

PROVIDER NO. 15-2010 SSH - INDIANAPOLIS  
PERIOD FROM 12/01/2007 TO 11/30/2008

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
IN LIEU OF FORM CMS-2552-96 (11/98)

VERSION: 2009.01  
04/07/2009 14:18

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT  
CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S  
PARTS I & II

INTERMEDIARY [ ] AUDITED DATE RECEIVED \_\_\_\_\_ [ ] INITIAL [ ] RE-OPENING  
USE ONLY: [ ] DESK REVIEWED INTERMEDIARY NO. \_\_\_\_\_ [ ] FINAL [ ] MCR CODE

PART I - CERTIFICATION

CHECK XX ELECTRONICALLY FILED COST REPORT DATE: 04/07/2009  
APPLICABLE BOX \_\_\_\_\_ MANUALLY SUBMITTED COST REPORT TIME: 14:18

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 WHERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY SSH - INDIANAPOLIS (15-2010) (PROVIDER NAME(S) AND NUMBER(S)) FOR THE COST REPORTING PERIOD BEGINNING 12/01/2007 AND ENDING 11/30/2008, AND THAT TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT 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.

(SIGNED) \_\_\_\_\_  
OFFICER OR ADMINISTRATOR OF PROVIDER(S)

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

PART II - SETTLEMENT SUMMARY

	TITLE V	TITLE XVIII		TITLE XIX	
		PART A	PART B		
1	HOSPITAL	2	3	4	1
2	SUBPROVIDER I	377218			2
3	SWING BED - SNF				3
4	SWING BED - NF				4
5	SKILLED NURSING FACILITY				5
6	NURSING FACILITY				6
7	HOME HEALTH AGENCY				7
8	OUTPATIENT REHABILITATION PROVIDER				8
9	HEALTH CLINIC				9
100	TOTAL	377218			100

THE ABOVE AMOUNTS REPRESENT 'DUE TO' OR 'DUE FROM' THE APPLICABLE PROGRAM FOR THE ELEMENT OF THE ABOVE COMPLEX INDICATED.

ACCORDING TO THE PAPERWORK REDUCTION ACT OF 1995, NO PERSONS ARE REQUIRED TO RESPOND TO A COLLECTION OF INFORMATION UNLESS IT DISPLAYS A VALID OMB CONTROL NUMBER. THE VALID OMB CONTROL NUMBER FOR THIS INFORMATION COLLECTION IS 0938-0050. THE TIME REQUIRED TO COMPLETE THIS INFORMATION COLLECTION IS ESTIMATED 657 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 THIS FORM, PLEASE WRITE TO: HEALTH CARE FINANCING ADMINISTRATION, 7500 SECURITY BOULEVARD, N2-14-26, BALTIMORE, MARYLAND 21244-1850, AND TO THE OFFICE OF THE INFORMATION AND REGULATORY AFFAIRS, OFFICE OF MANAGEMENT AND BUDGET, WASHINGTON, D.C. 20503.

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HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ADDRESS:

1 STREET: 898 EAST MAIN STREET P.O. BOX: 1  
 1.01 CITY: GREENWOOD STATE: IN ZIP CODE: 46134 COUNTY: JOHNSON 1.01

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

COMPONENT 0	COMPONENT NAME 1	PROVIDER NUMBER 2	DATE CERTIFIED 3	PAYMENT SYSTEM (P,T,O OR N)			
				V 4	XVIII 5	XIX 6	
2	HOSPITAL	15-2010	12/01/1994	N	P	N	2
3	SUBPROVIDER I						3
4	SWING BEDS - SNF						4
5	SWING BEDS - NF						5
6	HOSPITAL-BASED SNF						6
7	HOSPITAL-BASED NF						7
8	HOSPITAL-BASED OLTC						8
9	HOSPITAL-BASED HHA						9
11	SEPARATELY CERTIFIED ASC						11
12	HOSPITAL-BASED HOSPICE						12
14	HOSP-BASED RHC						14
15	OUTPATIENT REHABILITATION PROVID						15
16	RENAL DIALYSIS						16

