31/2021	Date/Time Pre 5/23/2022 12:	
			Title	XVIII	Hospi tal	Cost	20 piii
			Charges	7	lioopi tui	0001	
	Cost Center Description	Inpatient	Outpati ent	Total (col 6	Cost or Other	TEFRA	
				+ col . 7)	Ratio	Inpatient	
				' ' ' ' ' ' ' '	1	Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	3, 680, 254		3, 680, 25	1		30.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	393, 045	9, 340, 420	9, 733, 46	0. 217894	0.000000	50.00
51.00	05100 RECOVERY ROOM	109, 437	2, 732, 296	2, 841, 73	0. 161892	0.000000	51.00
53.00	05300 ANESTHESI OLOGY	0	0		0. 000000	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	955, 382	29, 401, 861	30, 357, 24	0. 074733	0.000000	54.00
54.01	05401 ONCOLOGY	65	648, 792	648, 85	1. 367109	0.000000	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0. 000000	0.000000	55.00
60.00	06000 LABORATORY	1, 142, 720	12, 809, 815	13, 952, 53	0. 225177	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	259, 756	190, 410	450, 166	0. 705633	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	244, 082	1, 982, 384	2, 226, 466	0. 308941	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	210, 318	1, 596, 187	1, 806, 50	0. 237435	0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	82, 794	395, 458	478, 25	0. 277051	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	343, 984	3, 659, 815	4, 003, 79	0. 079905	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	254, 369	4, 828, 745	5, 083, 11	0. 259475	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	34, 241	3, 072, 799	3, 107, 040	0. 284287	0.000000	72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 053, 010	18, 136, 085			0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS		· · · · · ·				1
88. 00	08800 RURAL HEALTH CLINIC	0	1, 250, 087	1, 250, 08	7		88. 00
90.00	09000 CLI NI C	O	479, 561	479, 56°	3. 668780	0.000000	90.00
90. 01	09001 SURGI CAL ASSOCI ATES	0	14, 499	14, 49	15. 218153	0.000000	90. 01
90.02	09002 ORTHOPAEDI CS	O	77, 071	77, 07 ⁻	3. 041196	0.000000	
90. 03	09003 RHEUMATOLOGY	O	78, 597	78, 59 ⁻	3. 961843	0.000000	90. 03
90.04	09004 SPECIALTY CLINIC	O	199, 874	199, 87	4. 540245	0.000000	90.04
90.05	09005 PEDI ATRI CS	O	177, 453	177, 45	2. 757288	0.000000	90.05
90.06	09006 WOMEN'S HEALTH	O	265	26!	0. 000000	0.000000	90.06
90. 07	09007 PAIN MANAGEMENT	O	74, 662	74, 66	3. 581902	0.000000	90. 07
90.08	09008 ONCOLOGY MD	O	0		0. 000000	0.000000	90. 08
91.00	09100 EMERGENCY	82, 563	7, 105, 454	7, 188, 01 ⁻	0. 529214	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	29, 069	1, 028, 928	1, 057, 99	1. 035588	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	0	867, 162	867, 163	0. 356452	0. 000000	95. 00
200.00	Subtotal (see instructions)	8, 875, 089	100, 148, 680	109, 023, 769	9		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	8, 875, 089	100, 148, 680	109, 023, 76	9		202. 00

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		Worksheet C Part I Date/Time Prepared: 5/23/2022 12:28 pm

Title XVIII Hospital Cost
Ratio 11.00
11. 00 I NPATI ENT ROUTI NE SERVI CE 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 51. 00 05100 RECOVERY ROOM 0. 000000 51.
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 30. 00 ADULTS & PEDI ATRI CS 50. 00 05000 0PERATI NG ROOM 0. 000000 51. 00 05100 RECOVERY ROOM 0. 000000 51.
30. 00 03000 ADULTS & PEDI ATRI CS 30 ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM 0. 000000 51. 00 05100 RECOVERY ROOM 0. 000000 51
30. 00 03000 ADULTS & PEDI ATRI CS 30 ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM 0. 000000 51. 00 05100 RECOVERY ROOM 0. 000000 51
50. 00 05000 OPERATING ROOM 0.000000 50.000 51. 00 05100 RECOVERY ROOM 0.000000 51.000
51. 00 05100 RECOVERY ROOM 0. 000000 51
EQ 00 05000 ANECTHECLOLOGY
53. 00 05300 ANESTHESI OLOGY 0. 000000 53
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0. 000000 54
54. 01 05401 0NCOLOGY 0. 000000 54
55. 00 05500 RADI 0LOGY-THERAPEUTI C 0. 000000 55
60. 00 06000 LABORATORY 0. 000000 60
65. 00 06500 RESPI RATORY THERAPY 0. 000000 65
66. 00 06600 PHYSI CAL THERAPY 0. 000000 66
67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 67
68. 00 06800 SPEECH PATHOLOGY 0. 000000 68
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 70
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 72
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73
OUTPATIENT SERVICE COST CENTERS
88. 00 08800 RURAL HEALTH CLINIC 88
90. 00 09000 CLI NI C 0. 000000 90
90. 01 09001 SURGI CAL ASSOCI ATES 0. 000000 90
90. 02 09002 0RTH0PAEDI CS 0. 000000 90
90. 03 09003 RHEUMATOLOGY 0. 000000 90
90. 04 09004 SPECIALTY CLINIC 0. 000000 90
90. 05 09005 PEDI ATRI CS 0. 000000 90
90. 06 09006 WOMEN' S HEALTH 0. 000000 90
90. 07 09007 PAI N MANAGEMENT 0. 000000 90
90. 08 09008 0NCOLOGY MD 0. 000000 90
91. 00 09100 EMERGENCY 0. 000000 91
92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0.000000 92
OTHER REIMBURSABLE COST CENTERS
95. 00 09500 AMBULANCE SERVI CES 0. 000000 95
200.00 Subtotal (see instructions) 200
201.00 Less Observation Beds 201
202.00 Total (see instructions)

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-1304	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/23/2022 12:	
		Ti tl	e XIX	Hospi tal	Cost	
				0		

				To 12/31/2021	Date/Time Pre 5/23/2022 12:	
		Ti tl	e XIX	Hospi tal	Cost	
		<u>'</u>		Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00 03000 ADULTS & PEDI ATRI CS	3, 738, 675		3, 738, 67	5 0	3, 738, 675	30.00
ANCILLARY SERVICE COST CENTERS				_1		
50. 00 05000 OPERATING ROOM	2, 120, 859		2, 120, 85			1
51. 00 05100 RECOVERY ROOM	460, 055		460, 05			1
53. 00 05300 ANESTHESI OLOGY	0			0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 268, 691		2, 268, 69		2, 268, 691	
54. 01 05401 ONCOLOGY	887, 058		887, 05		887, 058	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0			0	0	
60. 00 06000 LABORATORY	3, 141, 789		3, 141, 78		-,	
65. 00 06500 RESPIRATORY THERAPY	317, 652	0	0.7700		317, 652	
66. 00 06600 PHYSI CAL THERAPY	687, 846	0	687, 84		687, 846	
67. 00 06700 OCCUPATI ONAL THERAPY	428, 927	0	428, 92		428, 927	
68. 00 06800 SPEECH PATHOLOGY	132, 500	0	132, 50		132, 500	1
69. 00 06900 ELECTROCARDI OLOGY	319, 925		319, 92		319, 925	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1 212 222			0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 318, 939		1, 318, 93		1, 318, 939	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	883, 290		883, 29		,	
73. 00 O7300 DRUGS CHARGED TO PATIENTS	6, 850, 499		6, 850, 49	9 0	6, 850, 499	73.00
OUTPATIENT SERVICE COST CENTERS	2 0/2 211		2.0/2.21	1	2.0/2.211	00 00
88. 00 08800 RURAL HEALTH CLINIC	2, 963, 211		2, 963, 21		,	
90. 00 09000 CLINI C	1, 759, 404		1, 759, 40		1, 759, 404	
90. 01 09001 SURGI CAL ASSOCI ATES	220, 648		220, 64		220, 648	
90. 02 09002 ORTHOPAEDI CS	234, 388		234, 38		234, 388	1
90. 03 09003 RHEUMATOLOGY	311, 389		311, 38		311, 389	
90. 04 09004 SPECIALTY CLINIC	907, 477		907, 47		907, 477	
90. 05 09005 PEDI ATRI CS	489, 289		489, 28		489, 289	1
90. 06 09006 WOMEN' S HEALTH	0			0	0	
90. 07 09007 PALN MANAGEMENT	267, 432		267, 43	2 0	267, 432	1
90. 08 09008 ONCOLOGY MD	0			0	0	90.08
91. 00 09100 EMERGENCY	3, 804, 002		3, 804, 00		3, 804, 002	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 095, 649		1, 095, 64	9	1, 095, 649	92.00
OTHER REIMBURSABLE COST CENTERS	200 100		200 10	2	200 102	05 00
95. 00 09500 AMBULANCE SERVICES	309, 102	^	309, 10			
200.00 Subtotal (see instructions)	35, 918, 696	0			,,	
201.00 Less Observation Beds	1, 095, 649	^	1, 095, 64		1, 095, 649 34, 823, 047	
202.00 Total (see instructions)	34, 823, 047	0	34, 823, 04	7 0	34, 823, 047	1202.00

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	From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/23/2022 12:28 pm

