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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1304 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 4/26/2024 1:37 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 4/26/2024 1:37 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, "L" for low, or "N" for no. [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 01/01/2023 and ending 12/31/2023 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	PRESIDENT & CEO			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	67, 103	-382, 798	0	-3, 804	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	9, 825	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		161, 997		0	10.00
200.00	TOTAL	0	76, 928	-220, 801	0	-3, 804	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

In Lieu of Form CMS-2552-10 Health Financial Systems RUSH MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1304 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 4/26/2024 1:37 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 5.00 Subprovi der - IRF 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 12/31/2023 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 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. 22.01 Did this hospital receive interim UCPs, including supplemental UCPs, for Ν Ν 22.01 this 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 a final UCP to be Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N 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

0

22 04

23.00

counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for

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

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.

yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to

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

yes or "N" for no.

complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1304 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 4/26/2024 1: 37 pm XVIII XIX 1. 00 2.00 3.00 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. 58.00 Pt. I Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61 02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	RUSH M	IEMORIAL HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: rom 01/01/2023	Worksheet S-2 Part I Date/Time Pre	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	4/26/2024 1:3 Ratio (col. 1/ (col. 1 + col. 2))	7 pm
			1.00	2. 00	3. 00	
Section 5504 of the ACA Base Year period that begins on or after a			·lhis base year	is your cost	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column)	s yes, or your facilit aber of unweighted nor otations occurring in e number of unweighted our hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
(F 00 Fatar in advant 1 if line (2	1. 00	2. 00	3.00	4. 00	5.00	45.00
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	65. 00
			FTEs	FTEsin	1/ (col. 1 +	
			Nonprovi der Si te	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 of 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 al. 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	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 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	67. 00

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1304 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 4/26/2024 1:37 pm 1.00 Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) 68.00 For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your 68.00 MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)? 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. 71.00 | If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 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 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for O 76.00 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. N 80.00 81.00 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. N 85.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87.00 N 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. Approved for Number of Permanent Approved Adiustment Permanent (Y/N)Adjustments 1.00 2.00 88. 00 88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target Ν amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments Effecti ve Wkst. A Line Approved Date Permanent No. Adjustment Amount Per Di scharge 3. 00 2.00 1.00 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0 00 0 89 00 on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per di scharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge. 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 Ν Υ 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 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 91.00 Υ 91.00 Ν 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. 92.00 Ν 92.00 93.00 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. Ν Ν 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 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the 96.00 Ν Ν 96.00 applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97.00 0.00 0.00

1103711		Provider C	CN: 15-1304	Peri od:	Worksheet S-	-2552-1 2
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		From 01/01/2023 To 12/31/2023	Part I	epared
				V	XIX	4
08 00	Does title V or XIX follow Medicare (title XVIII) for the i	ntorns and ros	cidents nest	1. 00 Y	2. 00 Y	98. 0
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX				1	90.0
98. 01	Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.				Y	98. 0
	Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.	or "N" for no	in column 1	Y	Y	98.0
8. 03	Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.				N	98.0
8. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.			N	N	98.0
98. 05	Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.				Y	98.0
	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			Y	N	98.0
05.05	Rural Providers					105 -
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	-inclusive met	thod of paymer	t Y		105. C
07. 00	Column 1: If line 105 is Y, is this facility eligible for c training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, do	n 1. (see ins	structions)	N		107. 0
07. 01	approved medical education program in the CAH's excluded I Enter "Y" for yes or "N" for no in column 2. (see instruct If this facility is a REH (line 3, column 4, is "12"), is i reimbursement for I&R training programs? Enter "Y" for yes	PF and/or IRF ions) t eligible for	uni t(s)?			107. (
08. 00	instructions) Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	edule? See 42	. N		108.0
		Physi cal	Occupati onal		Respiratory	
09. 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.	1. 00 Y	2. 00 N	3. 00 N	4. 00 N	109.0
					1.00	
	Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no.	If yes,	1. 00 N	110.0
	Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	"Y" for yes or	"N" for no.	If yes, ough 215, as	N	110.0
	Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	"Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating ir	Community period? Enter the column 2.	1 f yes, sugh 215, as		
	Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a	"Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating ir	Community period? Enter enter the column 2.	If yes, ugh 215, as	N 2. 00	110.0
11. 00	Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a	"Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating ir dditional beds	Community period? Enter the column 2.	1 f yes, sugh 215, as	N	111. (
11.00	Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital ce participation in the demonstration, if applicable.	"Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating ir dditional beds Ith Model eporting olumn 1 is pating in the	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ugh 215, as	N 2. 00	111. (
111. 00	Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide	"Y" for yes or rksheet E-2, I the Frontier (cost reporting olumn 1 is Y, rticipating ir dditional beds Ith Model eporting olumn 1 is pating in the assed or "N" for no B, or E only) 93" percent (includes	Community period? Enter enter the n column 2. s; and/or "C"	If yes, ugh 215, as	2. 00 3. 00	111. 0
111. 00 112. 00 115. 00	Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began particidemonstration. In column 3, enter the date the hospital ceparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes o in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care	"Y" for yes or rksheet E-2, I the Frontier (ost reporting olumn 1 is Y, rticipating ir dditional beds Ith Model eporting olumn 1 is pating in the ased ""N" for no B, or E only) 93" percent (includes irs) based on	Community period? Enter enter the column 2. s; and/or "C"	If yes, ugh 215, as	2. 00 3. 00	

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CN	MS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE		Provi der CCI		Peri od: From 01/01/2023 To 12/31/2023	Worksheet : Part Date/Time	S-2 Prepared:
			Premi ums	Losses	4/26/2024 Insurance	
			o a e	255555	7.104.41100	
			1. 00	2. 00	3. 00	
118.01 List amounts of malpractice premiums ar	nd paid Losses:		172, 70	01 0		0 118. 01
				1.00	2. 00	
118.02 Are malpractice premiums and paid losse Administrative and General? If yes, su and amounts contained therein.				N		118. 02
119.00D0 NOT USE THIS LINE 120.00ls this a SCH or EACH that qualifies for \$3121 and applicable amendments? (see i "N" for no. Is this a rural hospital wide Hold Harmless provision in ACA §3121 are Enter in column 2, "Y" for yes or "N" 1	nstructions) Enter in th < 100 beds that quand and applicable amendment	column 1, "Y" Hifies for th	for yes or ne Outpatient		N	119. 00 120. 00
121.00 Did this facility incur and report cost		itable devices	charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for 122.00 Does the cost report contain healthcare Act?Enter "Y" for yes or "N" for no in the Worksheet A line number where these	e related taxes as defi column 1. If column 1					122. 00
123.00 Did the facility and/or its subprovider services, e.g., legal, accounting, tax management/consulting services, from ar for yes or "N" for no.	rs (if applicable) purc preparation, bookkeepi n unrelated organizatio	ng, payroll, on? In column	and/or 1, enter "Y'		Y	123. 00
If column 1 is "Y", were the majority of professional services expenses, for ser located in a CBSA outside of the main he "N" for no. Certified Transplant Center Information	rvices purchased from u nospital CBSA? In colum	inrelated orga	ıni zati ons			
125.00 Does this facility operate a Medicare-o		enter? Enter "	Y" for yes	N		125. 00
and "N" for no. If yes, enter certifica						127 00
126.00 If this is a Medicare-certified kidney in column 1 and termination date, if a			ircation da	te		126. 00
127.00 If this is a Medicare-certified heart			ication date	е		127. 00
in column 1 and termination date, if and 128.00 lf this is a Medicare-certified liver 1			ication date	e		128. 00
in column 1 and termination date, if ap	oplicable, in column 2.					
129.00 If this is a Medicare-certified lung tr in column 1 and termination date, if a			cation date			129. 00
130.00 If this is a Medicare-certified pancrea	as transplant program,	enter the cer	ti fi cati on			130. 00
date in column 1 and termination date, 131.00 If this is a Medicare-certified intesti			orti fi cati or			131. 00
date in column 1 and termination date,			ertification			131.00
132.00 If this is a Medicare-certified islet t			ication date	Э		132. 00
in column 1 and termination date, if at 133.00 Removed and reserved	opricable, in corumn 2.					133. 00
134.00 If this is a hospital-based organ procuin column 1 and termination date, if as		PO), enter th	ne OPO number	r		134.00
All Providers 140.00 Are there any related organization or h	nome office costs as de	efined in CMS	Pub 15-1	N N		140. 00
chapter 10? Enter "Y" for yes or "N" for are claimed, enter in column 2 the home	or no in column 1. If y e office chain number.	es, and home	office costs	5		110.00
1.00 If this facility is part of a chain org	2.00 ganization, enter on Li	nes 141 throu	Jah 143 the	3.00 name and address	of the home	e
office and enter the home office contra	actor name and contract					
· · · · · · · · · · · · · · · · · · ·	Contractor's Name: PO Box:		Contracto	or's Number:		141. 00 142. 00
	State:		Zi p Code:	:		143. 00
					1 00	
144.00 Are provider based physicians' costs in	ncluded in Worksheet A?)			1. 00 Y	144. 00
				1.00		
145.00 f costs for renal services are claimed	on Wkst A line 74	are the costs	for	1.00	2. 00	145. 00
inpatient services only? Enter "Y" for no, does the dialysis facility include period? Enter "Y" for yes or "N" for r	yes or "N" for no in o Medicare utilization f	column 1. If c	column 1 is			143.00
146.00 Has the cost allocation methodology cha Enter "Y" for yes or "N" for no in colu yes, enter the approval date (mm/dd/yyy	anged from the previous umn 1. (See CMS Pub. 15			N N		146. 00

Health Financial Systems	RUSH MEN						eu of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	A	Provi der CC	CN: 15-1304		eriod: fom 01/01/202 0 12/31/202		epared:
							1.00	_
147.00 Was there a change in the statist	ical basis? Enter "Y"	for ves	s or "N" for	no			1.00 N	147.00
148.00Was there a change in the order o							N	148.00
149.00 Was there a change to the simplif	ied cost finding metho	od? Ente	er "Y" for y	es or "N"	for r	no.	N	149.00
			Part A	Part		Title V	Title XIX	
			1. 00	2. 00		3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or								
155. 00 Hospi tal		•	N	N		N	N	155. 00
156.00 Subprovi der - IPF			N	N		N	N	156.00
157.00 Subprovi der - I RF			N	N N		N	N	157. 00
158. 00 SUBPROVI DER								158. 00
159. 00 SNF			N	N N		N	N	159.00
160.00 HOME HEALTH AGENCY 161.00 CMHC			N	N N	-	N	N	160.00
161.00 CMHC				N		N	N	161.00
							1.00	
Mul ti campus								
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one o	or more camp	uses in di	ffere	ent CBSAs?	N	165. 00
	Name	(County	State	Zip (FTE/Campus	
	0		1. 00	2. 00	3. (00 4.00	5. 00	
166.00 f line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.0	00 166. 00
							1. 00	-
Health Information Technology (HI	T) incentive in the A	meri can	Recovery an	nd Rei nves	tment	Act		
167.00 Is this provider a meaningful use	r under §1886(n)? En	ter "Y"	for yes or	"N" for no) .		Y	167. 00
168.00 If this provider is a CAH (line 1				e 167 is '	'Y"),	enter the		168. 00
reasonable cost incurred for the		,	,		_			
168.01 If this provider is a CAH and is						a hardshi p		168. 01
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful	user (line 167 is "Y")					N"), enter th	ne 0. (00169.00
transition factor. (see instructi	UIIS)					Begi nni ng	Endi ng	
						1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and end	ding dat	te for the r	eporti ng		1, 55	2.00	170.00
period respectivery (min/dd/yyyy)								
171 00 6 1: - 1/7 : -		!!		11 - 4 ! -		1.00	2. 00	0171 0
171.00 If line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, umn 1. If column 1 is	, Pt. I,	line 2, co	I. 6? Ente		N		0 171.00

Health Financial Systems RUSH MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1304 Peri od: Worksheet S-2 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 4/26/2024 1:37 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Legal Oper. Y/N 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? Υ 02/22/2024 Υ 02/22/2024 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) Was the cost report prepared using the PS&R Report for 17.00 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 18.00 18.00 Ν N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

	Financial Systems RUSH MEMORIA	L HOSPITAL		In Lie	u of Form CM	S-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (CCN: 15-1304	Peri od: From 01/01/2023 To 12/31/2023		repared:
		Descr	i pti on	Y/N	Y/N	
00.00	16114447.1		0	1.00	3.00	00.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	Report data for other. Describe the other day astillenes.	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCI	EPT CHILDRENS	HOSPI TALS)		1.00	
	Capital Related Cost		,			
22.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions	5		N	22. 00
23.00	Have changes occurred in the Medicare depreciation expense	due to apprai	sals made du	ring the cost	N	23. 00
	reporting period? If yes, see instructions.					
24. 00	Were new leases and/or amendments to existing leases entero	ed into durino	g this cost r	eporting period?	N	24.00
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost ren	orting period	7 If ves see	N	25. 00
20.00	instructions.	the cost rept	or tring periou	. II yes, see	IN IN	23.00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the	he cost repor	ting period?	If yes, see	N	26. 00
	instructions.		3 1	<i>y</i> ,		
27. 00	Has the provider's capitalization policy changed during the	e cost reporti	ng period? I	f yes, submit	N	27. 00
	copy.					
20.00	Interest Expense	ntarad inta di	uni na tha asa	t ranartina	N	
28.00	Were new Loans, mortgage agreements or Letters of credit eleperiod? If yes, see instructions.	nterea into at	aring the cos	t reporting	N	28. 00
29. 00	Did the provider have a funded depreciation account and/or	hond funds (1	Deht Service	Reserve Fund)	Υ	29. 00
27.00	treated as a funded depreciation account? If yes, see inst		Debt Del Vice	Reserve runa)	'	27.00
30.00	Has existing debt been replaced prior to its scheduled mate		w debt? If ye	s, see	N	30.00
	instructions.	,	,			
31.00	Has debt been recalled before scheduled maturity without is	ssuance of new	w debt? If ye	s, see	N	31.00
	instructions.					
22.00	Purchased Services	mul acc funni al	and through a	antraatual	N	
32.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instru		ied through c	ontractual	IN IN	32.00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app		na to compet	itive biddina? If	N	33.00
	no, see instructions.	p				
	Provi der-Based Physi ci ans					
34.00	Were services furnished at the provider facility under an	arrangement wi	th provider-	based physicians?	Y	34.00
	If yes, see instructions.					
35.00	If line 34 is yes, were there new agreements or amended ex		ents with the	provi der-based	N	35. 00
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date	
				1. 00	2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report?			N		36.00
37. 00	If line 36 is yes, has a home office cost statement been p	repared by the	e home office	? N		37. 00
00.00	If yes, see instructions.	6' 1' 66				00.0-
38. 00	If line 36 is yes, was the fiscal year end of the home of			f N		38.00
39 NN	the provider? If yes, enter in column 2 the fiscal year end of line 36 is yes, did the provider render services to other			s, N		39.00
37.00	see instructions.	ci charif compo	mente: ii ye	, IN		37.00
40.00	If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40.00
	instructions.					
	0.1.0	1	. 00	2.	00	
41 00	Cost Report Preparer Contact Information	LANDON		ПУСКЕТТ		41 00
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	LANDON		HACKETT		41.00
	respectively.					
42.00		BLUE & CO., L	LC			42.00
	preparer.					
43.00		317-713-7929		LHACKETT@BLUEA	NDCO. COM	43.00
	report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems RUSH MEMOR	IAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-1304	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 4/26/2024 1:3	pared:
		3.00			
	Cost Report Preparer Contact Information				
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DI RECTOR			41.00
42. 00	Enter the employer/company name of the cost report preparer.				42. 00
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.				43. 00

 Health Financial Systems
 RUSH M

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-1304

						o 12/31/2023	Date/Time Pre 4/26/2024 1:3	
							1/P Days /	/ piii
							0/P Visits /	
							Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No. 1.00		2. 00	Available 3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA	1.00		2.00	3.00	4.00	3.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		23	8, 395	19, 608. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and	00.00		20	0,070	177 5551 55	Ü	
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			23	8, 395	19, 608. 00	0	7. 00
	beds) (see instructions)							
8. 00	INTENSIVE CARE UNIT	31. 00		2	730	2, 088. 00	0	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			0.5	0.405	04 (0/ 00	0	13.00
14.00	Total (see instructions)			25	9, 125	21, 696. 00	0	14.00
15. 00 15. 10	CAH visits					0.00	0	15. 00 15. 10
16. 00	REH hours and visits SUBPROVIDER - IPF					0.00	Ü	16. 00
17. 00	SUBPROVIDER - IPF							17.00
18. 00	SUBPROVI DER							18.00
19. 00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30.00						24. 10
25.00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC	88. 00					0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			25				27. 00
28. 00	Observation Bed Days						0	28. 00
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	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days							33. 00
33. 00	LTCH fion-covered days LTCH site neutral days and discharges							33. 00
	Temporary Expansion COVID-19 PHE Acute Care	30.00		0	O		0	
5 55	1. Imparison of the first floate out of	55.00	I	O	,	1 1	O	

Provider CCN: 15-1304

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 4/26/2024 1:37 pm

						4/26/2024 1: 3	7 pm
		I/P Days	/ O/P Visits	/ Tri ps	Full Time E	Equi val ents	
	0	T' 11 . \0/1/11	T' 11 . VI V	T. I. I. Al I	T. I. I. I. I.	F1	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
		4 00	7. 00	Patients 8.00	& Residents 9.00	Payrol I 10.00	
	PART I - STATISTICAL DATA	6. 00	7.00	0.00	9.00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	404	21	817			1.00
1.00	8 exclude Swing Bed, Observation Bed and	404	21	017			1.00
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	116	54				2.00
3. 00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO IRF Subprovider	0	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	43	0				5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	43	0				6.00
7. 00	Total Adults and Peds. (exclude observation	447	21				7.00
7.00	beds) (see instructions)	117	2.1				7.00
8. 00	I NTENSI VE CARE UNIT	23	1	87			8.00
9. 00	CORONARY CARE UNIT	20		j .			9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	470	22	947	0. 00	263. 88	•
15. 00	CAH visits	0	0		0.00	2001.00	15.00
15. 10	REH hours and visits	0	0	0			15. 10
16. 00	SUBPROVIDER - IPF			_			16.00
17. 00	SUBPROVIDER - IRF						17. 00
18. 00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	2, 692	169	10, 717	0.00	28. 56	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0. 00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0. 00	292. 44	27. 00
28. 00	Observation Bed Days		12	680			28. 00
29. 00	Ambulance Trips	111					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0				32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

Provider CCN: 15-1304

					J 12/31/2023	4/26/2024 1: 3	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12. 00	13.00	14.00	15.00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	137	5	279	1.00
2.00	HMO and other (see instructions)			31	19		2.00
3. 00	HMO IPF Subprovider				o		3.00
4.00	HMO IRF Subprovider				O		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation 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	137	5	279	
15. 00	CAH visits						15.00
15. 10	REH hours and visits						15. 10
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 21. 00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)						24. 00
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 Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care						34.00

Health Financial Systems HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	RUSH MEMORIA	Provider C	∩N. 1E 12∩4	Period:	eu of Form CMS Worksheet S-	
HUSPITAL-BASED RHC/FUHC STATISTICAL DATA		Provider C	UN: 15-1304	From 01/01/2023		8
		Component	CCN: 15-8539	To 12/31/2023		
				RHC I	4/26/2024 1: Cost	37 pm
				I KIIO I	0031	
				1	. 00	
Clinic Address and Identification				201 CONDAD HAI	OCCUPT WAY	1 1 0
1.00 Street		Ci	ty	201 CONRAD HAI State	ZIP Code	1.0
			00	2. 00	3.00	
2.00 City, State, ZIP Code, County		RUSHVI LLE			46173	2. 0
					1.00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "P" for rur	al or "II" for	urhan		1.00	0 3.0
5.00	er ik for fur	<u>ai 0i 0 10i</u>		nt Award	Date	3.0
				1. 00	2. 00	
Source of Federal Funds			ı			
4.00 Community Health Center (Section 330(d), PHS 5.00 Migrant Health Center (Section 329(d), PHS A						4. 0 5. 0
5.00 Migrant Health Center (Section 329(d), PHS A 6.00 Health Services for the Homeless (Section 34						6.0
7.00 Appal achi an Regional Commission	o(a), The het)					7.0
8. 00 Look-Alikes						8.0
9. 00 OTHER (SPECIFY)						9.0
				1.00	2.00	
10.00 Does this facility operate as other than a h	ospi tal -based	RHC or FQHC? E	nter "Y" for			0 10.0
yes or "N" for no in column 1. If yes, indic						
2. (Enter in subscripts of line 11 the type o	f other operat	ion(s) and the	operati ng			
hours.)	Sur	nday	Λ.	Monday	Tuesday	
	from	to	from	to	from	
	1. 00	2.00	3. 00	4. 00	5. 00	
Facility hours of operations (1)				1	1	
11. 00 CLINIC			08: 00	05: 00		11.0
				00.00	08: 00	11.0
						11.0
12.00 Have you received an approval for an excepti	on to the prod	luctivity stand		1. 00 Y	2.00	12.0
13.00 Is this a consolidated cost report as define	d in CMS Pub.	100-04, chapte	ard? r 9, section	1. 00 Y	2. 00	12.0
13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	ard? r 9, section mn 2 the	1. 00 Y	2. 00	12.0
13.00 Is 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.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	ard? r 9, section mn 2 the	1. 00 Y	2. 00	12.0
13.00 Is 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. numbers below.	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu es of all provi	ard? r 9, section mn 2 the ders and	1. 00 Y N	2.00	12.0
 13.00 Is 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. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 	d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y"	100-04, chapte enter in colu es of all provi consolidated RH for yes or "N"	ard? r 9, section mn 2 the ders and Cs (as defin for no. If	1.00 Y N	2.00	12.0
 13.00 Is 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. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli 	d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grou	100-04, chapte enter in colu es of all provi consolidated RH for yes or "N" upings and comp	ard? r 9, section mn 2 the ders and Cs (as defin for no. If	1.00 Y N	2.00	12.0
 13.00 Is 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. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated 	d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grouping.	100-04, chapte enter in colu es of all provi consolidated RH for yes or "N" upings and comp Consolidated	ard? r 9, section nn 2 the ders and Cs (as defin for no. If ete a RHC groupin	1.00 Y N	2.00	12.0
 13.00 Is 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. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered c 	d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grouping. onsolidated RH	100-04, chapte enter in colusts of all provinces of all provinces on "N" upings and comp Consolidated lCs in the grou	ard? r 9, section nn 2 the ders and Cs (as defin for no. If ete a RHC groupin	1.00 Y N	2.00	12.0
 13.00 Is 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. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated 	d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grouping. onsolidated RH	100-04, chapte enter in colusts of all provinces of all provinces on "N" upings and comp Consolidated lCs in the grou	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or	1.00 Y N ed N gs	2. 00 CCN	12.0
 13.00 Is 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. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH 	d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grouping. onsolidated RH	100-04, chapte enter in colusts of all provinces of all provinces on "N" upings and comp Consolidated lCs in the grou	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or	1.00 Y N	2.00	12. 0 0 13. 0
 13.00 Is 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. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH 	d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grou RHC grouping. onsolidated RH Cs in the grou	100-04, chapte enter in colues of all provi	ard? r 9, section nn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	1.00 Y N ed N gs ider name 1.00	2. 00 CCN 2. 00	12. 0 0 13. 0 0 13. 0
 13.00 Is 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. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH 	d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grou RHC grouping. onsolidated RH Cs in the grou	100-04, chapte enter in colues of all provi	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	1.00 Y N ed N gs ider name 1.00 XIX	2.00 CCN 2.00 Total Visits	12. 0 0 13. 0 0 13. 0
 13.00 Is 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. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered c comprised exclusively of new consolidated RH 14.00 RHC/FQHC name, CCN 	d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grou RHC grouping. onsolidated RH Cs in the grou	100-04, chapte enter in colues of all provi	ard? r 9, section nn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	1.00 Y N ed N gs ider name 1.00	2. 00 CCN 2. 00	12. 0 0 13. 0 0 13. 0
13.00 Is 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. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH 14.00 RHC/FOHC name, CCN 15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in	d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grouping. onsolidated RH Cs in the grou Y/N 1.00	100-04, chapte enter in colues of all provi	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	1.00 Y N ed N gs ider name 1.00 XIX	2.00 CCN 2.00 Total Visits	12. 0 0 13. 0 0 13. 0
 13.00 Is 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. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH 14.00 RHC/FOHC name, CCN 15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 	d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grouping. onsolidated RH Cs in the grou Y/N 1.00	100-04, chapte enter in colues of all provi	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	1.00 Y N ed N gs ider name 1.00 XIX	2.00 CCN 2.00 Total Visits	12. 0 0 13. 0 0 13. 0
 13.00 Is 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. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH 14.00 RHC/FOHC name, CCN 15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by 	d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grouping. onsolidated RH Cs in the grou Y/N 1.00	100-04, chapte enter in colues of all provi	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	1.00 Y N ed N gs ider name 1.00 XIX	2.00 CCN 2.00 Total Visits	12. 0 0 13. 0 0 13. 0
 13.00 Is 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. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH 14.00 RHC/FQHC name, CCN 15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in 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 	d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grouping. onsolidated RH Cs in the grou Y/N 1.00	100-04, chapte enter in colues of all provi	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	1.00 Y N ed N gs ider name 1.00 XIX	2.00 CCN 2.00 Total Visits	12. 0 0 13. 0 0 13. 0
 13.00 Is 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. numbers below. 13.01 If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH 14.00 RHC/FOHC name, CCN 15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by 	d in CMS Pub. umn 1. If yes, List the name ing multiple c)? Enter "Y" dated RHC grouping. onsolidated RH Cs in the grou Y/N 1.00	100-04, chapte enter in colues of all provi	ard? r 9, section mn 2 the ders and Cs (as defin for no. If lete a RHC groupin ping or Prov	1.00 Y N ed N gs ider name 1.00 XIX	2.00 CCN 2.00 Total Visits	12. 0 0 13. 0 0 13. 0

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	3
				From 01/01/2023		
		Component	CCN: 15-8539	To 12/31/2023	Date/Time Pre 4/26/2024 1:3	
				RHC I	Cost	уу Ми
		Cou	inty			
		4.	00			
2.00 City, State, ZIP Code, County		RUSH				2.00
	Tuesday	Wedne	esday	Thur	sday	
	to	from	to	from	to	
	6. 00	7.00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	05: 00	08: 00	05: 00	08: 00	05: 00	11.00
	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

	EL	0001.741			6.5. 010.4	
	Financial Systems RUSH MEMORIAL H				u of Form CMS-2	
HOSPI 1	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	CN: 15-1304	Period: From 01/01/2023 To 12/31/2023		
				10 12/01/2020	4/26/2024 1: 3	
					1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA					
	Uncompensated and Indigent Care Cost-to-Charge Ratio					
1.00	Cost to charge ratio (see instructions)				0. 310437	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				1, 253, 378	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or suppleme	ai d?	Υ	4.00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments	from Medicai	d		0	5.00
6.00	Medi cai d charges				23, 648, 128	6.00
7.00	Medicaid cost (line 1 times line 6)				7, 341, 254	7.00
8.00	Difference between net revenue and costs for Medicaid program				6, 087, 876	8.00
	Children's Health Insurance Program (CHIP) (see instructions	for each lir	ne)			
9.00	Net revenue from stand-alone CHIP				0	9.00
10.00	Stand-alone CHIP charges				0	10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP	(see instru	uctions)		0	12.00
	Other state or local government indigent care program (see in	structions f	for each line)		
13.00	Net revenue from state or local indigent care program (Not in	cluded on li	nes 2, 5 or	9)	0	13.00
14.00	Charges for patients covered under state or local indigent ca	re program ((Not included	in lines 6 or	0	14.00
	10)					
15. 00	State or local indigent care program cost (line 1 times line				0	15.00
16. 00	Difference between net revenue and costs for state or local i				0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, Cl	HP and stat	e/local indi	gent care progra	ms (see	
	instructions for each line)					
17. 00	9 .				0	
18. 00	Government grants, appropriations or transfers for support of				0	18. 00
19. 00		al indigent	care program	s (sum of lines	6, 087, 876	19. 00
	8, 12 and 16)		Uni navina d	Language	T-+-1 (1 1	
			Uni nsured	Insured	Total (col. 1	
		-	patients 1.00	patients 2.00	+ col . 2) 3.00	
	Uncompensated care cost (see instructions for each line)		1.00	2.00	3.00	
20. 00	Charity care charges and uninsured discounts (see instructions	(2	41, 90	18, 488	60, 394	20. 00
21. 00	Cost of patients approved for charity care and uninsured disc	, I	13, 00	·	31, 497	21.00
21.00	instructions)	builts (see	13, 00	10, 400	31, 477	21.00
22. 00	Payments received from patients for amounts previously written	n off as		0 0	0	22. 00
22.00	charity care	011 45		٥		22.00
23.00			13, 00	18, 488	31, 497	23. 00
			-, -			
					1. 00	
24. 00	Does the amount on line 20 col. 2, include charges for patien	t days beyor	nd a Length c	f stay limit	N	24. 00
	imposed on patients covered by Medicaid or other indigent care	e program?	Ü	•		
25.00	If line 24 is yes, enter the charges for patient days beyond	m's length of	0	25.00		
	stay limit	Ü				
25. 01	5.01 Charges for insured patients' liability (see instructions)					25. 01
26.00	.00 Bad debt amount (see instructions)					26.00
27.00	.00 Medicare reimbursable bad debts (see instructions)					27.00
27. 01	Medicare allowable bad debts (see instructions)				367, 247 564, 995	27. 01
28.00	Non-Medicare bad debt amount (see instructions)				2, 936, 357	28. 00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt a	mounts (see	instructions)	1, 109, 302	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)				1, 140, 799	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			7, 228, 675	31.00
		•				

łospi -	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-1304	Peri od: From 01/01/2023 To 12/31/2023		epare
				1. 00	\vdash
	PART II - HOSPITAL DATA				
	Uncompensated and Indigent Care Cost-to-Charge Ratio				
00	Cost to charge ratio (see instructions)				1
	Medicaid (see instructions for each line)				4 .
00	Net revenue from Medicaid				2
00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplement	al nayments from Medi	coi d2		3 4
00	If line 4 is no, then enter DSH and/or supplemental payments fr	. ,	Cai u ?		5
00	Medi cai d charges	oiii wedi cai d			6
00	Medicaid cost (line 1 times line 6)				7
00	Difference between net revenue and costs for Medicaid program (see instructions)			8
	Children's Health Insurance Program (CHIP) (see instructions fo				Ī
00	Net revenue from stand-alone CHIP				7 9
. 00	Stand-alone CHIP charges				10
. 00	Stand-alone CHIP cost (line 1 times line 10)				11
. 00	Difference between net revenue and costs for stand-alone CHIP (`		12
00	Other state or local government indigent care program (see inst				1,2
. 00	Net revenue from state or local indigent care program (Not incl Charges for patients covered under state or local indigent care				13
. 00	10)	program (Not Therade	a III IIIles o oi		'4
. 00	State or local indigent care program cost (line 1 times line 14	.)			15
. 00	Difference between net revenue and costs for state or local ind		ee instructions)		16
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state/local ind	ligent care progra	ms (see	
	instructions for each line)				
. 00	Private grants, donations, or endowment income restricted to fu				17
. 00	Government grants, appropriations or transfers for support of h		(- !		18
. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	rndrgent care progra	IIIS (Suill OI TITIES		19
		Uni nsured	Insured	Total (col. 1	
		patients	pati ents	+ col . 2)	
		1.00	2. 00	3. 00	
00	Uncompensated care cost (see instructions for each line)				٠.,
. 00	Charity care charges and uninsured discounts (see instructions) Cost of patients approved for charity care and uninsured discou				20
. 00	instructions)	ints (see			21
. 00	Payments received from patients for amounts previously written	off as			22
	charity care				
. 00	Cost of charity care (see instructions)				23
00	Doos the amount on Line 20 cel 2 include charges for nationt	days bayand a Langth	of stay limit	1. 00	24
UU	Does the amount on line 20 col. 2, include charges for patient imposed on patients covered by Medicaid or other indigent care		or Stay IIIIII t		24
00			am's length of		25
01	Charges for insured patients' liability (see instructions)				25
	Bad debt amount (see instructions)				26
. 00	,				27
. 01	,				27
	Non-Medicare had debt amount (see instructions)				28