17 COST REPORTING PERIOD (MM/DD/YYYY) FROM: 12/01/2007 TO: 11/30/2008 17  
 18 TYPE OF CONTROL 1 2 4 18

TYPE OF HOSPITAL/SUBPROVIDER

19 HOSPITAL 2 19  
 20 SUBPROVIDER I 20

OTHER INFORMATION

21	INDICATE IF YOUR HOSPITAL IS EITHER (1) URBAN OR (2) RURAL AT THE END OF THE COST REPORTING PERIOD IN COLUMN 1. IF YOUR HOSPITAL IS GEOGRAPHICALLY CLASSIFIED OR LOCATED IN A RURAL AREA, IS YOUR BED SIZE IN ACCORDANCE WITH CFR 42 412.105 LESS THAN OR EQUAL TO 100 BEDS, ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO.						21
21.01	DOES YOUR FACILITY QUALIFY AND IS CURRENTLY RECEIVING PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR 412.106?			NO			21.01
21.02	HAS YOUR FACILITY RECEIVED GEOGRAPHIC RECLASSIFICATION? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, REPORT IN COLUMN 2 THE EFFECTIVE DATE.						21.02
21.03	ENTER IN COLUMN 1 YOUR GEOGRAPHIC LOCATION EITHER (1) URBAN (2) RURAL. IF YOU ANSWERED URBAN IN COLUMN 1 INDICATE IF YOU RECEIVED EITHER A WAGE OR STANDARD GEOGRAPHIC RECLASSIFICATION TO A RURAL LOCATION, ENTER IN COLUMN 2 'Y' AND 'N' FOR NO. IF COLUMN 2 IS YES, ENTER IN COLUMN 3 THE EFFECTIVE DATE (mm/dd/yyyy) (SEE INSTRUCTION). DOES YOUR FACILITY CONTAIN 100 OR FEWER BEDS IN ACCORDANCE WITH 42 CFR 412.105? ENTER IN COLUMN 4 'Y' FOR YES AND 'N' FOR NO. ENTER IN COLUMN 5 THE PROVIDERS ACTUAL MSA OR CBSA.			1	N	Y	21.03
21.04	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.			1			21.04
21.05	FOR STANDARD GEOGRAPHIC RECLASSIFICATION (NOT WAGE), WHAT IS YOUR STATUS AT THE END OF THE COST REPORTING PERIOD. ENTER (1) URBAN AND (2) RURAL.			1			21.05
21.06	DOES THIS HOSPITAL QUALIFY FOR THE THREE-YEAR TRANSITION OF HOLD HARMLESS PAYMENTS FOR A SMALL RURAL HOSPITAL UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT SERVICES UNDER DRA SECTION 5105? ENTER 'Y' FOR YES AND 'N' FOR NO.			NO			21.06
22	ARE YOU CLASSIFIED AS A REFERRAL CENTER?			NO			22
23	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? IF YES, ENTER CERTIFICATION DATE(S) BELOW			NO			23
23.01	IF THIS IS A MEDICARE CERTIFIED KIDNEY TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.01
23.02	IF THIS IS A MEDICARE CERTIFIED HEART TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.02
23.03	IF THIS IS A MEDICARE CERTIFIED LIVER TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.03
23.04	IF THIS IS A MEDICARE CERTIFIED LUNG TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.04
23.05	IF MEDICARE PANCREAS TRANSPLANTS ARE PERFORMED SEE INSTRUCTIONS FOR ENTERING CERTIFICATION AND TERMINATION DATE.						23.05
23.06	IF THIS IS A MEDICARE CERTIFIED INTESTINAL TRANSPLANT CENTER, ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.06
23.07	IF THIS IS A MEDICARE CERTIFIED ISLET TRANSPLANT CENTER ENTER THE CERTIFICATION DATE IN COL. 2 AND TERMINATION IN COL. 3.						23.07
24	IF THIS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COL 2. AND TERMINATION IN COL. 3.						24
24.01	IF THIS A MEDICARE TRANSPLANT CENTER; ENTER THE CCN (PROVIDER NUMBER) IN COL 2, THE CERTIFICATION DATE OR RECERTIFICATION DATE (AFTER DECEMBER 26, 2007) IN COL 3.						24.01
25	IS THIS A TEACHING HOSPITAL OR AFFILIATED WITH A TEACHING HOSPITAL AND YOU ARE MAKING PAYMENTS FOR I & R?			NO			25
25.01	IS THIS TEACHING PROGRAM APPROVED IN ACCORDANCE WITH CMS PUB. 15-1, CHAPTER 4?			NO			25.01
25.02	IF LINE 25.01 IS YES, WAS MEDICARE PARTICIPATION AND APPROVED TEACHING PROGRAM STATUS IN EFFECT DURING THE FIRST MONTH OF THE COST REPORTING PERIOD? IF YES, COMPLETE WORKSHEET E-3, PART IV. IF NO, COMPLETE WORKSHEET D-2, PART II.			NO			25.02
25.03	AS A TEACHING HOSPITAL, DID YOU ELECT COST REIMBURSEMENT FOR PHYSICIANS' SERVICES AS DEFINED IN CMS PUB. 15-1, SECTION 2148? IF YES, COMPLETE WORKSHEET D-9.			NO			25.03
25.04	ARE YOU CLAIMING COSTS ON LINE 70 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2			NO			25.04
25.05	HAS YOUR FACILITY DIRECT GME FTE CAP (COLUMN 1) OR IME CAP (COLUMN 2) BEEN REDUCED UNDER 42 CFR 413.79(c)(3) OR 42 CFR 412.105(f)(1)(iv)(B)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			NO		NO	25.05
25.06	HAS YOUR FACILITY RECEIVED ADDITIONAL DIRECT GME FTE RESIDENT CAP SLOTS OR IME FTE RESIDENT CAP SLOTS UNDER 42 CFR 413.79(c)(4) OR 42 CFR 412.105(f)(1)(iv)(C)? ENTER 'Y' FOR YES AND 'N' FOR NO IN THE APPLICABLE COLUMNS. (SEE INSTRUCTIONS)			NO		NO	25.06

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 (CONTINUED)

OTHER INFORMATION

26	IF THIS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF SCH STATUS ON LINE 26.01. SUBSCRIPT LINE 26.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.				26
26.01	ENTER THE APPLICABLE SCH DATES:	BEGINNING:	ENDING:		26.01
26.03	IF THIS A SOLE COMMUNITY HOSPITAL (SCH) FOR ANY PART OF THE COST REPORTING PERIOD, ENTER THE NUMBER OF PERIODS WITHIN THIS COST REPORTING PERIOD THAT SCH STATUS WAS IN EFFECT AND THE SCH WAS EITHER PHYSICALLY LOCATED OR CLASSIFIED IN A RURAL AREA.				26.03
26.04	IF LINE 26.03 COLUMN 1 IS GREATER THAN ONE ENTER THE EFFECTIVE DATES (SEE INSTRUCTIONS):	BEGINNING:	ENDING:		26.04
27	DOES THIS HOSPITAL HAVE AN AGREEMENT UNDER EITHER SECTION 1883 OR SECTION 1913 FOR SWING BEDS? IF YES, ENTER THE AGREEMENT DATE (mm/dd/yyyy) IN COLUMN 2.			NO	27
28	IF THIS FACILITY CONTAINS A HOSPITAL-BASED SNF, ARE ALL PATIENTS UNDER MANAGED CARE OR THERE WAS NO MEDICARE UTILIZATION ENTER 'Y', IF 'N' COMPLETE LINES 28.01 AND 28.02.				28
28.01	IF HOSPITAL BASED SNF ENTER APPROPRIATE TRANSITION PERIOD 1, 2, 3, OR 100 IN COL 1, ENTER IN COLS 2 AND 3 THE WAGE INDEX ADJUSTMENT FACTOR BEFORE AND ON OR AFTER OCTOBER 1st				28.01
28.02	ENTER IN COL 1 THE HOSPITAL BASED SNF FACILITY SPECIFIC RATE (FROM YOUR F.I.) IF YOU HAVE NOT TRANSITIONED TO 100% PPS SNF PAYMENT. IN COL 2 ENTER THE FACILITY CLASSIFICATION URBAN(1) OR RURAL(2). IN COL 3, ENTER THE SNF MSA CODE OR TWO CHARACTER CODE IF A RURAL BASED FACILITY. IN COL 4, ENTER THE SNF CBSA CODE OR TWO CHARACTER CODE IF RURAL BASED FACILITY.				28.02
A NOTICE PUBLISHED IN THE 'FEDERAL REGISTER' VOL. 68, NO. 149 AUGUST 4, 2003 PROVIDED FOR AN INCREASE IN THE RUG PAYMENTS BEGINNING 10/01/2003. CONGRESS EXPECTED THIS INCREASE TO BE USED FOR DIRECT PATIENT CARE AND RELATED EXPENSES. ENTER IN COLUMN 1 THE PERCENTAGE OF TOTAL EXPENSES FOR EACH CATEGORY TO TOTAL SNF REVENUE FROM WORKSHEET G-2, PART I, LINE 6, COLUMN 3. INDICATE IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO IF THE SPENDING REFLECTS INCREASES ASSOCIATED WITH DIRECT PATIENT CARE AND RELATED EXPENSES FOR EACH CATEGORY. (SEE INSTRUCTIONS)					
28.03	STAFFING	0.00		N	28.03
28.04	RECRUITMENT	0.00		N	28.04
28.05	RETENTION OF EMPLOYEES	0.00		N	28.05
28.06	TRAINING	0.00		N	28.06
28.07	OTHER (SPECIFY)				28.07
29	IS THIS A RURAL HOSPITAL WITH A CERTIFIED SNF WHICH HAS FEWER THAN 50 BEDS IN THE AGGREGATE FOR BOTH COMPONENTS, USING THE SWING BED OPTIONAL METHOD OF REIMBURSEMENT?			NO	29
30	DOES THIS HOSPITAL QUALIFY AS A RURAL PRIMARY CARE HOSPITAL (RPCH)/CRITICAL ACCESS HOSPITAL (CAH)? SEE 42 CFR 485.606ff.			NO	30
30.01	IF SO, IS THIS THE INITIAL 12 MONTH PERIOD FOR THE FACILITY OPERATED AS A RPCH/CAH? SEE 42 CFR 413.70.				30.01
30.02	IF THIS FACILITY QUALIFIES AS AN RPCH/CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES?				30.02
30.03	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR AMBULANCE SERVICES? IF YES, ENTER IN COLUMN 2 THE DATE OF ELIGIBILITY DETERMINATION (DATE MUST BE ON OR AFTER 12/21/2000)				30.03
30.04	IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 AND THE PROGRAM WOULD BE COST REIMBURSED. IF YES COMPLETE WORKSHEET D-2, PART II.				30.04
31	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR 412.113(c).			NO	31
MISCELLANEOUS COST REPORTING INFORMATION					
32	IS THIS AN ALL-INCLUSIVE RATE PROVIDER? IF YES, ENTER THE METHOD USED (A, B, OR E ONLY) IN COLUMN 2.			NO	32
33	IS THIS A NEW HOSPITAL UNDER 42 CFR 412.300 PPS CAPITAL? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2002, DO YOU ELECT TO BE REIMBURSED AT 100% FEDERAL CAPITAL PAYMENT. ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 2.			NO	33
34	IS THIS A NEW HOSPITAL UNDER 42 CFR 413.40(f)(1)(i) TEFRA?			NO	34
35	HAVE YOU ESTABLISHED A NEW SUBPROVIDER I (EXCLUDED UNIT) UNDER 42 CFR 413.40(f)(1)(i)?			NO	35
PROSPECTIVE PAYMENT SYSTEM (PPS) - CAPITAL					
		V	XVIII	XIX	
36	DO YOU ELECT FULLY PROSPECTIVE PAYMENT METHODOLOGY FOR CAPITAL COSTS?	1	2	3	
36.01	DOES YOUR FACILITY QUALIFY AND RECEIVE PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42CFR412.320?	NO	YES	NO	36
37	DO YOU ELECT HOLD HARMLESS PAYMENT METHODOLOGY FOR CAPITAL COSTS?	NO	NO	NO	37
37.01	IF YOU ARE A HOLD HARMLESS PROVIDER, ARE YOU FILING ON THE BASIS OF 100% OF FEDERAL RATE?	NO	NO	NO	37.01