				-	Го 12/31/2021	Date/Time Pre 5/23/2022 12:	
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30.00	03000 ADULTS & PEDI ATRI CS	3, 680, 254		3, 680, 25	1		30.00
	ANCILLARY SERVICE COST CENTERS				_		
50.00		393, 045	9, 340, 420			0. 000000	
51.00	05100 RECOVERY ROOM	109, 437	2, 732, 296	2, 841, 733	0. 161892	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0		0.000000	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	955, 382	29, 401, 861			0. 000000	
54. 01	05401 ONCOLOGY	65	648, 792	648, 85		0. 000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0.000000	0. 000000	
60.00	06000 LABORATORY	1, 142, 720	12, 809, 815	13, 952, 53		0. 000000	
65.00	06500 RESPI RATORY THERAPY	259, 756	190, 410	450, 166		0. 000000	
66.00	06600 PHYSI CAL THERAPY	244, 082	1, 982, 384	2, 226, 466	0. 308941	0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	210, 318	1, 596, 187	1, 806, 50	0. 237435	0. 000000	67.00
68.00	06800 SPEECH PATHOLOGY	82, 794	395, 458	478, 252	0. 277051	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	343, 984	3, 659, 815	4, 003, 799	0. 079905	0. 000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0.000000	0. 000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	254, 369	4, 828, 745	5, 083, 114	0. 259475	0. 000000	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	34, 241	3, 072, 799	3, 107, 040		0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 053, 010	18, 136, 085	19, 189, 09	0. 357000	0. 000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	1, 250, 087	1, 250, 08	2. 370404	0. 000000	
90.00	09000 CLI NI C	0	479, 561	479, 56°	3. 668780	0. 000000	90.00
90. 01	09001 SURGI CAL ASSOCI ATES	0	14, 499	14, 499	15. 218153	0. 000000	90. 01
90. 02	09002 ORTHOPAEDI CS	0	77, 071	77, 07 ⁻	3. 041196	0. 000000	90. 02
90. 03	09003 RHEUMATOLOGY	0	78, 597	78, 59	3. 961843	0. 000000	
90.04	09004 SPECIALTY CLINIC	0	199, 874	199, 874	4. 540245	0. 000000	90.04
90.05	09005 PEDI ATRI CS	0	177, 453	177, 453	2. 757288	0. 000000	90.05
90.06	09006 WOMEN'S HEALTH	0	265	265	0.000000	0. 000000	90.06
90. 07	09007 PAIN MANAGEMENT	0	74, 662	74, 662	3. 581902	0. 000000	90. 07
90.08	09008 ONCOLOGY MD	0	0	(0.000000	0. 000000	90.08
91.00	09100 EMERGENCY	82, 563	7, 105, 454	7, 188, 01	0. 529214	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	29, 069	1, 028, 928	1, 057, 99	1. 035588	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	867, 162	867, 162	0. 356452	0. 000000	95.00
200.00	Subtotal (see instructions)	8, 875, 089	100, 148, 680	109, 023, 769	9		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	8, 875, 089	100, 148, 680	109, 023, 76	9		202. 00

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	From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/23/2022 12:28 pm

Cost Center Description				10 12/31/2021	5/23/2022 12: 28 pm
Inpatient routine Service Cost Centers 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.			Title XIX	Hospi tal	
INPATIENT ROUTINE SERVICE COST CENTERS	Cost Center Description	PPS Inpatient			
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.	· ·	Ratio			
30. 00		11. 00			
ANCILLARY SERVICE COST CENTERS 50.00	INPATIENT ROUTINE SERVICE COST CENT	ERS			
ANCILLARY SERVICE COST CENTERS 50.00	30. 00 03000 ADULTS & PEDIATRICS				30.00
51.00 05100 RECOVERY ROOM 0.000000 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 5					
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90. 06 09006 WOMEN' S HEALTH 0. 000000 90. 07 09007 PAI N MANAGEMENT 0. 000000 90. 07 90. 08 09008 0NCOLOGY MD 0. 000000 91. 00 09100 EMERGENCY 0. 000000 91. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 000000 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 000000 92. 00 000000 000000 000000 000000 000000	90. 04 09004 SPECIALTY CLINIC	0. 000000			90.04
90. 07 09007 PAI N MANAGEMENT 0. 000000 90. 07 90. 08 09008 0NCOLOGY MD 0. 000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0. 000000 92. 00 07 07 07 07 07 07 07	90. 05 09005 PEDI ATRI CS	0. 000000			90. 05
90. 08 09008 0NCOLOGY MD 0.000000 91. 00 09100 EMERGENCY 0.000000 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0.000000 0.000000 92. 00 0THER REI MBURSABLE COST CENTERS 0.000000 95. 00 000000 95. 00 0000000 95. 00 0000000 0000000 0000000 000000	90.06 09006 WOMEN'S HEALTH	0. 000000			90.06
91.00 09100 EMERGENCY 0.000000 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 0.000000 95.00 200.00 Subtotal (see instructions) Less Observation Beds 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00	90. 07 09007 PAIN MANAGEMENT	0. 000000			90. 07
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.0000000 92.00 0THER 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	90. 08 09008 ONCOLOGY MD	0. 000000			90.08
OTHER REIMBURSABLE COST CENTERS 95.00	91. 00 09100 EMERGENCY	0. 000000			91.00
95. 00 09500 AMBULANCE SERVICES 0.000000 95. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	92.00 09200 OBSERVATION BEDS (NON-DISTING	T PART) 0. 000000			92.00
200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00					
201.00 Less Observation Beds 201.00	95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
	200.00 Subtotal (see instructions)				200.00
202. 00 Total (see instructions) 202. 00	201.00 Less Observation Beds				201. 00
	202.00 Total (see instructions)				202. 00

Heal th Financial	Systems			RUSH MEMORIA	L HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT OF	INPATIENT AN	NCILLARY SERVICE	CAPI TAL	COSTS	P	rovider C	CN: 15-1304	Peri od:	Worksheet D	
								From 01/01/2021		
								To 12/31/2021	Date/Time Pre	
									5/23/2022 12:	28 pm
						Titl∈	XVIII	Hospi tal	Cost	
Cost	Center Desci	ri pti on		Capi tal	Tota	l Charges	Ratio of Cos	st Inpatient	Capital Costs	
				Related Cost	(fr	om Wkst.	to Charges	Program	(column 3 x	

				To 12/31/2021	Date/Time Pre 5/23/2022 12:	pared:
		Title	: XVIII	Hospi tal	Cost	20 μπ
Cost Center Description	Capi tal	Total Charges			Capital Costs	
, , , , , , , , , , , , , , , , , , ,	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)		,	
	col. 26)	,				
	1. 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	182, 427				2, 725	
51.00 05100 RECOVERY ROOM	25, 883	2, 841, 733	0.00910	31, 412	286	51.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	119, 456				1, 765	
54. 01 05401 0NCOLOGY	93, 069	648, 857			0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0.0000		0	55.00
60. 00 06000 LABORATORY	95, 503	13, 952, 535				60.00
65. 00 06500 RESPIRATORY THERAPY	6, 045	450, 166	0. 01342	3 112, 579	1, 512	65.00
66. 00 06600 PHYSI CAL THERAPY	49, 374					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	22, 668	1, 806, 505	0. 01254	3 131, 338	1, 648	67.00
68. 00 06800 SPEECH PATHOLOGY	5, 092	478, 252				68.00
69. 00 06900 ELECTROCARDI OLOGY	26, 706	4, 003, 799	0. 00667	183, 085	1, 221	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 928	5, 083, 114	0. 00293	7 40, 707	120	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	16, 498	3, 107, 040	0. 00531			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	83, 548	19, 189, 095	0.00435	514, 738	2, 241	73.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	167, 538				0	88. 00
90. 00 09000 CLI NI C	229, 782				0	90.00
90. 01 09001 SURGI CAL ASSOCI ATES	38, 307				0	90. 01
90. 02 09002 ORTHOPAEDI CS	26, 146				0	90. 02
90. 03 09003 RHEUMATOLOGY	54, 259				0	90. 03
90. 04 09004 SPECIALTY CLINIC	81, 427	199, 874			0	90. 04
90. 05 09005 PEDI ATRI CS	79, 541	177, 453			0	90.05
90. 06 09006 WOMEN' S HEALTH	0	265			0	90.06
90. 07 09007 PAI N MANAGEMENT	38, 161	74, 662			0	90. 07
90. 08 09008 ONCOLOGY MD	0	0	0.0000		0	90. 08
91. 00 09100 EMERGENCY	150, 529					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	102, 266	1, 057, 997	0. 09666	1, 566	151	92.00
OTHER REIMBURSABLE COST CENTERS			1			
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	1, 709, 153	104, 476, 353		2, 386, 301	19, 615	200. 00

Health Financial Systems	S RUSH MEMORIAL HOSPITAL			In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1304		Worksheet D		
THROUGH COSTS			From 01/01/2021	Part IV		

TTIKOOC	11 60313				To 12/31/2021	Date/Time Pre 5/23/2022 12:	
			Title	e XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0)	0	0	
51. 00	05100 RECOVERY ROOM	0	0)	0	0	0 00
53.00	05300 ANESTHESI OLOGY	0	0)	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	54.00
54. 01	05401 ONCOLOGY	0	0)	0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0)	0	0	
60.00	06000 LABORATORY	0	0)	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0)	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0)	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0)	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0)	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
90.00	09000 CLI NI C	0	0		0 0	0	90.00
90. 01	09001 SURGI CAL ASSOCI ATES	0	0		0	0	90. 01
90. 02	09002 ORTHOPAEDI CS	0	0		0	0	90. 02
90. 03	09003 RHEUMATOLOGY	0	0		0 0	0	90.03
90.04	09004 SPECIALTY CLINIC	0	0		0 0	0	90.04
90.05	09005 PEDI ATRI CS	0	0		0 0	0	90.05
90.06	09006 WOMEN' S HEALTH	0	0		0 0	0	90.06
90. 07	09007 PAIN MANAGEMENT	0	0		0 0	0	90. 07
90. 08	09008 ONCOLOGY MD	0	1 0		0 0	0	90.08
91.00	09100 EMERGENCY	0	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				•		
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0)	0 0	0	200.00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	RUSH MEMORIAL HOSPITAL			
APPORTIONMENT OF INPATIENT/OUTPA THROUGH COSTS	TIENT ANCILLARY SERVICE OTHER PASS Provider	CCN: 15-1304	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/23/2022 12:28 pm	

THROUGH COSTS				To 12/31/2021	Date/Time Pre 5/23/2022 12:	pared:
		Title	xVIII	Hospi tal	Cost	20 μιι
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col . 8)	col. 7)	
		,	and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0	(9, 733, 465	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	(2, 841, 733	0.000000	51.00
53. 00 05300 ANESTHESI OLOGY	0	0	(0	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(30, 357, 243	0.000000	54.00
54. 01 05401 ONCOLOGY	0	0	(648, 857	0.000000	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0.000000	55.00
60. 00 06000 LABORATORY	0	0	(13, 952, 535	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	(450, 166	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(2, 226, 466	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(1, 806, 505	0.000000	67.00
68.00 O6800 SPEECH PATHOLOGY	0	0	(478, 252	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(4, 003, 799	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	(5, 083, 114	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(3, 107, 040	0.000000	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	(19, 189, 095	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	(1, 250, 087	0. 000000	88. 00
90. 00 09000 CLI NI C	0	0	(479, 561	0. 000000	90.00
90. 01 09001 SURGI CAL ASSOCI ATES	0	0	(14, 499	0.000000	90. 01
90. 02 09002 ORTHOPAEDI CS	0	0	(77, 071	0. 000000	90. 02
90. 03 09003 RHEUMATOLOGY	0	0	(78, 597	0. 000000	90. 03
90. 04 09004 SPECIALTY CLINIC	0	0	(199, 874	0. 000000	90.04
90. 05 09005 PEDI ATRI CS	0	0	(177, 453	0. 000000	90. 05
90. 06 09006 WOMEN' S HEALTH	0	0	(265	0. 000000	90.06
90. 07 09007 PAI N MANAGEMENT	0	0	(74, 662	0. 000000	90. 07
90. 08 09008 0NCOLOGY MD	0	0	(0	0. 000000	90. 08
91. 00 09100 EMERGENCY	0	0	(7, 188, 017	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(1, 057, 997	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0	(104, 476, 353		200. 00