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

28.00 29. 00 30. 00

31.00

Heal th	Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		eri od:	Worksheet A	
					rom 01/01/2023		
					o 12/31/2023	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cat	4/26/2024 1: 3 Recl assi fi ed	/ pili
	Cost Center Description	Sararres	other	+ col . 2)			
				+ COI. 2)	i ons (See A-6)	Trial Balance	
					A-0)	(col. 3 +-	
		1. 00	2. 00	3. 00	4. 00	col . 4)	
	CENEDAL CEDVICE COCT CENTEDS	1.00	2.00	3.00	4.00	5. 00	
1 00	GENERAL SERVICE COST CENTERS		2 200 420	2 200 420	ol	2 200 420	1 00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	F70 244	2, 300, 439			2, 300, 439	1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	570, 344	6, 177, 951			6, 765, 489	4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL	3, 285, 212	6, 292, 622			9, 440, 278	
7.00	00700 OPERATION OF PLANT	437, 675	926, 988			1, 407, 649	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	99, 192			99, 192	
9. 00	00900 HOUSEKEEPI NG	585, 813	273, 521			902, 320	•
10.00	01000 DI ETARY	378, 116	94, 795			172, 384	
11. 00	01100 CAFETERI A	0	0	_	334, 916	334, 916	
13. 00	01300 NURSING ADMINISTRATION	216, 796	4, 964			221, 760	
14.00	01400 CENTRAL SERVICES & SUPPLY	164, 718	66, 697			241, 941	•
15. 00	01500 PHARMACY	587, 151	5, 299, 026			5, 886, 177	1
16.00	01600 MEDICAL RECORDS & LIBRARY	194, 348	39, 978	234, 326	0	234, 326	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			ı			
30.00	03000 ADULTS & PEDIATRICS	1, 929, 442	94, 295			1, 980, 759	1
31.00	03100 INTENSIVE CARE UNIT	100, 068	249, 342	349, 410	-332	349, 078	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 795, 596	1, 292, 319	3, 087, 915	-1, 020, 755	2, 067, 160	50.00
51.00	05100 RECOVERY ROOM	0	38, 000	38, 000	213, 112	251, 112	51.00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 307, 899	708, 402	2, 016, 301	-78, 473	1, 937, 828	54.00
54.01	05401 ONCOLOGY	401, 896	223, 734	625, 630	-7, 028	618, 602	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	o	0	(o	0	55.00
60.00	06000 LABORATORY	879, 496	1, 210, 777	2, 090, 273	-98, 381	1, 991, 892	60.00
65.00	06500 RESPI RATORY THERAPY	175, 579	35, 190		-82	210, 687	65.00
66.00	06600 PHYSI CAL THERAPY	682, 902	59, 894	742, 796	-289, 570	453, 226	66.00
67.00	06700 OCCUPATI ONAL THERAPY	-10, 819	4, 744	-6, 075		241, 947	
68. 00	06800 SPEECH PATHOLOGY	-10, 333	652			30, 482	1
69. 00	06900 ELECTROCARDI OLOGY	109, 855	10, 194			191, 841	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0			0	•
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			1, 533, 703	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	Ö	1, 786, 610	-		1, 786, 610	
73. 00	07300 DRUGS CHARGED TO PATIENTS	53, 407	5, 820			56, 607	•
73.00	OUTPATIENT SERVICE COST CENTERS	33, 407	3, 020	37, 221	2,020	30,007	75.00
88. 00	08800 RURAL HEALTH CLINIC	2, 232, 891	197, 854	2, 430, 745	-254, 835	2, 175, 910	88. 00
90.00	09000 CLI NI C	937, 891	174, 472			972, 409	
90. 00	09001 SURGI CAL ASSOCI ATES	757, 071	616, 814			616, 594	•
90. 01	09002 ORTHOPAEDI CS	-3, 220	420, 690	•		670, 968	
90. 02	09003 RHEUMATOLOGY	-34, 917	6, 335			34, 488	
90.03	09003 RHEDWATOLOGT	2, 905, 419				· ·	1
90.04	09005 PEDIATRICS		399, 439			2, 562, 138	ł
		484, 081	32, 092			493, 057	
90.06		-21, 150	6, 042			34, 507	
90.07	09007 PAIN MANAGEMENT	633, 360	135, 994			768, 949	
	09008 ONCOLOGY MD	0 0	0	0 404 704	_	0	
	09100 EMERGENCY	856, 663	1, 638, 038	2, 494, 701	-38, 152	2, 456, 549	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	291, 830	27, 264	319, 094	-286	318, 808	95.00
	SPECIAL PURPOSE COST CENTERS						
118.00		22, 118, 009	30, 951, 180	53, 069, 189	-256, 407	52, 812, 782	118.00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	l	0		192. 00
	19300 NONPALD WORKERS	0	0	C	_		193. 00
	19301 FOUNDATI ON	159, 033	685	159, 718	0	159, 718	
	19302 OCCUPATIONAL MEDICINE	0	0	C			193. 02
	19303 GUEST MEALS	0	0	C	0		193. 03
193. 04	19304 BEHAVIORAL HEALTH CLINIC	0	0	(256, 407	256, 407	
200.00	TOTAL (SUM OF LINES 118 through 199)	22, 277, 042	30, 951, 865	53, 228, 907	o	53, 228, 907	200.00

 Health Financial
 Systems
 RUSH MEMO

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 4/26/2024 1: 37 pm Provi der CCN: 15-1304

				10	12/31/2023 Date/1	ne Prepared: 024 1:37 pm
	Cost Center Description	Adjustments	Net Expenses	<u> </u>	17 207 2	52 1 11 07 pin
	·	(See A-8)	For			
			Allocation			
		6. 00	7. 00			
1 00	GENERAL SERVICE COST CENTERS	(4.0(0	0.000 574			1.00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	-61, 868				1.00
4. 00 5. 00	00500 ADMINISTRATIVE & GENERAL	-180, 658 -3, 702, 587				4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	-3, 702, 387 -927	1, 406, 722			7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	99, 192			8.00
9. 00	00900 HOUSEKEEPI NG	0	902, 320			9. 00
10.00	01000 DI ETARY	-1, 028				10.00
11. 00	01100 CAFETERI A	-78, 213	256, 703			11.00
13.00	01300 NURSING ADMINISTRATION	-2, 349				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	= ,			14.00
15.00	01500 PHARMACY	-152, 974				15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-28	234, 298			16.00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	-943, 880	1, 036, 879			30.00
31. 00	03100 NTENSIVE CARE UNIT	-232, 333				31.00
01.00	ANCILLARY SERVICE COST CENTERS	202, 000	110,710			01.00
50.00		-770, 991	1, 296, 169			50.00
51.00	05100 RECOVERY ROOM	0	251, 112			51.00
53.00	05300 ANESTHESI OLOGY	0	0			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-740, 932				54.00
54. 01	05401 ONCOLOGY	0	618, 602			54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	1 000 073			55.00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	-3, 020				60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	210, 687 453, 226			66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	241, 947			67.00
68. 00	06800 SPEECH PATHOLOGY	0	30, 482			68.00
69.00	06900 ELECTROCARDI OLOGY	-39	1			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-6, 727	1, 526, 976			71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	1, 786, 610			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	56, 607			73. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	140 150	2 004 752			88. 00
90.00	09000 CLINIC	-169, 158 -520, 378				90.00
90. 01	09001 SURGI CAL ASSOCI ATES	-614, 095				90.00
90. 02	09002 ORTHOPAEDI CS	-366, 765				90. 02
90. 03	09003 RHEUMATOLOGY	0	34, 488			90. 03
90. 04	09004 SPECIALTY CLINIC	-2, 310, 695	1			90. 04
90. 05	09005 PEDI ATRI CS	-378, 000	115, 057			90. 05
90.06	09006 WOMEN'S HEALTH	0	34, 507			90.06
90. 07	09007 PAIN MANAGEMENT	-780, 623	· · ·			90. 07
90.08	09008 ONCOLOGY MD	0	0			90.08
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 456, 549			91.00
92. 00	OTHER REIMBURSABLE COST CENTERS					92.00
95 00	09500 AMBULANCE SERVICES	-1, 105	317, 703			95. 00
,5.00	SPECIAL PURPOSE COST CENTERS	1, 103	317,700			/5.00
118.00		-12, 019, 373	40, 793, 409			118. 00
	NONREI MBURSABLE COST CENTERS					
	19200 PHYSICIANS' PRIVATE OFFICES	0	1			192. 00
	19300 NONPALD WORKERS	0	0			193. 00
	19301 FOUNDATION	0	159, 718			193. 01
	19302 OCCUPATIONAL MEDICINE	0	0			193. 02
	19303 GUEST MEALS 19304 BEHAVIORAL HEALTH CLINIC	0	0 256, 407			193. 03 193. 04
200.00		-12, 019, 373				200. 00
200.00	TOTAL (SOM OF LINES THE CHILDUGH 199)	12,017,373	1 71,207,334			1200.00

| Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

					4/26/2024 1:3	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	A - SALARY RECLASS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	17, 195	0		1.00
2.00	OPERATION OF PLANT	7. 00	42, 986	0		2.00
3.00	HOUSEKEEPI NG	9. 00	42, 986	0		3.00
4.00	DI ETARY	10.00	34, 389	0		4.00
5.00	RECOVERY ROOM	51.00	228, 082	0		5.00
			365, 638			1
	B - DIETARY/ CAFETERIA					1
1.00	CAFETERI A	11.00	267, 782	67, 134		1.00
			267, 782	67, 134		
	C - MED SUPPLY RECLASS	<u> </u>	,	,		1
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	1, 533, 703		1.00
	PATI ENTS			,		
2.00	CENTRAL SERVICES & SUPPLY	14. 00	ol	10, 526		2.00
3.00		0.00	o	0		3.00
4.00		0.00	O	0		4.00
5. 00		0. 00	o	0		5. 00
6. 00		0. 00	o	0		6. 00
7. 00		0. 00	o	0		7. 00
8. 00		0. 00	ő	0		8. 00
9. 00		0. 00	ő	0		9. 00
10.00		0.00	o	0		10.00
11. 00		0.00	0	0		11.00
12. 00		0.00	0	0		12.00
13. 00		0.00	0	0		13. 00
		I .		0		1
14.00		0.00	0			14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20. 00		0. 00	0	0		20.00
21. 00		0. 00	0	0		21.00
22. 00		0. 00	0	0		22.00
23. 00		0. 00	0	0		23. 00
24. 00		0.00	0_	0	4	24.00
	0		0	1, 544, 229		1
	E - RHC & BH RECLASS					4
1.00	BEHAVI ORAL HEALTH CLINIC	1 <u>93.</u> 04	225, 629	3 <u>0, 7</u> 78		1.00
	TOTALS		225, 629	30, 778]
	F - ECHO EXPENSE RECLASS					
1.00	ELECTROCARDI OLOGY	<u>69.</u> 00	0_	7 <u>2, 1</u> 48		1.00
	0		0	72, 148]
	G - RECLASS RHC EXPENSE					
1.00	RURAL HEALTH CLINIC	88. 00	31, 960	0		1.00
	0		31, 960	0		
	H - THERAPIES RECLASS					
1.00	OCCUPATI ONAL THERAPY	67.00	248, 101	0		1.00
2.00	SPEECH PATHOLOGY	68. 00	40, 401	0		2.00
	TOTALS	- $ +$	288, 502	₀		
	I - SPECIALTY RECLASS					
1.00	ORTHOPAEDICS	90. 02	256, 846	0		1.00
2. 00	RHEUMATOLOGY	90. 03	63, 993	0		2.00
3.00	WOMEN'S HEALTH	90.06	49, 615	0		3. 00
00	TOTALS	— — / 	370, 454	$\frac{6}{0}$	1	
500 00	Grand Total: Increases		1, 549, 965	1, 714, 289		500.00
	1	ı	., = , . 50	.,, 207	I control of the cont	, , , , , , ,

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1304

						То	12/31/2023 Da	te/Time '26/2024	
		Decreases							
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref	÷.			
	6. 00	7. 00	8. 00	9. 00	10. 00				
	A - SALARY RECLASS								
1. 00	ADMINISTRATIVE & GENERAL	5. 00	137, 556	(0			1.00
2.00	OPERATING ROOM	50. 00	228, 082	(0			2.00
3.00		0.00	0	(0			3.00
4.00		0.00	0	(0			4.00
5. 00		0.00		(<u>o</u>			5. 00
	B - DIETARY/ CAFETERIA		365, 638)				
1. 00	DI ETARY	10.00	267, 782	67, 134	1	0			1.00
1.00	0	10.00	267, 782	67, 132		4			1.00
	C - MED SUPPLY RECLASS		207, 702	07, 13-	·				
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1	1	0			1, 00
2. 00	ADULTS & PEDIATRICS	30.00	o	11, 018		0			2.00
3.00	INTENSIVE CARE UNIT	31. 00	o	332		o			3.00
4. 00	OPERATING ROOM	50.00	o	792, 673		o			4.00
5.00	RECOVERY ROOM	51.00	0	14, 970		0			5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	O	6, 325	5	0			6. 00
7.00	ONCOLOGY	54. 01	О	7, 028	3	0			7. 00
8.00	LABORATORY	60.00	0	98, 381		0			8. 00
9.00	RESPI RATORY THERAPY	65. 00	0	82	2	0			9. 00
10.00	PHYSI CAL THERAPY	66. 00	0	1, 068	3	0			10.00
11. 00	OCCUPATI ONAL THERAPY	67. 00	0	79	9	0			11.00
12.00	SPEECH PATHOLOGY	68. 00	0	238	3	0			12.00
13.00	ELECTROCARDI OLOGY	69. 00	0	356		0			13.00
14.00	DRUGS CHARGED TO PATIENTS	73. 00	0	2, 620		0			14. 00
15. 00	RURAL HEALTH CLINIC	88. 00	0	30, 388		0			15. 00
16. 00	CLINIC	90. 00	0	139, 954		0			16.00
17. 00	SURGI CAL ASSOCI ATES	90. 01	0	220		0			17.00
18.00	ORTHOPAEDI CS	90. 02	0	3, 348		0			18.00
19. 00	RHEUMATOLOGY	90. 03	0	923		0			19.00
20.00	SPECIALTY CLINIC	90.04	0	372, 266		0			20.00
21. 00 22. 00	PEDIATRICS PAIN MANAGEMENT	90. 05 90. 07	0	23, 11 <i>6</i> 405		0			21. 00 22. 00
23. 00	EMERGENCY	91.00	ol Ol	38, 152		0			23. 00
24. 00	AMBULANCE SERVICES	95. 00	O O	286		0			24.00
24.00	n	73.00	— — 	1, 544, 229		٩			24.00
	E - RHC & BH RECLASS		<u> </u>	1, 544, 22	′1	_			
1. 00	RURAL HEALTH CLINIC	88. 00	225, 629	30, 778	3	0			1.00
	TOTALS		225, 629	30, 778		7			
	F - ECHO EXPENSE RECLASS	,			<u>'</u>				
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	72, 148	3	0			1.00
	0 — — — — —			72, 148	3 — —	7			
	G - RECLASS RHC EXPENSE								
1.00	ADULTS & PEDIATRICS	30. 00	31, 960	(0			1.00
	0		31, 960						
	H - THERAPIES RECLASS								
1.00	PHYSI CAL THERAPY	66. 00	288, 502	(0			1. 00
2.00		0.00			<u> </u>	o			2. 00
	TOTALS		288, 502)				
	I - SPECIALTY RECLASS		!						
1.00	SPECIALTY CLINIC	90. 04	370, 454	(0			1.00
2.00		0.00	0	(0			2.00
3. 00	TOTAL C	0.00		(익			3. 00
E00 00	TOTALS Grand Total: Decreases		370, 454	1, 714, 289		\dashv			500.00
500.00	Jordina Tatar. Decreases	ı l	1, 549, 965	1, / 14, 285	1 1	I			300.00

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

				10	12/31/2023	4/26/2024 1:3	
			,	Acqui si ti ons			
		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	T BALANCES					
1.00	Land	591, 263	0	0	0	0	1.00
2.00	Land Improvements	785, 101	0	0	0	0	2.00
3.00	Buildings and Fixtures	22, 481, 510	1, 748, 802	0	1, 748, 802	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fi xed Equi pment	6, 250, 139	240, 558	0	240, 558	1, 494, 410	5.00
6.00	Movable Equipment	21, 326, 672	1, 268, 566	0	1, 268, 566	0	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	51, 434, 685	3, 257, 926	0	3, 257, 926	1, 494, 410	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	51, 434, 685	3, 257, 926	0	3, 257, 926	1, 494, 410	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	591, 263	0				1. 00
2.00	Land Improvements	785, 101	0				2.00
3.00	Buildings and Fixtures	24, 230, 312	0				3. 00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	4, 996, 287	0				5.00
6.00	Movable Equipment	22, 595, 238	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	53, 198, 201	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	53, 198, 201	0				10.00

Heal th	Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2023 To 12/31/2023		pared:
			SU	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see instructions)	instructions)	
		9. 00	10. 00	11.00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	2, 141, 436	0	61, 42	97, 575	0	1.00
3.00	Total (sum of lines 1-2)	2, 141, 436	0	61, 42	97, 575	0	3.00
		SUMMARY O	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 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	2, 300, 439				1.00
3. 00	Total (sum of lines 1-2)	0	2, 300, 439				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 01/01/2023 To 12/31/2023		pared:
						4/26/2024 1: 3	
		COMF	PUTATION OF RAT	TI 0S	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	53, 198, 201	0	53, 198, 201			1.00
3. 00	Total (sum of lines 1-2)	53, 198, 201	0	53, 198, 201			3. 00
		ALLOCAT	TION OF OTHER (CAPITAL	SUMMARY O	F CAPITAL	
	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	0.440.004		
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	(2, 140, 996		1.00
3. 00	Total (sum of lines 1-2)	0	0	(() () () () () () () () () (2, 140, 996	0	3. 00
			SL	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)	Capi tal -Rel at	(sum of cols.	
			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						
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	,,,,,,	•		2, 238, 571	1.00
3.00	Total (sum of lines 1-2)	0	97, 575	(0	2, 238, 571	3.00

					From 01/01/2023 To 12/31/2023	Date/Time Pre	
				Expense Classification or To/From Which the Amount is		4/26/2024 1: 3	7 pm
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter			NEW CAP REL COSTS-BLDG & FLXT	1.00	0	1.00
2. 00	2) Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	Investment income - other (chapter 2)		0		0.00	0	3.00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
8. 00	21) Tel evi si on and radi o servi ce (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -7, 736, 739		0. 00	0	
11. 00	adjustment Sale of scrap, waste, etc.	0 2	0		0.00	0	
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		0		0. 00 0. 00	0	
16. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19. 00
	Vending machines Income from imposition of		0		0. 00 0. 00	0	0.00
	interest, finance or penalty charges (chapter 21)					_	
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG &	1.00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP			*** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	1		28.00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
30. 99	therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99

Provider CCN: 15-1304 Peri od: Worksheet A-8 From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

					12/31/2023	4/26/2024 1: 3	
				Expense Classification on	Worksheet A	17 207 202 1 1.0	, p
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	oost center bescription	(2)	runoarre	Jose Johnson	LITIO "	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
31.00	pathology costs in excess of	A 0 3		SI ELGII I ATTIOLOGI	00.00		31.00
	limitation (chapter 14)						
22 00	CAH HIT Adjustment for	Α	440	NEW CAP REL COSTS-BLDG &	1. 00	9	32.00
32.00	Depreciation and Interest	^	-440	FLXT	1.00	7	32.00
33. 00	CAFETERIA	В	70 212	CAFETERI A	11. 00	0	33.00
33. 00	SALE OF PODIATRY SUPPLIES	B B		MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 00
33.01	SALE OF PODIATRY SUPPLIES	D	-0, 121	PATIENTS	71.00	U	33.01
22 02	DUVELCIAN ADDITION FEEC	В	2 500		F 00	0	22.02
33. 02	PHYSICIAN APPLICATION FEES NSF FEES	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 03				EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 03
33. 04	MEDICAL RECORDS TRANSCRIPTIONS	В	-28	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 04
00.05	FEES		2.040	ADMINISTRATIVE & CENEDAL	F 00		00.05
33. 05	COPI ER FEES	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 06	ATHLETIC TRAINER - SCHOOL REV	В		ADMINISTRATIVE & GENERAL	5. 00	0	33.06
33. 07	OCCUPATI ONAL HEALTH	В	-78, 021		90.00	0	33. 07
33. 08	SHUTTLE BUS SERVICES	В		AMBULANCE SERVICES	95. 00	0	33. 08
33. 09	MISC. INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	INTEREST INCOME	В	-61, 428	NEW CAP REL COSTS-BLDG &	1. 00	11	33. 10
				FI XT			
33. 11	TELEPHONE SALARY	В		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 12	TELEPHONE OTHER	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 13	TELEPHONE BENEFITS	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
33. 14	ADVERTI SI NG	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 14
33. 15	IHA & AHA LOBBYING	Α	-5, 032	ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
33. 16	REBATES	Α	-4, 268	ADMINISTRATIVE & GENERAL	5. 00	0	33. 16
33. 17	REBATES	В	-927	OPERATION OF PLANT	7. 00	0	33. 17
33. 18	REBATES	В	-1, 028	DI ETARY	10.00	0	33. 18
33. 19	REBATES	В	-2, 349	NURSING ADMINISTRATION	13. 00	0	33. 19
33. 20	REBATES	В	-152, 974	PHARMACY	15. 00	0	33. 20
33. 21	REBATES	В	-122	ADULTS & PEDIATRICS	30.00	0	33. 21
33. 22	REBATES	В		OPERATING ROOM	50. 00	0	33. 22
33. 23	REBATES	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 23
33. 24	REBATES	В		LABORATORY	60. 00	0	33. 24
33. 25	REBATES	В		ELECTROCARDI OLOGY	69. 00	0	33. 25
33. 26	REBATES	В		RURAL HEALTH CLINIC	88. 00	0	33. 26
33. 27	REBATES	В		SPECIALTY CLINIC	90. 04	0	33. 27
33. 28	HAF EXPENSE	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 28
33. 29	PHYSI CI AN RECRUI TMENTS	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 29
33. 30	ADVERTI SI NG	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 29
50.00	TOTAL (sum of lines 1 thru 49)		-12, 019, 373		5.00	U	50.00
50.00	(Transfer to Worksheet A,		-12,017,3/3				30.00
	column 6, line 200.)		l				

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Provider CCN: 15-1304

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 4/26/2024 1: 37 pm

							4/26/2024 1: 3	3 / pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1 00								1.00
1. 00		ADULTS & PEDIATRICS	943, 758					
2. 00		INTENSIVE CARE UNIT	232, 333		0			2.00
3.00	50. 00	OPERATING ROOM	768, 249	764, 200			_	3.00
4.00	54. 00	RADI OLOGY-DI AGNOSTI C	752, 577	738, 532	14, 045	0	0	4.00
5. 00	54 01	ONCOLOGY	187, 800				0	5. 00
6. 00		LABORATORY	75, 000					6. 00
7. 00		RURAL HEALTH CLINIC	167, 686					7. 00
8. 00		CLINIC	464, 269		21, 912			8. 00
9. 00		SURGI CAL ASSOCI ATES	615, 999					9. 00
10.00		ORTHOPAEDI CS	370, 485	366, 765	3, 720	0	0	10.00
11. 00	90. 04	SPECIALTY CLINIC	2, 413, 103	2, 310, 618	102, 485	0	0	11.00
12.00		PEDI ATRI CS	406, 571	378, 000		1	0	12.00
13. 00		PAIN MANAGEMENT	793, 540				1	13. 00
14. 00		EMERGENCY	1, 474, 381	0 700,023			Ö	14. 00
	91.00	EWERGENCT				U		
200.00			9, 665, 751	7, 736, 739			0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2.00	8. 00	9. 00	12.00	13.00	14.00	
1. 00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2. 00		INTENSIVE CARE UNIT	0	0	0	0		2. 00
3. 00		OPERATING ROOM	0					3. 00
4. 00		RADI OLOGY-DI AGNOSTI C						4. 00
			_				1	
5. 00		ONCOLOGY	0	0				5. 00
6. 00		LABORATORY	0	0	0		_	6. 00
7. 00		RURAL HEALTH CLINIC	0	0	0	0	_	7. 00
8.00	90. 00	CLINIC	0	0	0	0	0	8.00
9.00	90. 01	SURGI CAL ASSOCI ATES	0	0	0	0	0	9.00
10.00	90. 02	ORTHOPAEDI CS	0	l 0	0	l o	ol o	10.00
11. 00	90 04	SPECIALTY CLINIC	0	1 0	0	1 0	0	11.00
12. 00		PEDI ATRI CS	1 0	l o	0		o o	12. 00
13. 00		PAIN MANAGEMENT	0		0	,	1	13.00
		1			_	-		
14.00	91.00	EMERGENCY	0	0	0			14.00
200.00		0 1 0 1 (5)	0	0	0	0	0	200.00
	Wkst. A Line #	J	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	943, 758	3	1. 00
2. 00		INTENSIVE CARE UNIT	0					2.00
3. 00		OPERATING ROOM	Ö			,		3. 00
4. 00		RADI OLOGY-DI AGNOSTI C				, , , , , , ,		4. 00
							•	
5. 00		ONCOLOGY	0	0				5. 00
6. 00		LABORATORY	0	0	0		1	6. 00
7.00	88. 00	RURAL HEALTH CLINIC	0	0	0	165, 458	3	7.00
8. 00		CLINIC	0	0	0	442, 357	·	8. 00
9. 00	90. 01	SURGI CAL ASSOCIATES	0	0	0	614, 095	•	9. 00
10. 00		ORTHOPAEDI CS	0	Ö	_		•	10.00
		SPECIALTY CLINIC						
11. 00								11.00
12. 00		PEDI ATRI CS	0					12.00
13. 00		PAIN MANAGEMENT	0				i	13.00
14.00	91. 00	EMERGENCY	0	0	0	0)	14.00
200.00			0	0	0	7, 736, 739)	200.00
		•	•	•	•	•	•	•

	Financial Systems	RUSH MEMORIAL				u of Form CMS-2	
	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provider CO	CN: 15-1304	Peri od: From 01/01/2023 To 12/31/2023	Worksheet A-8 Parts I-VI Date/Time Pre 4/26/2024 1:3	pared:
					Physical Therapy	Cost	
						1. 00	
4 00	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week	s) (see Enstruct	Tions)			52 780	1.00 2.00
3. 00	Number of unduplicated days in which supervi	sor or therapist	was on provi	der site (se	e instructions)	59	3.00
4.00	Number of unduplicated days in which therapy		n provider si	te but neith	er supervi sor	0	4. 00
5. 00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe	,	nists (see in	nstructions)		0	5.00
6. 00	Number of unduplicated offsite visits - ther	apy assistants (include only	visits made		0	6.00
	assistant and on which supervisor and/or the	rapist was not p	resent durinç	g the visit(s)) (see		
7. 00	instructions) Standard travel expense rate					0. 00	7.00
8. 00	Optional travel expense rate per mile					0. 00	8. 00
		Supervi sors 1.00	Therapi sts 2.00	Assi stants 3.00	Ai des 4.00	Trai nees 5. 00	
9. 00	Total hours worked	0.00	527. 50		_	0.00	9. 00
	AHSEA (see instructions)	0. 00	97. 62			0. 00	
11. 00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	48. 81	48. 81	0. (00		11.00
	one-half of column 3, line 10)						
	Number of travel hours (provider site)	0	0		0		12.00
	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12. 01 13. 00
	Number of miles driven (offsite)	0	0		0		13. 01
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
	Supervisors (column 1, line 9 times column 1					-	14.00
15. 00 16. 00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					51, 495 0	15. 00 16. 00
17. 00	Subtotal allowance amount (sum of lines 14 a		atory therapy	y or lines 14	-16 for all	51, 495	
10 00	others)	10)				0	10.00
	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l					0	18. 00 19. 00
20. 00	Total allowance amount (sum of lines 17-19 f	or respiratory t				51, 495	20.00
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
	amount from line 20. Otherwise complete line	es 21-23.					
21. 00	Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3,			um of columns	1 and 2, line 9	97. 62	21.00
22. 00	Weighted allowance excluding aides and train					76, 144	22. 00
23. 00	Total salary equivalency (see instructions)					76, 144	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	WANCE AND TRAVEL	EXPENSE COMP	PUTATION - PR	OVI DER SITE		
24. 00	Therapists (line 3 times column 2, line 11)					2, 880	24.00
25.00	Assistants (line 4 times column 3, line 11)	sum of lines 2/	and OF for a	all others)		2 880	25.00
	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3			,	3 and 4 for all	2, 880 0	26. 00 27. 00
	others)						
28. 00	Total standard travel allowance and standard 27)	travel expense	at the provid	der site (sum	of lines 26 and	2, 880	28. 00
	Optional Travel Allowance and Optional Travel	Expense					
	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3		I 2, line 12))		0	29. 00 30. 00
31. 00	Subtotal (line 29 for respiratory therapy or		and 30 for a	all others)		0	31.00
32.00	Optional travel expense (line 8 times column	s 1 and 2, line	13 for respir	ratory therap	y or sum of	0	32.00
33. 00	columns 1-3, line 13 for all others) Standard travel allowance and standard trave	l expense (line	28)			2, 880	33.00
	Optional travel allowance and standard trave			nd 31)		0	34.00
35. 00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW				VICES OUTSIDE DE	0	35.00
	Standard Travel Expense	ANCE AND TRAVEL	LAFLINGL COMPC	JIATION - SER	VICES OUTSIDE FR	OVIDER SITE	
36.00	Therapists (line 5 times column 2, line 11)					0	•
37.00	Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)					0	37. 00 38. 00
	Standard travel expense (line 7 times the su	m of lines 5 and	l 6)			0	39.00
	Optional Travel Allowance and Optional Travel	Expense					
40. 00 41. 00	Therapists (sum of columns 1 and 2, line 12.4 Assistants (column 3, line 12.01 times column		2, line 10)			0	40. 00 41. 00
	Subtotal (sum of lines 40 and 41)	5, TING 10 <i>)</i>				0	42.00
43.00	Optional travel expense (line 8 times the su				Laudaa Abaa S	0	43.00
	Total Travel Allowance and Travel Expense - (ILISTIA SARVICAS	· LOMPLATA OF	IP OI THE TOL	rowing three lin	145 44 45 Or	ı
	46, as appropriate.	51131 to 501 V1003	, comprete or	ie or the ror		103 11, 10, 01	

44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)
45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)

0 44.00 0 45.00

EASONABLE COST DETERMINATION FOR THERAPY SERVICES UTSIDE SUPPLIERS	FURNI SHED BY	Provider CC	CN: 15-1304	Peri od: From 01/01/2023 To 12/31/2023		pared:
				Physi cal Therapy	Cost	
					1. 00	
6.00 Optional travel allowance and optional trave	expense (sum o	flines 42 ar	nd 43 - see i	nstructions)		46.00
		Assi stants	Ai des	Trai nees	Total	
PART V - OVERTIME COMPUTATION	1. 00	2. 00	3. 00	4. 00	5. 00	
7.00 Overtime hours worked during reporting	0.00	0.00	0. (0.00	0.00	47. 00
period (if column 5, line 47, is zero or equal to or greater than 2,080, do not	0.00	0.00	0.1	0.00	0.00	171.00
complete lines 48-55 and enter zero in each						
column of line 56) 8.00 Overtime rate (see instructions)	0.00	0. 00	0. (0. 00		48. 00
9.00 Total overtime (including base and overtime	0.00	0.00				49. 00
allowance) (multiply line 47 times line 48)						
CALCULATION OF LIMIT						
0.00 Percentage of overtime hours by category (divide the hours in each column on line 47)	0. 00	0. 00	0. 0	0.00	0. 00	50.00
by the total overtime worked - column 5,						
line 47)						
1.00 Allocation of provider's standard work year	0. 00	0. 00	0. 0	0.00	0.00	51.00
for one full-time employee times the						
percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE						
2.00 Adjusted hourly salary equivalency amount	97. 62	0.00	0. (0.00		52.00
(see instructions)	771.02	0.00	0	0.00		02.00
3.00 Overtime cost limitation (line 51 times line	0	0		0 0		53.00
52)						F 4 00
4.00 Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
5.00 Portion of overtime already included in	0	0		0 0		55.00
hourly computation at the AHSEA (multiply						
line 47 times line 52)						
6.00 Overtime allowance (line 54 minus line 55 -	0	0		0	0	56.00
if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for						
respiratory therapy and columns 1 through 3						
for all others.)						
Doort VI COMPUTATION OF THEDADY LIMITATION	ND EVERS COST	AD ILICTMENT			1. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION A 7.00 Salary equivalency amount (from line 23)	AND EXCESS COST	ADJUSTMENT			76, 144	57. 00
8.00 Travel allowance and expense - provider site	(from lines 33.	34. or 35))			2, 880	58.00
9.00 Travel allowance and expense - Offsite service			5)		0	59.00
0.00 Overtime allowance (from column 5, line 56)					0	60.00
1.00 Equipment cost (see instructions)					0	61.00
2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62)					79, 024	62.00
4.00 Total cost of outside supplier services (from	n vour records)				44, 165	
5.00 Excess over limitation (line 64 minus line 65		enter zero)			0	
LINE 33 CALCULATION						
00.00 Line 26 = line 24 for respiratory therapy or						100.00
00.01 Line 27 = line 7 times line 3 for respirator	y therapy or sum	of lines 3 a	and 4 for all	others		100.01
00.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION					2, 880	100. 02
01.00 Line 27 = line 7 times line 3 for respirator	/ therapy or sum	of lines 3 a	and 4 for all	others	0	101.00
01.01 Line 31 = line 29 for respiratory therapy or						101. 01
01.02 Line 34 = sum of lines 27 and 31					0	101. 02
LINE 35 CALCULATION						
02.00 Line 31 = line 29 for respiratory therapy or				umpo 1 2 ! = :		102. 00 102. 01
00 01 1 1 2 2 1 1 2 0 + 1						LLUZ ()"
02.01 Line 32 = line 8 times columns 1 and 2, line 13 for all others	is for respirat	ory therapy t	or sum or cor	ulling 1-5, Title		102.0