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WORKSHEET S-2  
 (CONTINUED)

TITLE XIX INPATIENT HOSPITAL SERVICES

38 DO YOU HAVE TITLE XIX INPATIENT HOSPITAL SERVICES? NO 38  
 38.01 IS THIS HOSPITAL REIMBURSED FOR TITLE XIX THROUGH THE COST REPORT EITHER IN FULL OR IN PART? NO 38.01  
 38.02 DOES THE TITLE XIX PROGRAM REDUCE CAPITAL FOLLOWING THE MEDICARE METHODOLOGY? NO 38.02  
 38.03 ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (DUAL CERTIFICATION)? NO 38.03  
 38.04 DO YOU OPERATE AN ICF/MR FACILITY FOR PURPOSES OF TITLE XIX? NO 38.04

40 ARE THERE ANY RELATED ORGANIZATION OR HOME OFFICE COSTS AS DEFINED IN CMS PUB. 15-I, YES 52-880 40  
 CHAPTER 10? IF YES, AND THERE ARE HOME OFFICE COSTS, ENTER IN COLUMN 2 THE HOME OFFICE  
 PROVIDER NUMBER. (SEE INSTRUCTIONS) IF THIS FACILITY IS PART OF A CHAIN ORGANIZATION,  
 ENTER THE NAME AND ADDRESS OF THE HOME OFFICE.

40.01 NAME: SELECT MEDICAL CORPORATION FI/CONTRACTOR'S NAME: FI/CONTRACTOR'S NUMBER: 40.01  
 40.02 STREET: 4714 OLD GETTYSBURG ROAD P.O.BOX: 40.02  
 40.03 CITY: MECHANICSBURG STATE: PA ZIP CODE: 17055 40.03

41 ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A? YES 41  
 42 ARE PHYSICAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? NO 42  
 42.01 ARE OCCUPATIONAL THERAPY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? NO 42.01  
 42.02 ARE SPEECH PATHOLOGY SERVICES PROVIDED BY OUTSIDE SUPPLIERS? YES 42.02  
 43 ARE RESPIRATORY THERAPY SERVICES PROVIDED BY OUTSIDE PROVIDERS? YES 43  
 44 IF YOU ARE CLAIMING COST FOR RENAL SERVICES ON WORKSHEET A, ARE THEY INPAT SERVICES ONLY? YES 44  
 45 HAVE YOU CHANGED YOUR COST ALLOCATION METHODOLOGY FROM THE PREVIOUSLY FILE COST REPORT? NO 45  
 SEE CMS PUB. 15-II, SECTION 3617. IF YES, ENTER THE APPROVAL DATE (mm/dd/yyyy) IN COLUMN 2.

45.01 WAS THERE A CHANGE IN THE STATISTICAL BASIS? 45.01  
 45.02 WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? 45.02  
 45.03 WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? 45.03  
 46 IF YOU ARE PARTICIPATING IN THE NHCQM DEMONSTRATION PROJECT (MUST HAVE A HOSPITAL-BASED SNF) DURING THIS COST REPORTING PERIOD, ENTER THE PHASE. 46

IF THIS FACILITY CONTAINS A PROVIDER THAT QUALIFIES FOR AN EXEMPTION FROM THE APPLICATION OF THE LOWER OF COST OR CHARGES, ENTER A 'Y' FOR EACH COMPONENT AND TYPE OF SERVICE THAT QUALIFIES FOR THE EXEMPTION; ENTER 'N' IF NOT EXEMPT (SEE 42 CFR 413.13).

	PART A	PART B	OUTPATIENT ASC	OUTPATIENT RADIOLOGY	OUTPATIENT DIAGNOSTIC					
	1	2	3	4	5					
47 HOSPITAL	N	N	N	N	N	47				
48 SUBPROVIDER I	N	N	N	N	N	48				
49 SKILLED NURSING FACILITY	N	N				49				
50 HOME HEALTH AGENCY	N	N				50				
52 DOES THIS HOSPITAL CLAIM EXPENDITURES FOR EXTRAORDINARY CIRCUMSTANCES IN ACCORDANCE WITH 42 CFR 412.348(e)?				NO		52				
52.01 IF YOU ARE A FULLY PROSPECTIVE OR HOLD HARMLESS PROVIDER ARE YOU ELIGIBLE FOR THE SPECIAL EXCEPTION PAYMENT PURSUANT TO 42 CFR 412.348(g)? IF YES, COMPLETE L, PART IV.				NO		52.01				
53 IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT. ENTER BEGINNING AND ENDING DATES OF MDH STATUS ON LINE 53.01. SUBSCRIPT LINE 53.01 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.						53				
53.01 MDH PERIOD: BEGINNING: ENDING:						53.01				
54 LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES: PREMIUMS: PAID LOSSES: AND/OR SELF INSURANCE:						54				
54.01 ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.				NO		54.01				
55 DOES YOUR FACILITY QUALIFY FOR ADDITIONAL PROSPECTIVE PAYMENT IN ACCORDANCE WITH 42 CFR 412.107. ENTER 'Y' FOR YES AND 'N' FOR NO.				NO		55				
56 ARE YOU CLAIMING AMBULANCE COSTS? IF YES, ENTER IN COL 2 THE PAYMENT LIMIT PROVIDED FROM YOUR FISCAL INTERMEDIARY. IF THIS IS FIRST YEAR OF OPERATIONS, NO ENTRY IS REQUIRED IN COL 2. IF COL 1 IS 'Y', ENTER 'Y' OR 'N' IN COL 3 WHETHER THIS IS YOUR FIRST YEAR OF OPERATIONS FOR RENDERING AMBULANCE SERVICES. ENTER IN COL 4, IF APPLICABLE, THE FEE SCHEDULES AMOUNTS FOR THE PERIOD BEGINNING ON OR AFTER 4/1/2002.				DATE 0 / / NO	Y/N 1 2 3 4 NO	LIMIT 0.00	Y/N NO	FEE\$		56
57 ARE YOU CLAIMING NURSING AND ALLIED HEALTH COSTS?				NO		57				
58 ARE YOU AN INPATIENT REHABILITATION FACILITY (IRF), OR DO YOU CONTAIN AN IRF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. THIS OPTION IS ONLY AVAILABLE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER 1/1/2002 AND BEFORE 10/1/2002.				NO		58				
58.01 IF LINE 58 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH FR VOL 70, NO 156 DATED AUGUST 15, 2005 PAGE 47929? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS) IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5. (SEE INSTRUCTIONS)						58.01				
59 ARE YOU A LONG TERM CARE HOSPITAL (LTCH), OR DO YOU CONTAIN A LTCH SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES HAVE YOU MADE THE ELECTION FOR 100% PPS REIMBURSEMENT? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)				YES		59				