Heal th	Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PASS	Provi der C	F	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/23/2022 12:	pared: 28 pm
			Title	: XVIII	Hospi tal	Cost	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10. 00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS	7. 00	10.00	11.00	12.00	10.00	
50.00	05000 OPERATING ROOM	0. 000000	145, 381		0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	31, 412		0	0	51.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	448, 567		0	0	54.00
54. 01	05401 ONCOLOGY	0. 000000	0	(0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	(0	0	55.00
60.00	06000 LABORATORY	0. 000000	564, 506	(0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	112, 579	(0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	156, 234	(0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	131, 338	(0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	49, 787	(0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	183, 085	(0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	(0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	40, 707		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	3, 010		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	514, 738		0	0	73.00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>					
88.00	08800 RURAL HEALTH CLINIC	0.000000	0	(0	0	88. 00

0. 000000

0.000000

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0. 000000 0. 000000

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3, 391

1, 566

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0 92.00

90.01

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90.03

90.04

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90. 07

90.08

91.00

95.00

0 200.00

90. 00 09000 CLINIC

90.01

90.02

90. 03 90. 04

90.05

90.06

90. 07

90.08

91.00

92.00

200.00

09001 SURGI CAL ASSOCI ATES

09002 ORTHOPAEDI CS

09005 PEDI ATRI CS

09008 ONCOLOGY MD

95. 00 09500 AMBULANCE SERVICES

09100 EMERGENCY

09003 RHEUMATOLOGY 09004 SPECIALTY CLINIC

09006 WOMEN'S HEALTH

09007 PAIN MANAGEMENT

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1304 Peri od: Worksheet D From 01/01/2021 Part V Date/Time Prepared: 12/31/2021 5/23/2022 12:28 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 696, 070 0. 217894 50.00 05100 RECOVERY ROOM 0 566, 670 51.00 0.161892 0 51.00 0 05300 ANESTHESI OLOGY 53.00 0.000000 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.074733 7, 577, 689 0 0 0 0 54.00 54.01 05401 ONCOLOGY 1.367109 303, 175 0 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 0 55.00 60.00 06000 LABORATORY 0. 225177 3, 558, 146 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.705633 40, 839 0 0 0 65.00 06600 PHYSI CAL THERAPY 0.308941 636, 470 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 332, 748 67.00 0.237435 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.277051 118, 448 0 0 68.00 06900 ELECTROCARDI OLOGY 0.079905 0 69.00 1, 306, 179 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 70 00 Ω Ω 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.259475 0 78, 237 107, 506 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 284287 0 651, 547 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.357000 0 9, 738, 055 2, 280 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 90.00 09000 CLI NI C 3.668780 32, 773 90.00 90. 01 09001 SURGI CAL ASSOCI ATES 15. 218153 0 7,686 0 0 0 90.01 90 02 09002 ORTHOPAEDI CS 3.041196 0 52,013 90 02 0 90.03 09003 RHEUMATOLOGY 3.961843 50, 372 0 90.03 09004 SPECIALTY CLINIC 4. 540245 117, 346 0 0 90.04 90.04 0 09005 PEDI ATRI CS 2. 757288 90.05 90.05 C 0 09006 WOMEN'S HEALTH 0.000000 0 90.06 90.06 0 0 90.07 09007 PAIN MANAGEMENT 3.581902 0 25, 615 0 90.07 o 90.08 09008 ONCOLOGY MD 0.000000 0 0 90.08 09100 EMERGENCY 1, 325, 519 0 91.00 91 00 0.529214 Ω 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1.035588 0 375, 123 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.356452 95.00 200.00 Subtotal (see instructions) ol 30, 590, 720 109, 786 0 200.00

30, 590, 720

109, 786

201.00

0 202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

| Peri od: | Worksheet D | From 01/01/2021 | Part V | To | 12/31/2021 | Date/Time Prepared:

				10 12/31/2021	5/23/2022 12:	
		Title	XVIII	Hospi tal	Cost	20 0111
	Cos					
Cost Center Description	Cost	Cost				
· ·	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	805, 351	0				50.00
51.00 05100 RECOVERY ROOM	91, 739	0				51.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	566, 303	0				54.00
54. 01 05401 ONCOLOGY	414, 473	0				54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
60. 00 06000 LABORATORY	801, 213	0				60.00
65. 00 06500 RESPIRATORY THERAPY	28, 817	0				65.00
66. 00 06600 PHYSI CAL THERAPY	196, 632	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	79, 006	0				67.00
68. 00 06800 SPEECH PATHOLOGY	32, 816	0	1			68.00
69. 00 06900 ELECTROCARDI OLOGY	104, 370	0	ł			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	1			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 301	27, 895	1			71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	185, 226	27,070	i			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 476, 486	814	i .			73.00
OUTPATIENT SERVICE COST CENTERS	0, 170, 100	011				70.00
88. 00 08800 RURAL HEALTH CLINIC						88. 00
90. 00 09000 CLINI C	120, 237	0				90.00
90. 01 09001 SURGI CAL ASSOCI ATES	116, 967	0				90. 01
90. 02 09002 ORTHOPAEDI CS	158, 182	0				90. 02
90. 03 09003 RHEUMATOLOGY	199, 566	0				90. 03
90. 04 09004 SPECIALTY CLINIC	532, 780	0				90.04
90. 05 09005 PEDI ATRI CS	0 0 0	0				90.05
90. 06 09006 WOMEN' S HEALTH	0	0				90.06
90. 07 09007 PAI N MANAGEMENT	91, 750	0				90.07
90. 08 09008 0NCOLOGY MD	71,730	0				90.08
91. 00 09100 EMERGENCY	701, 483	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	388, 473	0	•			92.00
OTHER REIMBURSABLE COST CENTERS	300,473	0				72.00
95. 00 09500 AMBULANCE SERVICES	0					95. 00
200.00 Subtotal (see instructions)	9, 112, 171	28, 709				200.00
201.00 Less PBP Clinic Lab. Services-Program	7, 112, 1/1	20, 709				201.00
Only Charges						201.00
202.00 Net Charges (line 200 - line 201)	9, 112, 171	28, 709				202. 00
202.00	1 7,112,171	20, 709	I			1202.00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1304	Peri od: From 01/01/2021	Worksheet D-1		
		To 12/31/2021	Date/Time Pre 5/23/2022 12:		
	Title XVIII	Hospi tal	Cost		
Cost Center Description					
			1. 00		
PART I - ALL PROVIDER COMPONENTS					

		Title XVIII	Hospi tal	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		1, 929	1.00
2.00	Inpatient days (including private room days, excluding swing-			1, 899	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pri	vate room days,	0	3.00
4 00	do not complete this line.			4 005	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		21 of the cost	1, 335 25	4. 00 5. 00
5.00	reporting period	oni days) trii odgii becember	31 Of the cost	25	5.00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December 3	1 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)	3 /			
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	5	7.00
0.00	reporting period		-6 +1+	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after becember 31	or the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	792	9. 00
	newborn days) (see instructions)	3 (4 4 4 9	3		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		om days)	25	10.00
44 00	through December 31 of the cost reporting period (see instruc				44 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		om days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		room days)	0	12.00
.2.00	through December 31 of the cost reporting period	A city (the during private	. com dayo)	· ·	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
	after December 31 of the cost reporting period (if calendar y			_	
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed d	ays)	0	14. 00 15. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	16.00
10.00	SWING BED ADJUSTMENT			J	10.00
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost		17.00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	207. 68	19 00
. ,	reporting period	o till ough becomes. e. e.		2071 00	.,
20. 00	Medicald rate for swing-bed NF services applicable to service	s after December 31 of th	e cost	0. 00	20.00
21 00	reporting period	2)		2 720 475	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ng period (line	3, 738, 675 0	21. 00 22. 00
22.00	5 x line 17)	ci 31 di the cost reporti	ng perrou (ring	J	22.00
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23.00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 of the cost reportin	g period (line	1, 038	24. 00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or or the cost reporting	perrou (rriie o	Ü	20.00
26. 00	Total swing-bed cost (see instructions)			49, 604	26.00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 689, 071	27. 00
29 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had cha	race)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	u and observation bed cha	i ges)	0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33. 00	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		ı ons)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ile 31)	-	0. 00 0	35. 00 36. 00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost dif	 ferential (line	3, 689, 071	37.00
200	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			2 - 1 - 1	
38.00	Adjusted general inpatient routine service cost per diem (see	•		1, 942. 64 1, 538, 571	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			1, 538, 571	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39			1, 538, 571	
		•	'		

	Financial Systems	RUSH MEMORIAI				u of Form CMS-2	
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der (Peri od: From 01/01/2021	Worksheet D-1	
					To 12/31/2021	Date/Time Pre 5/23/2022 12:	pared: 28 pm
		Talal		e XVIII	Hospi tal	Cost	
	Cost Center Description	Total Inpatient	Total Inpati ent	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42 00	NURSERY (title V & XIX only)	1. 00	2. 00	3. 00	4. 00	5. 00	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT						43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	<u> </u>					1.00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ons)		583, 309 2, 121, 880	1
47.00	PASS THROUGH COST ADJUSTMENTS	+1 through +0)	(See Thistructi	Oliay		2, 121, 000	47.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	om Wkst. D, sur	n of Parts I and	0	50.00
51. 00	<pre> </pre>	atient ancillar	ry services (f	from Wkst. D,	sum of Parts II	0	51.00
F0 00	and IV)	FO F4)					F0 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		elated. non-ph	nvsician anestl	netist and	0	
	medical education costs (line 49 minus line	9 1					
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge						55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	argot amount /	(lino 56 minus	lino 52)	0	
58. 00	Bonus payment (see instructions)	ing cost and ta	inger amount ((Title 50 IIITius	111le 53)	0	1
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	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, up	dated by the	market basket		0.00	60.00
61.00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the les	sser of 50% of		0	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		ts (lines 54)	(60), or 1% o	f the target		
62.00	Relief payment (see instructions)	,				0	
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	ne cost reporti	ng period (See	48, 566	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	ner 31 of the	cost reporting	neriod (See	0	65. 00
	instructions)(title XVIII only)			·			
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	I only). For	48, 566	66. 00
67.00	,	e costs through	December 31	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	o costs after [Occombor 21 of	f the cost ron	arting pariod	_	68. 00
08.00	(line 13 x line 20)	e costs after L	becember 31 or	the cost repo	or tring period		00.00
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)		70. 00
71.00	Adjusted general inpatient routine service c		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	n (line 14 x l	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv			*			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	Worksheet B, I	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	,					77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p		,			79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		cost limitatio	on (line 78 mii	nus line 79)		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		ns)				83. 00 84. 00
85.00	Utilization review - physician compensation		ons)				85.00
86. 00	Total Program inpatient operating costs (sum		rough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					564	87. 00
88.00	Adjusted general inpatient routine cost per	diem (line 27 ÷				1, 942. 64	88. 00
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)	1			1, 095, 649	89. UU