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1304

					To	12/31/2023	Date/Time Pre 4/26/2024 1:3	pared:
		Cost Center Description	Net Expenses for Cost Allocation	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL	7 ()111
			(from Wkst A					
			col. 7) 0	1.00	4.00	4A	5. 00	
	GENER.	AL SERVICE COST CENTERS	0	1.00	4.00	44	3.00	
1.00		NEW CAP REL COSTS-BLDG & FIXT	2, 238, 571	2, 238, 571				1.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	6, 584, 831	80, 485				4.00
5.00		ADMINISTRATIVE & GENERAL	5, 737, 691	177, 902		6, 882, 891	6, 882, 891	5.00
7.00		OPERATION OF PLANT	1, 406, 722	l .		1, 894, 869	379, 944	7.00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	99, 192 902, 320	l e	-	99, 192 1, 158, 935		8. 00 9. 00
10.00		DI ETARY	171, 356	l .		290, 253		1
11. 00		CAFETERI A	256, 703	l .		356, 852	71, 553	1
13.00		NURSING ADMINISTRATION	219, 411	2, 355		288, 389	1	13.00
14.00		CENTRAL SERVICES & SUPPLY	241, 941	46, 971	50, 619	339, 531	68, 080	14.00
15.00		PHARMACY	5, 733, 203	l .		5, 948, 736		15. 00
16. 00		MEDICAL RECORDS & LIBRARY	234, 298	79, 617	59, 724	373, 639	74, 919	16. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	1, 036, 879	118, 884	583, 108	1, 738, 871	348, 665	30.00
31. 00		INTENSIVE CARE UNIT	116, 745	l .		188, 038	l .	31.00
		LARY SERVICE COST CENTERS			227.23	,	21/121	
50.00		OPERATING ROOM	1, 296, 169	131, 916	481, 706	1, 909, 791	382, 936	50.00
51.00		RECOVERY ROOM	251, 112	11, 371		332, 574	66, 685	
53.00		ANESTHESI OLOGY	0	0	_	0	0	53.00
54. 00 54. 01		RADI OLOGY-DI AGNOSTI C ONCOLOGY	1, 196, 896 618, 602	1		1, 676, 526 817, 110	336, 164 163, 840	1
55. 00		RADI OLOGY-THERAPEUTI C	010, 002	1		017, 110	103, 640	55.00
60.00		LABORATORY	1, 988, 872			2, 313, 414		60.00
65.00	06500	RESPI RATORY THERAPY	210, 687	2, 703		267, 346		•
66.00		PHYSI CAL THERAPY	453, 226			608, 251	121, 962	
67.00		OCCUPATI ONAL THERAPY	241, 947	20, 985		335, 850		1
68.00		SPEECH PATHOLOGY	30, 482	l .		43, 216	l	
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	191, 802 0	21, 178 0		246, 739 0	49, 474 0	69. 00 70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 526, 976			1, 526, 976		
72. 00	07200	IMPL. DEV. CHARGED TO PATIENT	1, 786, 610	l e		1, 786, 610		72.00
73.00		DRUGS CHARGED TO PATIENTS	56, 607	6, 313	16, 412	79, 332	15, 907	73.00
		TIENT SERVICE COST CENTERS						
88. 00 90. 00	008800	RURAL HEALTH CLINIC CLINIC	2, 006, 752 452, 031	125, 545 177, 921		2, 758, 962 918, 172	553, 205 184, 105	88. 00 90. 00
90.00		SURGI CAL ASSOCI ATES	2, 499			34, 469	l .	90.00
90. 02		ORTHOPAEDI CS	304, 203	l .		402, 029	l .	1
90. 03	09003	RHEUMATOLOGY	34, 488	l .		87, 170	17, 479	90. 03
90.04		SPECIALTY CLINIC	251, 443	l .		1, 091, 980	l .	
90.05		PEDI ATRI CS	115, 057	64, 848		328, 666	1	90.05
90. 06 90. 07		WOMEN'S HEALTH PAIN MANAGEMENT	34, 507	0		43, 254	8, 673 42, 643	
90.07		ONCOLOGY MD	-11, 674	29, 711 0	194, 635	212, 672 0	42, 643	90.07
91. 00		EMERGENCY	2, 456, 549	77, 223	263, 258	2, 797, 030		1
92.00		OBSERVATION BEDS (NON-DISTINCT PART)	_,,	,		0		92.00
	OTHER	REIMBURSABLE COST CENTERS						
95.00		AMBULANCE SERVICES	317, 703	34, 866	89, 681	442, 250	88, 676	95.00
118. 00	_	AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	40, 793, 409	2, 183, 956	6, 547, 107	40, 620, 585	6, 764, 799	118 00
110.00		IMBURSABLE COST CENTERS	40, 773, 407	2, 103, 730	0, 547, 107	40, 020, 303	0,704,777	1110.00
192.00		PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
		NONPALD WORKERS	0	0	0	0		193. 00
		FOUNDATION	159, 718	36, 970	48, 872	245, 560	49, 238	
		OCCUPATIONAL MEDICINE GUEST MEALS	0	0		0		193. 02 193. 03
		BEHAVI ORAL HEALTH CLINI C	256, 407	17, 645	69, 337	343, 389	68, 854	
200.00		Cross Foot Adjustments				0		200. 00
201.00		Negative Cost Centers		0	-	0		201. 00
202.00)	TOTAL (sum lines 118 through 201)	41, 209, 534	2, 238, 571	6, 665, 316	41, 209, 534	6, 882, 891	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1304

				To	12/31/2023	Date/Time Pre 4/26/2024 1:3	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A) pili
	cost contor boson per on	PLANT	LINEN SERVICE	I I I I I I I I I I I I I I I I I I I	512171111	0,11 2 1 2 1 1 1 1	
		7. 00	8. 00	9.00	10.00	11. 00	
(GENERAL SERVICE COST CENTERS						
	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINISTRATIVE & GENERAL						5.00
	00700 OPERATION OF PLANT	2, 274, 813					7. 00
	00800 LAUNDRY & LINEN SERVICE	0	119, 081				8. 00
	00900 HOUSEKEEPI NG	87, 928					9. 00
	01000 DI ETARY	103, 247	3, 427		525, 359	470 004	10.00
	01100 CAFETERI A	24, 774	0		0	470, 031	11.00
	01300 NURSI NG ADMI NI STRATI ON	3, 267	0	_,	0	4, 180	1
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	65, 162	0	,	0	8, 338	1
	01600 MEDICAL RECORDS & LIBRARY	48, 691	0		0 0	14, 103	1
H-	NPATIENT ROUTINE SERVICE COST CENTERS	110, 452	l 0	75, 133	U	11, 645	16.00
	03000 ADULTS & PEDIATRICS	164, 928	71, 436	112, 190	474, 799	44, 146	30.00
	03100 INTENSIVE CARE UNIT	56, 244			50, 560	3, 055	1
	ANCILLARY SERVICE COST CENTERS	30, 244	0,210	30, 237	30, 300	3, 033	31.00
	05000 OPERATING ROOM	183, 006	7, 794	124, 487	0	32, 593	50.00
	05100 RECOVERY ROOM	15, 775	0		Ö	13, 437	
	05300 ANESTHESI OLOGY	0	Ö	0	o	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	107, 800	5, 036	73, 330	0	29, 882	
54.01	05401 ONCOLOGY	104, 051	0		o	15, 228	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
60.00	06000 LABORATORY	75, 286	0	51, 212	0	33, 442	60.00
65.00	06500 RESPIRATORY THERAPY	3, 750	1, 003	2, 551	0	5, 811	65.00
66.00	D6600 PHYSI CAL THERAPY	46, 923	2, 344	31, 919	0	12, 104	66.00
67.00	06700 OCCUPATI ONAL THERAPY	29, 113	1, 078	19, 804	0	7, 809	67. 00
	06800 SPEECH PATHOLOGY	4, 848	46	3, 298	0	1, 332	68. 00
	06900 ELECTROCARDI OLOGY	29, 381	0	19, 986	0	4, 617	1
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	0	
	07300 DRUGS CHARGED TO PATIENTS	8, 758	0	5, 957	0	2, 159	73. 00
	OUTPATIENT SERVICE COST CENTERS	474.4(0		110 475	ام	/F F00	00.00
	D8800 RURAL HEALTH CLINIC D9000 CLINIC	174, 168	0		O O	65, 598	1
	09000 CETNIC 09001 SURGI CAL ASSOCI ATES	246, 826 44, 352	0	167, 902 30, 170	0	34, 522 184	1
	09002 ORTHOPAEDI CS	27, 586	0	18, 765	0	19, 317	1
	09003 RHEUMATOLOGY	60, 690	0	41, 283	o	2, 572	
	09004 SPECIALTY CLINIC	85, 356	0	58, 063	Ö	29, 354	1
	09005 PEDI ATRI CS	89, 963	0	61, 196	o	11, 530	1
	09006 WOMEN' S HEALTH	0 // 100	Ö	0 0	o	2, 136	1
	09007 PALN MANAGEMENT	41, 219	Ö	28, 038	o	9, 004	
90.08	09008 ONCOLOGY MD	0	0	0	o	0	90. 08
	09100 EMERGENCY	107, 131	12, 349	72, 874	o	27, 172	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	48, 370	0	32, 903	0	12, 518	95. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	2, 199, 045	119, 081	1, 436, 060	525, 359	457, 788	118. 00
	NONRE MBURSABLE COST CENTERS						
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0		192.00
	19300 NONPALD WORKERS	0	0		0		193.00
	19301 FOUNDATION	51, 289	0	34, 889	0		193. 01
	19302 OCCUPATIONAL MEDICINE	0	0]	0		193.02
	19303 GUEST MEALS	0	0	0	0		193. 03
	19304 BEHAVI ORAL HEALTH CLINIC	24, 479	0	16, 652	O	7, 603	193. 04
200.00	Cross Foot Adjustments Negative Cost Centers	_	_			^	200. 00 201. 00
201. 00 202. 00	TOTAL (sum lines 118 through 201)	2 27/ 012	110 001	1, 487, 601	E3E 3E0		
202.00	TIVIAL (Sum Times 110 through 201)	2, 274, 813	119, 081	1,407,001	525, 359	470, 031	1202. UU

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Period: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: Provider CCN: 15-1304

				To	12/31/2023	Date/Time Pre	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	4/26/2024 1: 3 Subtotal	/ piii
	2001 201101 20001 1 21 011	ADMI NI STRATI O	SERVICES &		RECORDS &	oub to tu.	
		N	SUPPLY		LI BRARY		
	JOSUS DA LA COLLA	13. 00	14. 00	15. 00	16. 00	24. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT			I I	T		1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	255 224					11.00
13.00	01300 NURSING ADMINISTRATION	355, 884	F2F 427				13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0 0	525, 437 2, 219	7, 239, 651			14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY		104	7, 237, 031	645, 892		16.00
.0.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		<u> </u>	0107072		10.00
30.00	03000 ADULTS & PEDIATRICS	64, 039	2, 960	0	15, 293	3, 037, 327	30.00
31.00	03100 INTENSIVE CARE UNIT	4, 421	21	0	1, 088	385, 600	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	47, 292	38, 011	0	66, 142	2, 792, 052	
51. 00 53. 00	05100 RECOVERY ROOM	19, 486	2, 534	0	15, 401	476, 623	
54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 43, 355	0 5, 364	0	0 159, 161	0 2, 436, 618	53. 00 54. 00
54. 01	05401 ONCOLOGY	22, 091	1, 972	0	6, 167	1, 201, 238	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55.00
60.00	06000 LABORATORY	48, 519	76, 642	0	78, 293	3, 140, 675	1
65. 00	06500 RESPI RATORY THERAPY	8, 414	660	0	2, 129	345, 270	
66. 00	06600 PHYSI CAL THERAPY	17, 550	1, 182	0	13, 570	855, 805	
67.00	06700 OCCUPATI ONAL THERAPY	11, 343	128		8, 179	480, 646	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 938 6, 700	29 1, 313		1, 395 21, 824	64, 767 380, 034	
70.00	07000 ELECTROENCEPHALOGRAPHY	0, 700	1, 313		21, 624	380, 034	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	l o	171, 753		43, 139	2, 048, 045	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	200, 039		36, 333	2, 381, 219	
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 144	324	7, 239, 651	108, 273	7, 463, 505	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	2, 930		8, 490	3, 681, 828	
90. 00 90. 01	09000 CLINIC 09001 SURGICAL ASSOCIATES	0	3, 083 186	0	3, 526 136	1, 558, 136 116, 408	
90.01	09002 ORTHOPAEDI CS		303		471	549, 083	
90. 03	09003 RHEUMATOLOGY	l o	183		253	209, 630	1
90. 04	09004 SPECIALTY CLINIC	0	2, 327	0	936	1, 486, 971	90. 04
90.05	09005 PEDI ATRI CS	0	576	0	1, 122	558, 954	90.05
90.06	09006 WOMEN' S HEALTH	0	292	0	79	54, 434	1
90. 07	09007 PAIN MANAGEMENT	0	519	0	377	334, 472	
90.08	09008 ONCOLOGY MD 09100 EMERGENCY	0	0 272	0	40.053	0	
91. 00 92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	39, 426	9, 373	0	49, 952	3, 676, 145	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95.00	09500 AMBULANCE SERVICES	18, 166	410	0	4, 163	647, 456	95. 00
	SPECIAL PURPOSE COST CENTERS					·	
118.00		355, 884	525, 437	7, 239, 651	645, 892	40, 362, 941	118. 00
	NONREI MBURSABLE COST CENTERS	T		TT			
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0 0	0		0		192. 00 193. 00
	19300 NONPALD WORKERS 19301 FOUNDATI ON		0	0	0	385, 616	
	2 19302 OCCUPATIONAL MEDICINE		0		ol Ol		193. 01
	19303 GUEST MEALS		0	Ö	Ö		193. 03
193. 04	19304 BEHAVIORAL HEALTH CLINIC	0	0	0	o	460, 977	
200.00							200. 00
201.00		0	0	0 7 000 (51	0		201.00
202.00	TOTAL (sum lines 118 through 201)	355, 884	525, 437	7, 239, 651	645, 892	41, 209, 534	J2U2. UU

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

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1304 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 4/26/2024 1:37 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 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 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 3, 037, 327 30.00 03100 INTENSIVE CARE UNIT 385, 600 31.00 0 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 2, 792, 052 50.00 05100 RECOVERY ROOM 51.00 000000000000000 476, 623 51.00 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 2, 436, 618 54.00 54.00 54.01 05401 ONCOLOGY 1, 201, 238 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 60 00 06000 LABORATORY 3, 140, 675 60 00 06500 RESPIRATORY THERAPY 345, 270 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 855, 805 66.00 06700 OCCUPATI ONAL THERAPY 67.00 480, 646 67.00 06800 SPEECH PATHOLOGY 68 00 64.767 68 00 69.00 06900 ELECTROCARDI OLOGY 380, 034 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2,048,045 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 2, 381, 219 72 00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 7, 463, 505 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 3, 681, 828 88.00 0 09000 CLI NI C 1, 558, 136 90.00 90.00 0 90.01 09001 SURGI CAL ASSOCI ATES 116, 408 90.01 90.02 09002 ORTHOPAEDI CS 00000 549, 083 90.02 09003 RHEUMATOLOGY 90.03 209, 630 90.03 09004 SPECIALTY CLINIC 90.04 1, 486, 971 90.04 90.05 09005 PEDI ATRI CS 558, 954 90.05 09006 WOMEN'S HEALTH 54, 434 90.06 90.06 09007 PAIN MANAGEMENT 90.07 90.07 334, 472 90.08 09008 ONCOLOGY MD 0 90.08 91.00 09100 EMERGENCY 0 3, 676, 145 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 647, 456 95.00 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 40, 362, 941 118.00 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192.00 193. 00 19300 NONPALD WORKERS 0 193.00 193. 01 19301 FOUNDATION 0 193. 01 385, 616 0 193. 02 19302 OCCUPATIONAL MEDICINE 193.02

0 0

0

460.977

41, 209, 534

C

193. 03

193. 04

200. 00

201.00

202.00

193. 03 19303 GUEST MEALS

200.00

201.00

202.00

193. 04 19304 BEHAVI ORAL HEALTH CLINIC

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1304

				To	12/31/2023	Date/Time Pre 4/26/2024 1:3	
			CAPI TAL			1 47 207 2024 1. 3	7 DIII
			RELATED COSTS				
	Cost Center Description	Di rectl y	NEW BLDG &	Subtotal	EMPLOYEE	ADMINISTRATIV	
		Assigned New	FLXT		BENEFI TS	E & GENERAL	
		Capi tal			DEPARTMENT		
		Related Costs	1.00	2.4			
	CENEDAL CEDILICE COCT CENTEDO	0	1. 00	2A	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT	T					1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	80, 485	80, 485	80, 485		4.00
5. 00	00500 ADMINI STRATI VE & GENERAL	0	177, 902		11, 675	1	5.00
	00700 OPERATION OF PLANT	0	340, 437		1, 784		7.00
	00800 LAUNDRY & LINEN SERVICE	0	0 0		1, 704	l	8.00
9. 00	00900 HOUSEKEEPI NG	0	63, 381	63, 381	2, 333	l	9. 00
	01000 DI ETARY	0	74, 423		537	1, 603	10.00
11.00	01100 CAFETERI A	0	17, 858		994		11.00
13.00	01300 NURSING ADMINISTRATION	0	2, 355	2, 355	805	1, 593	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	46, 971	46, 971	611	1, 875	14.00
	01500 PHARMACY	0	35, 098		2, 179		15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	79, 617	79, 617	721	2, 064	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	1	110.004	110.001	7.040		
	03000 ADULTS & PEDIATRICS	0			7, 042		30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	40, 542	40, 542	371	1, 039	31.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	131, 916	131, 916	5, 817	10, 548	50.00
	05100 RECOVERY ROOM	0	11, 371		846	l	51.00
53. 00	05300 ANESTHESI OLOGY	0	11,371		0+0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	77, 705	-	4, 854	9, 259	54.00
	05401 ONCOLOGY	0	75, 003		1, 491	4, 513	ł
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	l	55.00
60.00	06000 LABORATORY	0	54, 268	54, 268	3, 264	12, 777	60.00
65.00	06500 RESPI RATORY THERAPY	0	2, 703	2, 703	652	1, 477	65. 00
	06600 PHYSI CAL THERAPY	0	33, 824		1, 464	l .	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	20, 985		881	1, 855	67.00
68.00	06800 SPEECH PATHOLOGY	0	3, 494		112		68.00
	06900 ELECTROCARDI OLOGY	0	21, 178		408		69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	_	0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	8, 433 9, 867	71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS	0	6, 313	-	198		73.00
	OUTPATIENT SERVICE COST CENTERS		0, 313	0, 313	170	1 +30	73.00
	08800 RURAL HEALTH CLINIC	0	125, 545	125, 545	7, 568	15, 238	88. 00
90.00	09000 CLINIC	0	177, 921		3, 481	5, 071	90.00
90. 01	09001 SURGI CAL ASSOCI ATES	0	31, 970		0	190	90. 01
90.02	09002 ORTHOPAEDI CS	0	19, 885	19, 885	941	2, 220	90. 02
90. 03	09003 RHEUMATOLOGY	0	43, 747	43, 747	108	481	90. 03
	09004 SPECIALTY CLINIC	0	61, 527		9, 407	6, 031	90. 04
90. 05	09005 PEDI ATRI CS	0	64, 848		1, 796		90.05
	09006 WOMEN'S HEALTH	0	0	-	106	239	90.06
	09007 PAIN MANAGEMENT	0	29, 711	29, 711	2, 350 0	l .	
	09008 ONCOLOGY MD 09100 EMERGENCY	0	0	١	ū		1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	77, 223	77, 223	3, 179	13, 440	91.00
72.00	OTHER REIMBURSABLE COST CENTERS			0		l .	72.00
95.00	09500 AMBULANCE SERVICES	0	34, 866	34, 866	1, 083	2, 443	95. 00
	SPECIAL PURPOSE COST CENTERS		0 17 000	0 17 000	1, 000	2,110	70.00
118.00		0	2, 183, 956	2, 183, 956	79, 058	186, 324	118.00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	- 1	0		192. 00
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	19301 FOUNDATI ON	0	36, 970		590		193. 01
	19302 OCCUPATI ONAL MEDI CI NE	0	0	0	0		193. 02
	19303 GUEST MEALS	0	0	17 (45	0		193. 03
	19304 BEHAVI ORAL HEALTH CLINIC	0	17, 645	17, 645	837		193. 04 200. 00
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers		_		0		200.00
201.00		0	2, 238, 571	2, 238, 571	80, 485	l	
202.00	1.31712 (3diii 111103 110 tili 0dgii 201)	ı	2,200,071	2, 200, 071	00, 400	107, 377	1-02.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1304

Cost Center Description					To	12/31/2023	Date/Time Pre 4/26/2024 1:3	pared:
CENERAL SERVICE COST CENTERS		Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		/ piii
CENTRAL STRVICE COST CRITIES 1.00 00100 INDEX CAP PREL COSTS-BLOG & FIXT		·						
1.00		CENEDAL CEDVICE COST CENTEDS	7. 00	8.00	9.00	10. 00	11.00	
4. 00 00000 IMPLOYEE BENEFITS DEPARTWENT 352,686 5.00 00000 OURSTATION OF PLANT 352,686 5.00 00000 OURSTATION OF PLANT 352,686 6.00 00000 OURSTATION OF PLANT 300,0000 00000 OURSTATION OF PLANT 300,0000 388 85,785 8.00 00000 OURSTATION OF PLANT 300,0000 388 85,785 8.00 00000 OURSTATION 300,00000 00000 00000 00000 00000 00000 000000	1 00							1 00
0.000 0.00								
9.00 00800 LANDRY & LINEN SERVICE 0 548 8 00 0.00 00900 DUSEXEEPING 13, 363 38 8, 785 9, 60 0.00 001 01 01 01 01 01								•
9.00 0,000		l I	352, 686					7. 00
10.00 1000 DIETARY 16, 007 16			_	ł				1
11.00 0100 (CAFETRIA 3, 841 0 972 0 25, 354 11.00 14.00 01400 (CENTRAL SERVICES & SUPPLY 10, 10.3 0 2,556 0 455 14.00 14.00 01400 (CENTRAL SERVICES & SUPPLY 10, 10.3 0 2,556 0 455 14.00 16.00 01600 (MEDI CAR, ECCORDS & LIBRARY 17, 124 0 4,333 0 635 16.00				ł		04 434		•
13.00 01300 NURSING ADMINISTRATION 507 0 128 0 228 13.00		l I		l			25 636	•
14.00 01400 CENTRAL SERVICES & SUPPLY 10, 103 0 2,556 0 4.55 14.00 16.00 16.00 01600 MEDICAL RECORDS & LIBRARY 17, 124 0 4,333 0 6.35 16.00 16.00 MEDICAL RECORDS & LIBRARY 17, 124 0 4,333 0 6.35 16.00 16.00 MEDICAL RECORDS & LIBRARY 17, 124 0 4,333 0 6.35 16.00						٩		1
16. 00	14.00			O		0		•
INPATI ENT ROUTINE SERVICE COST CENTERS 3.00 0.00 30.00 0.00 5.00								1
30.00 30000 ADULTS & PEDI ATRICS 25.570 328 6.470 87,336 2.408 30.00 10.00 10.00 INTENSIVE CARE UNIT 8,720 29 2,206 9,300 167 31.00 10.0	16. 00		17, 124	0	4, 333	0	635	16. 00
10 03100 INTENSIVE CARE UNIT 8,720 29 2,206 9,300 167 31,00	20.00		25 570	220	4 470	07 224	2 400	20.00
MODILLARY SERVICE COST CENTERS				l e			· ·	•
50.00	31.00		0,720	2,	2,200	7, 500	107	31.00
53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 53.00	50.00	05000 OPERATING ROOM	28, 373	36	7, 179	0	1, 778	50.00
54.00 05400 RADI OLOCY-DIAGNOSTIC 16, 713 23 4, 229 0 1, 630 54.00 55.00 05500 RADI OLOCY-THERAPEUTIC 0 0 0 0 0 0 0 0 0			2, 446	l e		0		ł
54.01			_	l .	I	- 1		•
55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 55.00		l		l e		- 1		1
0.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.0000000 0.00000000		l				٩		1
65. 00 06500 RESPIRATORY THERAPY 5.81 5					- 1	-1		•
67.00 06700 06700 06700 06700 06700 06700 06800 088000 088	65.00	06500 RESPIRATORY THERAPY		5		0		
68. 00 06900 DEECH PATHOLOGY 0 752 0 190 0 73 68. 00	66.00		7, 275	11	1, 841	0		1
69-00						~ 		•
70.00 07000 Cale				l		- 1		•
71.00				l		٩		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 344 0 118 73. 00			Ö	1	-	- 1		1
Name			0	o	0	0	0	•
88. 00 08800 RURAL HEALTH CLINIC 27, 003 0 6, 832 0 3, 574 88. 00 90. 00 09000 CLINIC 38, 269 0 9, 681 0 1, 883 90. 00 90. 01 99001 SURGI CAL ASSOCIATES 6, 876 0 1, 740 0 10 90. 01 90. 01 90. 01 90. 02 9002 ORTHOPAEDI CS 4, 277 0 1, 082 0 1, 054 90. 02 90. 03 09003 REHMATOLOGY 9, 409 0 2, 381 0 140 90. 03 90. 03 REHMATOLOGY 9, 409 0 2, 381 0 140 90. 03 90. 03 REHMATOLOGY 9, 409 0 2, 381 0 140 90. 03 90. 05	73. 00		1, 358	0	344	0	118	73. 00
90. 00 09000 CLINIC 38, 269 0 9, 681 0 1,883 90. 00 90. 01 09001 SURGI CAL ASSOCIATES 6,876 0 1,740 0 10 90. 01 90. 02 09002 ORTHOPAEDI CS 4,277 0 1,082 0 1,054 90. 02 90. 03 09003 RHEUMATOLOGY 9,409 0 2,381 0 140 90. 03 90. 04 09004 SPECI ALTY CLINIC 13,234 0 3,348 0 1,601 90. 05 09005 PEDI ATRI CS 13,948 0 3,529 0 629 90. 05 90. 06 09006 WOMEN'S HEALTH 0 0 0 0 0 117 90. 06 90. 07 09007 PAIN MANAGEMENT 6,391 0 1,617 0 491 90. 08 09008 ONCOLOGY MD 0 0 0 0 0 0 91. 00 09100 EMERGENCY 16,609 57 4,202 0 1,482 91. 00 09100 EMERGENCY 0 0 0 0 0 0 92. 00 09500 AMBULANCE SERVI CES 7,499 0 1,897 0 683 95. 00 09500 AMBULANCE SERVI CES 7,499 0 1,897 0 683 95. 00 09500 AMBULANCE SERVI CES 7,499 0 1,897 0 683 95. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 01 19301 FOUNDATI ON 7,952 0 2,012 0 253 193. 01 193. 02 19302 OCCUPATI ONAL MEDI CINE 0 0 0 0 0 193. 04 19304 BEHAVI ORAL HEALTH CLINIC 3,795 0 960 0 0 0 193. 04 19304 BEHAVI ORAL HEALTH CLINIC 3,795 0 960 0 0 0 193. 00 Nogati ve Cost Centers 0 0 0 0 0 0 190. 00 Nogati ve Cost Centers 0 0 0 0 0 0 190. 00 Nogati ve Cost Centers 0 0 0 0 0 0 190. 00 00 0 0 0 0 0 190. 00 00 0 0 0 0 0 190. 00 00 0 0 0 0 0 190. 00 00 0 0 0 0 0 190. 00 00 0 0 0 0 190. 00 00 0 0 0 0 190. 00 00 0 0 0 0 190. 00 00 0 0 0 0 190. 00 00 0 0 0 0 190. 00 00 0 0 0 0 190. 00 00 0 0 0 0 0 190. 00 00 0 0 0 0 0 190. 00 00 0 0 0 0 0 190. 00 00 0 0 0 0 0 190. 00 00 0 0 0 0 0 19	00.00		07.000			٥	0.574	00.00
90. 01 09001 SURGI CAL ASSOCIATES 6, 876 0 1, 740 0 10 90. 01 90. 02 09002 ORTHOPAEDI CS 4, 277 0 1, 082 0 1, 054 90. 02 90. 03 09003 RHEUMAROLOGY 9, 409 0 2, 381 0 140 90. 03 90. 04 09004 SPECI ALTY CLINI C 13, 234 0 3, 348 0 1, 601 90. 04 90. 05 09005 PEDI ATRI CS 13, 948 0 3, 529 0 629 90. 05 90. 06 09006 WOMEN' S HEALTH 0 0 0 0 0 117 90. 06 90. 07 09007 PAI N MANAGEMENT 6, 391 0 1, 617 0 491 90. 07 90. 08 09008 ONCOLOGY MD 0 0 0 0 0 0 0 91. 00 09100 EMERGENCY 16, 609 57 4, 202 0 1, 482 91. 00 92. 00 09200 OSSERVATI ON BEDS (NON-DI STI NCT PART) 0 16, 609 57 4, 202 0 1, 482 91. 00 92. 00 09200 ABBULANCE SERVI CES 7, 499 0 1, 897 0 683 95. 00 SPECI AL PURPOSE COST CENTERS 0 0 0 0 0 0 193. 00 193. 00 19300 ONORAI E BUSTABLE COST CENTERS 0 0 0 0 0 0 193. 00 193. 00 19300 ONORAI D WORKERS 0 0 0 0 0 0 193. 00 193. 01 19301 FOUNDATI ON 7, 952 0 2, 012 0 253 193. 01 193. 02 19302 OCLUPATI ONAL MEDI CINE 0 0 0 0 0 0 193. 02 193. 04 19304 BEHAVI ORAL HEALTH CLINI C 3, 795 0 960 0 0 0 193. 02 200. 00 Nongati ve Cost Centers 0 0 0 0 0 0 0 0 0 200. 00 Nongati ve Cost Centers 0 0 0 0 0 0 0 0 200. 00 Nongati ve Cost Centers 0 0 0 0 0 0 0 200. 00 Nongati ve Cost Centers 0 0 0 0 0 0 0 0 200. 00 Nongati ve Cost Centers 0 0 0 0 0 0 0 200. 00 Nongati ve Cost Centers 0 0 0 0 0 0 0 200. 00 Nongati ve Cost Centers 0 0 0 0 0 0 0 200. 00 Nongati ve Cost Centers 0 0 0 0 0 0 0 200. 00 Nongati ve Cost Centers 0 0 0 0 0 0 0 200. 00 Nongati ve Cost Centers 0 0 0 0 0 0 0 200. 00 00 0 0 0 0 0 0 0				l e			· ·	•
90. 02 09002 ORTHOPAEDICS		l I	,	ŀ		-	•	•
90. 04 09004 SPECIALTY CLINIC 13, 234 0 3, 348 0 1, 601 90. 04 90. 05 90005 PEDIATRICS 13, 948 0 3, 529 0 629 90. 05 90. 06 90006 WOMEN'S HEALTH 0 0 0 0 0 0 117 90. 06 90. 07 90. 07 90. 07 90. 08 90				i e		- 1		1
90. 05		09003 RHEUMATOLOGY	9, 409	0	2, 381	0	140	90. 03
90. 06				1		- 1	· ·	•
90. 07			13, 948	1		0		•
90. 08			6 391	· -		0		1
91. 00			0,371	1		o		ł
95. 00 OTHER REIMBURSABLE COST CENTERS OP5.00 AMBULANCE SERVICES 7, 499 O 1, 897 O 683 95. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 340, 939 548 82, 813 96, 636 24, 968 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 193. 00 19301 FOUNDATI ON 7, 952 0 2, 012 0 253 193. 01 193. 01 19302 OCCUPATI ONAL MEDI CI NE 0 0 0 0 0 0 193. 02 1930. 03 19303 GUEST MEALS 0 0 0 0 0 0 0 193. 02 193. 04 19304 BEHAVI ORAL HEALTH CLI NI C 3, 795 0 960 0 415 193. 03 193. 04 19304 BEHAVI ORAL HEALTH CLI NI C 3, 795 0 960 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			16, 609		- 1	o		ł
95. 00 09500 AMBULANCE SERVI CES 7, 499 0 1,897 0 683 95. 00 SPECI AL PURPOSE COST CENTERS 340,939 548 82,813 96,636 24,968 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 192. 00 192.00 192.00 192.00 192.00 193.00	92.00							92.00
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 340, 939 548 82,813 96,636 24,968 118.00 NONREI MBURSABLE COST CENTERS O								
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 340,939 548 82,813 96,636 24,968 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 192.00 193.00 193.00 193.00 193.00 193.00 193.00 193.01 193.01 193.01 193.01 193.01 193.01 193.02 193.02 193.02 193.02 193.02 193.02 193.03	95.00		7, 499	0	1, 897	0	683	95.00
NONRE MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 192.00	118 00		340 939	548	82 813	96, 636	24 968	118 00
192. 00	110.00	, ,	340, 737	J - 540	02,013	70, 030	24, 700	1110.00
193. 01 19301 FOUNDATION 7, 952 0 2, 012 0 253 193. 01 193. 02 19302 0CCUPATI ONAL MEDI CI NE 0 0 0 0 0 193. 02 193. 03 19303 GUEST MEALS 0 0 0 0 0 0 193. 03 193. 04 19304 BEHAVI ORAL HEALTH CLI NI C 3, 795 0 960 0 415 193. 04 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 201. 00	192.00		0	0	0	0	0	192. 00
193. 02 19302 OCCUPATI ONAL MEDI CI NE 0 0 0 0 0 193. 02 193. 03 19303 GUEST MEALS 0 0 0 0 0 0 193. 03 193. 04 19304 BEHAVI ORAL HEALTH CLI NI C 3, 795 0 960 0 415 193. 04 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 201. 00		l I		ı	- 1	0		
193. 03 19303 GUEST MEALS 0 0 0 0 0 193. 03 193. 04 193. 04 19304 BEHAVI ORAL HEALTH CLINI C 3, 795 0 960 0 415 193. 04 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00				l		0		
193. 04 19304 BEHAVI ORAL HEALTH CLINIC 3,795 0 960 0 415 193. 04 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00			0	1	-	0		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 0 201.00		l I	3 705	1	-	0		1
201.00 Negative Cost Centers 0 0 0 0 201.00			3, , , 3	ĺ	,30	J	713	
202.00 TOTAL (sum lines 118 through 201) 352,686 548 85,785 96,636 25,636 202.00	201.00	Negative Cost Centers	0	1	_	О		201. 00
	202.00	TOTAL (sum lines 118 through 201)	352, 686	548	85, 785	96, 636	25, 636	202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1304