HOSPITAL AND HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2  
 (CONTINUED)

60	ARE YOU AN INPATIENT PSYCHIATRIC FACILITY (IPF), OR DO YOU CONTAIN AN IPF SUBPROVIDER? ENTER IN COLUMN 1 'Y' FOR YES AND 'N' FOR NO. IF YES, IS THE IPF OR IPF SUBPROVIDER A NEW FACILITY? ENTER IN COLUMN 2 'Y' FOR YES AND 'N' FOR NO. (SEE INSTRUCTIONS)	NO	60
60.01	IF LINE 60 COLUMN 1 IS Y, DOES THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. IS THE FACILITY TRAINING RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR SEC. 412.424(d)(1)(iii)(2)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3 (SEE INSTRUCTIONS). IF THE CURRENT COST REPORTING PERIOD COVERS THE BEGINNING OF THE FOURTH ENTER 4 IN COLUMN 3, OR IF THE SUBSEQUENT ACADEMIC YEARS OF THE NEW TEACHING PROGRAM IN EXISTENCE, ENTER 5 (SEE INSTR.)		60.01
MULTICAMPUS			
61	DOES THE HOSPITAL HAVE A MULTICAMPUS? ENTER 'Y' FOR YES AND 'N' FOR NO. IF LINE 61 IS YES, ENTER THE NAME IN COL. 0, COUNTY IN COL. 1, STATE IN COL. 2, ZIP IN COL. 3, CBSA IN COL. 4 AND FTE/CAMPUS IN COL. 5.	NO	61
	COUNTY: 1	STATE: 2	ZIP CODE 3
		CBSA 4	FTE/ CAMPUS 5
SETTLEMENT DATA			
63	WAS THE COST REPORT FILED USING THE PS&R (EITHER IN ITS ENTIRETY OR FOR TOTAL CHARGES AND DAYS ONLY)? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF COLUMN 1 IS 'Y', ENTER THE 'PAID THROUGH' DATE OF THE PS&R IN COLUMN 2 (mm/dd/yyyy)	NO	63





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HOSPITAL AND HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3  
 PART I  
 (CONTINUED)

COMPONENT	-----DISCHARGES-----				TOTAL ALL PATIENTS	
	TITLE	TITLE	TITLE			
	V	XVIII	XIX			
	12	13	14	15		
1	HOSPITAL ADULTS & PEDS, EXCL. SWING BED, OBSERV & HOSPICE DAYS		175		216	1
2	HMO XIX					2
3	HOSPITAL ADULTS & PEDS - SWING BED SNF					3
4	HOSPITAL ADULTS & PEDS - SWING BED NF					4
5	TOTAL ADULTS & PEDS EXCL OBSERVATION BEDS					5
6	INTENSIVE CARE UNIT					6
7	CORONARY CARE UNIT					7
8	BURN INTENSIVE CARE UNIT					8
9	SURGICAL INTENSIVE CARE UNIT					9
10	OTHER SPECIAL CARE (SPECIFY)					10
11	NURSERY					11
12	TOTAL HOSPITAL		175		216	12
13	RPCH VISITS					13
14	SUBPROVIDER I					14
15	SKILLED NURSING FACILITY					15
16	NURSING FACILITY					16
17	OTHER LONG TERM CARE					17
18	HOME HEALTH AGENCY					18
20	ASC (DISTINCT PART)					20
21	HOSPICE (DISTINCT PART)					21
23	O/P REHAB PROVIDER					23
24	RHC I					24
25	TOTAL					25
26	OBSERVATION BED DAYS					26
27	AMBULANCE TRIPS					27
28	EMPLOYEE DISCOUNT DAYS					28

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HOSPITAL WAGE INDEX INFORMATION							WORKSHEET S-3	
PART II - WAGE DATA		AMOUNT	RECLASS. OF SALARIES FROM WKST.	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	DATA SOURCE	PART II
		1	A-6	3	4	5	6	
SALARIES								
1	TOTAL SALARIES	3423709			121074.00			1
2	NON-PHYSICIAN ANESTHETIST PART A							2
3	NON-PHYSICIAN ANESTHETIST PART B							3
4	PHYSICIAN - PART A							4
4.01	TEACHING PHYSICIAN SALARIES							4.01
5	PHYSICIAN - PART B							5
5.01	NON-PHYSICIAN - PART B							5.01
6	INTERNS & RESIDENTS (IN APPR PGM)							6
6.01	CONTRACT SERVICES, I&R							6.01
7	HOME OFFICE PERSONNEL							7
8	SNF							8
8.01	EXCLUDED AREA SALARIES		14018		1129.00			8.01
	OTHER WAGES & RELATED COSTS							
9	CONTRACT LABOR	1172681			22674.00			9
9.01	PHARMACY SERVICES UNDER CONTRACT							9.01
9.02	LABORATORY SERVICES UNDER CONTRACT							9.02
9.03	MANAGEMENT AND ADMINISTRATIVE SERVICES'							9.03
10	CONTRACT LABOR: PHYSICIAN PART A	326517			4598.00			10
10.01	TEACHING PHYSICIAN UNDER CONTRACT							10.01
11	HOME OFFICE SALARIES & WAGE REL COSTS	216561			7549.00			11
12	HOME OFFICE: PHYSICIAN PART A							12
12.01	TEACHING PHYSICIAN SALARIES							12.01
	WAGE-RELATED COSTS							
13	WAGE RELATED COSTS (CORE)	613922				CMS 339		13
14	WAGE RELATED COSTS (OTHER)					CMS 339		14
15	EXCLUDED AREAS					CMS 339		15
16	NON-PHYSICIAN ANESTHETIST PART A					CMS 339		16
17	NON-PHYSICIAN ANESTHETIST PART B					CMS 339		17
18	PHYSICIAN PART A					CMS 339		18
18.01	PART A TEACHING PHYSICIANS					CMS 339		18.01
19	PHYSICIAN PART B					CMS 339		19
19.01	WAGE RELATED COSTS (RHC/FQHC)					CMS 339		19.01
20	INTERNS & RESIDENTS (IN APPR PGM)					CMS 339		20
	OVERHEAD COSTS - DIRECT SALARIES							
21	EMPLOYEE BENEFITS	573			10.63			21
22	ADMINISTRATIVE & GENERAL	513311	-14018		10591.00			22
22.01	ADMINISTRATIVE & GENERAL UNDER CONTACT							22.01
23	MAINTENANCE & REPAIRS							23
24	OPERATION OF PLANT							24
25	LAUNDRY & LINEN SERVICE							25
26	HOUSEKEEPING							26
26.01	HOUSEKEEPING UNDER CONTRACT							26.01
27	DIETARY	36671			2095.00			27
27.01	DIETARY UNDER CONTRACT							27.01
28	CAFETERIA							28
29	MAINTENANCE OF PERSONNEL							29
30	NURSING ADMINISTRATION	68258			1320.00			30
31	CENTRAL SERVICES AND SUPPLY							31
32	PHARMACY							32
33	MEDICAL RECORDS & MEDICAL RECORDS LIBR	51814			1707.00			33
34	SOCIAL SERVICE							34
35	OTHER GENERAL SERVICE							35