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 01/01/2021 To 12/31/2021	Date/Time Pre 5/23/2022 12:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	348, 962	3, 738, 675	0. 09333	8 1, 095, 649	102, 266	90.00
91.00 Nursing Program cost	0	3, 738, 675	0.00000	0 1, 095, 649	0	91.00
92.00 Allied health cost	0	3, 738, 675	0.00000	0 1, 095, 649	0	92.00
93.00 All other Medical Education	o	3, 738, 675	0. 00000	0 1, 095, 649	0	93. 00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1304	Peri od: From 01/01/2021	Worksheet D-1	
			Date/Time Pre 5/23/2022 12:	
	Title XIX	Hospi tal	Cost	<u> </u>
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

		Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		1, 929	1.00
2.00	Inpatient days (including private room days, excluding swing-	bed and newborn days)		1, 899	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3.00
	do not complete this line.			4 005	
4. 00	Semi -private room days (excluding swing-bed and observation b		. 21 -6 -1	1, 335	4.00
5. 00	Total swing-bed SNF type inpatient days (including private reporting period	olli days) through becellibe	1 31 OF THE COST	25	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om davs) 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 roo	m days) through December	31 of the cost	5	7.00
0.00	reporting period		1 -6 -1	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	m days) after December 3	Tor the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swi ng-bed and	23	9. 00
	newborn days) (see instructions)		3		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days)	0	10.00
11 00	through December 31 of the cost reporting period (see instruc		som dava) after	0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
	through December 31 of the cost reporting period				
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
14 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14 00
14. 00 15. 00	Total nursery days (title V or XIX only)	alli (excluding swing-bed	uays)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16.00
	SWI NG BED ADJUSTMENT			-	
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17.00
40.00	reporting period	Cl D l 21 C			40.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	tne cost		18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19.00
	reporting period	3			
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20.00
21 00	reporting period	->		2 720 /75	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line	3, 738, 675 0	21. 00 22. 00
22.00	5 x line 17)	er or the cost report	riig perroa (iriid	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 🛭	0	23.00
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	neriod (line 8	0	25. 00
23.00	x line 20)	or the cost reporting	perrod (rrie o	O	23.00
26.00	Total swing-bed cost (see instructions)			48, 580	26.00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 690, 095	27.00
20.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	d and abaseriation had ab	ongoo)	0	20.00
29.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed ch	ar ges)	0	
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	+ 111le 20)		0. 000000	
33. 00	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 li			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	3, 690, 095	
	27 minus line 36)	<u> </u>			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	LICTMENTS			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			1 042 10	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, 943. 18 44, 693	
40.00	Medically necessary private room cost applicable to the Progr			44, 693	40.00
	Total Program general inpatient routine service cost (line 39			44, 693	
		•	'		

	Financial Systems	RUSH MEMORIAL				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der 0		Period: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Pre	pared:
			T: ±1	I - VIV		5/23/2022 12:	28 pm
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospi tal Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1. 00	2. 00	3.00	4. 00	5. 00	42.00
42.00	Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT						43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk				,	30, 988	•
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructi	ons)		75, 681	49. 00
50.00	Pass through costs applicable to Program inp	patient routine	services (fro	om Wkst. D, sur	m of Parts I and	0	50.00
E4 00					C D		F4 00
51. 00	Pass through costs applicable to Program inpland IV)	atient anciliar	ry services (T	rom WKST. D, S	sum or Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, non-ph	nysician anestl	netist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	ő	1
58.00	Bonus payment (see instructions)		1007			0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period	ending 1996,	updated and co	ompounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	1
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than					0	61.00
	amount (line 56), otherwise enter zero (see		.s (Titles 54 A	(00), 01 1% 0	the target		
62.00						0	1
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see Enstru	ICTI ONS)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	ne cost reporti	ing period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	ner 31 of the	cost reporting	n period (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost re	eporting period	0	67.00
68. 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre>	na costs aftar D	December 31 of	the cost ren	orting period	0	68.00
00.00	(line 13 x line 20)	ie costs arter b	becember 31 or	the cost rep	or tring period		00.00
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)		70.00
71.00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	n (line 14 x l	ine 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	rice costs (line	e 72 + line 73	3)			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	Worksheet B, I	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77.00	Program capital -related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	provi der recor	ds)			78. 00 79. 00
80.00	Total Program routine service costs for comp	parison to the c		,	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (* .				83. 00
84.00	Program inpatient ancillary services (see in	istructions)					84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS						
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	Line 2)			564 1, 943. 18	•
	Observation bed cost (line 87 x line 88) (se	•	,			1, 943. 18	
		-,				•	•

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 01/01/2021 To 12/31/2021	Date/Time Pre 5/23/2022 12:	
		Ti tl e	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	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	348, 962	3, 738, 675	0. 09333	8 1, 095, 954	102, 294	90.00
91.00 Nursing Program cost	0	3, 738, 675	0.00000	0 1, 095, 954	0	91.00
92.00 Allied health cost	o	3, 738, 675	0.00000	0 1, 095, 954	0	92.00
93.00 All other Medical Education	o	3, 738, 675	0.00000	0 1, 095, 954	0	93.00

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1304	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-3 Date/Time Pre 5/23/2022 12:	pare
	Ti tl e	e XVIII	Hospi tal	Cost	20 pi
Cost Center Description	11 (1)	Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
			ŭ	col . 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
0.00 03000 ADULTS & PEDIATRICS			1, 484, 209		30.
ANCILLARY SERVICE COST CENTERS					
0.00 05000 OPERATI NG ROOM		0. 21789		31, 678	1
. 00 05100 RECOVERY ROOM		0. 16189		5, 085	1
3. 00 05300 ANESTHESI OLOGY		0. 00000		0	
I. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 07473	· ·	33, 523	1
. 01 05401 ONCOLOGY		1. 36710		0	
5. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000		0	
0. 00 06000 LABORATORY		0. 2251		127, 114	
5. 00 06500 RESPIRATORY THERAPY		0. 70563		79, 439	
5. 00 06600 PHYSI CAL THERAPY		0. 30894		48, 267	
7. 00 06700 OCCUPATI ONAL THERAPY		0. 23743		31, 184	1
3. 00 06800 SPEECH PATHOLOGY		0. 27705		13, 794	
P. 00 06900 ELECTROCARDI OLOGY		0. 07990		14, 629	
0. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	1
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2594		10, 562	1
2.00 07200 IMPL. DEV. CHARGED TO PATIENT 3.00 07300 DRUGS CHARGED TO PATIENTS		0. 28428		856	1
B. 00 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS		0. 35700	00 514, 738	183, 761	/3.
B. 00 08800 RURAL HEALTH CLINIC		0.00000	20	0	88.
0. 00 09000 CLI NI C		3. 66878		0	
0. 01 09001 SURGI CAL ASSOCI ATES		15. 2181		0	
0. 02 09002 ORTHOPAEDI CS		3. 04119		0	
0. 03 09003 RHEUMATOLOGY		3. 96184		0	
0. 04 09004 SPECIALTY CLINIC		4. 54024		0	
0. 05 09005 PEDI ATRI CS		2. 75728		0	1
0. 06 09006 WOMEN' S HEALTH		0.00000		0	
0. 07 09007 PAIN MANAGEMENT		3. 58190		0	
0. 08 09008 ONCOLOGY MD		0. 00000		0	90.
. 00 09100 EMERGENCY		0. 5292		1, 795	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 03558		1, 622	
OTHER REIMBURSABLE COST CENTERS					
5. 00 09500 AMBULANCE SERVICES					95.
OO.00 Total (sum of lines 50 through 94 and 96 through			2, 386, 301	583, 309	200.
11.00 Less PBP Clinic Laboratory Services-Program only	charges (line 61)		0		201.
Net charges (line 200 minus line 201)			2, 386, 301		202.

NPATI	IENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1304	Peri od:	Worksheet D-3	3
		Component	CCN: 15-Z304	From 01/01/202 To 12/31/202	Date/Time Pre	epared
		T: +1 o	. VVIII	Cui na Dodo CN	5/23/2022 12:	28 pm
	Cost Center Description	II tie	Ratio of Cos	Swing Beds - SN st Inpatient	F Cost Inpatient	
	Cost Center Description		To Charges	Program	Program Costs	
			10 charges	Charges	(col . 1 x	
				charges	col . 2)	
			1.00	2. 00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00						30.0
	ANCILLARY SERVICE COST CENTERS					
0. 00			0. 2178		0	1
1. 00			0. 1618		0	
3. 00	05300 ANESTHESI OLOGY		0.0000		1	
4. 00			0. 0747			
4. 01	05401 ONCOLOGY		1. 3671			
5. 00	05500 RADI OLOGY-THERAPEUTI C		0.0000		-1	
0. 00	06000 LABORATORY		0. 2251			
5. 00	06500 RESPI RATORY THERAPY		0. 7056			1
5.00	06600 PHYSI CAL THERAPY		0. 3089			
7.00			0. 2374			
3. 00 9. 00			0. 2770			
). 00). 00			0. 0799 0. 0000			
1. 00			0. 2594			
2. 00	07200 IMPL. DEV. CHARGED TO PATIENT		0. 2842		0 0	1
3.00			0. 3570			
5. 00	OUTPATIENT SERVICE COST CENTERS		0.3370	15, 57	5 4,775	1 / 3. \
8. 00			0.0000	00	0	88. 0
0. 00	09000 CLI NI C		3. 6687	80	ol o	90.0
0. 01	09001 SURGI CAL ASSOCI ATES		15. 2181		o o	90.
0. 02	09002 ORTHOPAEDI CS		3. 0411	96	0	90.
0. 03			3. 9618	43	0	90.
0. 04	09004 SPECIALTY CLINIC		4. 5402	45	0	90.
). 05	09005 PEDI ATRI CS		2. 7572	88	0	90.
). 06	09006 WOMEN'S HEALTH		0.0000		0	1
0. 07	09007 PAIN MANAGEMENT		3. 5819		0	
0. 08	09008 ONCOLOGY MD		0.0000		-1	1
1.00			0. 5292		0	
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 0355	88 (0	92.
- 00	OTHER REI MBURSABLE COST CENTERS					۱ ۵-
. 00				70 17	2 0, 050	95.
00.00		(11 (6)		73, 17	26, 853	
01.00		ges (line 61)		70 47		201.
02.00	Net charges (line 200 minus line 201)		1	73, 17	/	202.