					To	12/31/2023	Date/Time Pre 4/26/2024 1:3	
		Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	/ piii
		· ·	ADMI NI STRATI O	SERVICES &		RECORDS &		
			N	SUPPLY	15.00	LI BRARY		
	CENED	AL CEDITICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	24. 00	
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00	1 1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00		ADMINISTRATIVE & GENERAL						5.00
7.00		OPERATION OF PLANT						7. 00
8.00	00800	LAUNDRY & LINEN SERVICE						8. 00
9.00		HOUSEKEEPI NG						9. 00
10.00		DI ETARY						10.00
11.00		CAFETERIA NURSING ADMINISTRATION	F (1)					11.00
13. 00 14. 00		CENTRAL SERVICES & SUPPLY	5, 616	62, 571				13. 00 14. 00
15. 00		PHARMACY	0	264	80, 614			15.00
16. 00		MEDICAL RECORDS & LIBRARY	o	12		104, 506		16.00
	INPAT	IENT ROUTINE SERVICE COST CENTERS						
30. 00		ADULTS & PEDIATRICS	1, 009	352		2, 475	261, 478	
31. 00		INTENSIVE CARE UNIT	70	2	0	176	62, 622	31.00
EO 00		LARY SERVICE COST CENTERS	744	4 527		10, 704	201 424	FO 00
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	746 307	4, 527 302	0	2, 492	201, 624 20, 953	
53.00	1 .	ANESTHESI OLOGY	0	0		2, 492	20, 453	53.00
54. 00		RADI OLOGY-DI AGNOSTI C	684	639		25, 734	141, 470	•
54. 01		ONCOLOGY	349	235		998	103, 634	1
55.00		RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
60.00		LABORATORY	766	9, 127	0	12, 671	109, 322	60.00
65.00		RESPI RATORY THERAPY	133	79		345	6, 439	65.00
66. 00 67. 00	1 1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	277 179	141	0	2, 196 1, 324	51, 048 31, 326	1
68. 00		SPEECH PATHOLOGY	31	15 3		226	5, 120	1
69. 00		ELECTROCARDI OLOGY	106	156		3, 532	32, 703	1
70. 00		ELECTROENCEPHALOGRAPHY	0	0		0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	O	20, 453	0	6, 981	35, 867	71.00
72.00		IMPL. DEV. CHARGED TO PATIENT	0	23, 821	0	5, 880	39, 568	1
73. 00		DRUGS CHARGED TO PATIENTS	50	39	80, 614	17, 522	106, 994	73. 00
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0	349	O	1, 374	187, 483	88. 00
90.00		CLINIC		367	0	571	237, 244	1
90. 01		SURGI CAL ASSOCI ATES	Ö	22		22	40, 830	1
90. 02		ORTHOPAEDI CS	0	36		76	29, 571	90. 02
90. 03		RHEUMATOLOGY	0	22	0	41	56, 329	90. 03
90. 04	1	SPECIALTY CLINIC	0	277	0	152	95, 577	90. 04
90.05	1	PEDI ATRI CS	0	69	0	182	86, 816	1
90. 06 90. 07		WOMEN'S HEALTH PAIN MANAGEMENT	0	35 62	0	13	510	90. 06 90. 07
90.07	1 .	ONCOLOGY MD	0	02	-	61	41, 858 0	90.07
91.00		EMERGENCY	622	1, 116	-	8, 084	128, 022	91.00
92.00	1	OBSERVATION BEDS (NON-DISTINCT PART)		.,		2, 22.	,	92.00
		REIMBURSABLE COST CENTERS				,		
95. 00		AMBULANCE SERVICES	287	49	0	674	49, 481	95.00
118. 00		AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	5, 616	62, 571	80, 614	104, 506	2, 163, 889	110 00
110.00		IMBURSABLE COST CENTERS	5,010	02, 371	80, 014	104, 500	2, 103, 009	1110.00
192.00		PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	0	192. 00
		NONPALD WORKERS	0	0		0		193. 00
		FOUNDATION	0	0		0	49, 133	
		OCCUPATIONAL MEDICINE GUEST MEALS		0		0		193. 02 193. 03
		BEHAVIORAL HEALTH CLINIC		0	0	0	25, 549	
200.00		Cross Foot Adjustments		0		٩	23, 347	200.00
201.00		Negative Cost Centers	o	0	o	О	0	201.00
202.00		TOTAL (sum lines 118 through 201)	5, 616	62, 571	80, 614	104, 506	2, 238, 571	202. 00

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

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1304 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 4/26/2024 1:37 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 261, 478 30.00 03100 INTENSIVE CARE UNIT 31.00 0 62, 622 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 201, 624 50.00 05100 RECOVERY ROOM 51.00 000000000000000 20, 953 51.00 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 141.470 54.00 54.01 05401 ONCOLOGY 103, 634 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 60 00 06000 LABORATORY 109, 322 60 00 06500 RESPIRATORY THERAPY 65.00 6, 439 65.00 66.00 06600 PHYSI CAL THERAPY 51, 048 66.00 06700 OCCUPATI ONAL THERAPY 67.00 31, 326 67.00 06800 SPEECH PATHOLOGY 68 00 5, 120 68 00 06900 ELECTROCARDI OLOGY 69.00 32, 703 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 C 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 35, 867 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 39, 568 72 00 72.00 73.00 0 106, 994 73.00 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 187, 483 88.00 09000 CLI NI C 237. 244 90.00 90.00 0 90.01 09001 SURGI CAL ASSOCI ATES 40,830 90.01 90.02 09002 ORTHOPAEDI CS 00000 29, 571 90.02 09003 RHEUMATOLOGY 90.03 56, 329 90.03 09004 SPECIALTY CLINIC 90.04 95, 577 90.04 90.05 09005 PEDI ATRI CS 86,816 90.05 09006 WOMEN'S HEALTH 90.06 510 90.06 09007 PAIN MANAGEMENT 90.07 90.07 41,858 0 90.08 09008 ONCOLOGY MD 90.08 91.00 09100 EMERGENCY 0 128, 022 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 49, 481 95.00 95.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 118.00 2, 163, 889 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192.00 193. 00 19300 NONPALD WORKERS 0 193.00

0

0

0 0

0

49, 133

25. 549

2, 238, 571

C

C

193. 01

193.02

193. 03

193. 04

200. 00

201.00

202.00

193. 01 19301 FOUNDATION

193. 03 19303 GUEST MEALS

200.00

201.00

202.00

193. 02 19302 OCCUPATIONAL MEDICINE

193. 04 19304 BEHAVI ORAL HEALTH CLINIC

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1304 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 4/26/2024 1:37 pm CAPI TAL RELATED COSTS OPERATION OF NEW BLDG & **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description **BENEFLTS** E & GENERAL PI ANT FI XT n (SQUARE (SQUARE DEPARTMENT (ACCUM. (GROSS COST) FEET) FEET) SALARIES) 1. 00 4.00 5A 5. 00 7. 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 115, 954 1 00 00400 EMPLOYEE BENEFITS DEPARTMENT 21, 689, 503 4.00 4, 169 4.00 00500 ADMINISTRATIVE & GENERAL 9, 215 3, 147, 656 -6, 882, 891 34, 326, 643 5.00 5.00 00700 OPERATION OF PLANT 1, 894, 869 7.00 17, 634 480, 661 84, 936 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 0 99, 192 0 8.00 9.00 00900 HOUSEKEEPI NG 3, 283 628, 799 0 1, 158, 935 3, 283 9.00 01000 DI ETARY 144, 723 0 290, 253 10 00 3 855 3 855 10 00 0 11.00 01100 CAFETERI A 925 267, 782 356, 852 925 11.00 13.00 01300 NURSING ADMINISTRATION 122 216, 796 0 288, 389 122 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 2, 433 164, 718 0 339, 531 2, 433 14.00 0 01500 PHARMACY 15 00 1 818 587, 151 5, 948, 736 1 818 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 4, 124 194, 348 0 373, 639 4, 124 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 158 1, 897, 482 0 1, 738, 871 30.00 6.158 0 03100 INTENSIVE CARE UNIT 100, 068 2, 100 31.00 2, 100 188, 038 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6,833 1, 567, 514 0 1, 909, 791 6,833 50.00 05100 RECOVERY ROOM 0 589 51 00 589 228, 082 332, 574 51 00 0 53.00 05300 ANESTHESI OLOGY 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 4,025 1, 307, 899 1, 676, 526 4, 025 54.00 54.00 817, 110 54.01 05401 ONCOLOGY 3,885 401, 896 0 3,885 54.01 05500 RADI OLOGY-THERAPEUTI C 0 55 00 Ω 0 55 00 2, 811 0 60.00 06000 LABORATORY 879, 496 2, 313, 414 2,811 60.00 06500 RESPIRATORY THERAPY 0 65.00 140 175, 579 267, 346 140 65.00 06600 PHYSI CAL THERAPY 0 66.00 1.752 394.400 608. 251 1.752 66,00 06700 OCCUPATIONAL THERAPY 1, 087 0 67.00 237, 282 335, 850 1,087 67.00 06800 SPEECH PATHOLOGY 181 30,068 0 43, 216 181 68.00 68.00 06900 ELECTROCARDI OLOGY 69 00 1,097 109,855 0 246, 739 1,097 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 C 0 0 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 0 1, 526, 976 71 00 0 r 0 71 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 1, 786, 610 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 327 53, 407 0 79, 332 327 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 6.503 2, 039, 222 0 2, 758, 962 6,503 88 00 918, 172 90.00 09000 CLI NI C 9, 216 937, 891 0 9, 216 90.00 09001 SURGI CAL ASSOCI ATES 0 34, 469 90.01 90.01 1.656 1,656 1, 030 09002 ORTHOPAEDLCS 0 402, 029 1.030 90 02 253, 626 90 02 90.03 09003 RHEUMATOLOGY 2, 266 29,076 0 87, 170 2, 266 90.03 90.04 09004 SPECIALTY CLINIC 3, 187 2, 534, 965 0 1, 091, 980 3, 187 90.04 09005 PEDI ATRI CS 484, 081 0 328, 666 3, 359 90.05 3.359 90.05 0 90.06 09006 WOMEN'S HEALTH 28, 465 43, 254 Ω 90.06 90.07 09007 PAIN MANAGEMENT 1,539 633, 360 0 212, 672 1,539 90.07 09008 ONCOLOGY MD 0 90.08 90.08 0 09100 EMERGENCY 0 2, 797, 030 91 00 4,000 856, 663 4,000 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 291, 830 0 95.00 95.00 1, 806 442, 250 1, 806 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 113, 125 21, 304, 841 -6, 882, 891 33, 737, 694 82, 107 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192 00 0 0 0 193. 00 19300 NONPALD WORKERS 0 \cap 0 193.00 193. 01 19301 FOUNDATI ON 1, 915 159, 033 0 245, 560 1, 915 193. 01 193. 02 19302 OCCUPATIONAL MEDICINE 0 0 193.02 193. 03 19303 GUEST MEALS 0 0 193 03 193. 04 19304 BEHAVI ORAL HEALTH CLINIC 914 225, 629 0 343, 389 914 193.04 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 6, 882, 891 2, 274, 813 202. 00 202.00 Cost to be allocated (per Wkst. B, 2, 238, 571 6, 665, 316 Part I) Unit cost multiplier (Wkst. B, Part I) 19. 305682 0.200512 26. 782672 203. 00 203.00 0.307306 204.00 Cost to be allocated (per Wkst. B, 80.485 189, 577 352, 686 204. 00 Part II) 4. 152374 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 0.003711 0.005523 11) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2023		
				Го 12/31/2023	Date/Time Pre 4/26/2024 1:3	pared: 7 pm
	CAPI TAL RELATED COSTS					
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIV E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	1. 00	4.00	5A	5. 00	7. 00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1304 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 4/26/2024 1:37 pm Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG LINEN SERVICE (MEALS ADMI NI STRATI O (SQUARE (FTE'S) (POUNDS OF FEET) SERVED) Ν LAUNDRY) (DI RECT NRSING HRS) 8.00 9.00 10.00 11.00 13.00 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 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 28, 495 8.00 8.00 9.00 00900 HOUSEKEEPI NG 2.000 81,653 9.00 820 10.00 01000 DI ETARY 3, 855 2,712 10.00 01100 CAFETERI A 925 20, 464 11.00 0 0 11.00 01300 NURSING ADMINISTRATION 0 182 222, 174 13.00 13.00 122 0 14.00 01400 CENTRAL SERVICES & SUPPLY 0 2, 433 0 363 0 14.00 15.00 01500 PHARMACY 0 1,818 0 614 0 15.00 01600 MEDICAL RECORDS & LIBRARY 507 16.00 0 16.00 4, 124 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 17,094 6, 158 2, 451 1, 922 39, 978 30.00 03100 INTENSIVE CARE UNIT 31.00 1, 486 2, 100 261 31.00 133 2,760 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1,865 6, 833 0 1, 419 29, 524 50.00 05100 RECOVERY ROOM 0 51.00 0 589 585 12, 165 51.00 05300 ANESTHESI OLOGY 0 53.00 53.00 0 4, 025 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 205 1, 301 27,066 54.00 54.01 05401 ONCOLOGY 0 3,885 0 663 13, 791 54.01 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 06000 LABORATORY 2, 811 0 1, 456 30, 290 60 00 60 00 0 06500 RESPIRATORY THERAPY 0 65.00 240 140 253 5, 253 65.00 06600 PHYSI CAL THERAPY 1, 752 527 10, 956 66.00 561 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 258 1,087 340 7, 081 67.00 06800 SPEECH PATHOLOGY 0 68 00 58 1, 210 68 00 11 181 0 69.00 06900 ELECTROCARDI OLOGY 0 1,097 201 4, 183 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 70.00 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS C 0 0 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 72 00 C 0 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 327 0 94 1, 963 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 6. 503 0 2.856 0 88.00 90.00 09000 CLI NI C 0 0 90.00 9.216 1,503 0 90.01 09001 SURGI CAL ASSOCI ATES 0 1,656 0 90.01 0 90.02 09002 ORTHOPAEDI CS 0 1,030 0 841 0 90 02 0 09003 RHEUMATOLOGY 0 90.03 90.03 2, 266 112 0 09004 SPECIALTY CLINIC 0 90.04 3, 187 1.278 0 90.04 90.05 09005 PEDI ATRI CS 0 3, 359 0 502 0 90.05 09006 WOMEN'S HEALTH 0 90.06 90.06 0 93 0 0 90.07 09007 PAIN MANAGEMENT 0 1.539 392 0 90.07 90.08 09008 ONCOLOGY MD 0 0 0 90.08 91.00 09100 EMERGENCY 2, 955 4,000 O 1, 183 91.00 24.613 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 545 11, 341 95.00 0 1, 806 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118.00 28, 495 78,824 2,712 19, 931 222, 174 118. 00 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192, 00 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 0 193. 01 19301 FOUNDATION 1, 915 0 193.01 0 0 202 193. 02 19302 OCCUPATIONAL MEDICINE 0 0 0 0 193.02 0 193.03 193. 03 19303 GUEST MEALS 0 0 193. 04 19304 BEHAVI ORAL HEALTH CLINIC 0 914 0 331 0 193.04 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 119,081 1, 487, 601 525, 359 470, 031 355, 884 202. 00 Part I) 1. 601826 203. 00 Unit cost multiplier (Wkst. B, Part I) 193, 716445 203 00 4 179014 18 218571 22 968677 204.00 Cost to be allocated (per Wkst. B, 85, 785 25, 636 5, 616 204. 00 548 96,636 Part II) 0. 025277 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 0.019231 1.050604 35. 632743 1. 252737 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 RUSH MEMORIAL HOSPITAL Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 4/26/2024 1: 37 pm Provider CCN: 15-1304

						4/26/2024 1: 3	/ pili
		Cost Center Description	CENTRAL	PHARMACY	MEDI CAL		
			SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY		
			(COSTED	·	(GROSS		
			REQUIS.)		CHARGES)		
			14. 00	15. 00	16. 00		
	CENED	AL SERVICE COST CENTERS	14.00	13.00	10.00		
		NEW CAP REL COSTS-BLDG & FIXT	1				1 00
	1	l .					1.00
	1	EMPLOYEE BENEFITS DEPARTMENT					4.00
		ADMINISTRATIVE & GENERAL					5.00
	00700	OPERATION OF PLANT					7. 00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPI NG					9.00
		DI ETARY					10.00
		CAFETERI A					11.00
		NURSING ADMINISTRATION					13. 00
			4 400 007				
	1	CENTRAL SERVICES & SUPPLY	4, 692, 007	400		•	14.00
		PHARMACY	19, 811	100			15. 00
16. 00		MEDICAL RECORDS & LIBRARY	933	0	130, 019, 726		16.00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	26, 428	0	3, 078, 271		30.00
31.00	03100	INTENSIVE CARE UNIT	186	o	219, 067		31.00
		LARY SERVICE COST CENTERS		-1	,		
50.00		OPERATING ROOM	339, 430	0	13, 313, 680		50.00
		RECOVERY ROOM	22, 624	ő	3, 100, 102		51.00
	1	l .		_			
	1	ANESTHESI OLOGY	0	0	0	•	53.00
		RADI OLOGY-DI AGNOSTI C	47, 901	0	32, 046, 308		54.00
		ONCOLOGY	17, 609	0	1, 241, 408		54.01
55.00	05500	RADI OLOGY-THERAPEUTI C	0	0	0		55.00
60.00	06000	LABORATORY	684, 390	0	15, 759, 455		60.00
65.00	06500	RESPI RATORY THERAPY	5, 891	ol	428, 576		65.00
		PHYSI CAL THERAPY	10, 559	ol	2, 731, 448		66. 00
		OCCUPATIONAL THERAPY	1, 140	ol	1, 646, 300		67. 00
		SPEECH PATHOLOGY					68. 00
			257	0	280, 867		
		ELECTROCARDI OLOGY	11, 724	0	4, 392, 970	•	69.00
		ELECTROENCEPHALOGRAPHY	0	0	0		70.00
		MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 533, 703	0	8, 683, 338		71.00
		IMPL. DEV. CHARGED TO PATIENT	1, 786, 305	0	7, 313, 338		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2, 896	100	21, 794, 062		73.00
	OUTPA	TIENT SERVICE COST CENTERS					
		RURAL HEALTH CLINIC	26, 163	0	1, 708, 886		88.00
90.00	09000	CLINIC	27, 532	ol	709, 785		90.00
		SURGI CAL ASSOCI ATES	1, 661	o	27, 358		90. 01
		ORTHOPAEDI CS	2, 708	o	94, 787		90. 02
70.02		RHEUMATOLOGY		Ö	50, 997		90. 03
00 03	00003			Ч	30, 777		7 0. 03
			1, 638	ام	100 475		00 04
90.04	09004	SPECIALTY CLINIC	20, 783	0	188, 475		90.04
90. 04 90. 05	09004 09005	SPECIALTY CLINIC PEDIATRICS	20, 783 5, 140	0	225, 754		90.05
90. 04 90. 05 90. 06	09004 09005 09006	SPECIALTY CLINIC PEDIATRICS WOMEN'S HEALTH	20, 783 5, 140 2, 605		225, 754 15, 811		90. 05 90. 06
90. 04 90. 05 90. 06 90. 07	09004 09005 09006 09007	SPECIALTY CLINIC PEDIATRICS WOMEN'S HEALTH PAIN MANAGEMENT	20, 783 5, 140	0	225, 754		90. 05 90. 06 90. 07
90. 04 90. 05 90. 06 90. 07	09004 09005 09006 09007	SPECIALTY CLINIC PEDIATRICS WOMEN'S HEALTH	20, 783 5, 140 2, 605	0	225, 754 15, 811		90. 05 90. 06
90. 04 90. 05 90. 06 90. 07 90. 08	09004 09005 09006 09007 09008	SPECIALTY CLINIC PEDIATRICS WOMEN'S HEALTH PAIN MANAGEMENT	20, 783 5, 140 2, 605	0 0 0	225, 754 15, 811 75, 842		90. 05 90. 06 90. 07
90. 04 90. 05 90. 06 90. 07 90. 08 91. 00	09004 09005 09006 09007 09008 09100	SPECIALTY CLINIC PEDIATRICS WOMEN'S HEALTH PAIN MANAGEMENT ONCOLOGY MD EMERGENCY	20, 783 5, 140 2, 605 4, 633 0	0 0 0 0	225, 754 15, 811 75, 842 0		90. 05 90. 06 90. 07 90. 08 91. 00
90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00	09004 09005 09006 09007 09008 09100 09200	SPECIALTY CLINIC PEDIATRICS WOMEN'S HEALTH PAIN MANAGEMENT ONCOLOGY MD EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	20, 783 5, 140 2, 605 4, 633 0	0 0 0 0	225, 754 15, 811 75, 842 0		90. 05 90. 06 90. 07 90. 08
90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00	09004 09005 09006 09007 09008 09100 09200 OTHER	SPECIALTY CLINIC PEDIATRICS WOMEN'S HEALTH PAIN MANAGEMENT ONCOLOGY MD EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS	20, 783 5, 140 2, 605 4, 633 0 83, 695	0 0 0 0 0	225, 754 15, 811 75, 842 0 10, 054, 828		90. 05 90. 06 90. 07 90. 08 91. 00 92. 00
90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00	09004 09005 09006 09007 09008 09100 09200 OTHER 09500	SPECIALTY CLINIC PEDIATRICS WOMEN'S HEALTH PAIN MANAGEMENT ONCOLOGY MD EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS AMBULANCE SERVICES	20, 783 5, 140 2, 605 4, 633 0	0 0 0 0	225, 754 15, 811 75, 842 0 10, 054, 828		90. 05 90. 06 90. 07 90. 08 91. 00
90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00	09004 09005 09006 09007 09008 09100 09200 0THER 09500 SPECI	SPECIALTY CLINIC PEDIATRICS WOMEN'S HEALTH PAIN MANAGEMENT ONCOLOGY MD EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS AMBULANCE SERVICES AL PURPOSE COST CENTERS	20, 783 5, 140 2, 605 4, 633 0 83, 695	0 0 0 0	225, 754 15, 811 75, 842 0 10, 054, 828		90. 05 90. 06 90. 07 90. 08 91. 00 92. 00
90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00	09004 09005 09006 09007 09008 09100 09200 0THER 09500 SPECI	SPECIALTY CLINIC PEDIATRICS WOMEN'S HEALTH PAIN MANAGEMENT ONCOLOGY MD EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	20, 783 5, 140 2, 605 4, 633 0 83, 695	0 0 0 0 0	225, 754 15, 811 75, 842 0 10, 054, 828		90. 05 90. 06 90. 07 90. 08 91. 00 92. 00
90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 95. 00	09004 09005 09006 09007 09008 09100 09200 0THER 09500 SPECI	SPECIALTY CLINIC PEDIATRICS WOMEN'S HEALTH PAIN MANAGEMENT ONCOLOGY MD EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	20, 783 5, 140 2, 605 4, 633 0 83, 695 3, 662	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	225, 754 15, 811 75, 842 0 10, 054, 828 838, 013		90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 95. 00
90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 95. 00 118. 00	09004 09005 09006 09007 09008 09100 09200 0THER 09500 SPECI NONRE 19200	SPECIALTY CLINIC PEDIATRICS WOMEN'S HEALTH PAIN MANAGEMENT ONCOLOGY MD EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS AMBULANCE SERVICES AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS PHYSICIANS' PRIVATE OFFICES	20, 783 5, 140 2, 605 4, 633 0 83, 695	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	225, 754 15, 811 75, 842 0 10, 054, 828 838, 013 130, 019, 726		90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 95. 00 118. 00
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90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 118. 00 193. 00 193. 01 193. 02 193. 03 193. 04 200. 00 201. 00 202. 00	09004 09005 09006 09007 09008 09100 09200 0THER 09500 SPECI NONRE 19200 19300 19301 19302 19303 19304	SPECIALTY CLINIC PEDIATRICS WOMEN'S HEALTH PAIN MANAGEMENT ONCOLOGY MD EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS AMBULANCE SERVICES AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS PHYSICIANS' PRIVATE OFFICES NONPAID WORKERS FOUNDATION OCCUPATIONAL MEDICINE GUEST MEALS BEHAVIORAL HEALTH CLINIC Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) Cost to be allocated (per Wkst. B, Part II)	20, 783 5, 140 2, 605 4, 633 0 83, 695 3, 662 4, 692, 007 0 0 0 0 0 525, 437 0. 111986 62, 571	0 0 0 0 0 100 0 0 0 0 0 0 7, 239, 651 72, 396. 510000 80, 614	225, 754 15, 811 75, 842 0 10, 054, 828 838, 013 130, 019, 726 0 0 0 0 0 0 0 0 0 645, 892 0. 004968 104, 506		90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 95. 00 118. 00 193. 00 193. 01 193. 02 193. 03 193. 04 200. 00 201. 00 202. 00
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90. 04 90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 118. 00 193. 00 193. 01 193. 02 193. 03 193. 04 200. 00 201. 00 204. 00	09004 09005 09006 09007 09008 09100 071HER 09500 SPECI NONRE 19200 19300 19301 19302 19303	SPECIALTY CLINIC PEDIATRICS WOMEN'S HEALTH PAIN MANAGEMENT ONCOLOGY MD EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS AMBULANCE SERVICES AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS PHYSICIANS' PRIVATE OFFICES NONPAID WORKERS FOUNDATION OCCUPATIONAL MEDICINE GUEST MEALS BEHAVIORAL HEALTH CLINIC Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,	20, 783 5, 140 2, 605 4, 633 0 83, 695 3, 662 4, 692, 007 0 0 0 0 0 525, 437 0. 111986 62, 571	0 0 0 0 0 100 0 0 0 0 0 0 7, 239, 651 72, 396. 510000 80, 614	225, 754 15, 811 75, 842 0 10, 054, 828 838, 013 130, 019, 726 0 0 0 0 0 0 0 0 0 645, 892 0. 004968 104, 506		90. 05 90. 06 90. 07 90. 08 91. 00 92. 00 95. 00 118. 00 193. 00 193. 01 193. 02 193. 03 193. 04 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
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Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304	Period: Worksheet C From 01/01/2023 Part I
		To 12/31/2023 Date/Time Prepared

				o 12/31/2023	Date/Time Pre	
		Title	XVIII	Hospi tal	4/26/2024 1: 3 Cost	7 рііі
		11110	XVIII	Costs	0031	
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	col . 26) 1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	3, 037, 327		3, 037, 327	0	0	30.00
31. 00 03100 NTENSI VE CARE UNI T	3,037,327		385, 600			31.00
ANCILLARY SERVICE COST CENTERS	303, 000		303,000	<u> </u>	0	31.00
50. 00 05000 OPERATING ROOM	2, 792, 052		2, 792, 052	. 0	0	50.00
51. 00 05100 RECOVERY ROOM	476, 623		476, 623			51.00
53. 00 05300 ANESTHESI OLOGY	0		170,020	Ö	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 436, 618		2, 436, 618	-	0	54.00
54. 01 05401 0NCOLOGY	1, 201, 238		1, 201, 238		0	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	l .	1,201,200	0	Ö	55.00
60. 00 06000 LABORATORY	3, 140, 675		3, 140, 675	· -	0	60.00
65. 00 06500 RESPIRATORY THERAPY	345, 270				0	65.00
66. 00 06600 PHYSI CAL THERAPY	855, 805		855, 805		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	480, 646		480, 646		0	67.00
68. 00 06800 SPEECH PATHOLOGY	64, 767		64, 767		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	380, 034		380, 034		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	000,001		000,001	Ö	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 048, 045		2, 048, 045		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 381, 219		2, 381, 219		_	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	7, 463, 505		7, 463, 505			73.00
OUTPATIENT SERVICE COST CENTERS	7, 100, 000		7, 100, 000	<u> </u>	0	70.00
88. 00 08800 RURAL HEALTH CLINIC	3, 681, 828		3, 681, 828	0	0	88. 00
90. 00 09000 CLINIC	1, 558, 136		1, 558, 136		0	90.00
90. 01 09001 SURGI CAL ASSOCI ATES	116, 408		116, 408		0	90. 01
90. 02 09002 0RTH0PAEDI CS	549, 083		549, 083		0	90.02
90. 03 09003 RHEUMATOLOGY	209, 630		209, 630		0	90. 03
90. 04 09004 SPECI ALTY CLINI C	1, 486, 971		1, 486, 971		0	90.04
90. 05 09005 PEDI ATRI CS	558, 954		558, 954		0	90.05
90. 06 09006 WOMEN' S HEALTH	54, 434		54, 434		0	90.06
90. 07 09007 PAI N MANAGEMENT	334, 472		334, 472		0	90.07
90. 08 09008 0NCOLOGY MD	001,112		00.7.72	o o	0	90.08
91. 00 09100 EMERGENCY	3, 676, 145		3, 676, 145	1	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 341, 157		1, 341, 157	1	0	92.00
OTHER REIMBURSABLE COST CENTERS	1/011/10/		1,011,107			72.00
95. 00 09500 AMBULANCE SERVI CES	647, 456		647, 456	0	0	95.00
200.00 Subtotal (see instructions)	41, 704, 098	ł .		1		200.00
201.00 Less Observation Beds	1, 341, 157		1, 341, 157	1		201.00
202.00 Total (see instructions)	40, 362, 941					202.00
		,		-1		