HOSPITAL WAGE INDEX INFORMATION							WORKSHEET S-3
PART III - HOSPITAL WAGE INDEX SUMMARY		AMOUNT	RECLASS. OF SALARIES FROM WKST.	ADJUSTED SALARIES (COL.1 + COL.2)	PAID HOURS RELATED TO SALARY IN COL.3	AVERAGE HOURLY WAGE (COL.3 / COL.4)	PART III
		1	A-6	3	4	5	
1	NET SALARIES	3423709		3423709	121074.00	28.28	1
2	EXCLUDED AREA SALARIES		14018	14018	1129.00	12.42	2
3	SUBTOTAL SALARIES (LINE 1 MINUS LINE 2)	3423709	-14018	3409691	119945.00	28.43	3
4	SUBTOTAL OTHER WAGES & REL COSTS	1715759		1715759	34821.00	49.27	4
5	SUBTOTAL WAGE-RELATED COSTS	613922		613922		18.018	5
6	TOTAL (SUM OF LINES 3 THRU 5)	5753390	-14018	5739372	154766.00	37.08	6
7	NET SALARIES						7
8	EXCLUDED AREA SALARIES						8
9	SUBTOTAL SALARIES (LINE 7 MINUS LINE 8)						9
10	SUBTOTAL OTHER WAGES & REL COSTS						10
11	SUBTOTAL WAGE-RELATED COSTS						11
12	TOTAL (SUM OF LINES 9 THRU 11)						12
13	TOTAL OVERHEAD COSTS	670627	-14018	656609	15723.63	41.76	13

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NHCMQ DEMONSTRATION STATISTICAL DATA  
 STATISTICAL DATA

WORKSHEET S-7

GROUP	M3PI REVENUE CODE	SERVICES PRIOR TO JANUARY 1		SERVICES ON OR AFTER JANUARY 1		TOTAL
		RATE	DAYS	RATE	DAYS	
1	2	3	3.01	4	4.01	5
1	RVC/RUC					1
2	RVB/RUB					2
3	RVA/RUA					3
3.01	RUX					3.01
3.02	RUL					3.02
4	RHD/RVC					4
5	RHC/RVB					5
6	RHB/RVA					6
6.01	RVX					6.01
6.02	RVL					6.02
7	RHA/RHC					7
8	RMC/RHB					8
9	RMB/RHA					9
9.01	RHX					9.01
9.02	RHL					9.02
10	RMA/RMC					10
11	RLB/RMB					11
12	RLA/RMA					12
12.01	RMX					12.01
12.02	RML					12.02
13	SE3/RLB					13
14	SE2/RLA					14
14.01	RLX					14.01
15	SE1/SE3					15
16	SSC/SE2					16
17	SSB/SE1					17
18	SSA/SSC					18
19	CD2/SSB					19
20	CD1/SSA					20
21	CC2					21
22	CC1					22
23	CB2					23
24	CB1					24
25	CA2					25
26	CA1					26
27	IB2					27
28	IB1					28
29	IA2					29
30	IA1					30
31	BB2					31
32	BB1					32
33	BA2					33
34	BA1					34
35	PE2					35
36	PE1					36
37	PD2					37
38	PD1					38
39	PC2					39
40	PC1					40
41	PB2					41
42	PB1					42
43	PA2					43
44	PA1					44
45	DEFAULT RATE					45
46	TOTAL					46

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

COST CENTER		SALARIES	OTHER	TOTAL	RECLASSI- FICATIONS	RECLASS. TRIAL BALANCE	ADJUST- MENTS	NET EXP FOR ALLOCATION
		1	2	3	4	5	6	7
GENERAL SERVICE COST CENTERS								
1	0100 OLD CAP REL COSTS-BLDG & FIXT							1
2	0200 OLD CAP REL COSTS-MVBLE EQUIP							2
3	0300 NEW CAP REL COSTS-BLDG & FIXT				490936	490936		3
4	0400 NEW CAP REL COSTS-MVBLE EQUIP		1207869	1207869	-783599	424270	48949	4
5	0500 EMPLOYEE BENEFITS	573	-2448		12175	10300		5
6	0600 ADMINISTRATIVE & GENERAL	513311	1249831	1763142	100427	1863569	-407697	6
7	0700 MAINTENANCE & REPAIRS							7
8	0800 OPERATION OF PLANT				118400	118400		8
9	0900 LAUNDRY & LINEN SERVICE		62988	62988		62988		9
10	1000 HOUSEKEEPING		83132	83132	41773	124905		10
11	1100 DIETARY	36671	79813	116484		116484		11
12	1200 CAFETERIA							12
13	1300 MAINTENANCE OF PERSONNEL							13
14	1400 NURSING ADMINISTRATION	68258	8873	77131		77131		14
15	1500 CENTRAL SERVICES & SUPPLY							15
16	1600 PHARMACY							16
17	1700 MEDICAL RECORDS & LIBRARY	51814	22448	74262		74262	-2378	17
18	1800 SOCIAL SERVICE							18
20	2000 NONPHYSICIAN ANESTHETISTS							20
21	2100 NURSING SCHOOL							21
22	2200 I&R SERVICES-SALARY & FRINGES A							22
23	2300 I&R SERVICES-OTHER PRGM COSTS A							23
24	2400 PARAMED ED PRGM-(SPECIFY)							24
INPATIENT ROUTINE SERV COST CENTERS								
25	2500 ADULTS & PEDIATRICS	1812968	1724000	3536968		3536968		25
ANCILLARY SERVICE COST CENTERS								
37	3700 OPERATING ROOM		138664	138664		138664		37
41	4100 RADIOLOGY-DIAGNOSTIC		219516	219516		219516		41
44	4400 LABORATORY		720860	720860		720860		44
46.30	4650 BLOOD CLOTTING FACTORS ADMIN CO							46.30
49	4900 RESPIRATORY THERAPY	376157	192095	568252		568252		49
50	5000 PHYSICAL THERAPY	87247	74265	161512		161512		50
51	5100 OCCUPATIONAL THERAPY	59682	32585	92267		92267		51
52	5200 SPEECH PATHOLOGY	81	50823	50904		50904		52
53.01	3950 RENAL DIALYSIS	172422	49800	222222		222222		53.01
55	5500 MEDICAL SUPPLIES CHARGED TO PAT	43339	546971	590310		590310		55
56	5600 DRUGS CHARGED TO PATIENTS	201186	649791	850977		850977		56
OUTPATIENT SERVICE COST CENTERS								
62	6200 OBSERVATION BEDS (NON-DISTINCT							62
63.50	6310 RHC							63.50
63.60	6320 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS								
69.10	6910 CMHC							69.10
69.20	6920 OUTPATIENT PHYSICAL THERAPY							69.20
69.30	6930 OUTPATIENT OCCUPATIONAL THERAPY							69.30
69.40	6940 OUTPATIENT SPEECH PATHOLOGY							69.40
71	7100 HOME HEALTH AGENCY							71
SPECIAL PURPOSE COST CENTERS								
85.01	8510 PANCREAS ACQUISITION							85.01
85.02	8520 INTESTINAL ACQUISITION							85.02
85.03	8530 ISLET CELL ACQUISITION							85.03
95	SUBTOTALS	3423709	7111876	10535585	-19888	10515697	-361126	10154571
NONREIMBURSABLE COST CENTERS								
100	7950 PROVIDER RELATIONS NRCC				19888	19888		19888
101	TOTAL	3423709	7111876	10535585		10535585	-361126	10174459