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1304	Peri od:	Worksheet D-3	3
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/23/2022 12:	pared 28 pr
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
	·		To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
0. 00	03000 ADULTS & PEDI ATRI CS			45, 855		30.
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 21789		0	1
	05100 RECOVERY ROOM		0. 16189		0	
	05300 ANESTHESI OLOGY		0. 00000		0	53.
	05400 RADI OLOGY-DI AGNOSTI C		0. 07473	·	2, 623	1
	05401 ONCOLOGY		1. 36710		0	
	05500 RADI OLOGY-THERAPEUTI C		0. 00000		0	
0. 00	06000 LABORATORY		0. 22517	·	7, 025	
	06500 RESPI RATORY THERAPY		0. 70563	·	7, 763	
5. 00	06600 PHYSI CAL THERAPY		0. 30894		253	
	06700 OCCUPATI ONAL THERAPY		0. 23743		181	
3. 00	06800 SPEECH PATHOLOGY		0. 27705		0	
	06900 ELECTROCARDI OLOGY		0. 07990		1, 079	
	07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 25947		56	
	07200 IMPL. DEV. CHARGED TO PATIENT		0. 28428		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 35700	00 18, 910	6, 751	73.
	OUTPATIENT SERVICE COST CENTERS					
	08800 RURAL HEALTH CLINIC		2. 37040		0	
	09000 CLI NI C		3. 66878		0	
	09001 SURGI CAL ASSOCI ATES		15. 21815		0	
	09002 ORTHOPAEDI CS		3. 04119		0	
	09003 RHEUMATOLOGY		3. 96184		0	
	09004 SPECIALTY CLINIC		4. 54024		0	
	09005 PEDI ATRI CS		2. 75728		0	
	09006 WOMEN'S HEALTH		0. 00000		0	90.
	09007 PAIN MANAGEMENT		3. 58190		0	
	09008 ONCOLOGY MD		0.00000		0	1
	09100 EMERGENCY		0. 52921	·	5, 257	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 03558	38 0	0	92.
	OTHER REIMBURSABLE COST CENTERS					۱ ۵-
	09500 AMBULANCE SERVICES			404		95.
00.00	Total (sum of lines 50 through 94 and 96 through 98)			121, 447	30, 988	
01.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.
02.00	Net charges (line 200 minus line 201)		1	121, 447		202.

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1304	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/23/2022 12:28 pm

Mart B			Title XVIII	Hospi tal	5/23/2022 12:	28 pm
Name			TI LIE XVIII	Hospi tal	Cost	
					1. 00	
Medical and other services reliabursed under dryps (see Instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES				
3.00 DPS payments 0 3 4 4 1 1 1 1 1 1 1 1	1.00	Medical and other services (see instructions)			9, 140, 880	1.00
0.01 Fig. payment (see instructions) 0.4			tions)			2.00
Quitier reconciliation amount (see Instructions)						3.00
Internation Content					_	4.00
Line 2 times Line 5 0.00 7		, , , , , , , , , , , , , , , , , , ,	stions)		_	4. 01 5. 00
2.00 Sam of Flines 3, 4, and 4, 01, divided by line 6 0.00 7 7 7 7 7 7 7 7 7			Ztrons)			6.00
Transit floral corridor payment (see instructions) 0 0 0 0 0 0 0 0 0					_	
Ancil lary service other pass through costs from West. D. Pt. IV, col. 13, Iline 200 0 0 10 10 10 10 10						8.00
1.00		Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	9.00
2.00 Ancillary service charges 0 1 1 1 1 1 1 1 1 1	10.00				0	10.00
Reasonable charges	11. 00				9, 140, 880	11.00
12.00 Ancillary service charges 0 12						
13.00 Organ acquisition charges (Efron Wisst, D-4, Pt. III., col. 4, line 69) 0 13	10.00				0	1 10 00
14.00 Total reasonable charges (sum of lines 12 and 13)			20 (0)		_	12. 00 13. 00
Discourary charges Discour			Tie 69)			
15.00 Aggregate amount actually collected from patients Italia for payment for services on a chargebasis 0 16	14.00					14.00
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis of had active payment been made in accordance with 42 CFR \$413.13(e) 0.000000 17.00 18.10 0.000000 18.10 0.000000 18.10 0.000000 18.10 0.000000 18.10 0.000000 18.10 0.000000 18.10 0.000000 18.10 0.000000 18.10 0.000000 18.10 0.000000 18.10 0.000000 18.10 0.000000 18.10 0.000000 18.10 0.0000000 18.10 0.00000000 18.10 0.00000000000000000000000000000000	15. 00		payment for services on	a charge basis	0	15.00
had such payment been made in accordance with 42 CFR §413.13(e)					0	16.00
18.00 Total customary charges (see instructions) 0 18 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 0 19 10 10 10 10 10 10				· ·		
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions) 19 19 19 19 19 19 19 1						
Instructions						18. 00
20. 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20 20 21 21. 00 1. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 22. 00 2	19. 00		y if line 18 exceeds li	ne 11) (see	0	19.00
Instructions	20.00		v if line 11 eveneds li	no 10) (coo	0	20.00
1.00 Lesser of cost or charges (see instructions) 9,232,289 21	20.00		y IT TITLE IT exceeds IT	ne ro) (see	U	20.00
22 0.0 Interns and residents (see instructions) 0 22 23 0.0 Coto fphysicians' services in a teaching hospital (see instructions) 0 23 24 0.0 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 0 24 25 0.0 26 26 27 0.0 27 0.0 28 28 25 0.0 29 0.0 29 29 0.0 29 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0 29 0.0	21.00				9, 232, 289	21.00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 0.23 0.24 0.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 0.24 0.00 0.24 0.00 0.24 0.00 0.25 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0		9 \				22.00
COMPUTATION OF REIMBURSEMENT SETILEMENT Set	23.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23.00
25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 45,592 25.00 Deductibles and Coinsurance amounts etal ating to amount on line 24 (for CAH, see instructions) 5,366,722 26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 5,366,722 26.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28 28.00 Direct graduate medical education payments (from Wkst. E-4, line 36) 0 29 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29 29.00 Direct graduate medical education costs (from Wkst. E-4, line 36) 0 29 29 29 29 29 29 29	24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
26. 00 Deductible sa and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 5,366,722 22 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 3,819,975 27 28. 00 Direct graduate medical education payments (from Wkst. E-4, line 36) 0 28 30. 00 Direct graduate medical education costs (from Wkst. E-4, line 36) 3,819,975 30 30. 00 Subtotal (sum of lines 27 through 29) 3,819,975 30 30. 00 Subtotal (sum of lines 27 through 29) 3,819,975 30 32. 00 Subtotal (line 30 minus line 31) 3,818,987 32 33. 00 Composite rate ESRD (from Wkst. I-5, line 11) 0 3 34. 00 All lowable bad debts (see instructions) 877,365 34 36. 00 All lowable bad debts (see instructions) 670,984 36 36. 00 MSP-LCC reconciliation amount from PS&R 4,389,274 38 39. 50 Pioneer ACD demonstration payment adjustment amount before sequestration 9 39 99. 70 Demonstration payment adjustment amount after sequestration		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00 Time Value of Money (see instructions)			i +L ONC D L 45 C	-1	_	43.01
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions)	44.00		nce with CMS Pub. 15-2,	chapter 1,	0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00 93.00						1
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92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92 93.00 Time Value of Money (see instructions)						
93.00 Time Value of Money (see instructions) 0 93.		,				
94.00 Total (sum of lines 91 and 93)						
V /T-	94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems RUS

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Peri od: Worksheet E-1
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/23/2022 12: 28 pm Provider CCN: 15-1304

					5/23/2022 12: 2	28 pm
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		1, 537, 740		5, 732, 435	1. 00
2. 00	Interim payments payable on individual bills, either		(0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	11/12/2021	112, 700)	0	3.01
3.02			()	0	3.02
3.03			(0	3.03
3.04)	0	3.04
3.05)	0	3.05
	Provider to Program	<u> </u>	•	•		
3.50	ADJUSTMENTS TO PROGRAM		()	0	3.50
3. 51)	0	3.51
3. 52			()	0	3. 52
3.53)	0	3.53
3.54)	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		112, 700)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 650, 440)	5, 732, 435	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	1				
5. 01	TENTATI VE TO PROVI DER		(0	5. 01
5. 02			(0	5. 02
5. 03			()	0	5. 03
F F0	Provi der to Program					F F0
5. 50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51			(0	5. 51
5. 52	Cultural ((0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		()	0	5. 99
	5. 50-5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on					6. 00
4 01	the cost report. (1) SETTLEMENT TO PROVIDER		210 750			4 01
6. 01			219, 759		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1 970 100	1	1, 343, 161	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 870, 199		4, 389, 274 NPR Date	7. 00
				Contractor Number	(Mo/Day/Yr)	
)	1. 00	2. 00	
8. 00	Name of Contractor		9	1.00	2.00	8. 00
0.00	Name of Contractor	I		1	1	0.00

Health Financial Systems RUS

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

					5/23/2022 12:	28 pm
		Title	XVIII S	Swing Beds - SNF		
		Inpatien	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		52, 650)	0	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
0.01	Program to Provider		1			0.01
3. 01	ADJUSTMENTS TO PROVIDER)	0	3. 01
3. 02				0	0	3. 02
3. 03 3. 04					0	3. 03 3. 04
3. 04						3.04
3.05	Provider to Program			<u>J</u>		3.05
3. 50	ADJUSTMENTS TO PROGRAM		1	O	0	3.50
3. 51	ADSOSTMENTS TO TROOKAW			0	Ö	3.51
3. 52				Ö	Ö	3. 52
3. 53				0	0	3.53
3. 54				0	o o	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			o o	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		52, 650	O	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		T		Г	
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)					
5. 01	Program to Provi der TENTATI VE TO PROVI DER		1		0	5. 01
5. 01	TENTATIVE TO PROVIDER				0	5.02
5. 02					0	5.03
5. 05	Provider to Program		'	<u> </u>		3.03
5. 50	TENTATI VE TO PROGRAM			O	0	5.50
5. 51				0	o o	5. 51
5. 52				o o	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		23, 52	4	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1	O	0	6. 02
7. 00	Total Medicare program liability (see instructions)		76, 17		0	7.00
				Contractor	NPR Date	
			2	Number	(Mo/Day/Yr)	
0.00	None of Contractor)	1. 00	2.00	0.00
8. 00	Name of Contractor					8.00