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1304	Period: Worksheet C From 01/01/2023 Part I
		To 12/31/2023 Date/Time Prepared

					To 12/31/2023	Date/Time Pre	epared: 37 pm
			Title	: XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Rati o	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	1, 717, 193		1, 717, 19	3		30.00
	03100 INTENSIVE CARE UNIT	219, 067		219, 06	7		31.00
	NCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	288, 970	13, 024, 710	13, 313, 68			
	05100 RECOVERY ROOM	76, 286	3, 023, 816	3, 100, 10			
	D5300 ANESTHESI OLOGY	0	0	(0.000000		
	D5400 RADI OLOGY-DI AGNOSTI C	679, 936	31, 366, 372	32, 046, 30		0. 000000	
	05401 ONCOLOGY	0	1, 241, 408	1, 241, 40		0. 000000	
	05500 RADI OLOGY-THERAPEUTI C	0	0		0.000000	0. 000000	
	06000 LABORATORY	850, 000	14, 909, 455	15, 759, 45	0. 199288		
65.00	06500 RESPIRATORY THERAPY	185, 961	242, 615	428, 57	0. 805621	0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	128, 313	2, 603, 135	2, 731, 44	0. 313316	0. 000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	124, 814	1, 521, 486	1, 646, 30	0. 291955	0. 000000	67.00
68.00	06800 SPEECH PATHOLOGY	22, 505	258, 362	280, 86	7 0. 230597	0. 000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	309, 587	4, 083, 383	4, 392, 97	0. 086510	0. 000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0.000000	0. 000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	237, 565	8, 445, 773	8, 683, 33	0. 235859	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	87, 149	7, 226, 189	7, 313, 33	0. 325599	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	674, 709	21, 119, 353	21, 794, 06	0. 342456	0. 000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	1, 708, 886	1, 708, 88	6		88. 00
	09000 CLI NI C	0	709, 785	709, 78	5 2. 195222	0. 000000	
	09001 SURGI CAL ASSOCI ATES	0	27, 358	27, 35	4. 254989	0. 000000	90. 01
90. 02	09002 ORTHOPAEDI CS	0	94, 787	94, 78	7 5. 792809	0. 000000	90. 02
90. 03	09003 RHEUMATOLOGY	0	50, 997	50, 99	7 4. 110634	0. 000000	90. 03
90. 04	09004 SPECIALTY CLINIC	0	188, 475	188, 47	7. 889487	0. 000000	90.04
90.05	09005 PEDI ATRI CS	0	225, 754	225, 75	4 2. 475943	0. 000000	90.05
90.06	09006 WOMEN'S HEALTH	0	15, 811	15, 81	1 3. 442793	0. 000000	90.06
90. 07	09007 PAIN MANAGEMENT	0	75, 842	75, 84	4. 410116	0. 000000	90. 07
90.08	09008 ONCOLOGY MD	0	0	(0.000000	0. 000000	90.08
91.00	09100 EMERGENCY	152, 840	9, 901, 988	10, 054, 82	0. 365610	0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 137	1, 355, 941	1, 361, 07	0. 985364	0. 000000	92.00
	THER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	0	838, 013	838, 01	0. 772609	0. 000000	95.00
200.00	Subtotal (see instructions)	5, 760, 032	124, 259, 694	130, 019, 72	6		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	5, 760, 032	124, 259, 694	130, 019, 72	6		202.00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304	Period: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 4/26/2024 1:37 pm

			To 12/31/2023	Date/Time Prepared: 4/26/2024 1:37 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01 05401 0NCOLOGY	0. 000000			54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC				88.00
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 SURGI CAL ASSOCI ATES	0. 000000			90. 01
90. 02 09002 ORTHOPAEDI CS	0. 000000			90. 02
90. 03 09003 RHEUMATOLOGY	0. 000000			90. 03
90. 04 09004 SPECI ALTY CLINI C	0. 000000			90.04
90. 05 09005 PEDI ATRI CS	0. 000000			90.05
90. 06 09006 WOMEN'S HEALTH	0. 000000			90.06
90. 07 09007 PALN MANAGEMENT	0. 000000			90. 07
90. 08 09008 ONCOLOGY MD	0. 000000			90. 08
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS				72.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
	1			, ,=, ,,

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1304	Period: Worksheet C From 01/01/2023 Part I
		To 12/31/2023 Date/Time Prepared

				rom 01/01/2023 o 12/31/2023	Date/Time Pre	
		Ti +l	e XIX	Hospi tal	4/26/2024 1: 3 Cost	/ pm
		11 (1	C XIX	Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	col . 26) 1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	3, 037, 327		3, 037, 327	0	3, 037, 327	30.00
31. 00 03100 I NTENSI VE CARE UNI T	385, 600		385, 600			31.00
ANCILLARY SERVICE COST CENTERS	0007000		1 000,000	·	000,000	01.00
50. 00 05000 OPERATING ROOM	2, 792, 052		2, 792, 052	0	2, 792, 052	50.00
51. 00 05100 RECOVERY ROOM	476, 623		476, 623	0		51.00
53. 00 05300 ANESTHESI OLOGY	0		l	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 436, 618		2, 436, 618	0	2, 436, 618	54.00
54. 01 05401 ONCOLOGY	1, 201, 238		1, 201, 238	0	1, 201, 238	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		[c	0	0	55.00
60. 00 06000 LABORATORY	3, 140, 675		3, 140, 675	0	3, 140, 675	60.00
65. 00 06500 RESPIRATORY THERAPY	345, 270	0	345, 270	0	345, 270	65.00
66. 00 06600 PHYSI CAL THERAPY	855, 805	0	855, 805	0	855, 805	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	480, 646	0	480, 646	0	480, 646	67.00
68.00 06800 SPEECH PATHOLOGY	64, 767	0	64, 767	0	64, 767	68. 00
69. 00 06900 ELECTROCARDI OLOGY	380, 034		380, 034	0	380, 034	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		C	0	_	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 048, 045		2, 048, 045	0	2, 048, 045	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 381, 219		2, 381, 219		, ,	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	7, 463, 505		7, 463, 505	0	7, 463, 505	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	3, 681, 828		3, 681, 828			88. 00
90. 00 09000 CLI NI C	1, 558, 136		1, 558, 136		1, 558, 136	90.00
90. 01 09001 SURGI CAL ASSOCI ATES	116, 408		116, 408			90. 01
90. 02 09002 ORTHOPAEDI CS	549, 083		549, 083		549, 083	90. 02
90. 03 09003 RHEUMATOLOGY	209, 630		209, 630		,	90.03
90. 04 09004 SPECI ALTY CLI NI C	1, 486, 971		1, 486, 971		.,,	1
90. 05 09005 PEDI ATRI CS	558, 954		558, 954		558, 954	90.05
90. 06 09006 WOMEN' S HEALTH	54, 434		54, 434		54, 434	•
90. 07 09007 PAIN MANAGEMENT	334, 472		334, 472		334, 472	90.07
90. 08 09008 0NCOLOGY MD	0		C	<u> </u>		90.08
91. 00 09100 EMERGENCY	3, 676, 145	ł c	3, 676, 145		3, 676, 145	•
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 341, 157		1, 341, 157		1, 341, 157	92.00
OTHER REIMBURSABLE COST CENTERS	(47.45/	ı	/ 47 45/	0	(47.45/	05 00
95. 00 09500 AMBULANCE SERVICES	647, 456		647, 456			
200.00 Subtotal (see instructions) 201.00 Less Observation Beds	41, 704, 098	B .	, ,		41, 704, 098 1, 341, 157	
201.00 Less Observation Beds 202.00 Total (see instructions)	1, 341, 157 40, 362, 941		1, 341, 157 40, 362, 941			
202.00 Total (See Histinctions)	40, 302, 941	1	1 40, 302, 941	ı U	40, 302, 941	J2U2. UU

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1304	Period: Worksheet C
		From 01/01/2023 Part

					To 12/31/2023	Date/Time Pre 4/26/2024 1:3	
		_		e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
		6. 00	7. 00	8. 00	9. 00	Rati o 10. 00	
LN	IPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
	3000 ADULTS & PEDIATRICS	1, 717, 193		1, 717, 193	al .		30.00
	3100 INTENSIVE CARE UNIT	219, 067		219, 06			31.00
	ICI LLARY SERVI CE COST CENTERS	2177007		217700			000
	5000 OPERATING ROOM	288, 970	13, 024, 710	13, 313, 680	0. 209713	0.000000	50.00
51.00 05	5100 RECOVERY ROOM	76, 286	3, 023, 816	3, 100, 102	0. 153744	0.000000	51.00
53. 00 05	ANESTHESI OLOGY	0	0	(0. 000000	0.000000	53.00
	5400 RADI OLOGY-DI AGNOSTI C	679, 936	31, 366, 372	32, 046, 308	0. 076034	0.000000	54.00
54. 01 05	5401 ONCOLOGY	0	1, 241, 408	1, 241, 408	0. 967642	0. 000000	54. 01
	5500 RADI OLOGY-THERAPEUTI C	0	0			0. 000000	
	6000 LABORATORY	850, 000	14, 909, 455			0. 000000	
	5500 RESPI RATORY THERAPY	185, 961	242, 615			0. 000000	
	6600 PHYSI CAL THERAPY	128, 313	2, 603, 135			0. 000000	
	5700 OCCUPATI ONAL THERAPY	124, 814	1, 521, 486			0. 000000	
	SPEECH PATHOLOGY	22, 505	258, 362			0. 000000	
	5900 ELECTROCARDI OLOGY	309, 587	4, 083, 383			0. 000000	
	7000 ELECTROENCEPHALOGRAPHY	0	0		0.00000	0.000000	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7200 IMPL. DEV. CHARGED TO PATIENT	237, 565	8, 445, 773			0.000000	
	7300 DRUGS CHARGED TO PATIENT	87, 149	7, 226, 189 21, 119, 353			0. 000000 0. 000000	
	JTPATIENT SERVICE COST CENTERS	674, 709	21, 119, 353	21, 794, 062	0. 342450	0.000000	73.00
	38800 RURAL HEALTH CLINIC	0	1, 708, 886	1, 708, 886	2. 154519	0. 000000	88. 00
	2000 CLINIC		709, 785			0. 000000	
	2001 SURGI CAL ASSOCI ATES	0	27, 358			0.000000	
	9002 ORTHOPAEDI CS	0	94, 787			0. 000000	
	POO3 RHEUMATOLOGY	0	50, 997			0. 000000	
	9004 SPECIALTY CLINIC	o	188, 475			0. 000000	
	POO5 PEDI ATRI CS	0	225, 754			0.000000	
90.06 09	9006 WOMEN'S HEALTH	0	15, 811	15, 81 ⁻	3. 442793	0.000000	90.06
90. 07 09	POO7 PAIN MANAGEMENT	0	75, 842	75, 842	4. 410116	0.000000	90. 07
90. 08 09	POOR ONCOLOGY MD	0	0	(0. 000000	0.000000	90. 08
	9100 EMERGENCY	152, 840	9, 901, 988	10, 054, 828		0.000000	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 137	1, 355, 941	1, 361, 078	0. 985364	0. 000000	92.00
	THER REIMBURSABLE COST CENTERS						
	9500 AMBULANCE SERVICES	0	838, 013			0. 000000	
200.00	Subtotal (see instructions)	5, 760, 032	124, 259, 694	130, 019, 726			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	5, 760, 032	124, 259, 694	130, 019, 726	P		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 01/01/2023	Worksheet C Part I Date/Time Prepared: 4/26/2024 1:37 pm

			10 12/31/2023	Date/Time Prepared: 4/26/2024 1:37 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 I NTENSI VE CARE UNI T				31.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01 05401 0NCOLOGY	0. 000000			54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OUTPATIENT SERVICE COST CENTERS	0.00000			
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88.00
90. 00 09000 CLINIC	0. 000000			90.00
90. 01 09001 SURGI CAL ASSOCI ATES	0. 000000			90. 01
90. 02 09002 ORTHOPAEDI CS	0. 000000			90. 02
90. 03 09003 RHEUMATOLOGY	0. 000000			90. 03
90. 04 09004 SPECIALTY CLINIC	0. 000000			90.04
90. 05 09005 PEDI ATRI CS	0. 000000			90.05
90. 06 09006 WOMEN' S HEALTH 90. 07 09007 PALN MANAGEMENT	0. 000000			90.06
	0.000000			90. 07 90. 08
	0. 000000			
91. 00 09100 EMERGENCY	0. 000000 0. 000000			91. 00 92. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0.000000			92.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
200.00 Subtotal (see instructions)	0.000000			200.00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				201.00
202.00 Total (See Tristi uctions)	1			J202.00

Health Financial Systems	RUSH MEMORIAL H	OSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL	COSTS	Provider CCN: 15-1	From 01/01/2023	Worksheet D Part II Date/Time Prepared: 4/26/2024 1:37 pm
		Title XVIII	Hospi tal	Cost

				rom 01/01/2023 o 12/31/2023		
		Ti +l e	e XVIII	Hospi tal	4/26/2024 1:3 Cost	7 рііі
Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
oost conten bescription	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)	3	.,	
	col. 26)		,			
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	·	•	•			
50. 00 05000 OPERATING ROOM	201, 624	13, 313, 680	0. 015144	96, 831	1, 466	50.00
51.00 05100 RECOVERY ROOM	20, 953	3, 100, 102	0. 006759	21, 006	142	51.00
53. 00 05300 ANESTHESI OLOGY) c	0. 000000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	141, 470	32, 046, 308	0. 004415	265, 313	1, 171	54.00
54. 01 05401 ONCOLOGY	103, 634	1, 241, 408	0. 083481	0	0	54.01
55. 00 05500 RADI OLOGY-THERAPEUTI C) c	0. 000000	0	0	55.00
60. 00 06000 LABORATORY	109, 322	15, 759, 455	0. 006937	336, 773	2, 336	60.00
65. 00 06500 RESPIRATORY THERAPY	6, 439	428, 576	0. 015024	63, 437	953	65.00
66.00 06600 PHYSI CAL THERAPY	51, 048	2, 731, 448	0. 018689	64, 949	1, 214	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	31, 326	1, 646, 300	0. 019028	61, 512	1, 170	67.00
68.00 06800 SPEECH PATHOLOGY	5, 120	280, 867	0. 018229	10, 397	190	68.00
69. 00 06900 ELECTROCARDI OLOGY	32, 703	4, 392, 970	0. 007444	132, 262	985	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0	0.000000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED T	O PATIENTS 35, 867	8, 683, 338	0. 004131	22, 116	91	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATI	ENT 39, 568	7, 313, 338	0. 005410	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	106, 994	21, 794, 062	0. 004909	269, 567	1, 323	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	187, 483				0	88. 00
90. 00 09000 CLI NI C	237, 244				0	90.00
90. 01 09001 SURGI CAL ASSOCI ATES	40, 830				0	90. 01
90. 02 09002 ORTHOPAEDI CS	29, 571				0	90. 02
90. 03 09003 RHEUMATOLOGY	56, 329				0	90. 03
90. 04 09004 SPECIALTY CLINIC	95, 577	1	•		0	90. 04
90. 05 09005 PEDI ATRI CS	86, 816				0	90.05
90.06 09006 WOMEN'S HEALTH	510				0	90.06
90. 07 09007 PAIN MANAGEMENT	41, 858	1			0	90. 07
90. 08 09008 ONCOLOGY MD		ή	0.00000		0	90.08
91. 00 09100 EMERGENCY	128, 022		•			91.00
92.00 09200 OBSERVATION BEDS (NON-DIST	INCT PART) 115, 458	1, 361, 078	0. 084828	4, 575	388	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 19	9) 1, 905, 766	127, 245, 453	i	1, 350, 278	11, 449	200. 00

Health Financial Systems	RUSH MEMORIAL I	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1304	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared

				lo 12/31/2023	Date/lime Pre 4/26/2024 1:3	
		Title	xVIII	Hospi tal	Cost	7 рііі
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						
50. 00 05000 OPERATI NG ROOM	0	0		0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0	0	51.00
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	55.00
60. 00 06000 LABORATORY	0	0		0	0	60.00
65. 00 06500 RESPIRATORY 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	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0		0	0	
90. 00 09000 CLI NI C	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	90. 03
90. 04 09004 SPECIALTY CLINIC	0	0		0	0	90. 04
90. 05 09005 PEDI ATRI CS	0	0		0	0	90. 05
90.06 09006 WOMEN'S HEALTH	0	0		0	0	90.06
90. 07 09007 PAI N MANAGEMENT	0	0		0	0	90. 07
90. 08 09008 ONCOLOGY MD	0	0		0	0	90.08
91. 00 09100 EMERGENCY	0	0		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	O			O	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	0	0		0	0	200. 00

Health Financial Systems	RUSH MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1304		Worksheet D Part IV Date/Time Prepared: 4/26/2024 1:37 pm

THROUGH COSTS				To 12/31/2023	Date/Time Pre	pared:
-		Ti tl c	e XVIII	Hospi tal	4/26/2024 1:3 Cost	/ pm
Cost Center Description	All Other	Total Cost	Total	Total Charges		
oust deliter bescription	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum of		(col . 5 ÷	
	Cost	4)	col s. 2, 3,	col . 8)	col. 7)	
	0031	")	and 4)	COI. 0)	(see	
			and 1)		instructions)	
	4. 00	5.00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS				1	2.22	
50.00 05000 OPERATING ROOM	0	0)	0 13, 313, 680	0.000000	50.00
51. 00 05100 RECOVERY ROOM	0	0)	3, 100, 102	0.000000	51.00
53. 00 05300 ANESTHESI OLOGY	0	1 0		0 0	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			32, 046, 308	0. 000000	54.00
54. 01 05401 0NCOLOGY	0			1, 241, 408	0. 000000	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0. 000000	55.00
60. 00 06000 LABORATORY	0	0		0 15, 759, 455	0. 000000	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 428, 576		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		2, 731, 448	0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		1, 646, 300	0. 000000	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		280, 867	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 4, 392, 970	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		8, 683, 338	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		7, 313, 338	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 21, 794, 062	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS		•				İ
88. 00 08800 RURAL HEALTH CLINIC	0	0)	0 1, 708, 886	0.000000	88. 00
90. 00 09000 CLI NI C	0	0)	0 709, 785	0.000000	90.00
90. 01 09001 SURGI CAL ASSOCI ATES	0	0)	0 27, 358	0.000000	90. 01
90. 02 09002 ORTHOPAEDI CS	0	0)	94, 787	0.000000	90. 02
90. 03 09003 RHEUMATOLOGY	0	0)	50, 997	0.000000	90. 03
90. 04 09004 SPECIALTY CLINIC	0	0)	0 188, 475	0.000000	90.04
90. 05 09005 PEDI ATRI CS	0	0)	0 225, 754	0.000000	90.05
90. 06 09006 WOMEN'S HEALTH	0	0)	0 15, 811	0.000000	90.06
90. 07 09007 PAIN MANAGEMENT	0	0)	75, 842	0.000000	90. 07
90. 08 09008 ONCOLOGY MD	0	0)	0	0.000000	90.08
91. 00 09100 EMERGENCY	0			0 10, 054, 828	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	Ö		l	1, 361, 078	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0)	0 127, 245, 453		200.00
	•		•			

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AND THROUGH COSTS	ILLARY SERVICE OTHER PASS	Provider C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 4/26/2024 1:3	
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through		Outpatient Program Pass-Through	

Cost Center Description							4/26/2024 1: 3	7 pm
Rati o of Cost Coharges					XVIII	Hospi tal	Cost	
Charges		Cost Center Description		I npati ent	I npati ent	Outpati ent	Outpati ent	
COL 6 COL 7 COL 8 COSTS (COL 8 X COL 12) X COL 1			Ratio of Cost	Program	Program	Program	Program	
ANCILLARY SERVICE COST CENTERS 9.00			to Charges	Charges	Pass-Through	Charges	Pass-Through	
NOIL LLARY SERVICE COST CENTERS								
ANCI LLARY SERVICE COST CENTERS							x col. 12)	
50.00			9. 00	10.00	11. 00	12.00	13.00	
51.00 05100 RECOVERY ROOM	1A	NCILLARY SERVICE COST CENTERS						
53.00 05300 AMESTHESI OLOGY 0.000000 0 0 0 0 53.00	50.00 0	5000 OPERATING ROOM	0. 000000	96, 831	0	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0 0 0 0 54. 00 54. 01 05401 05401 0000000 0 0 0 0 0 55. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 55. 00 60. 00 06000 LABORATORY 0.000000 336, 773 0 0 0 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 63, 437 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 64, 949 0 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 64, 949 0 0 0 0 0 68. 00 06800 SPECH PATHOLOGY 0.000000 61, 512 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0.000000 132, 262 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 0 0 0 0 0 73. 00 07300 DRIGS CHARGED TO PATI ENT 0.000000 0 0 0 0 0 74. 00 07300 DRIGS CHARGED TO PATI ENT 0.000000 0 0 0 0 0 75. 00 07300 DRIGS CHARGED TO PATI ENT 0.000000 0 0 0 0 0 76. 00 07000 07000 07000 07000 0	51.00 0	5100 RECOVERY ROOM	0. 000000	21, 006	0	0	0	51.00
54.01 05401 0NCOLGGY	53.00 0	5300 ANESTHESI OLOGY	0. 000000	0	0	0	0	53.00
55.00 05500 RADI OLOGY-THERAPEUTI C	54. 00 0!	5400 RADI OLOGY-DI AGNOSTI C	0. 000000	265, 313	0	0	0	54.00
60. 00 06000 LABORATORY 0.000000 336, 773 0 0 0 60.00 65. 00 06500 RESPIRATORY THERAPY 0.000000 63, 437 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0.000000 64, 949 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 61, 512 0 0 0 0 68. 00 06800 SPECCH PATHOLOGY 0.000000 10, 397 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0.000000 132, 262 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0.000000 132, 262 0 0 0 0 71. 00 07000 ELECTROECREPHALOGRAPHY 0.000000 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENT 0.000000 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 269, 567 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 88. 00 0800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 90. 01 09001 SURGI CAL ASSOCIATES 0.000000 0 0 0 0 90. 02 09002 DRTHOPAEDICS 0.000000 0 0 0 0 90. 03 09003 RHEUMATOLOGY 0.000000 0 0 0 0 90. 04 09004 SPECI ALTY CLINIC 0.000000 0 0 0 0 90. 05 09005 PEDI ATRI CS 0.000000 0 0 0 0 90. 06 09006 WOMEN'S HEALTH 0.000000 0 0 0 0 90. 07 09007 PAIN MANAGEMENT 0.000000 0 0 0 0 90. 08 09008 NICOLOGY MD 0.000000 0 0 0 0 90. 09000 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 0 90. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 90. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 90. 00 09500 AMBULANCE SERVICES	54. 01 0!	5401 ONCOLOGY	0. 000000	0	0	0	0	54.01
65. 00 06500 RESPI RATORY THERAPY 0.000000 63, 437 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 64, 949 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 61, 512 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 10, 397 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 132, 262 0 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0.000000 0 0 0 0 0 71. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 22, 116 0 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATIENT 0.000000 269, 567 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 269, 567 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 74. 00 09000 CLIN C 0.000000 0 0 0 0 75. 00 09000 CLIN C 0.000000 0 0 0 0 76. 00 09000 00 00 0 0 0 77. 00 09000 00 00 00 0 0 78. 00 09000 00 00 00 0 0 79. 01 09001 SURGI CAL ASSOCI ATES 0.000000 0 0 0 0 79. 02 09002 0RTHOPAEDI CS 0.000000 0 0 0 0 79. 03 09003 RIEUMATOLOGY 0.000000 0 0 0 0 79. 04 09004 SPECI ALTY CLINIC 0.000000 0 0 0 0 79. 05 09005 PEDI ATRI CS 0.000000 0 0 0 0 79. 06 09006 WOMEN'S HEALTH 0.000000 0 0 0 0 79. 07 09007 PAI N MANAGEMENT 0.000000 0 0 0 0 79. 08 09008 ONCOLOGY MD 0.000000 0 0 0 0 79. 09 09000 DESERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 0 0 0 79. 00 09500 DESERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 0 0 79. 00 09500 DESERVATI ON BEDS (SON-DI STI NCT PART) 0.000000 0 0 79. 00 09500	55. 00 0!	5500 RADI OLOGY-THERAPEUTI C	0. 000000	0	0	0	0	55. 00
66.00 06600 PHYSI CAL THERAPY 0.000000 64,949 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 10,512 0 0 0 67.00 68.00 06800 SPECE PATHOLOGY 0.000000 10,397 0 0 0 69.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 132,262 0 0 0 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 22,116 0 0 0 0 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 269,567 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 269,567 0 0 0 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 90.01 09000 CLINIC 0.000000 0 0 0 0 90.02 09000 CLINIC 0.000000 0 0 0 0 90.03 09003 RHEUMATOLOGY 0.000000 0 0 0 0 90.04 09004 SPECI ALTY CLINIC 0.000000 0 0 0 0 90.05 09005 PEDI ATRI CS 0.000000 0 0 0 0 90.06 09006 WOMEN'S HEALTH 0.000000 0 0 0 0 90.07 09007 PAI N MANAGEMENT 0.000000 0 0 0 0 90.08 09008 NOCLOGY MD 0 0 0 0 90.09 09100 EMERGENCY 0.000000 0 0 0 0 90.00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 90.00 09500 ABBULANCE SERVICES 95.00	60.00 0	6000 LABORATORY	0. 000000	336, 773	0	0	0	60.00
67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 61, 512 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 10, 397 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 132, 262 0 0 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 22, 116 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 22, 116 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 269, 567 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 269, 567 0 0 0 74. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 75. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 76. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 77. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 78. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 79. 00 09000 CLI NI C 0.000000 0 0 0 0 79. 00 09000 CLI NI C 0.000000 0 0 0 0 79. 00 09000 DRUGS CAL ASSOCIATES 0.000000 0 0 0 0 79. 00 09000 ORTHOPAEDI CS 0.000000 0 0 0 0 79. 00 09000 ORTHOPAEDI CS 0.000000 0 0 0 79. 00 09000 ORTHOPAEDI CS 0.000000 0 0 0 79. 00 09000 PEDI ATRI CS 0.000000 0 0 0 79. 00 09000 PEDI ATRI CS 0.000000 0 0 0 79. 00 09000 ORTHOPAEDI CS 0.000000 0 0 0 79. 00 09000 ORTHOPAEDI CS 0.000000 0 0 0 79. 00 09000 ORTHOPAEDI CS 0.000000 0 0 0 79. 00 09000 ORTHOPAEDI CS 0.000000 0 0 0 79. 00 09000 ORTHOPAEDI CS 0.000000 0 0 0 79. 00 09000 ORTHOPAEDI CS 0.000000 0 0 0 79. 00 09000 ORTHOPAEDI CS 0.000000 0 0 0 79. 00 09000 ORTHOPAEDI CS 0.000000 0 0 0 79. 00 09000 ORTHOPAEDI CS 0.000000 0 0 0 79. 00 09000 ORTHOPAEDI CS 0.000000 0 0 0 79. 00 09000 ORTHOPAEDI CS 0.000000 0 0 0 79. 00 09000 ORT	65.00 0	6500 RESPIRATORY THERAPY	0. 000000	63, 437	0	0	0	65.00
68.00 06800 SPEECH PATHOLOGY 0.000000 10,397 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 132,262 0 0 0 69.00 70.00 07000 ELECTROCARDI PATI ENT 0.000000 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 22,1116 0 0 0 0 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENT 0.000000 0 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENT 0.000000 269,567 0 0 0 0 0UTPATI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 0 90.01 09000 CLINIC 0.000000 0 0 0 0 0 90.01 09001 SURGI CAL ASSOCI ATES 0.000000 0 0 0 0 0 90.02 09002 ORTHOPAEDI CS 0.000000 0 0 0 0 0 90.03 09003 RHEUMATOLOGY 0.000000 0 0 0 0 0 90.04 09004 SPECI ALTY CLINIC 0.000000 0 0 0 0 90.05 09005 PEDI ATRI CS 0.000000 0 0 0 0 90.06 09006 WOMEN' S HEALTH 0.000000 0 0 0 0 90.07 09007 PAIN MANAGEMENT 0.000000 0 0 0 0 90.08 09008 ONCOLLOGY MD 0.000000 0 0 0 0 90.09 09200 OSERVATI ON BEDS (NON-DISTINCT PART) 0.000000 1,540 0 0 0 95.00 09500 AMBULANCE SERVI CES	66.00 0	6600 PHYSI CAL THERAPY	0. 000000	64, 949	0	0	0	66.00
68.00 06800 SPEECH PATHOLOGY 0.000000 10,397 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 132,262 0 0 0 69.00 70.00 07000 ELECTROCARDI PATI ENT 0.000000 0 0 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 22,1116 0 0 0 0 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENT 0.000000 0 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENT 0.000000 269,567 0 0 0 0 0UTPATI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 0 90.01 09000 CLINIC 0.000000 0 0 0 0 0 90.01 09001 SURGI CAL ASSOCI ATES 0.000000 0 0 0 0 0 90.02 09002 ORTHOPAEDI CS 0.000000 0 0 0 0 0 90.03 09003 RHEUMATOLOGY 0.000000 0 0 0 0 0 90.04 09004 SPECI ALTY CLINIC 0.000000 0 0 0 0 90.05 09005 PEDI ATRI CS 0.000000 0 0 0 0 90.06 09006 WOMEN' S HEALTH 0.000000 0 0 0 0 90.07 09007 PAIN MANAGEMENT 0.000000 0 0 0 0 90.08 09008 ONCOLLOGY MD 0.000000 0 0 0 0 90.09 09200 OSERVATI ON BEDS (NON-DISTINCT PART) 0.000000 1,540 0 0 0 95.00 09500 AMBULANCE SERVI CES	67.00 0	6700 OCCUPATI ONAL THERAPY	0. 000000	61, 512	0	0	0	67.00
69.00 06900 ELECTROCARDI OLOGY 0.000000 132, 262 0 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 22, 116 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 269, 567 0 0 0 0UTPATIENT SERVICE COST CENTERS	68. 00 0	6800 SPEECH PATHOLOGY	0. 000000			0	0	
70.00	69.00 0	6900 ELECTROCARDI OLOGY	0. 000000			0	0	69.00
72. 00	70.00 0	7000 ELECTROENCEPHALOGRAPHY	0. 000000			0	0	70.00
72. 00	71. 00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	22, 116	0	0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 269, 567 0 0 0 0 0 0 0 0 0	72. 00 0	7200 IMPL. DEV. CHARGED TO PATIENT				0	0	72.00
SB. 00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 88.00				269, 567	0	0	0	
88. 00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 0 88. 00 90. 00 09000 CLINIC 0.000000 0 0 0 0 0 90. 00 90. 00 90. 00 90. 01 09001 SURGI CAL ASSOCIATES 0.000000 0 0 0 0 0 0 90. 01 90. 02 90. 02 90. 03 09002 RTHOPAEDICS 0.000000 0 0 0 0 0 0 90. 02 90. 03 09003 RHEUMATOLOGY 0.000000 0 0 0 0 0 0 90. 03 90. 04 09004 SPECI ALTY CLINIC 0.000000 0 0 0 0 0 90. 04 90. 05 PEDI ATRICS 0.000000 0 0 0 0 90. 05 90. 06 09006 WOMEN'S HEALTH 0.000000 0 0 0 0 0 90. 05 90. 07 09007 PAI N MANAGEMENT 0.000000 0 0 0 0 90. 07 90. 08 09008 ONCOLOGY MD 0.000000 0 0 0 0 90. 08 91. 00 09100 EMERGENCY 0.000000 1,540 0 0 0 92. 00 07 92. 00 OFTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	_							
90. 01 09001 SURGI CAL ASSOCI ATES 0.000000 0 0 0 90. 01 90. 02 09002 ORTHOPAEDI CS 0.000000 0 0 0 90. 02 90. 03 09003 RHEUMATOLOGY 0.000000 0 0 0 0 90. 03 90. 04 09004 SPECI ALTY CLI NI C 0.000000 0 0 0 0 90. 04 90. 05 09005 PEDI ATRI CS 0.000000 0 0 0 0 90. 05 90. 06 09006 WOMEN'S HEALTH 0.000000 0 0 0 0 90. 05 90. 07 09007 PAI N MANAGEMENT 0.000000 0 0 0 0 90. 07 90. 08 09008 ONCOLOGY MD 0.000000 0 0 0 0 90. 07 91. 00 09100 EMERGENCY 0.000000 1,540 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 4,575 0 0 92. 00 0THER REI MBURSABLE COST CENTERS			0. 000000	0	0	0	0	88. 00
90. 02 09002 0RTHOPAEDI CS 0.000000 0 0 0 0 90. 02 90. 03 09003 RHEUMATOLOGY 0.000000 0 0 0 0 90. 03 90. 04 09004 SPECI ALTY CLINI C 0.000000 0 0 0 0 90. 04 90. 05 09005 PEDI ATRI CS 0.000000 0 0 0 0 90. 05 90. 06 09006 WOMEN'S HEALTH 0.000000 0 0 0 0 90. 06 90. 07 09007 PAI N MANAGEMENT 0.000000 0 0 0 0 90. 07 90. 08 09008 0NCOLOGY MD 0.000000 0 0 0 0 90. 08 91. 00 09100 EMERGENCY 0.000000 1,540 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 4,575 0 0 92. 00 0THER REI MBURSABLE COST CENTERS	90.00 0	9000 CLI NI C	0. 000000	0	0	0	0	90.00
90. 03	90. 01 09	9001 SURGI CAL ASSOCI ATES	0. 000000	0	0	0	0	90. 01
90. 04 09004 SPECIALTY CLINIC 0.000000 0 0 0 90. 04 90. 05 09005 PEDIATRICS 0.000000 0 0 0 0 90. 05 90. 06 09006 WOMEN'S HEALTH 0.000000 0 0 0 0 90. 06 90. 07 09007 PAI N MANAGEMENT 0.000000 0 0 0 0 90. 07 90. 08 09008 0NCOLOGY MD 0.000000 0 0 0 0 0 90. 08 91. 00 09100 EMERGENCY 0.000000 1,540 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 4,575 0 0 0 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00	90. 02 0	9002 ORTHOPAEDI CS	0. 000000	0	0	0	0	90. 02
90. 05 09005 PEDI ATRI CS 0. 000000 0 0 0 0 90. 05 90. 06 09006 WOMEN' S HEALTH 0. 000000 0 0 0 0 90. 06 90. 07 09007 PAI N MANAGEMENT 0. 000000 0 0 0 0 90. 07 90. 08 09008 ONCOLOGY MD 0. 000000 0 0 0 0 0 90. 08 91. 00 09100 EMERGENCY 0. 000000 1, 540 0 0 0 91. 00 92. 00 09200 OSSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 4, 575 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00	90. 03 0	9003 RHEUMATOLOGY	0. 000000	0	0	0	0	90. 03
90. 05 09005 PEDI ATRI CS 0. 000000 0 0 0 0 90. 05 90. 06 09006 WOMEN' S HEALTH 0. 000000 0 0 0 0 90. 06 90. 07 09007 PAI N MANAGEMENT 0. 000000 0 0 0 0 90. 07 90. 08 09008 ONCOLOGY MD 0. 000000 0 0 0 0 0 90. 08 91. 00 09100 EMERGENCY 0. 000000 1, 540 0 0 0 91. 00 92. 00 09200 OSSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 4, 575 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00				0	0	0	0	
90. 06 09006 WOMEN' S HEALTH 0. 000000 0 0 0 90. 06 90. 07 09007 PAI N MANAGEMENT 0. 000000 0 0 0 90. 07 90. 08 09008 0NCOLOGY MD 0. 000000 0 0 0 0 90. 08 91. 00 09100 EMERGENCY 0. 000000 1, 540 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 4, 575 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00			1	0	0	0	0	1
90. 07 09007 PAI N MANAGEMENT 0. 000000 0 0 0 0 90. 07 90. 08 09008 0NCOLOGY MD 0. 000000 0 0 0 0 90. 08 91. 00 09100 EMERGENCY 0. 000000 1, 540 0 0 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 4, 575 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00	90.06 0	9006 WOMEN'S HEALTH		0	0	0	0	90.06
90. 08 09008 0NCOLOGY MD 0.000000 0 0 0 90. 08 91. 00 91. 00 92. 00 08SERVATI ON BEDS (NON-DISTINCT PART) 0.000000 4, 575 0 0 0 92. 00 95. 00 09500 AMBULANCE SERVICES 95. 00 9			1	0	0	0	0	1
91. 00 09100 EMERGENCY 0. 000000 1, 540 0 0 0 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 000000 4, 575 0 0 0 92. 00 000000 000000 0000000 000000				0	0	0	0	90.08
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0.0000000 4,575 0 0 0 92. 00			1	1, 540	0	0	0	
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00						0	0	
95. 00			2. 222000	., 0, 0				1
								95.00
200, 001 10 tai (11105 30 tii) 000 1777 1,330,270 0 0 0 0 0 0 200, 00	200.00	Total (lines 50 through 199)		1, 350, 278	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1304 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 4/26/2024 1:37 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 0. 209713 3, 125, 778 50.00 05100 RECOVERY ROOM 0 51.00 0.153744 0 579, 521 51.00 0 05300 ANESTHESI OLOGY 53.00 0.000000 0 0 53.00 6, 405, 407 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.076034 0 0 0 0 0 0 0 0 54.00 54.01 05401 ONCOLOGY 0.967642 349, 244 0 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 0 55.00 0 60.00 06000 LABORATORY 0. 199288 3, 340, 837 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.805621 32, 832 0 65.00 06600 PHYSI CAL THERAPY 0. 313316 892, 252 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0.291955 67.00 396, 880 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.230597 31, 423 0 68.00 06900 ELECTROCARDI OLOGY 69.00 0.086510 1, 251, 278 0 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70 00 0.000000 0 1, 926, 262 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.235859 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 325599 0 2, 870, 990 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 342456 9, 283, 039 4, 675 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 90.00 09000 CLI NI C 2. 195222 34, 980 90.00 90. 01 09001 SURGI CAL ASSOCI ATES 4. 254989 0 7,002 0 0 0 90.01 09002 ORTHOPAEDI CS 90 02 5. 792809 0 55, 281 90.02 0 90.03 09003 RHEUMATOLOGY 4. 110634 30, 499 0 90.03 09004 SPECIALTY CLINIC 7.889487 98, 310 0 0 90.04 90.04 0 09005 PEDI ATRI CS 2. 475943 90.05 90.05 0 0 09006 WOMEN'S HEALTH 3.442793 0 1.315 90.06 90.06 0 90.07 09007 PAIN MANAGEMENT 4. 410116 0 19, 320 0 0 90.07 90.08 09008 ONCOLOGY MD 0.000000 0 ol 0 90.08 09100 EMERGENCY 91.00 91 00 0.365610 Ω 1, 364, 187 898 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.985364 0 257, 323 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.772609 95.00 200.00 Subtotal (see instructions) ol 32, 353, 960 0 200.00 5.573 201.00 Less PBP Clinic Lab. Services-Program 201.00