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RECLASSIFICATIONS

WORKSHEET A-6  
 PAGE 1

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	----- INCREASE -----			
		COST CENTER	LINE #	SALARY	
1		2	3	4	5
1 FACILITY RENT	A	NEW CAP REL COSTS-BLDG & FIXT	3		651109 1
2 EMPLOYEE BENEFITS	B	EMPLOYEE BENEFITS	5		12175 2
3 OPERATING PORTION OF THE LEASE	C	OPERATION OF PLANT	8		118400 3
4 OPERATING PORTION OF THE LEASE	C	HOUSEKEEPING	10		41773 4
5 CAPITAL RECONCILIATION	D	ADMINISTRATIVE & GENERAL	6		132490 5
6 PROVIDER RELATIONS NRCC	E	PROVIDER RELATIONS NRCC	100	14018	5870 6
7					7
8					8
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
35					35
36 TOTAL RECLASSIFICATIONS				14018	961817 36

RECLASSIFICATIONS

WORKSHEET A-6  
 PAGE 1

EXPLANATION OF RECLASSIFICATION ENTRY	CODE	COST CENTER	DECREASE		OTHER	WKST A-7 REF.
			LINE #	SALARY		
1	1	6	7	8	9	10
1 FACILITY RENT	A	NEW CAP REL COSTS-MVBLE EQUIP	4		651109	10 1
2 EMPLOYEE BENEFITS	B	ADMINISTRATIVE & GENERAL	6		12175	2
3 OPERATING PORTION OF THE LEASE	C	NEW CAP REL COSTS-BLDG & FIXT	3		118400	10 3
4 OPERATING PORTION OF THE LEASE	C	NEW CAP REL COSTS-BLDG & FIXT	3		41773	10 4
5 CAPITAL RECONCILIATION	D	NEW CAP REL COSTS-MVBLE EQUIP	4		132490	12 5
6 PROVIDER RELATIONS NRCC	E	ADMINISTRATIVE & GENERAL	6	14018	5870	6
7						7
8						8
9						9
10						10
11						11
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
22						22
23						23
24						24
25						25
26						26
27						27
28						28
29						29
30						30
31						31
32						32
33						33
34						34
35						35
36 TOTAL RECLASSIFICATIONS				14018	961817	36

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ANALYSIS OF CHANGES DURING COST REPORTING  
 PERIOD IN CAPITAL ASSET BALANCES OF HOSPITAL  
 AND HOSPITAL HEALTH CARE COMPLEX CERTIFIED  
 TO PARTICIPATE IN HEALTH CARE PROGRAMS

WORKSHEET A-7  
 PARTS I & II

PART I - ANALYSIS OF CHANGES IN OLD CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	----- ACQUISITIONS -----			DISPOSALS	ENDING	FULLY
	BALANCES	PURCHASE	DONATION	TOTAL	AND	BALANCE	DEPRECIATED
	1	2	3	4	RETIREMENTS	6	ASSETS
					5		7
1 LAND							1
2 LAND IMPROVEMENTS							2
3 BUILDINGS AND FIXTURES							3
4 BUILDING IMPROVEMENTS							4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT							6
7 SUBTOTAL							7
8 RECONCILING ITEMS							8
9 TOTAL							9

PART II - ANALYSIS OF CHANGES IN NEW CAPITAL ASSET BALANCES

DESCRIPTION	BEGINNING	----- ACQUISITIONS -----			DISPOSALS	ENDING	FULLY
	BALANCES	PURCHASE	DONATION	TOTAL	AND	BALANCE	DEPRECIATED
	1	2	3	4	RETIREMENTS	6	ASSETS
					5		7
1 LAND							1
2 LAND IMPROVEMENTS							2
3 BUILDINGS AND FIXTURES							3
4 BUILDING IMPROVEMENTS	1879011				1266575	612436	4
5 FIXED EQUIPMENT							5
6 MOVABLE EQUIPMENT	2081131	519360		519360		2600491	6
7 SUBTOTAL	3960142	519360		519360	1266575	3212927	7
8 RECONCILING ITEMS							8
9 TOTAL	3960142	519360		519360	1266575	3212927	9

PART III - RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7  
 PARTS III & IV

DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL			TOTAL
	GROSS ASSETS	CAPITALIZED LEASES	GROSS ASSETS FOR RATIO	RATIO	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	
	1	2	3	4	5	6	7	8
1 OLD CAP REL COSTS-BLDG & FIXT				.000000				1
2 OLD CAP REL COSTS-MVBLE EQUIP				.000000				2
3 NEW CAP REL COSTS-BLDG & FIXT	612436		612436	.190616				3
4 NEW CAP REL COSTS-MVBLE EQUIP	2600491		2600491	.809384				4
5 TOTAL	3212927		3212927	1.000000				5

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL-RELATED COSTS	TOTAL
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES		
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT			490936				490936 3
4 NEW CAP REL COSTS-MVBLE EQUIP	451055				20980	1184	473219 4
5 TOTAL	451055	490936			20980	1184	964155 5

PART IV - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 THRU 4

DESCRIPTION	SUMMARY OF OLD AND NEW CAPITAL					OTHER CAPITAL-RELATED COSTS	TOTAL
	DEPRECIATION	LEASE	INTEREST	INSURANCE	TAXES		
	9	10	11	12	13	14	15
1 OLD CAP REL COSTS-BLDG & FIXT							1
2 OLD CAP REL COSTS-MVBLE EQUIP							2
3 NEW CAP REL COSTS-BLDG & FIXT							3
4 NEW CAP REL COSTS-MVBLE EQUIP	402106	651109		132490	20980	1184	1207869 4
5 TOTAL	402106	651109		132490	20980	1184	1207869 5