Heal th	Financial Systems RUSH MEMORIAL I	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCU	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1304	Peri od:	Worksheet E-1	
			From 01/01/2021	Part II	
			To 12/31/2021	Date/Time Pre 5/23/2022 12:	:parea: 28 nm
		Title XVIII	Hospi tal	Cost	20 piii
				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.	· · · · · · · · · · · · · · · · · · ·		ı	1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and	8 through 12, and plus	for cost	i	2.00
	reporting periods beginning on or after 10/01/2013, line 32)			i	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			i	3.00
4. 00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines	1, and 8 through 12, and	d plus for cost	i	4. 00
	reporting periods beginning on or after 10/01/2013, line 32)			İ	
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			i	5. 00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 I			ı	6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	certified HIT technology	Wkst. S-2, Pt. I	i	7. 00
	line 168			İ	
8. 00	Calculation of the HIT incentive payment (see instructions)			i	8. 00
9. 00	Sequestration adjustment amount (see instructions)			i	9. 00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				4
	Initial/interim HIT payment adjustment (see instructions)			ı	30.00
	Other Adjustment (specify)			ı	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32.00

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1304	Peri od:	Worksheet E-2
			From 01/01/2021	
		Component CCN: 15-Z304	To 12/31/2021	Date/Time Prepared:
		· ·		5/22/2022 12:20 pm

		Component CCN: 15-Z304	To 12/31/2021	Date/Time Pre 5/23/2022 12:	pared: 28 pm
		Title XVIII S	wing Beds - SNF		20 p
			Part A	Part B	
	COMPUTATION OF MET COOT OF COMPETE OFFI		1. 00	2. 00	
1. 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		49, 052	0	1.00
2. 00	Inpatient routine services - swing bed-NF (see instructions)		49, 052	U	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	27, 122	0	3.00	
0.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	277.22	ŭ	0.00
	instructions)				
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teach	ing program (see		0.00	4.00
	instructions)			_	
5.00	Program days		25	0	
6. 00 7. 00	Interns and residents not in approved teaching program (see i Utilization review - physician compensation - SNF optional me			0	6. 00 7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	thou only	76, 174	0	
9. 00	Primary payer payments (see instructions)		70, 174	0	
10. 00	Subtotal (line 8 minus line 9)		76, 174	0	
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	0	0	
	professional services)				
12.00	Subtotal (line 10 minus line 11)		76, 174	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	0	0	13.00
	for physician professional services)			_	
14.00	80% of Part B costs (line 12 x 80%)		7/ 474	0	14.00
15.00	Subtotal (see instructions)		76, 174	0	
16. 00 16. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	c)	U	U	16. 00 16. 50
16. 55	Rural community hospital demonstration project (§410A Demonst	•	0		16. 55
10. 55	adjustment (see instructions)	ration) payment			10.55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	18.00
19. 00	Total (see instructions)		76, 174	0	
19. 01	Sequestration adjustment (see instructions)		0	0	
19. 02	Demonstration payment adjustment amount after sequestration)		O	0	
19. 03 19. 25	Sequestration adjustment-PARHM pass-throughs Sequestration for non-claims based amounts (see instructions)		0	0	19. 03 19. 25
20. 00	Interim payments		52, 650	0	20.00
	Interim payments Interim payments-PARHM		32, 030	O	20.00
21. 00	Tentative settlement (for contractor use only)		0	0	
21. 01	Tentative settlement-PARHM (for contractor use only)				21. 01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.0	2, 19.25, 20, and 21)	23, 524	0	22.00
22. 01	Balance due provider/program-PARHM (see instructions)				22. 01
23. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2				
200 00	Rural Community Hospital Demonstration Project (§410A Demonst				200 00
200.00	Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	riod under the 21St			200.00
	Cost Reimbursement				1
201.00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3, col. 3, line			202.00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)	C' C II	1.5	1 12	204. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the currer	it 5-year demons	tration	
205.00	period) Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 t	imes line 204)			206.00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				200.00
207.00	Program reimbursement under the §410A Demonstration (see inst				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-	•			208.00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 00
210.00	Reserved for future use				210.00
045 05	Comparision of PPS versus Cost Reimbursement	200 -1 11 2522 (015 05
∠15.00	Total adjustment to Medicare swing-bed SNF PPS payment (line instructions)	209 plus line 210) (see			215. 00
	[This is do it offs]		1		I

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1304	From 01/01/2021	Worksheet E-3 Part V Date/Time Prepared: 5/23/2022 12:28 pm
	Title XVIII	Hospi tal	Cost

				5/23/2022 12:	28 pm_
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1. 00	Inpatient services			2, 121, 880	1.00
2. 00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	2.00
3.00	Organ acquisition			0	3.00
4. 00	Subtotal (sum of lines 1 through 3)			2, 121, 880	
5. 00	Primary payer payments			0	5.00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 143, 099	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
7 00	Reasonable 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
11 00	Customary charges Aggregate amount actually collected from patients liable for	normant for complete on	a abarga basi s	0	11.00
11. 00 12. 00	Amounts that would have been realized from patients liable for				12.00
12.00	had such payment been made in accordance with 42 CFR 413.13(e		ni a charge basis	ď	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
15. 00	Excess of customary charges over reasonable cost (complete or	dy if line 14 exceeds li	ne 6) (see	Ö	15.00
13.00	instructions)	if y it time is exceeds if	110 0) (300	Ĭ	13.00
16. 00	Excess of reasonable cost over customary charges (complete or	lvifline 6 exceeds lin	ne 14) (see	0	16, 00
	instructions)	ye e exceede	.0 (000		
17.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	,		•	İ
18.00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	18. 00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2, 143, 099	19.00
20.00	Deductibles (exclude professional component)			282, 080	20.00
21.00	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 861, 019	22. 00
23.00	Coinsurance			0	23. 00
24.00	Subtotal (line 22 minus line 23)			1, 861, 019	
25. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		14, 123	
26. 00	Adjusted reimbursable bad debts (see instructions)			9, 180	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		3, 429	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 870, 199	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	29. 50
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	
30.00	Subtotal (see instructions)			1, 870, 199	
30. 01	Sequestration adjustment (see instructions)			0	
30. 02	Demonstration payment adjustment amount after sequestration			0	30.02
30. 03 31. 00	Sequestration adjustment-PARHM			1 /50 //0	30. 03 31. 00
31.00	Interim payments			1, 650, 440	31.00
32. 00	Interim payments-PARHM Tentative settlement (for contractor use only)			0	32.00
32. 00	Tentative settlement (Tor contractor use only)			0	32.00
32.01	Balance due provider/program (line 30 minus lines 30.01, 30.0	12 31 and 22)		219, 759	
33. 00	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m		and 32 01)	217, 739	33.00
34. 00				0	34.00
5 7. 00	§115. 2		5ap (5) 1,		5 1. 55
	10			ı	

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1304	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part VII Date/Time Prepared: 5/23/2022 12:28 pm

Title XIX				10 12/31/2021	5/23/2022 12:	28 pm
PART VII			Title XIX	Hospi tal		
DATE COMPUTATION OF THE INSURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				I npati ent	Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0				1. 00	2. 00	
Inpatient hospital/SNE/ME services			RVICES FOR TITLES V OR XI	X SERVICES		
Medical and other services 0 2.00						
Organ acquisition (certified transplant centers only) 0 75,681 0 4,00	1.00			75, 681		1.00
Subtotal (sum of lines 1, 2 and 3)	2.00				0	2.00
Inpati ent primary payer payments 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	3.00			0		3.00
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3.00 Subtratal (Line & less sum of lines 5 and 6) 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.				0		
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges A5,855 8.00 Routine service charges 121,447 0.90 0.00 Another service charges 121,447 0.90 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.						
Reasonable Charges 8.0 Routine service charges 45,855 8.0 Routine service charges 121,447 0.9 9.00 10.00 00 10.00 00 10.00 00	7. 00			75, 681	0	7.00
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13.00 Annount actually collected from patients	12.00			167, 302	0	12.00
basis	12 00		r condices on a change		0	12 00
14.00 Amounts that would have been realized from patients Ilable for payment for services on a rarge basis had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 0.000000 15.00 16.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.	13.00	, , , , , , , , , , , , , , , , , , , ,	r services on a charge	U	U	13.00
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20. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 20. 00 21. 00 21. 00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 0 0 22. 00 23. 00 24. 00 24. 00 24. 00 24. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00	19. 00			0	0	19.00
21.00 Cost of covered services (enter the lesser of line 4 or line 16) 75, 681 0 21.00			ructions)			
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				75, 681	0	
22. 00 Other than outlier payments 0 0 22. 00 23. 00 Outlier payments 0 0 23. 00 24. 00 Program capit al payments 0 24. 00 25. 00 Capit al exception payments (see instructions) 0 25. 00 26. 00 Routine and Ancillary service other pass through costs 0 0 26. 00 27. 00 Subtotal (sum of lines 22 through 26) 0 0 27. 00 0 28. 00 0 27. 00 0 28. 00 0 28. 00 0 27. 00 0 28. 00 0 29. 00 0 27. 00 0 29. 00 0 29. 00 0 29. 00 0 28. 00 0 29. 00 0 29. 00 0 29. 00 0 29. 00 0 29. 00 0 29. 00 0 29. 00 0 29. 00 0 29. 00 0 29. 00 0 29. 00 0 29. 00 0 29. 00 0 29. 00 0 29. 00 0 29. 00 0 29. 00 0 29. 00 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
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28.00 Customary charges (title V or XIX PPS covered services only) 75,681 75,681 0 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00	26.00	Routine and Ancillary service other pass through costs		0	0	26.00
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Chapter 1, 9115.2	43.00	·	nce with CMS Pub 15-2,	0	0	43.00
		[Chapter 1, 9115.2				I

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

Health Financial Systems RUSH MEMOR 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: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/23/2022 12: 28 pm