32, 353, 960

5, 573

0 202.00

Only Charges

Net Charges (line 200 - line 201)

202.00

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

From 01/01/2023 Part V
To 12/31/2023 Date/Time Prepared: 4/26/2024 1:37 pm Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 655, 516 05100 RECOVERY ROOM 89, 098 51.00 0 51.00 05300 ANESTHESI OLOGY 0 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 487, 029 0 54.00 54.01 05401 ONCOLOGY 337, 943 54.01 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 0 60.00 06000 LABORATORY 665, 789 60.00 65.00 06500 RESPIRATORY THERAPY 26, 450 65.00 0 66.00 06600 PHYSI CAL THERAPY 279, 557 66.00 06700 OCCUPATI ONAL THERAPY 115, 871 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 7, 246 0 68.00 06900 ELECTROCARDI OLOGY 108, 248 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 454, 326 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 934, 791 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 3, 179, 032 1,601 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 90.00 09000 CLI NI C 76, 789 90.00 29, 793 90.01 09001 SURGI CAL ASSOCI ATES 0 90.01 09002 ORTHOPAEDI CS 90 02 320, 232 0 90 02 90.03 09003 RHEUMATOLOGY 125, 370 0 90.03 90.04 09004 SPECIALTY CLINIC 775, 615 90.04 90.05 09005 PEDI ATRI CS 0 90.05 90.06 09006 WOMEN'S HEALTH 90.06 4.527 0 90.07 09007 PAIN MANAGEMENT 85, 203 0 90.07 09008 ONCOLOGY MD 90.08 0 90.08 09100 EMERGENCY 498, 760 91 00 328 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 253, 557 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 9, 510, 742 200.00 Subtotal (see instructions) 1,929 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00

9, 510, 742

1, 929

202.00

Only Charges

Net Charges (line 200 - line 201)

202.00

Health Financial Systems	RUSH MEMORIA	L HOSPI TAL		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 4/26/2024 1:3	
-		Ti tl	e XIX	Hospi tal	Cost	7 рііі
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	261, 478	7, 301	254, 17	7 1, 497	169. 79	30.00
31.00 INTENSIVE CARE UNIT	62, 622		62, 62	2 87	719. 79	31.00
200.00 Total (lines 30 through 199)	324, 100		316, 79	9 1, 584		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	21	3, 566				30.00
31.00 INTENSIVE CARE UNIT	1	720	•			31.00
200.00 Total (lines 30 through 199)	22	4, 286				200. 00

Health Financial Sys	stems			RUSH MEMORIAL	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INP	PATIENT ANCILLAR	Y SERVICE	CAPI TAL	COSTS	Provi der	CCN:	15-1304	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 4/26/2024 1:3	
					Ti	tle	XIX	Hospi tal	Cost	

					Fo 12/31/2023	Date/Time Pre 4/26/2024 1:3	
			Ti +I	e XIX	Hospi tal	Cost	/ pili
	Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
	oost center bescription	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)	Charges	COT GIIIIT 4)	
		col . 26)	001. 0)	001. 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	201, 624	13, 313, 680	0. 01514	32, 995	500	50.00
51.00	05100 RECOVERY ROOM	20, 953	3, 100, 102	0. 00675	6, 912	47	51.00
53.00	05300 ANESTHESI OLOGY	0	0	0. 000000	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	141, 470	32, 046, 308	0. 00441!	37, 392	165	54.00
54. 01	05401 ONCOLOGY	103, 634	1, 241, 408	0. 08348	0	0	54. 01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0. 000000	0	0	55.00
60.00	06000 LABORATORY	109, 322	15, 759, 455	0.00693	31, 282	217	60.00
65.00	06500 RESPIRATORY THERAPY	6, 439	428, 576	0. 01502	1, 417	21	65.00
66.00	06600 PHYSI CAL THERAPY	51, 048	2, 731, 448	0. 018689	353	7	66.00
67.00	06700 OCCUPATI ONAL THERAPY	31, 326	1, 646, 300	0. 01902	471	9	67.00
68.00	06800 SPEECH PATHOLOGY	5, 120	280, 867	0. 01822	668	12	68.00
69.00	06900 ELECTROCARDI OLOGY	32, 703	4, 392, 970	0.00744	903	7	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0. 000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	35, 867	8, 683, 338	0. 00413	6, 618	27	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	39, 568	7, 313, 338	0. 005410	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	106, 994	21, 794, 062	0. 00490	21, 589	106	73.00
	OUTPATIENT SERVICE COST CENTERS				_		
88. 00	08800 RURAL HEALTH CLINIC	187, 483	1, 708, 886			0	00.00
90.00	09000 CLI NI C	237, 244	709, 785			0	90.00
90. 01	09001 SURGI CAL ASSOCI ATES	40, 830				0	90. 01
90. 02	09002 ORTHOPAEDI CS	29, 571	94, 787	0. 31197:		0	90. 02
90. 03	09003 RHEUMATOLOGY	56, 329	50, 997	1. 10455!		0	90. 03
90.04	09004 SPECIALTY CLINIC	95, 577	188, 475			0	90.04
90.05	09005 PEDI ATRI CS	86, 816	225, 754			0	90.05
90.06	09006 WOMEN' S HEALTH	510	15, 811			0	90.06
90. 07	09007 PAIN MANAGEMENT	41, 858	75, 842			0	90. 07
90.08	09008 ONCOLOGY MD	0	0	1 0.0000		0	90.08
91.00	09100 EMERGENCY	128, 022					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	115, 458	1, 361, 078	0. 084828	3 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	1		T	T		
95.00	09500 AMBULANCE SERVICES	4 005 7//	407.045 :50		450.000	4 00/	95.00
200.00	Total (lines 50 through 199)	1, 905, 766	127, 245, 453	I	153, 830	1, 286	200. 00

Health Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COS	STS Provider C		Period: From 01/01/2023 To 12/31/2023		epared: 37 pm
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0)	0 0	0	31.00
200.00 Total (lines 30 through 199)	0	0)	0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
·	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)				
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•		•	•		
30. 00 03000 ADULTS & PEDIATRICS	0	0	1, 49	7 0.00	21	30.00
31.00 03100 INTENSIVE CARE UNIT		l	8		1	31.00
200.00 Total (lines 30 through 199)		0	1, 58		l .	200.00
Cost Center Description	Inpatient		•	<u> </u>	<u> </u>	
'	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00 03100 INTENSIVE CARE UNIT	0					31.00
200.00 Total (lines 30 through 199)	0					200.00
1 1	1	1				

H	lealth Financial Systems	RUSH MEMORIAL I	HOSPI TAL	In Lieu	u of Form CMS-2552-10
	APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-1304	From 01/01/2023	Worksheet D Part IV Date/Time Prepared

					10 12/31/2023	4/26/2024 1:3	
			Ti tl	e XIX	Hospi tal	Cost	у ріп
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health		
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments		.,		
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS			•		•	
50.00	05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
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	0	54.01
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
60.00	06000 LABORATORY	0	0		0 0	0	00.00
65.00	06500 RESPIRATORY 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	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
90.00	09000 CLI NI C	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	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	90. 07
90.08	09008 ONCOLOGY MD	0	0		0	0	90.08
91.00	09100 EMERGENCY	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 SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0		0 0	0	200.00

Heal th Financial	Systems		RUS	SH MEMORIAL	HOSPI TAL			In Lieu	of Form CMS-2552-10
APPORTI ONMENT OF THROUGH COSTS	I NPATI ENT/OUTPATI ENT	ANCI LLARY	SERVI CE	OTHER PASS	Provi der	CCN:	15-1304	From 01/01/2023	Worksheet D Part IV Date/Time Prepared

THROUGH COSTS				From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
		Ti +I	e XIX	Hospi tal	4/26/2024 1:3 Cost	7 pm
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
cost center bescription	Medi cal	(sum of cols.	Outpatient	(from Wkst.	to Charges	
	Education	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col . 8)	col. 7)	
	0031	")	and 4)	COI. 0)	(see	
			and 4)		instructions)	
	4. 00	5.00	6, 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS				1	2.22	
50. 00 05000 OPERATING ROOM	0	0	1	0 13, 313, 680	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	1	3, 100, 102	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			32, 046, 308	0. 000000	54.00
54, 01 05401 ONCOLOGY	0			1, 241, 408	0. 000000	54. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		,	0	0. 000000	55.00
60. 00 06000 LABORATORY	0		,	0 15, 759, 455	0. 000000	60.00
65, 00 06500 RESPIRATORY THERAPY	0		,	0 428, 576	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	,	0 2, 731, 448	0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	,	0 1, 646, 300	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	,	280, 867	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	,	0 4, 392, 970	0.000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	,	0 0	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	,	0 8, 683, 338	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	,	7, 313, 338	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	,	0 21, 794, 062	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	(0 1, 708, 886	0.000000	88. 00
90. 00 09000 CLI NI C	0	0	1	709, 785	0.000000	90.00
90. 01 09001 SURGI CAL ASSOCI ATES	0	0	1	0 27, 358	0.000000	90. 01
90. 02 09002 ORTHOPAEDI CS	0	0)	94, 787	0.000000	90. 02
90. 03 09003 RHEUMATOLOGY	0	0)	50, 997	0.000000	90. 03
90. 04 09004 SPECIALTY CLINIC	0	0)	0 188, 475	0.000000	90.04
90. 05 09005 PEDI ATRI CS	0	0)	0 225, 754	0.000000	90.05
90.06 09006 WOMEN'S HEALTH	0	0)	0 15, 811	0.000000	90.06
90. 07 09007 PAI N MANAGEMENT	0	0)	75, 842	0.000000	90. 07
90. 08 09008 ONCOLOGY MD	0	0	1	0 0	0.000000	90.08
91. 00 09100 EMERGENCY	0	0	1	0 10, 054, 828	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1	0 1, 361, 078	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 127, 245, 453		200. 00

Health Financial S	Systems		RUSH MEMORIAL HOSPITAL				u of Form CMS-2	2552-10
APPORTIONMENT OF I	I NPATI ENT/OUTPATI ENT	ANCI LLARY	SERVI CE OTHER PAS	SS Provider C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 4/26/2024 1:3	
				Ti tl	e XIX	Hospi tal	Cost	
Cost (Center Description		Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
			Ratio of Cost	Program	Program	Program	Program	
			to Charges	Charges	Pass-Through		Pass-Through	

Cost Center Description			Ti tl	e XIX	Hospi tal	Cost	, p
Rati o of Cost to Charges	Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
COL 6 COL 7 COL 8 COSTS (COL 8 COSTS (COL 9 COL 12)	· ·						
COL 6 COL 7 COL 8 COSTS (COL 8 X COL 12) X COL 1		to Charges	Charges	Pass-Through	Charges	Pass-Through	
NOCILLARY SERVICE COST CENTERS			3		3		
ANCI LLARY SERVICE COST CENTERS		col. 7)				x col. 12)	
50.00		9. 00	10. 00	11. 00	12.00	13. 00	
51.00 05100 RECOVERY ROOM	ANCILLARY SERVICE COST CENTERS						
53.00 05300 AMESTHESI OLOCY 0.000000 0 0 0 53.00	50. 00 05000 OPERATING ROOM	0. 000000	32, 995	0	0	0	50.00
54. 00 05400 RADI OLOCY-DI AGNOSTI C 0.000000 37, 392 0 0 0 54. 00	51.00 05100 RECOVERY ROOM	0. 000000	6, 912	0	o	0	51.00
54. 01 05401 0NCOLOGY 0.000000 0 0 0 54. 01	53. 00 05300 ANESTHESI OLOGY	0. 000000	0	0	o	0	53.00
55.00 05500 RADI OLOGY_THERAPEUTI C	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	37, 392	0	0	0	54.00
60.00 06000 LABORATORY 0.000000 31,282 0 0 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 1,417 0 0 0 65.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 353 0 0 0 0 0 68.00 06600 PHYSI CAL THERAPY 0.000000 471 0 0 0 0 0 68.00 06700 0CCUPATI ONAL THERAPY 0.000000 471 0 0 0 0 0 68.00 06800 SPECCH PATHOLOGY 0.000000 668 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0.000000 903 0 0 0 0 0 70.00 07000 ELECTROCARDI OLOGY 0.000000 0 0 0 0 0 71.00 07000 ELECTROCARDI OLOGY 0.000000 0 0 0 0 72.00 07200 IMPLD DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 74.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 75.00 07000 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 75.00 07000 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 75.00 07000 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 75.00 07000 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 75.00 07000 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 75.00 07000 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 75.00 07000 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 75.00 07000 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 75.00 07000 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 75.00 07000 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 75.00 07000 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 75.00 07000 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 75.00 07000 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 75.00 07000 DRUGS CHARGED TO PATI ENTS 0.0000000 0 0 0 0 75.00 07000 DRUGS CHA	54. 01 05401 ONCOLOGY	0. 000000	0	0	0	0	54. 01
65. 00 06500 RESPI RATORY THERAPY 0.000000 1,417 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 353 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 471 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 668 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 903 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0.000000 0 0 0 0 71. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 21, 589 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 21, 589 0 0 0 74. 00 07000 UNAL HEATH CLINIC 0.000000 0 0 0 75. 00 09000 CLINIC 0.000000 0 0 0 0 76. 01 09001 SURGI CAL ASSOCI ATES 0.000000 0 0 0 0 77. 02 09002 ORTHOPAEDI CS 0.000000 0 0 0 0 77. 03 09003 RIEUMATOLOGY 0.000000 0 0 0 0 77. 04 09004 SPECI ALTY CLINIC 0.000000 0 0 0 0 77. 05 09005 PEDI ATRI CS 0.000000 0 0 0 0 78. 00 09006 WOMEN'S HEALTH 0.000000 0 0 0 0 79. 01 09007 PAI N MANAGEMENT 0.000000 0 0 0 0 79. 02 09008 ONCOLOGY MD 0.000000 0 0 0 0 79. 08 09008 ONCOLOGY MD 0.000000 0 0 0 0 79. 09 09009 ONCOLOGY MD 0.000000 0 0 0 79. 09 09500 ABBULANCE SERVI CES	55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	0	0	0	55.00
66. 00 06600 PHYSI CAL THERAPY 0.000000 353 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 471 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 668 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 903 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 6, 618 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0.000000 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 88. 00 08800 RURAL HEALTH CLINIC 0.000000 0 0 0 0 90. 01 09000 CLINIC 0.000000 0 0 0 0 90. 02 09000 CLINIC 0.000000 0 0 0 0 90. 03 09003 RHEUMATOLOGY 0.000000 0 0 0 0 90. 04 09004 SPECI ALTY CLINIC 0.000000 0 0 0 0 90. 05 09005 PEDIATRIC S 0.000000 0 0 0 0 90. 06 09006 WOMEN'S HEALTH 0.000000 0 0 0 0 90. 07 09007 PAIN MANAGEMENT 0.000000 0 0 0 0 90. 08 09008 MORGINET HEALTH 0.000000 0 0 0 90. 08 09008 MORGINET 0.000000 0 0 0 0 90. 08 09008 DRUGLOGY 0.000000 0 0 0 0 90. 09 09005 PEDIATRIC S 0.000000 0 0 0 0 90. 08 09008 MORGINET 0.000000 0 0 0 0 90. 08 09008 MORGINET 0.000000 0 0 0 0 90. 09 09005 PEDIATRIC S 0.000000 0 0 0 90. 08 09008 MORGINET 0.000000 0 0 0 90. 09 09009 DRUGLOGY 0 0 0 90. 09 09009 DRUGLOGY 0 0 0 90. 09 09009 00 00 00 0 90. 09 09009 00 00 00 00 90. 00 09000 00 00 00 00 90. 00 09000 00 00 00 00 90. 00 09000 00 00 00 00 90. 00 09000 00 00 00 00 90. 00 09000 00 00 00 00 90. 00 09000 00 00 00 00 90. 00 09000 00 00 00 90. 00 09000 00 00 00 00 90. 00 0	60. 00 06000 LABORATORY	0. 000000	31, 282	0	0	0	60.00
67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 471 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 668 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 903 0 0 0 0 68. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 21, 589 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 21, 589 0 0 0 73. 00 0017PATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0.000000 0 0 0 0 0 88. 00 90. 00 09000 CLINI C 0.000000 0 0 0 0 0 0 90. 01 90. 01 09001 SURGI CAL ASSOCI ATES 0.000000 0 0 0 0 0 0 90. 01 90. 02 09002 ORTHOPAEDI CS 0.000000 0 0 0 0 0 0 90. 02 90. 03 09003 RHEUMATOLOGY 0.000000 0 0 0 0 0 0 90. 03 90. 04 09004 SPECI ALTY CLINI C 0.000000 0 0 0 0 0 0 90. 03 90. 05 09005 PEDI ATRI CS 0.000000 0 0 0 0 0 0 0 90. 05 90. 06 09006 WOMEN'S HEALTH 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65. 00 06500 RESPIRATORY THERAPY	0. 000000	1, 417	0	0	0	65.00
68. 00 06800 SPEECH PATHOLOGY 0.000000 668 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 903 0 0 0 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 6,618 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 74. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 75. 00 07400 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 75. 00 07400 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 75. 00 07400 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 0 75. 00 07400 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 75. 00 07400 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 75. 00 07400 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 75. 00 07400 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 75. 00 07400 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 75. 00 07400 DRUGS CHARGED TO PATIENTS 0.000000 0 0 0 75. 00 07500 DRUGS CHARGED TO PATIENT 0.000000 0 0 0 75. 00 07500 DRUGS CHARGED TO PATIENT	66. 00 06600 PHYSI CAL THERAPY	0. 000000	353	0	0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY 0.000000 903 0 0 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 6, 618 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.000000 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENT 0.000000 21, 589 0 0 0 0017PATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0.000000 0 0 0 0 90. 00 09000 CLI NI C 0.000000 0 0 0 0 90. 01 09001 SURGI CAL ASSOCI ATES 0.000000 0 0 0 0 90. 02 09002 ORTHOPAEDI CS 0.000000 0 0 0 0 90. 03 09003 RHEUMATOLOGY 0.000000 0 0 0 0 90. 04 09004 SPECI ALTY CLINI C 0.000000 0 0 0 0 90. 05 09005 PEDI ATRI CS 0.000000 0 0 0 0 90. 06 09006 WOMEN'S HEALTH 0.000000 0 0 0 0 90. 07 09007 PAI N MANAGEMENT 0.000000 0 0 0 0 90. 08 09008 ONCOLOGY MD 0.000000 0 0 0 0 91. 00 09100 EMERGENCY 0.000000 0 0 0 0 92. 00 07500 ONBORD ONDOR ONDOR ONDOR ONDOR ONDOR 99. 00 ONDOR ONDOR ONDOR ONDOR ONDOR ONDOR 99. 00 ONDOR ONDOR ONDOR OND	67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	471	0	0	0	67.00
70.00	68. 00 06800 SPEECH PATHOLOGY	0. 000000	668	0	0	0	68.00
71. 00	69. 00 06900 ELECTROCARDI OLOGY	0. 000000	903	0	0	0	69.00
72. 00	70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	0	0	0	70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 21,589 0 0 0 0 0 0 0 0 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	6, 618	O	0	0	71.00
SB. 00 OBS00 RURAL HEALTH CLINIC O. 000000 O O O O O O O O	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0	0	0	0	72.00
88. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	21, 589	O	0	0	73.00
90. 00 09000 CLINIC 0.000000 0 0 0 0 90. 00 90. 01 09001 SURGI CAL ASSOCIATES 0.000000 0 0 0 0 90. 01 90. 02 09002 ORTHOPAEDI CS 0.000000 0 0 0 0 90. 02 90. 03 09003 RHEUMATOLOGY 0.000000 0 0 0 0 90. 02 90. 04 09004 SPECIALTY CLINIC 0.000000 0 0 0 0 90. 04 90. 05 09005 PEDIATRICS 0.000000 0 0 0 0 90. 05 90. 06 09006 WOMEN'S HEALTH 0.000000 0 0 0 0 90. 05 90. 07 09007 PAIN MANAGEMENT 0.000000 0 0 0 0 90. 07 90. 08 09008 ONCOLOGY MD 0.000000 0 0 0 0 90. 08 91. 00 09100 EMERGENCY 0.000000 13, 230 0 0 91. 00 92. 00 OP200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00	OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC 0.000000 0 0 0 0 90. 00 90. 01 09001 SURGI CAL ASSOCIATES 0.000000 0 0 0 0 90. 01 90. 02 09002 ORTHOPAEDI CS 0.000000 0 0 0 0 90. 02 90. 03 09003 RHEUMATOLOGY 0.000000 0 0 0 0 90. 02 90. 04 09004 SPECIALTY CLINIC 0.000000 0 0 0 0 90. 04 90. 05 09005 PEDIATRICS 0.000000 0 0 0 0 90. 05 90. 06 09006 WOMEN'S HEALTH 0.000000 0 0 0 0 90. 05 90. 07 09007 PAIN MANAGEMENT 0.000000 0 0 0 0 90. 07 90. 08 09008 ONCOLOGY MD 0.000000 0 0 0 0 90. 08 91. 00 09100 EMERGENCY 0.000000 13, 230 0 0 91. 00 92. 00 OP200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 92. 00 OTHER REIMBURSABLE COST CENTERS 95. 00	88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0	0	0	0	88. 00
90. 02		0. 000000	0	0	0	0	90.00
90. 03	90. 01 09001 SURGI CAL ASSOCI ATES	0. 000000	0	O	0	0	90. 01
90. 04 09004 SPECIALTY CLINIC 0.000000 0 0 0 90. 04 90. 05 09005 PEDIATRICS 0.000000 0 0 0 90. 05 90. 06 09006 WOMEN'S HEALTH 0.000000 0 0 0 0 90. 06 90. 07 09007 PAI N MANAGEMENT 0.000000 0 0 0 0 90. 07 90. 08 09008 0NCOLOGY MD 0.000000 0 0 0 0 90. 08 91. 00 09100 EMERGENCY 0.000000 13, 230 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00	90. 02 09002 ORTHOPAEDI CS	0. 000000	0	O	0	0	90. 02
90. 05	90. 03 09003 RHEUMATOLOGY	0. 000000	0	O	0	0	90.03
90. 06 09006 WOMEN' S HEALTH 0. 000000 0 0 0 90. 06 90. 07 09007 PAI N MANAGEMENT 0. 000000 0 0 0 90. 07 90. 08 09008 0NCOLOGY MD 0. 000000 0 0 0 0 90. 08 91. 00 09100 EMERGENCY 0. 000000 13, 230 0 0 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 0 0 0 0 0 0THER REI MBURSABLE COST CENTERS 95. 00	90. 04 09004 SPECIALTY CLINIC	0. 000000	0	O	0	0	90.04
90. 07 09007 PAI N MANAGEMENT 0. 000000 0 0 0 0 90. 07 90. 08 09008 0NCOLOGY MD 0. 000000 0 0 0 90. 08 91. 00 09100 EMERGENCY 0. 000000 13, 230 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 0 0 0 0 0THER REI MBURSABLE COST CENTERS 95. 00	90. 05 09005 PEDI ATRI CS	0. 000000	0	0	0	0	90.05
90. 08 09008 0NCOLOGY MD	90.06 09006 WOMEN'S HEALTH	0. 000000	0	O	0	0	90.06
91. 00 09100 EMERGENCY 0.000000 13, 230 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 0 92. 00 000000 0 0 0 0 0 0	90. 07 09007 PAIN MANAGEMENT	0. 000000	0	O	0	0	90. 07
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0.0000000 0 0 0 0 0 0 0	90. 08 09008 ONCOLOGY MD	0. 000000	0	O	0	0	90.08
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 0000000 0 0 0 0 0 0		0. 000000	13, 230	0	o	0	91.00
OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			0	0	92.00
		<u>'</u>		<u> </u>			1
200.00 Total (lines 50 through 199) 153,830 0 0 200.00	95. 00 09500 AMBULANCE SERVICES						95.00
	200.00 Total (lines 50 through 199)		153, 830	0	o	0	200.00

Heal th	Financial Systems	RUSH MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10		
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15-1304	Peri od: From 01/01/2023	Worksheet D-1			
				To 12/31/2023	Date/Time Prep 4/26/2024 1:3			
			Title XVIII	Hospi tal	Cost			
	Cost Center Description							
	·				1. 00			
'	PART I - ALL PROVIDER COMPONENTS							
	I NPATI ENT DAYS							
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn) 1,540							

	Cook Cooker Description	LOST	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	11.00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	1, 540	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	1, 497 0	2. 00 3. 00
4 00	do not complete this line.	017	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	817 43	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	404	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	43	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	
14. 00 15. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00 15. 00
16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18. 00
19. 00	Medical d rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0. 00	19. 00
20. 00	Medical d rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	3, 037, 327 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00	Total swing-bed cost (see instructions)	84, 808	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	2, 952, 519	27. 00
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
	Private room charges (excluding swing-bed charges)	0	
	Semi-private room charges (excluding swing-bed charges)	0 000000	
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)	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 minus line 33)(see instructions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2, 952, 519	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	_	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 972. 29	38.00
	Program general inpatient routine service cost (line 9 x line 38)	796, 805	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	796, 805	
	, 5 3 ,	,	

36.	00 Private room cost differential adjustment (line 3 x line 35)	[0]	36.0
37.	00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line	2, 952, 519	37.0
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.	00 Adjusted general inpatient routine service cost per diem (see instructions)	1, 972. 29	38.0
39.	00 Program general inpatient routine service cost (line 9 x line 38)	796, 805	39.0
40.	00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.0
41.	00 Total Program general inpatient routine service cost (line 39 + line 40)	796, 805	41.0

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST	RUSH MEMORIAL	Provi der C		Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2023 Fo 12/31/2023	Date/Time Pre	pare
			Ti +Lo	XVIII	Hospi tal	4/26/2024 1: 3 Cost	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient	Inpatient	Diem (col. 1		(col. 3 x	
		1.00	<u>Days</u> 2.00	÷ col. 2) 3.00	4. 00	col . 4) 5.00	
2. 00	NURSERY (title V & XIX only)		2.00	0.00		0.00	42.
	Intensive Care Type Inpatient Hospital Units		07	4 400 46	1 00	101 010	4.0
3. 00 4. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	385, 600	87	4, 432. 18	23	101, 940	43.
5. 00	BURN INTENSIVE CARE UNIT						45.
. 00	SURGICAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
						1. 00	
3. 00 3. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti	st. D-3, col. 3	3, line 200)	III lino 10	column 1)	316, 682 0	1
. 00	Total Program inpatient costs (sum of lines	41 through 48.0	11)(see instru	ctions)	COT UIIII 1)	1, 215, 427	
	PASS THROUGH COST ADJUSTMENTS		, (===			1, 213, 121	
. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sum	of Parts I and	0	50
. 00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancillar	v services (fi	com Wkst. D. s	um of Parts II	0	51
	and IV)		, 555 (11			ا	
. 00	Total Program excludable cost (sum of lines		alatad - · ·	uol ol see eeeesti	otiot '	0	1
. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		erated, non-pny	ysician anestn	etist, and	0	53
	TARGET AMOUNT AND LIMIT COMPUTATION	-					
	Program discharges Target amount per discharge					0 0. 00	54
. 00 . 01	Permanent adjustment amount per discharge					0.00	
. 02	Adjustment amount per discharge (contractor	use only)				0.00	
. 00	Target amount (line 54 x sum of lines 55, 55				>	0	
. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (I	ine 56 minus	line 53)	0	
. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost repo	ortina period	endi na 1996.	0. 00	
	updated and compounded by the market basket)		·	0 .			
. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	om prior year o	cost report, u	pdated by the	0. 00	60
. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of t	the amount by w	which operatin	g costs (line	0	61
	enter zero. (see instructions)					_	
2. 00 3. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ıcti ons)			0	62
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST	(300 1113110	1011 0113)			- C	
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	84, 808	64
. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	per 31 of the o	cost reporting	period (See	o	65
	instructions)(title XVIII only)			· -p · · · · · · · · · · · · ·	p =		
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	55)(title XVII	I only); for	84, 808	66
. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	of the cost re	porting period	o	67
	(line 12 x line 19)	-					
. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	December 31 of	the cost repo	rting period	0	68
. 00	Total title V or XIX swing-bed NF inpatient					0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER N						70
. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						71
. 00	Program routine service cost (line 9 x line	71)		•			72
	Medically necessary private room cost applic		7	•			73
. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				art II. column		74
	26, line 45)		. (,		
. 00	Per diem capital-related costs (line 75 ÷ li						76
00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						78
	Aggregate charges to beneficiaries for exces		provi der record	(et			79
00	Total Program routine service costs for comp		cost limitation	າ (line 78 min	us line 79)		80
. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81
	Reasonable inpatient routine service costs (•				83
	Program inpatient ancillary services (see in	structi ons)					84
. 00 . 00							1 0 5
. 00	Utilization review - physician compensation						85
. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:	of lines 83 th					86

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 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			1, 341, 157	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	261, 478	3, 037, 327	0. 08608	1, 341, 157	115, 458	90.00
91.00 Nursing Program cost	0	3, 037, 327	0.00000	0 1, 341, 157	0	91.00
92.00 Allied health cost	0	3, 037, 327	0.00000	0 1, 341, 157	0	92.00
93.00 All other Medical Education	o	3, 037, 327	0. 00000	0 1, 341, 157	0	93. 00

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1304	Peri od: From 01/01/2023	Worksheet D-1	
		To 12/31/2023	Date/Time Pre 4/26/2024 1:3	
	Title XIX	Hospi tal	Cost	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00 Inpatient days (including private room	n days and swing-bed days, excluding newborn)		1, 540	1.00
2.00 Inpatient days (including private room	days, excluding swing-bed and newborn days)		1, 497	2.00
			اء	

NAMITEM DAYS		Cost Center Description	1.00	
MEATLERT DAYS		DADT I _ ALL DROVLDED COMDONENTS	1. 00	
Inpatient days (including private room days and saing-bed days, excluding newborn) 1,540 1.00				
Inipatient days (including private room days) excluding saing-bed and newborn days) 1,477 2,00 3,00 Private room days (excluding saing-bed and observation bed days). If you have only private room days (excluding saing-bed and observation bed days). If you have only private room days 3,00 6,00 5,00 5,00 6,00 6,00 6,00 7,00	1.00		1, 540	1.00
do not complete this line. do not complete this line. do not complete this line. Total swing-bed SNF type inpatient duys (including private room duys) through December 31 of the cost 45 5.00 Total swing-bed SNF type inpatient duys (including private room duys) after December 31 of the cost 45 5.00 Total swing-bed SNF type inpatient duys (including private room duys) after December 31 of the cost 46 5.00 Total swing-bed SNF type inpatient duys (including private room duys) after December 31 of the cost 47 5.00 Total swing-bed SNF type inpatient duys (including private room duys) after December 31 of the cost 50 7.00 Total swing-bed SNF type inpatient duys (including private room duys) after December 31 of the cost 50 7.00 Total swing-bed SNF type inpatient duys (including private room duys) after December 31 of the cost 50 7.00 Total swing-bed SNF type inpatient duys applicable to the Program (excluding swing-bed and newborn duys) (see Instructions) Swing-bed SNF type inpatient duys applicable to title XVIII only (including private room duys) after 50 7.00 Swing-bed SNF type inpatient duys applicable to title XVIII only (including private room duys) after 50 7.00 Total swing-bed SNF type inpatient duys applicable to title XVIII only (including private room duys) after 50 7.00 Total swing-bed SNF type inpatient duys applicable to title XVIII only (including private room duys) after 50 7.00 Total swing-bed SNF type inpatient duys applicable to title XVIII only (including private room duys) after 50 7.00 Total swing-bed SNF type inpatient duys applicable to title XVIII only (including private room duys) after 50 7.00 Total swing-bed SNF type inpatient duys applicable to title XVIII only (including private room duys) after 50 7.00 Total swing-bed SNF type inpatient duys applicable to services after 50 7.00 Total swing-bed SNF type inpatient duys applicable to services through 50 7.00 Total swing-bed SNF type inpatient duys applicable to services through 50 7.00 Total swing-bed cost applicable to	2.00		1, 497	2.00
Semi_private room days (excluding swing-bed and observation bed days) Semi_private room days aing-bed SMT type inpatient days (Including private room days) after December 31 of the cost reporting period (reporting period (re	3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3.00
Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendary spar, enter 0 on this line) 6.00 7.00				
reporting period (1° calendar year, enter 0 on this line) 7.00 7				4.00
1.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 10	5. 00		43	5. 00
resporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed Ni Type Inpatient days (including private room days) through December 31 of the cost of reporting period resporting period (if calendar year, enter 0 on this line) 9.00 Total Inpatient days (including private room days) after December 31 of the cost on this line) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Modically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Medical roate for swing-bed SNF services applicable to services through December 31 of the cost 18.00 Medical roate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 Medical roate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 Medical roate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 Medical roate for swing-bed SNF services applicable to services after December 31 of the cost 18.00 Medical roate for swing-bed SNF services after December 31 of the cost reporting period (line S X IIIne 19) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line S X IIIne 19) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (l				,
Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost reporting period (17 calendar year, enter 0 on this line) Total inpatient days including private room days) after becember 31 of the cost reporting period (17 calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and reporting period (17 calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and reporting period (18 calendar year, enter 0 on this line) Total inpatient days applicable to the title XVIII only (including private room days) after becember 31 of the cost reporting period (18 calendar year, enter 0 on this line) Through Becamber 31 of the cost reporting period (18 calendar year, enter 0 on this line) Through Becamber 31 of the cost reporting period (18 calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) Through Becamber 31 of the cost reporting period (18 calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) Through Becamber 31 of the cost reporting period (18 calendar year, enter 0 on this line) Market Bed Now Instrument (18 calendar year, enter 0 on this line) Nursery days (title V or XIX only) Nursery days (title V or XIX only) Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (18 cost reporting period	6.00		O	6.00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (in calendar year, enter 0 on this line) 12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (in calendar year, enter 0 on this line) 13. 00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 16. 00 Inclain Jursery days (if the V or XIX only) 17. 00 Medically necessary private room days applicable to services through December 31 of the cost reporting period 18. 00 Medical care rate for awing-bed SNF services applicable to services through December 31 of the cost reporting period 19. 00 Medical care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 20. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 21. 01 December 31 of period may be applicable to SNF type services after December 31 of the cost reporting period (line of SNF type services after December 31 of the cost reporting period (line of SNF type services after December 31 of the cost reporting period (line of SNF type services after December 31	7 00			7 00
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5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 41,418 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				
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7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 952, 519) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 952, 519) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			-	
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x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 90.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 32.00 Average pri vate room per diem charge (line 29 ± line 3) 33.00 Average semi-private room per diem charge (line 30 ± line 4) 34.00 Average per diem private room charge differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 952, 519) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 88.00 Adjusted general inpatient routine service cost (line 9 x line 38) 41, 418 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		7 x line 19)		
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,972.29 38.00 Program general inpatient routine service cost (line 9 x line 38) 41,418 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				
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40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , ,	· ·	
41.00 Total Program general impatient routine service cost (fine 39 + fine 40)				
	41.00	Trotal Frogram general impatrent routine service cost (ITHE 39 + ITHE 40)	41, 418	41.00

Heal th	Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der C	F	eriod: rom 01/01/2023 o 12/31/2023	Worksheet D-1 Date/Time Pre	
						4/26/2024 1: 3	
	Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
	cost center bescription	Inpati ent	Inpatient	Di em (col. 1	Frogram bays	(col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
42.00	MUDCEDY (+: +1 - M 0 MIN1)	1. 00	2. 00	3. 00	4. 00	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT	385, 600	87	4, 432. 18	1	4, 432	43.00
44.00	CORONARY CARE UNIT						44.00
45. 00	BURN INTENSIVE CARE UNIT						45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
						1. 00	
48. 00	Program inpatient ancillary service cost (Wk			III line 10	column 1)	32, 473	1
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines	•			corumn 1)	0 78, 323	
17.00	PASS THROUGH COST ADJUSTMENTS	Tr till ough 10. (01) (300 1113114	0113)		70,020	17.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
E1 00	Deep through costs applicable to Drogram in	ationt anaille	ru corul coo (f	From What D o	um of Dorsto II	0	51.00
51. 00	Pass through costs applicable to Program inpland IV)	atrent anciliar	ry services (i	rom wkst. D, S	um or Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	etist, and	0	53.00
	medical education costs (line 49 minus line	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	
55. 01	Permanent adjustment amount per discharge					0. 00	55. 01
55. 02	Adjustment amount per discharge (contractor					0.00	
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			line 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ring cost and to	arget amount (Title 50 IIITlus	THE 33)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,		m the cost rep	orting period	endi ng 1996,	0. 00	59. 00
	updated and compounded by the market basket)					0.00	(0.00
60. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	om prior year	cost report, u	odated by the	0.00	60.00
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x	ser of 50% of	the amount by	which operating	g costs (line	0	61.00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ber 31 of the	cost reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus line	65)(title XVII	l only); for	0	66. 00
	CAH, see instructions					_	
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	h December 31	of the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after [December 31 of	the cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs	(line 67 + lin	ne 68)		0	69. 00
57.00	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY			
70.00	Skilled nursing facility/other nursing facil	,		•			70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ııne /O ÷ line	: 2)			71.00 72.00
73. 00	Medically necessary private room cost applic	,	m (line 14 x l	ine 35)			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, Pa	art 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		nrovider recor	·ds)			78. 00 79. 00
80.00	Total Program routine service costs for comp				us line 79)		80.00
81.00	Inpatient routine service cost per diem limi	tati on		•	ŕ		81.00
82.00	Inpatient routine service cost limitation (I						82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		115)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ons)				85. 00
86.00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PAS					400	07 00
	Total observation bed days (see instructions Adjusted general inpatient routine cost per		÷ line 2)			1, 972. 29	87. 00 88. 00
						·	

Health Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Ti tl e	e XIX	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			1, 341, 157	89. 00
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	261, 478	3, 037, 327	0. 08608	1, 341, 157	115, 458	90.00
91.00 Nursing Program cost	0	3, 037, 327	0.00000	0 1, 341, 157	0	91.00
92.00 Allied health cost	0	3, 037, 327	0.00000	0 1, 341, 157	0	92.00
93.00 All other Medical Education	o	3, 037, 327	0. 00000	0 1, 341, 157	0	93.00

NPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1304	Peri od:	Worksheet D-3	
				From 01/01/2023 To 12/31/2023	Date/Time Pre 4/26/2024 1:3	pare
		Ti tl e	e XVIII	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			811, 731		30.
1. 00	03100 I NTENSI VE CARE UNI T			69, 980		31.
	ANCILLARY SERVICE COST CENTERS					
0. 00	05000 OPERATING ROOM		0. 2097	13 96, 831	20, 307	50.
1. 00	05100 RECOVERY ROOM		0. 15374	·	3, 230	
3. 00	05300 ANESTHESI OLOGY		0.00000		0	
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 07603		20, 173	1
4. 01	05401 ONCOLOGY		0. 96764		0	
5. 00	05500 RADI OLOGY-THERAPEUTI C		0.00000		0	
0.00	06000 LABORATORY		0. 19928		67, 115	
5. 00	06500 RESPI RATORY THERAPY		0. 80562		51, 106	
5. 00	06600 PHYSI CAL THERAPY		0. 31331		20, 350	
7.00	06700 OCCUPATI ONAL THERAPY		0. 29195		17, 959	
8.00	06800 SPEECH PATHOLOGY		0. 23059		2, 398	
9.00	06900 ELECTROCARDI OLOGY		0.08651		11, 442	
0.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	
1. 00 2. 00	07200 IMPL. DEV. CHARGED TO PATIENT		0. 23585 0. 32559		5, 216 0	
	07300 DRUGS CHARGED TO PATIENTS		0. 34245		92, 315	
3.00	OUTPATIENT SERVICE COST CENTERS		0. 34243	209, 307	92, 313	/3.
8. 00	08800 RURAL HEALTH CLINIC		0.00000	nnl	0	88.
0.00	09000 CLI NI C		2. 19522		0	
0. 01	09001 SURGI CAL ASSOCI ATES		4. 25498		0	
0. 02	09002 ORTHOPAEDI CS		5. 79280		Ö	
0. 03	09003 RHEUMATOLOGY		4. 11063		0	
0. 04	09004 SPECIALTY CLINIC		7. 88948		0	1
0. 05	09005 PEDI ATRI CS		2. 47594		0	
0. 06	09006 WOMEN' S HEALTH		3. 44279		0	
0. 07	09007 PAIN MANAGEMENT		4. 4101		0	1
0. 08	09008 ONCOLOGY MD		0.00000		0	90.
1. 00	09100 EMERGENCY		0. 3656		563	91.
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 98536	64 4, 575	4, 508	92.
	OTHER REIMBURSABLE COST CENTERS					
5. 00	09500 AMBULANCE SERVICES					95.
00.00				1, 350, 278	316, 682	200.
01. 00		rges (line 61)		0		201.
02.00	Net charges (line 200 minus line 201)			1, 350, 278		202.

	ncial Systems RUSH MEMORIAL HOS NCILLARY SERVICE COST APPORTIONMENT		CN: 15-1304	In Li Peri od:	eu of Form CMS-: Worksheet D-3	
71117111211171			CCN: 15-Z304	From 01/01/202 To 12/31/202	3	
		•			4/26/2024 1: 3	
		Title		Swing Beds - Si		
	Cost Center Description		Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x	
				Charges	col. 2)	
			1.00	2. 00	3.00	
	LENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS					30.00
	INTENSIVE CARE UNIT					31.00
	LARY SERVICE COST CENTERS OPERATING ROOM		0. 2097	12	ol o	50.00
	RECOVERY ROOM		0. 2047			
	ANESTHESI OLOGY		0. 00000		ol ö	
	RADI OLOGY-DI AGNOSTI C		0. 0760		-1	
	ONCOLOGY		0. 9676		0 0	1
55.00 05500	RADI OLOGY-THERAPEUTI C		0. 00000	00	0 0	55.00
60.00 06000	LABORATORY		0. 1992	88 8, 56	7 1, 707	60.00
65.00 06500	RESPIRATORY THERAPY		0. 80562	21 20	1 162	65.00
	PHYSI CAL THERAPY		0. 3133°	16, 43	2 5, 148	66.00
	OCCUPATI ONAL THERAPY		0. 2919!			
	SPEECH PATHOLOGY		0. 2305		l e	
	ELECTROCARDI OLOGY		0. 0865		0	
	ELECTROENCEPHALOGRAPHY		0.0000		0 0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT		0. 2358! 0. 3255		1	71.00
	DRUGS CHARGED TO PATTENTS		0. 3255		٥ -	
	ATIENT SERVICE COST CENTERS		0. 3424	30 10, 64	7, 7, 10	73.00
	RURAL HEALTH CLINIC		0. 00000	00	T 0	88. 00
	CLINIC		2. 1952		ol ö	1
	SURGI CAL ASSOCI ATES		4. 25498		o o	1
90. 02 09002	ORTHOPAEDI CS		5. 79280	09	0 0	90. 02
90. 03 09003	RHEUMATOLOGY		4. 1106:	34	0 0	90.03
	SPECIALTY CLINIC		7. 88948		0 0	
	PEDI ATRI CS		2. 4759		0 0	
	WOMEN'S HEALTH		3. 4427		0	
	PAIN MANAGEMENT		4. 4101		0	
1	ONCOLOGY MD		0.0000		0	
1	EMERGENCY		0. 3656		0 0	
	O OBSERVATION BEDS (NON-DISTINCT PART) R REIMBURSABLE COST CENTERS		0. 9853	54	<u>U</u>	92.00
	AMBULANCE SERVICES					95. 00
200. 00	Total (sum of lines 50 through 94 and 96 through 98)			60, 07	0 17, 132	200.00
201. 00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		30,07	ol .,, 132	201.00
202. 00	Net charges (line 200 minus line 201)	/		60, 07	o	202.00
•			•	•	•	•

Cost Center Description	Ti tl	e XIX Ratio of Cos To Charges	From 01/01/2023 To 12/31/2023 Hospi tal t Inpati ent Program	Date/Time Pre 4/26/2024 1:3 Cost Inpatient	epare 37 pm
	Ti ti	Ratio of Cos	t Inpatient	Cost	57 p
			t Inpatient	I npati ent	
INDATIENT POLITINE SERVICE COST CENTERS		To Charges	Program		
INDATIENT POLITINE SERVICE COST CENTERS			Charges	Program Costs (col. 1 x	
INPATIENT POUTINE SERVICE COST CENTERS		1.00	2.00	col . 2) 3.00	
		1.00	2.00	3.00	_
00 03000 ADULTS & PEDIATRICS			39, 696		30.
00 03100 INTENSIVE CARE UNIT			1, 119		31.
ANCI LLARY SERVICE COST CENTERS			.,		1
05000 OPERATING ROOM		0. 2097	32, 995	6, 919	50.
00 05100 RECOVERY ROOM		0. 15374		1, 063	
00 05300 ANESTHESI OLOGY		0. 00000	00	0	53.
00 05400 RADI OLOGY-DI AGNOSTI C		0. 07603	37, 392	2, 843	54
01 05401 0NCOLOGY		0. 96764	12 0	0	54
00 05500 RADI OLOGY-THERAPEUTI C		0. 00000	00	0	55
00 06000 LABORATORY		0. 19928	31, 282	6, 234	60
00 06500 RESPIRATORY THERAPY		0. 80562	21 1, 417	1, 142	65
00 06600 PHYSI CAL THERAPY		0. 31331	16 353	111	66
00 06700 OCCUPATI ONAL THERAPY		0. 29195	55 471	138	67
00 06800 SPEECH PATHOLOGY		0. 23059	97 668	154	68
00 06900 ELECTROCARDI OLOGY		0. 08651	903	78	69
07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 23585	6, 618	1, 561	71
00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 32559		0	72
07300 DRUGS CHARGED TO PATIENTS		0. 34245	21, 589	7, 393	73
OUTPATIENT SERVICE COST CENTERS					
00 08800 RURAL HEALTH CLINIC		2. 15451			
00 09000 CLI NI C		2. 19522		0	
01 09001 SURGI CAL ASSOCI ATES		4. 25498		0	
02 09002 0RTH0PAEDI CS		5. 79280		0	
03 09003 RHEUMATOLOGY		4. 11063		0	
04 09004 SPECIALTY CLINIC		7. 88948		0	
05 09005 PEDI ATRI CS		2. 47594		0	1
06 09006 WOMEN'S HEALTH		3. 44279		0	1
07 09007 PAI N MANAGEMENT		4. 41011		0	
08 09008 0NCOLOGY MD		0.00000		0	
00 09100 EMERGENCY		0. 3656	· ·	4, 837	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 98536	0	0	92
OTHER REIMBURSABLE COST CENTERS		I			۱ ۵۰
00 09500 AMBULANCE SERVICES	00)		150 000	20 470	95
Total (sum of lines 50 through 94 and 96 through			153, 830	32, 473	
OO Less PBP Clinic Laboratory Services-Program only Net charges (line 200 minus line 201)	charges (Tine 61)		0 153, 830		201

He	alth Financial Systems	RUSH MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CA	ALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1304	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 4/26/2024 1:37 pm

		Title XVIII	Hospi tal	4/26/2024 1: 3 Cost	7 pm
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)				1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instructions) OPPS or REH payments				2. 00 3. 00
4. 00	Outlier payment (see instructions)			0	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructi	i ons)		0. 000	5.00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0. 00	6. 00 7. 00
8. 00	Transitional corridor payment (see instructions)			0.00	8.00
9.00	Ancillary service other pass through costs including REH direct	graduate medical educa	ation costs from	0	9. 00
10.00	Wkst. D, Pt. IV, col. 13, line 200			0	10.00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 9, 512, 671	10. 00 11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			7,012,071	
	Reasonabl e charges				
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	o 60)		0	12. 00 13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	e 07)		0	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for pay			0	15.00
16. 00	Amounts that would have been realized from patients liable for plant such payment been made in accordance with 42 CFR §413.13(e)	payment for services of	n a cnargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
18. 00	Total customary charges (see instructions)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lin	ne 18) (see	0	20.00
	instructions)		, (,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
21.00	Lesser of cost or charges (see instructions)			9, 607, 798	
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instruc	rtions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	cti ons)		0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	04 (for CALL oog ingtr	uati ana)	50, 833	
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line 2 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu			5, 727, 673 3, 829, 292	
27.00	instructions)	as the sam of fries 22	und 20] (300	0,027,272	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28. 00
28. 50 29. 00	REH facility payment amount (see instructions)			0	28. 50 29. 00
30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29)			3, 829, 292	
31.00	Pri mary payer payments			889	31.00
32.00	Subtotal (line 30 minus line 31)	2)		3, 828, 403	32.00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES Composite rate ESRD (from Wkst. I-5, line 11)	5)		0	33.00
	Allowable bad debts (see instructions)			556, 864	
	Adjusted reimbursable bad debts (see instructions)			361, 962	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	ctions)		357, 750	
37. 00 38. 00	MSP-LCC reconciliation amount from PS&R			4, 190, 365 0	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			_	39. 50
39. 75 39. 97	N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration			0	39. 75 39. 97
39. 98	Partial or full credits received from manufacturers for replaced	d devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	•	,	0	39. 99
40.00	Subtotal (see instructions)			4, 190, 365	40.00
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			83, 807 0	40. 01 40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			O	40. 03
41. 00	Interim payments			4, 489, 356	41.00
	Interim payments-PARHM			0	41.01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			-382, 798	43.00
43. 01	Balance due provider/program-PARHM (see instructions)		_		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2, o	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00
73.00	Thine varies of money (see thistractions)		l		75.00

Health Financial Systems	RUSH MEMORIAL H	IOSPI TAL	In Lieu of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1304 Peri od:		Worksheet E	
			From 01/01/2023 To 12/31/2023	Date/Time Prepared:	
				4/26/2024 1: 3	7 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days	0	200. 00			

Health Financial Systems RUS

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1304

Title XVIII					10 12/31/2023	4/26/2024 1: 3	
1.00			Ti tl	e XVIII	Hospi tal		
1.00 2.00 3.00 4.00 2.00 3.00 4.00 2.00 3.00 4.489,356 1.00 2.00 1.101 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "MONE" or enter a zero 2.00			Inpatie	nt Part A	Par	t B	
1.00 2.00 3.00 4.00 2.00 3.00 4.00 2.00 3.00 4.489,356 1.00 2.00 1.101 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "MONE" or enter a zero 2.00			mm/dd/\\\\\\	Amount	mm /dd /\\\\\	Amount	
1.00							
InterIm payments payable on Individual bilis, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "MONE" or neter a zero.	1 00	Total interim payments paid to provider	1.00				1 00
Submitted for to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero				707,0			
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	2.00					Ĭ	2.00
write "MONE" or enter a zero							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
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 ADJUSTMENTS TO PROVIDER 3.01 3.02 3.03 3.04 3.05 3.05 3.06 3.07 3.07 3.08 3.09 3.09 3.00 3.00 3.00 3.00 3.00 3.00	3.00						3. 00
payment. If none, write "NONE" or enter a zero. (1)		amount based on subsequent revision of the interim rate					
Program to Provider ADJUSTMENTS TO PROVIDER							
ADJUSTMENTS TO PROVIDER		payment. If none, write "NONE" or enter a zero. (1)					
3.02 0							
3.04 0		ADJUSTMENTS TO PROVIDER					3. 01
3.05 Provider to Program							3. 02
3. 05					-		3. 03
Provider to Program ADJUSTMENTS TO PROGRAM 0							3. 04
3.50 ADJUSTMENTS TO PROGRAM 0 0 3.55 3.51 0 0 0 3.55 3.52 0 0 0 3.55 3.53 0 0 0 3.55 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 3.55 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 0 0 3.55 3.90 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 967,093 4,489,356 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 967,093 4,489,356 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 70 70 70 70 TENTATIVE TO PROVIDER 0 0 5.07 5.01 TENTATIVE TO PROVIDER 0 0 5.57 5.02 5.03 0 0 0 5.57 5.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.00 SETILEMENT TO PROGRAM 0 382,798 6.00 6.01 SETILEMENT TO PROGRAM 0 382,798 6.00 6.02 SETILEMENT TO PROGRAM 0 382,798 6.00 7.00 Total Medicare program liability (see instructions) 0 0 2.00 7.00 Total Medicare program liability (see instructions) 0 0 0 0 7.00 Total Medicare program liability (see instructions) 0 0 0 0 7.00 Total Medicare program liability (see instructions) 0 0 0 0 7.00 Total Medicare program liability (see instructions) 0 0 0 0 7.00 Total Medicare program liability (see instructions) 0 0 0 0 7.00 Total Medicare program liability (see instructions) 0 0 0 0 7.00 Total Medicare program liability (see instructions) 0 0 0 0 7.00 Total Medicare program liability (see instructions) 0 0 0 0 7.00 Total Medicare program liability (see instructions) 0 0 0 0 7.00 Total Medicare program liability (see instructions) 0 0 0 0 7.00 Total Medicare program liability (see instructions) 0 0 0 0 0 7.00 Total Medicare program liability (see instruct	3. 05				0	0	3. 05
3.51 0					-1		
3.52 3.53 3.54 3.99 3.50 3.90 3.50 3.50 3.90 3.50 3.50 3.90 3.50 3.50 3.90 3.50		ADJUSTMENTS TO PROGRAM			-		
3.53 3.54 3.54 0 0 0 3.55					~		
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR					~		
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR					-		
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR		C.ht-t-1 (6 lines 2 01 2 10 minus6 lines			~		
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3. 99				O	0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4 00			047.00	12	4 400 254	4 00
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			907, 09	73	4, 489, 350	4.00
TO BE COMPLETED BY CONTRACTOR S. 00							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider				1			
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00						5.00
Write "NONE" or enter a zero. (1) Program to Provider	0.00						0.00
Program to Provider							
5. 02				•			
5.03 Provider to Program S.50 TENTATIVE TO PROGRAM O	5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
Provider to Program	5.02				0	0	5. 02
TENTATI VE TO PROGRAM	5.03				0	0	5. 03
5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 6.01 Total Medicare program liability (see instructions) 7.00 Total Medicare program liability (see instructions) 8.55 8.57 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.55 90 Subtotal (sum of lines 5.50-5.98) 90 Subtotal (sum of lines 5.50-5.98							
5. 52 0 0 5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 67, 103 0 6. 07 6. 02 SETTLEMENT TO PROGRAM 0 382, 798 6. 02 7. 00 Total Medicare program liability (see instructions) 1, 034, 196 Contractor Number (Mo/Day/Yr) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00		TENTATI VE TO PROGRAM					5. 50
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00							5. 51
5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00							
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99				0	0	5. 99
6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00	6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) 0	. 01				20		, 01
7.00 Total Medicare program liability (see instructions) 1,034,196 Contractor Number (Mo/Day/Yr) 0 1.00 2.00		1		67, 10)3		
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00				1 004 1	U		
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	liotal Medicare program Hability (see Instructions)		1, 034, 19			7.00
0 1.00 2.00							
				0			
	8 00	Name of Contractor			1.00	2.00	8. 00

Provider CCN: 15-1304 | Period: | Worksheet E-1 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 4/2/2024 1: 37 pm Provider CCN: 15-1304

					4/26/2024 1: 3	7 pm
				Swing Beds - SNF		
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4. 00	
1. 00	Total interim payments paid to provider		91, 07	5	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)					
	Program to Provider			_		
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3.03
3. 04				0	0	3. 04
3. 05				0	0	3.05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3. 54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		91, 07	5	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	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					ŀ
5. 01	TENTATI VE TO PROVI DER			o	0	5. 01
5. 02	TENTATIVE TO PROVIDER			0		5.01
5. 03				0		5.02
5. 05	Provider to Program			<u> </u>	0	3.03
5. 50	TENTATI VE TO PROGRAM			ol	0	5.50
5. 51	TENTALI VE TO TROGRAM			o		5.51
5. 52				o	0	5.52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			o		5. 99
0. 77	5. 50-5. 98)					0. //
6. 00	Determined net settlement amount (balance due) based on					6.00
00	the cost report. (1)					5.50
6. 01	SETTLEMENT TO PROVIDER		9, 82	5	o	6. 01
6. 02	SETTLEMENT TO PROGRAM			o	l o	
7. 00	Total Medicare program liability (see instructions)		100, 90	-	l o	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	
8. 00	Name of Contractor					8. 00
				•		

Heal th	Financial Systems RUSH MEMORIAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1304	Peri od:	Worksheet E-1	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre 4/26/2024 1:3	
-		Title XVIII	Hospi tal	Cost	тт ріп
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	I			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 lin	e 14		1.00
2.00 Medicare days (see instructions)					2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 I				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	certified HIT technology	Wkst. S-2, Pt. I		7.00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)				8.00
9. 00	Sequestration adjustment amount (see instructions)				9.00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH		<u> </u>		
	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00 Other Adjustment (specify)					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 H	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1304	Peri od: From 01/01/2023	Worksheet E-2
		Component CCN: 15-Z304		