——————————————————————————————————————					5/23/2022 12:	28 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	17, 139, 096	0	0	0	1.00
2.00	Temporary investments	2, 467, 485	0	0		2.00
3.00	Notes receivable	0	0	0	0	3.00
4. 00	Accounts receivable	19, 895, 090		0	0	1
5. 00 6. 00	Other receivable	363, 965		0	0	5. 00 6. 00
7. 00	Allowances for uncollectible notes and accounts receivable Inventory	-13, 141, 643 1, 261, 855		0	0	7.00
8. 00	Prepaid expenses	532, 718		0	0	
9. 00	Other current assets	0	Ö	0	0	
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	28, 518, 566	0	0	0	11.00
40.00	FI XED ASSETS	100 700	J			40.00
12. 00 13. 00	Land improvements	188, 708 549, 432		0	0	12. 00 13. 00
14. 00	Accumulated depreciation	-680, 356		0	0	14.00
15. 00	Bui I di ngs	22, 099, 164		0	Ő	15.00
16.00	Accumulated depreciation	-5, 216, 006		0	0	
17.00	Leasehold improvements	0	0	0	0	17.00
18. 00	Accumulated depreciation	0	0	0	0	18. 00
19.00	Fixed equipment	3, 642, 980		0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	-797, 866		0	0	20.00
21.00	Accumulated depreciation			0	0	21.00
23. 00	Major movable equipment	19, 639, 114	-	0	0	23.00
24. 00	Accumulated depreciation	-20, 734, 925		0	0	24.00
25.00	Mi nor equi pmen't depreci abl e	0	0	0	0	25. 00
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation	0	0	0	0	28.00
29. 00 30. 00	Minor equipment-nondepreciable	10 (00 245	0 0	0	0	29. 00 30. 00
30.00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	18, 690, 245	<u> </u>	0	0	30.00
31. 00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	47 200 011	0	0	0	35. 00 36. 00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	47, 208, 811	J U	0	0	30.00
37. 00	Accounts payable	2, 220, 050	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1, 794, 659		0	0	38. 00
39. 00	Payroll taxes payable	995, 207	0	0	0	
40.00	Notes and Loans payable (short term)	3, 478, 094	0	0	0	1
41.00	Deferred income	0		0	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	0		0	0	42. 00 43. 00
44. 00	Other current liabilities	14, 781, 180		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	23, 269, 190		0		1
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	
47.00	Notes payable	2, 150, 912		0	0	
48. 00	Unsecured Loans	0	0	0		
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	2, 150, 912	0	0	0	49. 00 50. 00
51.00	Total liabilities (sum of lines 45 and 50)	25, 420, 102		0		51.00
01.00	CAPITAL ACCOUNTS	20/120/102	·I 91			000
52.00	General fund balance	21, 788, 709)			52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted	ļ		0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0	0	56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	57. 00 58. 00
55. 55	replacement, and expansion					55.55
59. 00	Total fund balances (sum of lines 52 thru 58)	21, 788, 709	o	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	47, 208, 811	0	0	0	60.00
	[59]	l				l

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

Peri od: Worksheet G-1 From 01/01/2021 Provi der CCN: 15-1304

			То	12/31/2021	Date/Time Pro 5/23/2022 12:	28 pm
Gener	ral Fund	Speci al	Purp	oose Fund	Endowment Fund	
1.00	2.00	3 00		4 00	5 00	
d	15, 840, 4 ⁻ 5, 948, 23	70 35	0 0 0 0	0	((5. 00 6. 00 7. 00
7)	0 0 0 0 0 0	0	0 0 0 0 0 0	0 0	()	10.00 11.00 12.00 13.00 14.00 15.00 16.00
Endowment Fund	PI a	nt Fund				
6.00	7 00	8 00				
d	0	O O O O O O O	0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
7)	0 0 0 0 0	0 0 0 0 0 0 0	0 0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
	1.00 d line 29) cify) 7) al ance Endowment	d	1.00 2.00 3.00 d 15,840,470 5,948,235 21,788,705 4 21,788,709 ci fy) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00	1.00 2.00 3.00 4.00 d 15,840,470 5,948,235 21,788,705 0 4 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	General Fund 1.00 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 2.00 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 4.00 5.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6.00 1.100 3.00 6

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

			10) 12/31/2021	Date/IIme Prep 5/23/2022 12:3	
	Cost Center Description	Inpati	ent	Outpati ent	Total	20 piii
		1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES	<u>. </u>				
	General Inpatient Routine Services					
1.00	Hospi tal	2, 96	5, 136		2, 965, 136	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)	2, 96	5, 136		2, 965, 136	10.00
	Intensive Care Type Inpatient Hospital Services	<u> </u>				
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)		0			15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines 11-15)	5	0		0	16. 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	2.04	5, 136		2, 965, 136	17. 00
18.00	Ancillary services		6, 072	109, 155, 131	114, 511, 203	18.00
19. 00	Outpatient services	3, 33	0, 072	107, 133, 131	0	19. 00
20.00	RURAL HEALTH CLINIC		0	2, 158, 029	2, 158, 029	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	2, 100, 027	0	21.00
22. 00	HOME HEALTH AGENCY		Ŭ	Ŭ	ĭ	22.00
23. 00	AMBULANCE SERVICES		0	867, 162	867, 162	23. 00
24. 00	CMHC			0077.02	007,102	24.00
25. 00	AMBULATORY SURGI CAL CENTER (D. P.)					25. 00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECIFY)		0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27) (transfer column 3 to Wk	kst. 8,32	1, 208	112, 180, 322	120, 501, 530	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			44, 719, 749		29.00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33. 00			0			33.00
34.00			0			34.00
35. 00			0	_		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)		0			37.00
38.00			0			38.00
39.00			0			39.00
40.00			0			40. 00 41. 00
41.00	Total deductions (sum of lines 27 41)		U			41.00 42.00
42. 00 43. 00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	nefor		44, 719, 749		42. 00 43. 00
43.00	to Wkst. G-3, line 4)	11131 01		44, / 17, /49		43.00
	TO MASE. O S, TITLE 4)	I		ı	'	

Heal th	Financial Systems RUSH MEMORIAL	HOSPI TAI	Inlie	u of Form CMS-2	2552-10
	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1304	Peri od:	Worksheet G-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/23/2022 12:	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			120, 501, 530	1
2.00	Less contractual allowances and discounts on patients' accounts	nts		75, 151, 486	•
3.00	Net patient revenues (line 1 minus line 2)	10)		45, 350, 044	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		44, 719, 749	•
5. 00	Net income from service to patients (line 3 minus line 4)			630, 295	5.00
6. 00	OTHER INCOME Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			0	7.00
8. 00	Revenues from telephone and other miscellaneous communication	n sorvi cos		0	8.00
9. 00	Revenue from television and radio service	ii sei vi ces		0	1
10.00				0	10.00
11. 00				0	11.00
12. 00				0	12.00
13. 00				0	13.00
	Revenue from meals sold to employees and quests			0	14.00
15. 00				0	15.00
16. 00		than natients		0	16.00
17. 00		than patronto		0	17.00
18. 00				0	•
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
	Rental of vending machines			0	21.00
22. 00	· ·			0	22. 00
23.00	l · · ·			0	23. 00
24. 00	1 '' '			611, 379	24.00
24. 01	NON-OPERATING EXPENSES/INCOME			468, 343	
24. 02	CONTRACT PHARMACY			650, 188	24. 02
24.50	COVI D-19 PHE Fundi ng			3, 588, 030	24. 50
25.00	Total other income (sum of lines 6-24)			5, 317, 940	25.00
26. 00	Total (line 5 plus line 25)			5, 948, 235	26. 00
27. 00	OTHER			0	27. 00
28 00	Total other expenses (sum of line 27 and subscripts)			0	28 00

0 28.00 5, 948, 235 29.00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/23/2022 12:	pared: 28 pm
					RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	FACILITY HEALTH CARE STAFF COSTS	447.000		447.00		447.000	1 00
1.00	Physician	417, 093	C			417, 093	1.00
2.00	Physician Assistant	472 244	C		0 0	424 077	2.00 3.00
3. 00 4. 00	Nurse Practitioner Visiting Nurse	473, 344		473, 34	-36, 467	436, 877 0	4.00
5. 00	Other Nurse	40, 338		40, 33	0	40, 338	5.00
6. 00	Clinical Psychologist	40, 336		40, 33	0	40, 336	6.00
7. 00	Clinical Social Worker	22, 811		22, 81	1 0	22, 811	7.00
8. 00	Laboratory Techni ci an	22, 011		22,01		22,011	8.00
9. 00	Other Facility Health Care Staff Costs	332, 933	Č	332, 93	3 0	332, 933	9.00
10.00	Subtotal (sum of lines 1 through 9)	1, 286, 519	C	1, 286, 51		1, 250, 052	
11. 00	Physician Services Under Agreement	0	C	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	C		0 0	0	12.00
13.00	Other Costs Under Agreement	0	C		0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	C		0 0	0	14.00
15.00	Medical Supplies	0	23, 801	23, 80	-1, 055	22, 746	15.00
16.00	Transportation (Health Care Staff)	0	182	. 18	32 0	182	16.00
17.00	Depreciation-Medical Equipment	0	C		0	0	17.00
18.00	Professional Liability Insurance	0	C)	0 0	0	18.00
19.00	Other Health Care Costs	0	C)	0	0	19.00
20.00	Allowable GME Costs						20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	23, 983			22, 928	21.00
22. 00	Total Cost of Health Care Services (sum of	1, 286, 519	23, 983	1, 310, 50	-37, 522	1, 272, 980	22.00
	lines 10, 14, and 21)						ļ
22.00	COSTS OTHER THAN RHC/FQHC SERVICES					0	1 22 00
23. 00	Pharmacy	0	C	l .	0	0	23.00
24. 00 25. 00	Dental	0	C		0 0	0	24. 00 25. 00
25. 00	Optometry Telehealth	0			0 0	0	25.00
25. 01	Chronic Care Management	0			0 0	0	25.01
26. 00	All other nonreimbursable costs	0	0	l .	0 0	0	26.00
27. 00	Nonallowable GME costs	O	C			U	27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	C	,	0	0	28.00
20.00	through 27)	Ö				0	20.00
	FACILITY OVERHEAD						1
29. 00	Facility Costs	0	19, 524	19, 52	24 0	19, 524	29. 00
30.00	Administrative Costs	258, 893	92, 363			351, 256	30.00
31.00	Total Facility Overhead (sum of lines 29 and	258, 893	111, 887			370, 780	
	30)	·	•	1			l

1, 545, 412

135, 870

1, 681, 282

-37, 522

1, 643, 760

32.00

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	RUSH MEMORIA	L HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der CCN: 15-1304	Period: From 01/01/2021	Worksheet M-1
		Component CCN: 15-8539	To 12/31/2021	Date/Time Prepared: 5/23/2022 12:28 pm
			RHC I	Cost
	Adjustments	Net Expenses		

			Component	CCN. 13-0339	10	12/31/2021	5/23/2022 12	
						RHC I	Cost	
		Adjustments	Net Expenses					
		,	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	417, 093					1.00
2.00	Physician Assistant	0	0					2.00
3.00	Nurse Practitioner	0	436, 877					3.00
4.00	Visiting Nurse	0	0					4.00
5.00	Other Nurse	0	40, 338					5.00
6.00	Clinical Psychologist	0	0					6.00
7.00	Clinical Social Worker	0	22, 811					7. 00
8.00	Laboratory Techni ci an	0	0					8. 00
9.00	Other Facility Health Care Staff Costs	0	332, 933					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 250, 052					10.00
11.00	Physician Services Under Agreement	0	0					11.00
12.00	Physician Supervision Under Agreement	0	0					12.00
13.00	Other Costs Under Agreement	0	0					13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0					14.00
15.00	Medical Supplies	0	22, 746					15.00
16.00	Transportation (Health Care Staff)	0	182					16.00
17.00	Depreciation-Medical Equipment	0	0					17. 00
18.00	Professional Liability Insurance	0	0					18. 00
19.00	Other Health Care Costs	0	0					19. 00
20.00	Allowable GME Costs							20.00
21.00	Subtotal (sum of lines 15 through 20)	0	22, 928					21.00
22.00	Total Cost of Health Care Services (sum of	0	1, 272, 980					22.00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	, ,	0	0					23. 00
24. 00	Dental	0	0					24. 00
25. 00	Optometry	0	0					25. 00
25. 01	Tel eheal th	0	0					25. 01
25. 02	, ,	0	0					25. 02
26. 00		0	0					26. 00
27. 00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0					28. 00
	through 27)							
	FACILITY OVERHEAD	.1		1				
	Facility Costs	0	19, 524					29.00
30.00	Administrative Costs	0	351, 256	1				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	이	370, 780					31.00
22.00	30)		1 / 10 7/0					22.00
32. 00	, , ,	0	1, 643, 760					32.00
	and 31)	l l		l				1