	Component CCN: 15-Z304		To 12/31/2023	Date/Time Pre 4/26/2024 1:3	
	Title XVIII S				7 рііі
			Swing Beds - SNF Part A	Part B	
	COMPUTATION OF NET COOT OF COVERED OFFINACE		1. 00	2. 00	
1. 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		85, 656	0	1.00
2. 00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A, and sum of Wkst. D,	17, 303	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi			-	
	instructions)				
3. 01	Nursing and allied health payment-PARHM (see instructions)			0.00	3. 01
4. 00	Per diem cost for interns and residents not in approved teach instructions)	ing program (see		0.00	4.00
5. 00	Program days		43	0	5.00
6.00	Interns and residents not in approved teaching program (see i	nstructions)		0	
7. 00	Utilization review - physician compensation - SNF optional me	thod only	0		7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		102, 959	0	8.00
9. 00 10. 00	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		102, 959	0	
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	102, 939	0	11.00
	professional services)	cas. o to p.i.joi oi aii		Ü	
12.00	Subtotal (line 10 minus line 11)		102, 959	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	0	0	13. 00
14. 00	for physician professional services) 80% of Part B costs (line 12 x 80%)			0	14.00
15. 00	Subtotal (see instructions)		102, 959	0	
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	ő	
16. 50	Pioneer ACO demonstration payment adjustment (see instruction				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonst	ration) payment	0		16. 55
16. 99	adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	
18. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)	0	0	1
19. 00	Total (see instructions)		102, 959		
19. 01	Sequestration adjustment (see instructions)		2, 059	0	
19. 02 19. 03	Demonstration payment adjustment amount after sequestration) Sequestration adjustment-PARHM pass-throughs		U	0	19.02
19. 25	Sequestration for non-claims based amounts (see instructions)		0	0	1
20.00	Interim payments		91, 075	0	20.00
20. 01	Interim payments-PARHM				20. 01
21. 00 21. 01	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)		0	0	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.0	2. 19.25. 20. and 21)	9, 825	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	ration) Adivotment			
200.00	Rural Community Hospital Demonstration Project (§410A Demonstration per User this the first year of the current 5-year demonstration per User the Community Hospital Demonstration Project (§410A Demonstration Project (§4				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201. 00
202 00	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst D-3 col 3 lin	<u>e</u>		202.00
202.00	200 (title XVIII swing-bed SNF))	wkst. b 3, cor. 3, 1111			202.00
	Total (sum of lines 201 and 202)				203. 00
204.00	00 Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in period)	first year of the curre	nt 5-year demons	stration	
205.00	Medicare swing-bed SNF target amount				205.00
	00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
	.00 Program reimbursement under the §410A Demonstration (see instructions)		1		207. 00
208.00	.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 and 3)				208. 00
209.00	9.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				209. 00
	Reserved for future use	·			210.00
215 02	Comparision of PPS versus Cost Reimbursement	200 plus lin- 210) (1215 00
∠15.00	Total adjustment to Medicare swing-bed SNF PPS payment (line instructions)	207 prus rine 210) (See			215. 00
	1		- r	1	1

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1304	From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 4/26/2024 1:37 pm
	Title XVIII	Hosni tal	Cost

		T: +1 - \0.0111	Hanni kal	4/26/2024 1: 3	/ pm
		Title XVIII	Hospi tal	Cost	
				1 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	DADT A SERVICES COST	DELMBURCEMENT	1. 00	
1. 00	Inpatient services	PART A SERVICES - COST	KETINDUKSENIENT	1, 215, 427	1. 00
2. 00	Nursing and Allied Health Managed Care payment (see instruction	unc)		1, 213, 427	2.00
		IIIS)		0	
3.00	Organ acqui si ti on			0	3.00
3. 01	Cellular therapy acquisition cost (see instructions)			-	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)			1, 215, 427	4.00
5.00	Primary payer payments			0	5.00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 227, 581	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
7. 00	Reasonable charges Routine service charges		1	0	7. 00
8. 00	1			0	8.00
9. 00	Ancillary service charges			0	9.00
10.00	Organ acquisition charges, net of revenue			0	9. 00 10. 00
10.00	Total reasonable charges Customary charges			U	10.00
11. 00	Aggregate amount actually collected from patients liable for p	aymont for sorvices on	a chargo basis	0	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)		ii a charge basis	·	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 onl	vifling 14 avende li	no 6) (soo	0	15. 00
13.00	instructions)	y II IIIle 14 exceeds II	(366	U	13.00
16. 00	Excess of reasonable cost over customary charges (complete onl	v if line 6 exceeds lin	e 14) (see	0	16. 00
10.00	instructions)	y II IIIIc o exceeds IIII	(300	O	10.00
17. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	17. 00
.,, 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	401.01.0)		5	
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)	,		1, 227, 581	
20.00	Deductibles (exclude professional component)			177, 564	
21. 00	Excess reasonable cost (from line 16)			0	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 050, 017	
23. 00	Coinsurance			0	
24. 00	Subtotal (line 22 minus line 23)			1, 050, 017	
25. 00	Allowable bad debts (exclude bad debts for professional service	es) (see instructions)		8, 131	
26. 00	Adjusted reimbursable bad debts (see instructions)	(000 111011 4011 0110)		5, 285	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		110	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	461.61.6)		1, 055, 302	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions	3)		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, 055, 302	
30. 01	Seguestration adjustment (see instructions)			21, 106	
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Seguestration adjustment-PARHM			_	30. 03
31. 00	Interim payments			967, 093	
31. 01	Interim payments-PARHM			,	31. 01
32. 00	Tentative settlement (for contractor use only)			0	32. 00
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.02	. 31, and 32)		67, 103	
33. 01	Balance due provider/program-PARHM (Lines 2, 3, 18, and 26, mi		and 32, 01)	21, 100	33. 01
34.00	Protested amounts (nonallowable cost report items) in accordan		′ '	0	
	§115. 2	· · · · · · · · · · · · · · · · · · ·	, ,		
	•			. '	

Health Financial Systems	RUSH MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10)
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1304	Peri od: Worksheet E-3 From 01/01/2023 Part VII To 12/31/2023 Date/Time Prepared:	-

			10 12/31/2023	Date/lime Pre 4/26/2024 1:3	
		Title XIX	Hospi tal	Cost	7 рііі
		THE SALK	Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	THE PORT OF THE PROPERTY OF TH	7. OZ. (1. OZ. OZ. OZ. OZ. OZ. OZ. (1. OZ. OZ. OZ. OZ. OZ. OZ. OZ. OZ. OZ. OZ		1
1. 00	Inpatient hospital/SNF/NF services		78, 323		1.00
2. 00	Medical and other services			0	
3. 00	Organ acquisition (certified transplant programs only)		0	Ü	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		78, 323	0	
5. 00	Inpatient primary payer payments		0	Ü	5.00
6. 00	Outpatient primary payer payments			0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		78, 323	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		707020		7.00
	Reasonable Charges				1
8. 00	Routine service charges		40, 815		8.00
9.00	Ancillary service charges		153, 830	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
	Incentive from target amount computation		0		11.00
	Total reasonable charges (sum of lines 8 through 11)		194, 645	0	
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis	Ç .			
14.00	Amounts that would have been realized from patients liable for	payment for services on	o	0	14.00
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		194, 645	0	16.00
17.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	116, 322	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
	Cost of physicians' services in a teaching hospital (see instr		0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		78, 323	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid			
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0	0	25.00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		٦	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		70, 222	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		78, 323	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	0	30.00
	Excess of reasonable cost (from line 18)		_	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		78, 323	0	
32.00	Deducti bl es		0	0	
	Coinsurance		0	0	
35.00	Allowable bad debts (see instructions) Utilization review		0	Ü	35.00
		1 22)	78, 323	0	
37.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	1 33)	70, 323	0	
	Subtotal (line 36 ± line 37)		78, 323	0	
	Direct graduate medical education payments (from Wkst. E-4)		70, 323	U	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		78, 323	0	
41. 00	Interim payments		82, 127	0	1
41.00	1		-3, 804	0	1
42.00			-3, 604	0	
43.00	chapter 1, §115. 2	ice with own rub 13-2,		U	75.00
	10.14p.co. 1, 3110.2		1		1

Health 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)

Provi der CCN: 15-1304

Peri od: Worksheet G
From 01/01/2023
To 12/31/2023 Date/Time Prepared: 4/26/2024 1:37 pm

	——————————————————————————————————————					4/26/2024 1: 3	7 pm
Cultiest Asset Section Company Compa			General Fund			Plant Fund	
CURRENT ASSETS			1 00			4 00	
1.00 Cash on hand in nanks		CURRENT ASSETS	1.00	2.00	3. 00	4.00	
Notes receivable	1.00	Cash on hand in banks			0	0	1.00
Accounts receivable 24, 946, 388			2, 990, 252		0		
Other receivable 1,486,446 0 0 0 0 0 0 0 0 0			_		0		
All covames for uncol lectible notes and accounts receivable -16,671,998 0 0 0 0,00 0 7.00					0		1
1.00 Propel of expenses					0	1	
Proposition				1	0		
10.00 Due From other Funds FIXED ASSETS				1	0		1
11.00	9.00	Other current assets	0	0	0	0	9. 00
IXLD ASSETS			0	_	0		
12.00 Land Improvements	11. 00		26, 132, 674	0	0	0	11.00
13.00 Land Improvements	12 00		501 262		0		12.00
14.00 Accumul ated depreciation -770, 448 0 0 14.00							
15.00 Buildings					-	•	1
17.00 Leasehold Improvements			24, 230, 312	0	0	0	15. 00
18.00 Accumul ated depreciation 4,996,287 0 0 18.00			-6, 286, 379	1	0	1	1
19.00 Elxed equipment		•	0	- 1	0		1
20.00 Accumulated depreciation		•	4 004 207	_	0	1	1
21.00 Automobiles and trucks					0		1
22.00 Accumulated depreciation 0 0 0 22.00			-1,229,997		0	1	
24.00 Accumulated depreciation -22,950,697 0 0 24.00			Ö	-	0		1
25.00 Minor equipment depreciable 0 0 0 25.00	23.00	Major movable equipment	22, 595, 238	0	0	0	23. 00
Accumula faced depreciation	24.00	Accumulated depreciation	-22, 950, 697	0	0	0	1
17.00 HT designated Assets 0 0 0 0 0 27.00			0	_	0	1	
28. 00 Accumulated depreciation 0 0 0 0 28. 00			0	1	0		1
29. 00 Minor equipment-nondepreciable 0 0 0 0 29. 00 0 0 0 0 0 0 0 0 0			0		0	1	
Total fixed assets (sum of lines 12-29) 21,960,680 0 0 0 0 0 0 0 0 0		· •	0	-	0		
OTHER ASSETS			21, 960, 680		-	1	1
32.00 Deposits on leases 0 0 0 0 0 32.00 33.00 Due from owners/officers 0 0 0 0 0 33.00 34.00 Other assets 0 0 0 0 0 34.00 35.00 Total other assets (sum of lines 31-34) 0 0 0 0 0 35.00 50.00 Total other assets (sum of lines 11, 30, and 35) 48,093,354 0 0 0 0 35.00 50.00 CURRENT LIABILITIES							1
33.00 Due from owners/officers 0 0 0 0 0 33.00	31.00	Investments	0	0	0	0	31.00
33.00 Other assets 0 0 0 0 34.00			0	1	0	1	1
35.00 Total other assets (sum of lines 31-34) 0 0 0 0 0 35.00			0	1	0	1	
36.00 Total assets (sum of lines 11, 30, and 35) 48,093,354 0 0 0 36.00			0	1	0	•	1
CURRENT LIABILITIES			48, 093, 354		_	1	1
38.00 Salaries, wages, and fees payable 1,909,540 0 0 0 38.00 39.00 Payroll taxes payable 1,232,896 0 0 0 39.00 40.00 Notes and loans payable (short term) 2,284,149 0 0 0 0 41.00 41.00 Deferred income 0 0 0 0 41.00 42.00 Accelerated payments 0 0 0 0 42.00 43.00 Due to other funds 0 0 0 0 0 43.00 44.00 Other current liabilities 18,159,604 0 0 0 0 44.00 45.00 Total current liabilities (sum of lines 37 thru 44) 25,124,936 0 0 0 0 0 45.00 LONG TERM LIABILITIES 0 0 0 0 0 0 46.00 Mortgage payable 0 0 0 0 0 0 47.00 Notes payable 0 0 0 0 0 0 48.00 Unsecured loans 0 0 0 0 0 48.00 49.00 Other long term liabilities (sum of lines 46 thru 49) 0 0 0 0 0 0 50.00 Total long term liabilities (sum of lines 45 and 50) 25,124,936 0 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 52.00 General fund balance 54.00 55.00 Donor created - endowment fund balance - unrestricted 0 54.00 55.00 Donor created - endowment fund balance - unrestricted 0 55.00 55.00 Donor created - endowment fund balance - unrestricted 0 55.00 55.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total liabilities (sum of lines 52 thru 58) 22,968,421 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 48,093,357 0 0 0 0 0	00.00		10,0,0,001	<u> </u>	<u> </u>		00.00
39.00 Payrol taxes payable 1, 232,896 0 0 39.00 40.00	37.00	Accounts payable	1, 538, 747	0	0	0	37. 00
40. 00 Notes and Loans payable (short term) 41. 00 Deferred income 42. 00 Accelerated payments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1	0	1	1
41.00 Deferred income 42.00 Accelerated payments 42.00 Accelerated payments 42.00 Due to other funds 42.00 Unit of other funds 43.00 Due to other funds 44.00 Other current liabilities 45.00 Total current liabilities (sum of lines 37 thru 44) 45.00 Total current liabilities 46.00 Mortgage payable 47.00 Notes payable 48.00 Unsecured loans 49.00 Other long term liabilities 40.00 O					0	1	
42.00 Accelerated payments 0 0 0 0 0 43.00 43.00 Due to other funds 0 0 0 0 0 0 43.00 Other current liabilities 18,159,604 0 0 0 0 45.00 Total current liabilities (sum of lines 37 thru 44) 25,124,936 0 0 0 0 45.00 LONG TERM LIABILITIES			2, 284, 149		0		1
43.00 Due to other funds 44.00 Other current liabilities 45.00 Total current liabilities (sum of lines 37 thru 44) 45.00 Total current liabilities (sum of lines 37 thru 44) 45.00 Total current liabilities (sum of lines 37 thru 44) 46.00 Mortgage payable 46.00 Mortgage payable 47.00 Notes payable 48.00 Unsecured loans 49.00 Other long term liabilities 40.00 Total long term long term liabilities 40.00 Total long			0	١	U		
44.00 Other current liabilities				o	0	l o	1
LONG TERM LIABILITIES			18, 159, 604	O	0		1
Mortgage payable 0 0 0 0 0 0 0 0 0	45.00	Total current liabilities (sum of lines 37 thru 44)	25, 124, 936	0	0	0	45. 00
47.00 Notes payable							
48.00 Unsecured Loans 49.00 Other Long term Liabilities 50.00 Total long term Liabilities (sum of Lines 46 thru 49) 50.00 Total liabilities (sum of Lines 46 thru 49) 51.00 Total Liabilities (sum of Lines 45 and 50) CAPITAL ACCOUNTS 52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 55.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total Liabilities and fund balances (sum of Lines 51 and 48,093,357) 50.00 O O O O O O O O O O O O O O O O O O			_		-	-	
49.00 Other long term liabilities 0 0 0 0 0 0 49.00 50.00 Total long term liabilities (sum of lines 46 thru 49) 0 0 0 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 25, 124, 936 0 0 0 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund bal ance 52.00 Specific purpose fund 53.00 Specific purpose fund 54.00 Donor created - endowment fund bal ance - restricted 55.00 Donor created - endowment fund bal ance - unrestricted 56.00 Governing body created - endowment fund bal ance 57.00 Plant fund bal ance - invested in plant 58.00 Plant fund bal ance - reserve for plant improvement, replacement, and expansion 59.00 Total liabilities and fund bal ances (sum of lines 51 and 48,093,357) 0 0 0 0 60.00			_	_	_		
Total long term liabilities (sum of lines 46 thru 49)					_		
Total liabilities (sum of lines 45 and 50) 25, 124, 936 0 0 0 0			_	_	_		
52.00 General fund balance 22,968,421 52.00 53.00 54.00 Donor created - endowment fund balance - restricted 0 54.00 Donor created - endowment fund balance - unrestricted 0 55.00 Governing body created - endowment fund balance 0 56.00 56.00 Flant fund balance - invested in plant 0 57.00 Flant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 22,968,421 0 0 0 0 59.00 0 0 0 0 0 0 0 0 0			25, 124, 936				1
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 66.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 25.00 Constant Specific purpose fund 53.00 Constant Specific purpose fund 53.00 Constant Specific purpose fund 54.00 Constant Specific purpose fund 54.00 Constant Specific purpose fund 55.00 Constant Specific purpose fund 54.00 Constant Specific purpose fund 55.00 Constant Specific purpose fund 54.00 Constant Specific purpose fund 55.00 Cons		CAPITAL ACCOUNTS					
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 48,093,357 0 0 0 60.00			22, 968, 421	1			1
55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 48,093,357 0 0 0 60.00		' ' '		0			1
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 48,093,357) 56.00 57.00 58.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					_	ł	1
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 48,093,357) 0 0 0 0 60.00					_	ł	1
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 48,093,357) 0 0 0 60.00					O		1
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 48,093,357) 0 0 59.00 0 60.00		· ·					1
60.00 Total liabilities and fund balances (sum of lines 51 and 48,093,357 0 0 60.00							
		l · · · · · · · · · · · · · · · · · · ·		1	_		
(46)	60. 00		48, 093, 357	0	0	0	60.00
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Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES RUSH MEMORIAL HOSPITAL

| Period: | Worksheet G-1 | From 01/01/2023 | To 12/21/2023 | Provi der CCN: 15-1304

					To 12/31/2023	Date/Time Pre 4/26/2024 1:3	pared: 7 pm
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3.00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24, 670, 699 -1, 702, 278 22, 968, 421 0 22, 968, 421		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 22, 968, 421		0 0 0 0 0 0 0	0 0 0 0 0	13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund	_		
		6. 00	7. 00	8. 00	_		
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0		0		9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0			0		18. 00 19. 00

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

			10	12/31/2023	Date/IIme Pre 4/26/2024 1:3	
	Cost Center Description		I npati ent	Outpati ent	Total	, p
	•		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		1, 895, 685		1, 895, 685	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		19, 773		19, 773	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)		1, 915, 458		1, 915, 458	10.00
	Intensive Care Type Inpatient Hospital Services			,		
11.00	INTENSIVE CARE UNIT		219, 329		219, 329	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	219, 329		219, 329	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16))	2, 134, 787		2, 134, 787	17.00
18.00	Ancillary services		3, 435, 393	120, 661, 145	124, 096, 538	18.00
19.00	Outpatient services		0	0	0	19.00
20.00	RURAL HEALTH CLINIC		0	2, 950, 390	2, 950, 390	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES		0	838, 013	838, 013	23.00
24.00	CMHC				·	24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00	PROFESSI ONAL FEES		572, 739	13, 699, 585	14, 272, 324	27.00
28.00	Total patient revenues (sum of lines 17-27) (transfer column 3	to Wkst.	6, 142, 919	138, 149, 133	144, 292, 052	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			53, 228, 907		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			0			41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	2)(transfer		53, 228, 907		43.00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems RUSH MEMORIAL H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-1304	Peri od:	Worksheet G-3	
			From 01/01/2023		
			To 12/31/2023		
				4/26/2024 1: 3	/ pili
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir	e 28)		144, 292, 052	1.00
2.00	Less contractual allowances and discounts on patients' accour			93, 909, 022	2.00
3.00	Net patient revenues (line 1 minus line 2)			50, 383, 030	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		53, 228, 907	4.00
5.00	Net income from service to patients (line 3 minus line 4)	,		-2, 845, 877	5.00
	OTHER I NCOME				
6.00	Contributions, donations, beguests, etc			330, 073	6.00
7.00	Income from investments			615, 639	7.00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8.00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			177, 695	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			78, 213	14.00
15.00				0	15.00
16.00		han patients		6, 727	16.00
17.00	Revenue from sale of drugs to other than patients	•		0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			257, 397	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER OPERATING INCOME			106, 679	24.00
24. 01				-932, 827	24. 01
24. 02	CONTRACT PHARMACY			382, 878	24. 02
24. 50	COVI D-19 PHE Fundi ng			121, 125	24.50
25.00	Total other income (sum of lines 6-24)			1, 143, 599	25.00
26.00	Total (line 5 plus line 25)			-1, 702, 278	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
	Net income (or loss) for the period (line 26 minus line 28)			-1, 702, 278	29.00
			· ·		

		DUOL MEMORIA				6.5	
	Financial Systems SIS OF HOSPITAL-BASED RHC/FOHC COSTS	RUSH MEMORIA	Provider C	CN. 1E 1204	In Lie Period:	u of Form CMS-2 Worksheet M-1	
ANALYS	BIS OF HOSPITAL-BASED RHC/FUHC COSTS		Provider C	CIN: 15-1304	From 01/01/2023		
			Component	CCN: 15-8539	To 12/31/2023		
					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)	
	FACULTY WENT THE CARE OTATE COOTS	1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	101 010				404 040	
1.00	Physi ci an	431, 363	0	431, 36		431, 363	
2.00	Physician Assistant	0	0		0 0		
3.00	Nurse Practitioner	645, 477	0	645, 47			
4. 00	Visiting Nurse	0	0		0	0	
5. 00	Other Nurse	0	0		0	0	5.00
6. 00	Clinical Psychologist	00.010	0	00.01	0	0	
7.00	Clinical Social Worker	98, 213	0	98, 21	3 0	98, 213	
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor	0	0		0		7. 11
8. 00 9. 00	Laboratory Technician	560, 688	0	560, 68	٥	0	
	Other Facility Health Care Staff Costs	,	0			560, 688	1
10. 00 11. 00	Subtotal (sum of lines 1 through 9)	1, 735, 741	0	1, 735, 74	31, 960	1, 767, 701 0	1
	Physician Services Under Agreement	U	0		0	1	
12.00	Physician Supervision Under Agreement	U	0		0	0	
13. 00 14. 00	Other Costs Under Agreement	0	0		0	0	13. 00 14. 00
15. 00	Subtotal (sum of lines 11 through 13) Medical Supplies	0	42, 468	42.44	0 20 207	1	
16. 00		0	2, 088	•		12, 081	1
17. 00	Transportation (Health Care Staff) Depreciation-Medical Equipment	0	2,000	2,00	0 0	2, 088 0	1
18. 00	Professional Liability Insurance	0	0		0	0	1
19. 00	Other Health Care Costs	0	0		0	0	
20. 00	Allowable GME Costs	U	0		0	U	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	44, 556	44, 55	-30, 387	14, 169	
22. 00	Total Cost of Health Care Services (sum of	1, 735, 741	44, 556				1
22.00	lines 10, 14, and 21)	1,755,741	44, 550	1,700,27	1, 373	1, 701, 070	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23. 00	Pharmacy	0	0		0 0	0	23. 00
24. 00	Dental	0	0		0 0		1
25. 00	Optometry	0	0		0 0	l o	
25. 01	Tel eheal th	0	0		0 0	0	
25. 02	Chronic Care Management	0	0		0 0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0 0	0	26.00
27. 00	Nonallowable GME costs	-	_			_	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	1
	through 27)						
	FACILITY OVERHEAD			•	•		1
29. 00	Facility Costs	0	39, 409	39, 40	9 0	39, 409	29. 00
30.00	Administrative Costs	271, 520	113, 889	385, 40	-30, 778	354, 631	30.00
31.00	Total Facility Overhead (sum of lines 29 and	271, 520	153, 298	424, 81	8 -30, 778	394, 040	31.00
	30)						

2, 007, 261

197, 854

2, 205, 115

-29, 205

2, 175, 910 32.00

30)

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-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1304	Peri od: From 01/01/2023	Worksheet M-1	
		Component	CCN: 15-8539	To 12/31/2023	Date/Time Pre 4/26/2024 1:3	pared: 7 pm
				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	-165, 458	265, 905	5			1.00
2 00 Dhysisian Assistant		1	N.			2 00

		Adjustments	Net Expenses		
			for		
			Allocation		
			(col. 5 +		
			col. 6)		
		6. 00	7. 00		
	FACILITY HEALTH CARE STAFF COSTS				1
1. 00	Physi ci an	-165, 458	265, 905		1.00
2.00	Physician Assistant	0	0		2.00
3.00	Nurse Practitioner	0	677, 437		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	0		5.00
6.00	Clinical Psychologist	0	0		6.00
7.00	Clinical Social Worker	0	98, 213		7.00
7. 10	Marriage and Family Therapist				7. 10
7. 11	Mental Health Counselor				7. 11
8. 00	Laboratory Techni ci an	0	0		8.00
9. 00	Other Facility Health Care Staff Costs	0	560, 688	l .	9.00
10.00	Subtotal (sum of lines 1 through 9)	-165, 458		l .	10.00
11. 00	Physician Services Under Agreement	103, 430	0 1,002,243	l .	11.00
12. 00	Physician Supervision Under Agreement	0	0	l .	12.00
13. 00	Other Costs Under Agreement	0	0	l .	13.00
	Subtotal (sum of lines 11 through 13)	0	0	l .	14.00
14.00		2 700		l .	
15.00	Medical Supplies	-3, 700			15.00
16.00	Transportation (Health Care Staff)	0	2, 088	l .	16.00
17.00	Depreciation-Medical Equipment	0	0	l .	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)	-3, 700		·	21.00
22.00	Total Cost of Health Care Services (sum of	-169, 158	1, 612, 712		22.00
	lines 10, 14, and 21)				
	COSTS OTHER THAN RHC/FQHC SERVICES				
23.00	Pharmacy	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	Chronic Care Management	0	0		25. 02
26.00	All other nonreimbursable costs	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
29. 00	Facility Costs	0	39, 409		29. 00
30.00	Administrative Costs	0	354, 631	l control of the cont	30.00
31. 00	Total Facility Overhead (sum of lines 29 and	n	394, 040	l .	31.00
550	30)	J	3,,,010		355
32. 00	Total facility costs (sum of lines 22, 28	-169, 158	2, 006, 752		32.00
02.00	and 31)	.57, 100	2,000,702		32.00
	1=/	ļ	1	I	

	Financial Systems	RUSH MEMORIA	L HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C	CN: 15-1304	Peri od:	Worksheet M-2	
			Component	CCN: 15-8539	From 01/01/2023 To 12/31/2023	Date/Time Pre 4/26/2024 1:3	
					RHC I	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1	,	col. 2 or	
		1.00	2.00	2.00	1 x col . 3)	col . 4	
	VISITS AND PRODUCTIVITY	1. 00	2.00	3.00	4. 00	5. 00	
	Positions						
1. 00	Physi ci an	1.60	3, 101	I	1 2		1.00
2. 00	Physician Assistant	0.00		•	1 0		2.00
3. 00	Nurse Practitioner	5. 87		1	1 6		3.00
4. 00	Subtotal (sum of lines 1 through 3)	7. 47			. 8	9, 678	4.00
5.00	Visiting Nurse	0.00		1		0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	1.44	1, 039			1, 039	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
7. 03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7.04
8. 00	Total FTEs and Visits (sum of lines 4	8. 91	10, 717			10, 717	8. 00
9. 00	through 7) Physician Services Under Agreements		0			0	9. 00
9.00	Prhysician Services under Agreements					U	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	FD RHC/FOHC SEI	RVLCES		1.00	
10.00	Total costs of health care services (from Wk					1, 612, 712	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			1, 612, 712	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1. 000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet.	M-1, col. 7, li	ine 31)		394, 040	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			1, 675, 076	15.00
16.00	,					2, 069, 116	
17. 00	Allowable GME overhead (see instructions)					0	17. 00
18. 00	Enter the amount from line 16					2, 069, 116	1
19.00	the second secon					2, 069, 116	
20.00	Total allowable cost of hospital-based RHC/F	UHC services (sum of lines 10	u and 19)		3, 681, 828	20.00

CALCUL	Financial Systems RUSH MEMORIAL F ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC		Peri od: From 01/01/2023	u of Form CMS-2 Worksheet M-3	
SERVI C	ES	Component CCN: 15-8539	To 12/31/2023	Date/Time Pre 4/26/2024 1:3	
		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			3, 681, 828	1
2. 00 3. 00	Cost of injections/infusions and their administration (from W Total allowable cost excluding injections/infusions (line 1 m			279, 587 3, 402, 241	
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	inds frie 2)		10, 717	•
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
6. 00 7. 00	Total adjusted visits (line 4 plus line 5)			10, 717	
7.00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	317.46 of Limit (1)	7.00
			Rate Period N/A	Rate Period 1 (01/01/2023	
			IN/ A	through	
				12/31/2023)	
0.00	Dor visit normant limit (from CNC Dub. 100 04 sharter 0. 520	(or your contractor)	1.00	2.00	0.00
8. 00 9. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions)	. o or your contractor)	0. 00 0. 00	174. 33 174. 33	•
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		0	2, 653	
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contr	•	0	462, 497 39	1
13. 00	Program covered cost from mental health services (line 9 x li	•	0	6, 799	
14.00	Limit adjustment for mental health services (see instructions	•	0	6, 799	
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	469, 296	15. 00 16. 00
16. 01	Total program charges (see instructions)(from contractor's re	*	0	384, 704	1
16. 02	Total program preventive charges (see instructions)(from prov	ider's records)		76, 975	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times			93, 901	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		259, 482	16. 04
16. 05	Total program cost (see instructions)		0	353, 383	16. 05
17.00	Primary payer amounts	(6		0	17.00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(Trom contractor		51, 042	18.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instructio	ns) (from contractor		51, 146	19.00
20.00	records)	:>		252 202	20.00
20. 00 21. 00	Net program cost excluding injections/infusions (see instruct Program cost of vaccines and their administration (from Wkst.	•		353, 383 159, 780	
21. 50	Total program IOP OPPS payments (see instructions)	1, 11110 10)		107,700	21.50
21. 55	Total program IOP Costs (see instructions)				21. 55
21. 60 22. 00	Program IOP coinsurance (see instructions) Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus lina 21 60)		513, 163	21.60
	Allowable bad debts (see instructions)	mirius 1111e 21.00)		0	1
23. 01	Adjusted reimbursable bad debts (see instructions)			0	
24.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		0	1
25. 00 25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
25. 99	Demonstration payment adjustment amount before sequestration	•		0	25. 99
26.00	Net reimbursable amount (see instructions)			513, 163	•
26. 01 26. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			10, 263 0	
27. 00	Interim payments			340, 903	
28. 00	Tentative settlement (for contractor use only)			0	28.00
29. 00 30. 00	Balance due component/program (line 26 minus lines 26.01, 26. Protested amounts (nonallowable cost report items) in accorda			161, 997 0	1
50.00	chapter I, §115.2	TICC WITH OWS FUD. 10-11,	'] 30.00

OMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider Component (CN: 15-1304 CCN: 15-8539	Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-4 Date/Time Pre 4/26/2024 1:3	pared:
		Title	XVIII	RHC I	Cost	, рііі
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	1, 602, 243 0. 000085			1, 602, 243 0. 000000	1. 00 2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	136	1, 8	59 0	0	3. 0
. 00	Injections/infusions and related medical supplies costs (from your records)	2, 823	117, 6	46 0	0	4. 0
. 00	Direct cost of injections/infusions (line 3 plus line 4)	2, 959	119, 50	05	0	5.00
. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 612, 712			1, 612, 712	6.0
. 00	Total overhead (from Wkst. M-2, line 19)	2, 069, 116			2, 069, 116	7.0
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 001835			0. 000000	8.0
0. 00	Overhead cost - injection/infusion (line 7 x line 8)	3, 797			0	9.0
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	6, 756			0	10.0
1.00	Total number of injections/infusions (from your records)	25		41 0	0	
2.00	Cost per injection/infusion (line 10/line 11)	270. 24			0. 00	
3.00	Number of injection/infusion administered to Program beneficiaries	8	1'	97 0	0	13. C
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees	0.140	457 (0	0	13.0
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	2, 162	157, 6	18 0	0	14.0
					COST OF	
					INJECTIONS /	
					I NFUSI ONS AND	
					ADMINISTRATIO N	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	•	f columns 1,		279, 587	15. C
6. 00	Total Program cost of injections/infusions and their admin		s (sum of		159, 780	16. (
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou					

Health Financial Systems	RUSH MEMORIAL	HOSPI TAL		In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR			CCN: 15-1304 : CCN: 15-8539	From 01/01/2023	Worksheet M-5 Date/Time Prepared: 4/26/2024 1:37 pm
				DUC I	Coct

		Component Con. 13-8339	10 12/31/2023	4/26/2024 1: 3	
			RHC I	Cost	
			## ## ## ## ## ## ## ## ## ## ## ## ##	rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			340, 903	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	period. If none, write			
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount				3
	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)				
. 1	Program to Provider				,
)1)2				0	3
12					3
3 4					3
5					3
J	Provider to Program				,
0	11 ovi del 10 11 ogi dili			0	3
1				0	3
2				0	3
3				0	3
4				0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line)	340, 903	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
0	List separately each tentative settlement payment after des	sk review. Also show date o	of		5
	each payment. If none, write "NONE" or enter a zero. (1)				
1	Program to Provider			0	5
2					
3					5
5	Provider to Program				
0	11 ovi doi: to 11 ogi diii			0	5
1				0	5
2				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5
0	Determined net settlement amount (balance due) based on the	e cost report. (1)			6
1	SETTLEMENT TO PROVIDER			161, 997	6
)2	SETTLEMENT TO PROGRAM			0	6
0	Total Medicare program liability (see instructions)			502, 900	7
				(Mo/Day/Yr)	
		0	1. 00	2. 00	
00	Name of Contractor]	8