Number of FTE Personnel Total Visits Provider CCN: 15-1304 Period: F737/2021 Date/Time Prepared: 5/23/2022 12: 28 pm Cost Personnel Total Visits Productivity Standard (1) Visits Productivity Minimum Visits (col. 2 or col. 2 or col. 4 Visits Productivity Visits (col. 1 or col. 2 or col. 4 Visits Visits Visits (col. 2 or col. 2 or col. 4 Visits	Financial Systems	RUSH MEMORIA				u of Form CMS-2	2552-10	
Number of FTE Personnel Number of FTE Personnel Number of FTE Personnel Number of FTE Personnel Number of FTE Personnel Number of FTE Personnel Number of FTE Personnel Number of FTE Standard (1) Nists (col. 2 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 3 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or col. 4 or	ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der 0			Worksheet M-2	
Number of FTE Total Visits Productivity Standard (1) Visits (col. 2 or col. 2 or col. 4 1.00 2.00 3.00 4.00 5.00				Component				
Personnel Standard (1) Visits (col. col. 2 or 1 x col. 3) col. 4						RHC I	Cost	
No				Total Visits				
1.00 2.00 3.00 4.00 5.00			Personnel		Standard (1)	•		
VISITS AND PRODUCTIVITY								
Positions			1. 00	2. 00	3. 00	4. 00	5. 00	
1.00 Physician								
2.00 Physician Assistant								
3.00 Nurse Practitioner 3.67 7,081 1 4 3.00 4.00 Subtotal (sum of lines 1 through 3) 5.27 10,959 6 10,959 4.00 6.00 Clinical Psychologist 0.00 0 0 0 0.00 6.00 Clinical Psychologist 0.00 0 0 0 0 0.00 7.00 Clinical Social Worker 0.30 118 18 7.00 7.01 Medical Nutrition Therapist (FOHC only) 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 3			1			
4.00 Subtotal (sum of lines 1 through 3) 5.27 10,959 6 10,959 4.00						1 0		
5.00 Visiting Nurse						1 4		
Clinical Psychologist					1	6		
7. 00 Clinical Social Worker 0. 30 118 7. 00 7. 01 Medical Nutrition Therapist (FOHC only) 0. 00 0 0 7. 01 0. 7. 01 0. 10 0. 00 0 0 0 0 0 0 0					1			
7. 01 Medical Nutrition Therapist (FQHC only)					1		-	
7. 02 Diabetes Self Management Training (FQHC 0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					3			
only) 8.00 Total FTEs and Visits (sum of lines 4 5.57 11,077 11,077 11,077 8.00 through 7) 9.00 Physician Services Under Agreements 0 0 9.00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 1,272,980 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1,272,980 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1,000000 13.00 15.00 Parent provider overhead - (from Worksheet. M-1, col. 7, line 31) 370,780 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 1,319,451 15.00 17.00 Allowable GME overhead (see instructions) 1,690,231 16.00 17.00 Allowable GME overhead (see instructions) 1,690,231 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1,690,231 19.00							_	
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19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1,690,231 19.00								
			HC services (I	ine 13 x line	18)			

Heal th	Financial Systems RUSH MEMORIAL H	HOSPI TAI	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	Worksheet M-3	
SERVI (EES	Component CCN: 15-8539	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/23/2022 12:	
		Title XVIII	RHC I	Cost	
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst M-2 line 20)		2, 963, 211	1.00
2. 00	Cost of injections/infusions and their administration (from W			52, 321	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m			2, 910, 890	3.00
4.00	Total Visits (from Wkst. M-2, column 5, line 8)			11, 077	4.00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			11, 077	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	262.79 of Limit (1)	7.00
			Carcuration	OI LIMIT (I)	
			Rate Period 1	Rate Period 2	
			(01/01/2021	(04/01/2021	
			through	through	
			03/31/2021)	12/31/2021)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	1. 00	2. 00 262. 79	8.00
9. 00	Rate for Program covered visits (see instructions)	. o or your contractor)	262. 79		1
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from	contractor records)	760	2, 221	10.00
11. 00	Program cost excluding costs for mental health services (line	•	199, 720	583, 657	
12.00	Program covered visits for mental health services (from contr	•	2		12.00
13. 00 14. 00	Program covered cost from mental health services (line 9 x li Limit adjustment for mental health services (see instructions	•	526 526	2, 628 2, 628	
15. 00	Graduate Medical Education Pass Through Cost (see instructions		520	2,020	15.00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	786, 531	1
16. 01	Total program charges (see instructions) (from contractor's re	•		375, 910	1
16. 02	Total program preventive charges (see instructions)(from prov	ider's records)		43, 738	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	*		91, 514	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		516, 550	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	608, 064	16. 05
17. 00	Primary payer amounts		9	000,004	
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		49, 329	1
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		56, 574	19.00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			608, 064	20.00
21.00	Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		27, 637	1
22. 00	,	,		635, 701	1
23.00	Allowable bad debts (see instructions)			0	1
23. 01	, , , , , , , , , , , , , , , , , , , ,			0	
24.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
25. 00	, , , , ,)		0	
25. 50 25. 99	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	13)		0	1
26. 00	Net reimbursable amount (see instructions)			635, 701	
26. 01	Sequestration adjustment (see instructions)			0	
26. 02	, , , , , , , , , , , , , , , , , , , ,			0	
27. 00	1			360, 574	1
	Tentative settlement (for contractor use only)	00 07 and 00)		0	
29. 00 30. 00	Balance due component/program (line 26 minus lines 26.01, 26. Protested amounts (nonallowable cost report items) in accorda	•		275, 127 0	1
30.00	chapter I, §115.2	mee with ome rub. 19-11	'		30.00
	cnapter I, §115.2				I

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST		Provi der	CCN: 15-1304	Peri od:	Worksheet M-4	
			CCN 15 0520	From 01/01/2021	D-+- /T: D	
		Component	CCN: 15-8539	To 12/31/2021	5/23/2022 12:	
		Ti tl	e XVIII	RHC I	Cost	
	P	NEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY	
					DDODLICTC	

Title XVIII RRG Cost PNEUMOCOCCAL NETULINA COVID-19 MONOCLONAL ANTE BODY PRODUCTS VACCINES			Component	CCN: 15-8539 10	0 12/31/2021	5/23/2022 12:	pared: 28 pm
VACCINES VACCINES VACCINES ANTIBODY			Title	XVIII	RHC I		
1.00 2.00 2.01 2.02			PNEUMOCOCCAL				
1.00			VACCI NES	VACCI NES	VACCI NES	ANTI BODY	
1.00							
2.00 Ratio of injection/infusion staff time to total health care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 2) 4.00 Injections/infusions and related medical supplies costs (from your records) 5.00 Direct cost of injections/infusions (line 3 plus line 4) 6.00 Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst M-2, line 19) 8.00 Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 10.00 Total injection/infusion costs and their administration costs (sum of lines 5 and 9) 11.00 Total number of injection/infusion diministered to Program beneficiaries 13.01 Number of injections/infusions and their administration costs (line 10 time 10 time 10 times 13 and 13.01, as applicable) 15.00 Total Program cost of injections/infusions and their administration cost (sum of lines the sum of lines 13 and 13.01, as applicable) 16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2, 201, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2, 201, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2, 201, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2, 201, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2, 201, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2, 201, and 2.02, line 10) (transfer this amount to W							
Care staff time							
3.00 Injection/infusion health care staff cost (line 1 x line 2) 3.00 3.00 3.00 1.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.0	2. 00		0. 000465	0. 001915	0. 000000	0. 000000	2.00
20		1					
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13.01 Number of COVID-19 vaccine injections/infusions administered to MA enrollees 14.00 Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) 15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, and 2.02, administration costs (sum of columns 1, 2, 2.01, administration costs (sum of columns 1, 2, 2.01, administration costs (sum of columns 1, 2, 2.01, administration costs (sum of columns 1,	13.00	Number of injection/infusion administered to Program	42	206	0	0	13.00
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15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02,							
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16.00 Total Program cost of injections/infusions and their 27,637 administration costs (sum of columns 1, 2, 2.01, and 2.02,							
administration costs (sum of columns 1, 2, 2.01, and 2.02,	14 00			27 /27			17 00
	10.00			21,031			10.00
Title 17) (Charlet this amount to mat. in 5, The 21)							
		print in (transfer this amount to most. in 5, fine 21)			ı		

Health Financial Systems	RUSH MEMORIAL I	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 15-1304 Component CCN: 15-8539	Peri od: From 01/01/2021 To 12/31/2021	
			DUC I	C+

				5/23/2022 12: 2	28 pr
			RHC I	Cost	
			Par	rt B	
			mm/dd/yyyy	Cost Part B	
			1. 00	2.00	
.00	Total interim payments paid to hospital-based RHC/FQHC			360, 574	1.
00	Interim payments payable on individual bills, either submit	tted or to be submitted to		0	2.
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount	t based on subsequent			3.
	revision of the interim rate for the cost reporting period.				
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01	i regram to rrovi do.			0	3.
02					3.
03					3.
04					3.
05					3.
03	Provider to Program			U	٥.
50	Provider to Program				3.
50 51					3.
51 52				1	_
				1 -1	3.
53				1 -1	3.
54				1	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.				3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		360, 574	4.
	27)				
	TO BE COMPLETED BY CONTRACTOR		_		
00	List separately each tentative settlement payment after des	sk review. Also show date o	f		5.
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				1 -1	5.
02				1	5.
03				0	5.
	Provider to Program				
50				0	5.
51				0	5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5
00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6.
01	SETTLEMENT TO PROVIDER	•		275, 127	6
02	SETTLEMENT TO PROGRAM				6.
00	Total Medicare program liability (see instructions)			635, 701	7.
			Contractor		
			Number		
		0	1. 00	1 2.00 1	