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

DESCRIPTION	BASIS	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/ FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7
			COST CENTER	LINE NO.	
	1	2	3	4	5
1			OLD CAP REL COSTS-BLDG & FIXT	1	1
2			OLD CAP REL COSTS-MVBLE EQUIP	2	2
3			NEW CAP REL COSTS-BLDG & FIXT	3	3
4			NEW CAP REL COSTS-MVBLE EQUIP	4	4
5					5
6					6
7					7
8					8
9					9
10					10
11					11
12	PROVIDER-BASED PHYSICIAN ADJUSTMENT				
	WKST				
	A-8-2				12
13	SALE OF SCRAP, WASTE, ETC.				13
14	RELATED ORGANIZATION TRANSACTIONS				
	WKST				
	A-8-1	169846			14
15	LAUNDRY AND LINEN SERVICE				15
16	CAFETERIA - EMPLOYEES AND GUESTS				16
17	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS				17
18	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS				18
19	SALE OF DRUGS TO OTHER THAN PATIENTS				19
20	SALE OF MEDICAL RECORDS AND ABSTRACTS				20
21	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)				21
22	VENDING MACHINES				22
23	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES				23
24	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENT				24
25	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST	RESPIRATORY THERAPY	49	25
	A-8-4				
26	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST	PHYSICAL THERAPY	50	26
	A-8-4				
27	ADJ FOR HHA PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION	WKST	HOME HEALTH AGENCY	71	27
	A-8-3				
28	UTIL REVIEW-PHYSICIANS' COMPENSATION		UTILIZATION REVIEW-SNF	89	28
29	DEPRECIATION--OLD BUILDINGS & FIXTURES		OLD CAP REL COSTS-BLDG & FIXT	1	29
30	DEPRECIATION--OLD MOVABLE EQUIPMENT		OLD CAP REL COSTS-MVBLE EQUIP	2	30
31	DEPRECIATION--NEW BUILDINGS & FIXTURES		NEW CAP REL COSTS-BLDG & FIXT	3	31
32	DEPRECIATION--NEW MOVABLE EQUIPMENT		NEW CAP REL COSTS-MVBLE EQUIP	4	32
33	NON-PHYSICIAN ANESTHETIST		NONPHYSICIAN ANESTHETISTS	20	33
34	PHYSICIANS' ASSISTANT				34
35	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST			
	WKST A-8-4				35
36	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION - HOSPITAL	WKST	SPEECH PATHOLOGY	52	36
	WKST A-8-4				
37	BAD DEBT ALLOCATION	A	ADMINISTRATIVE & GENERAL	6	37
		-546502			
38	MEDICAL RECORDS INCOME	B	MEDICAL RECORDS & LIBRARY	17	38
		-2378			
39	GIFTS	A	ADMINISTRATIVE & GENERAL	6	39
		-41			
40	RESEARCH COSTS	A	NEW CAP REL COSTS-MVBLE EQUIP	4	40
		24138			9
41	OTHER PERSONNEL EXPENSE	A	ADMINISTRATIVE & GENERAL	6	41
		-6189			
42					42
43					43
44					44
45					45
46					46
47					47
48					48
49					49
50	TOTAL				50
		-361126			

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

WORKSHEET A-8-1

A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR THE CLAIMING OF HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT (INCL IN WKST A, COL 5)	NET ADJUSTMENTS	WKST A-7 REF
1	2	3	4	5	6	7
1	4	NEW CAP REL COSTS-MVBLE EQUIP	24811		24811	1
2	6	ADMINISTRATIVE & GENERAL	303859	158824	145035	2
3						3
4						4
5	TOTALS		328670	158824	169846	5

B. INTERRELATIONSHIP OF RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

THE SECRETARY, BY VIRTUE OF AUTHORITY GRANTED UNDER SECTION 1814(b)(1) OF THE SOCIAL SECURITY ACT, REQUIRES THAT YOU FURNISH THE INFORMATION REQUESTED UNDER PART B OF THIS WORKSHEET.

THE INFORMATION IS USED BY THE HEALTH CARE FINANCING ADMINISTRATION AND ITS INTERMEDIARIES IN DETERMINING THAT THE COSTS APPLICABLE TO SERVICES, FACILITIES, AND SUPPLIES FURNISHED BY ORGANIZATIONS RELATED TO YOU BY COMMON OWNERSHIP OR CONTROL REPRESENT REASONABLE COSTS AS DETERMINED UNDER SECTION 1861 OF THE SOCIAL SECURITY ACT. IF YOU DO NOT PROVIDE ALL OR ANY PART OF THE REQUESTED INFORMATION, THE COST REPORT IS CONSIDERED INCOMPLETE AND NOT ACCEPTABLE FOR PURPOSES OF CLAIMING REIMBURSEMENT UNDER TITLE XVIII.

SYMBOL (1)	NAME	PERCENT OF OWNERSHIP		PERCENT OF OWNERSHIP		TYPE OF BUSINESS
		3	4	5	6	
1	B		SELECT MEDICAL	100.00	HEALTHCARE	1
2						2
3						3
4						4
5						5

- (1) USE THE FOLLOWING SYMBOLS TO INDICATE THE INTERRELATIONSHIP TO RELATED ORGANIZATIONS:
- A. INDIVIDUAL HAS FINANCIAL INTEREST (STOCKHOLDER, PARTNER, ETC.) IN BOTH RELATED ORGANIZATION AND IN PROVIDER.
  - B. CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION HAS FINANCIAL INTEREST IN PROVIDER.
  - C. PROVIDER HAS FINANCIAL INTEREST IN CORPORATION, PARTNERSHIP, OR OTHER ORGANIZATION.
  - D. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN RELATED ORGANIZATION.
  - E. INDIVIDUAL IS DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF PROVIDER AND RELATED ORGANIZATION.
  - F. DIRECTOR, OFFICER, ADMINISTRATOR, OR KEY PERSON OF RELATED ORGANIZATION OR RELATIVE OF SUCH PERSON HAS FINANCIAL INTEREST IN PROVIDER.
  - G. OTHER (FINANCIAL OR NON-FINANCIAL) SPECIFY:

PROVIDER NO. 15-2010 SSH - INDIANAPOLIS  
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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2009.01  
 04/07/2009 14:18

PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		TOTAL REMUNERA- TION INCL FRINGES	PROFES- SIONAL COMPONENT	PROVIDER COMPONENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPONENT HOURS	UNAD- JUSTED RCE LIMIT	PERCENT OF UNAD- JUSTED RCE LIMIT
LINE NO.	2		3	4	5	6	7	8	9
1	25	ADULTS & PEDIATRICS	9840		9840	177200	145	12353	618
2	25	ADULTS & PEDIATRICS	28680		28680	177200	421	35866	1793
3	25	ADULTS & PEDIATRICS	15840		15840	177200	231	19679	984
4	25	ADULTS & PEDIATRICS	12000		12000	177200	180	15335	767
5	25	ADULTS & PEDIATRICS	4680		4680	177200	72	6134	307
6	25	ADULTS & PEDIATRICS	42900		42900	177200	624	53160	2658
7	25	ADULTS & PEDIATRICS	517		517	177200	7	596	30
8	25	ADULTS & PEDIATRICS	26920		26920	177200	394	33566	1678
9	25	ADULTS & PEDIATRICS	27660		27660	177200	406	34588	1729
10	25	ADULTS & PEDIATRICS	34055		34055	177200	508	43278	2164
11	25	ADULTS & PEDIATRICS	21840		21840	177200	312	26580	1329
12	25	ADULTS & PEDIATRICS	9240		9240	177200	132	11245	562
13	25	ADULTS & PEDIATRICS	5880		5880	177200	84	7156	358
14	25	ADULTS & PEDIATRICS	18440		18440	177200	263	22406	1120
15	25	ADULTS & PEDIATRICS	19620		19620	177200	288	24535	1227
16	25	ADULTS & PEDIATRICS	19020		19020	177200	276	23513	1176
17	25	ADULTS & PEDIATRICS	7560		7560	177200	108	9201	460
18	25	ADULTS & PEDIATRICS	54340		54340	177200	2644	225248	11262
101		TOTAL	359032		359032		7095	604439	30222

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/96)

VERSION: 2009.01  
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PROVIDER-BASED PHYSICIAN ADJUSTMENTS

WORKSHEET A-8-2

WKST A	COST CENTER/ PHYSICIAN IDENTIFIER		COST OF MEMBERSHIP & CONTIN. EDUCATION	PROVIDER COMPONENT SHARE OF	PHYSICIAN COST OF MALPRACTICE INSURANCE	PROVIDER COMPONENT SHARE OF	ADJUSTED RCE LIMIT	RCE DIS- ALLOWANCE	ADJUST- MENT
LINE NO.	11		12	13	14	15	16	17	18
1	25	ADULTS & PEDIATRICS	BASHALL				12353		
2	25	ADULTS & PEDIATRICS	BEASLEY				35866		
3	25	ADULTS & PEDIATRICS	BENSON				19679		
4	25	ADULTS & PEDIATRICS	CRANE				15335		
5	25	ADULTS & PEDIATRICS	DANDAMUDI				6134		
6	25	ADULTS & PEDIATRICS	DAVEL				53160		
7	25	ADULTS & PEDIATRICS	HOLLINGSWORTH				596		
8	25	ADULTS & PEDIATRICS	HUFFER				33566		
9	25	ADULTS & PEDIATRICS	JARADET				34588		
10	25	ADULTS & PEDIATRICS	LOPSHIRE				43278		
11	25	ADULTS & PEDIATRICS	MORIN				26580		
12	25	ADULTS & PEDIATRICS	MYERS				11245		
13	25	ADULTS & PEDIATRICS	OWNBY				7156		
14	25	ADULTS & PEDIATRICS	RICHESON				22406		
15	25	ADULTS & PEDIATRICS	SAFADI				24535		
16	25	ADULTS & PEDIATRICS	SIGUA				23513		
17	25	ADULTS & PEDIATRICS	TOLLIVER				9201		
18	25	ADULTS & PEDIATRICS	RCCC				225248		
101		TOTAL					604439		

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	NET EXP FOR COST ALLOCATION	NEW CAP BLDGS & FIXTURES	NEW CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS	SUBTOTAL	ADMINIS-TRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY + LINEN SERVICE	
	0	3	4	5	5A	6	8	9	
GENERAL SERVICE COST CENTERS									
1 OLD CAP REL COSTS-BLDG & FIXT									1
2 OLD CAP REL COSTS-MVBLE EQUIP									2
3 NEW CAP REL COSTS-BLDG & FIXT	490936	490936							3
4 NEW CAP REL COSTS-MVBLE EQUIP	473219		473219						4
5 EMPLOYEE BENEFITS	10300			10300					5
6 ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	1455872	134958	130088	1502	1722420	1722420			6
7									7
8 OPERATION OF PLANT	118400	6374	6144		130918	26680	157598		8
9 LAUNDRY & LINEN SERVICE	62988	11532	11116		85636	17452	5198	108286	9
10 HOUSEKEEPING	124905	811	782		126498	25779	366		10
11 DIETARY	116484	1869	1802	110	120265	24509	843		11
12 CAFETERIA									12
13 MAINTENANCE OF PERSONNEL									13
14 NURSING ADMINISTRATION	77131	9054	8728	205	95118	19384	4082		14
15 CENTRAL SERVICES & SUPPLY									15
16 PHARMACY									16
17 MEDICAL RECORDS & LIBRARY	71884	5135	4950	156	82125	16736	2315		17
18 SOCIAL SERVICE									18
20 NONPHYSICIAN ANESTHETISTS									20
21 NURSING SCHOOL									21
22 I&R SERVICES-SALARY & FRINGES A									22
23 I&R SERVICES-OTHER PRGM COSTS A									23
24 PARAMED ED PRGM-(SPECIFY)									24
INPATIENT ROUTINE SERV COST CENTERS									
25 ADULTS & PEDIATRICS	3536968	269106	259393	5456	4070923	829600	121310	108286	25
ANCILLARY SERVICE COST CENTERS									
37 OPERATING ROOM	138664				138664	28258			37
41 RADIOLOGY-DIAGNOSTIC	219516				219516	44735			41
44 LABORATORY	720860	1937	1867		724664	147678	873		44
46.30 BLOOD CLOTTING FACTORS ADMIN CO									46.30
49 RESPIRATORY THERAPY	568252	3851	3712	1132	576947	117575	1736		49
50 PHYSICAL THERAPY	161512	7433	7164	263	176372	35942	3351		50
51 OCCUPATIONAL THERAPY	92267	2095	2019	180	96561	19678	944		51
52 SPEECH PATHOLOGY	50904	1104	1064		53072	10815	498		52
53.01 RENAL DIALYSIS	222222	8424	8120	519	239285	48763	3797		53.01
55 MEDICAL SUPPLIES CHARGED TO PAT	590310	15856	15284	130	621580	126671	7148		55
56 DRUGS CHARGED TO PATIENTS	850977	8739	8424	605	868745	177040	3939		56
OUTPATIENT SERVICE COST CENTERS									
62 OBSERVATION BEDS (NON-DISTINCT									62
63.50 RHC									63.50
63.60 FQHC									63.60
OTHER REIMBURSABLE COST CENTERS									
69.10 CMHC									69.10
69.20 OUTPATIENT PHYSICAL THERAPY									69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY									69.30
69.40 OUTPATIENT SPEECH PATHOLOGY									69.40
71 HOME HEALTH AGENCY									71
SPECIAL PURPOSE COST CENTERS									
85.01 PANCREAS ACQUISITION									85.01
85.02 INTESTINAL ACQUISITION									85.02
85.03 ISLET CELL ACQUISITION									85.03
95 SUBTOTALS	10154571	488278	470657	10258	10149309	1717295	156400	108286	95
NONREIMBURSABLE COST CENTERS									
100 PROVIDER RELATIONS NRCC	19888	2658	2562	42	25150	5125	1198		100
101 CROSS FOOT ADJUSTMENTS									101
102 NEGATIVE COST CENTER									102
103 TOTAL	10174459	490936	473219	10300	10174459	1722420	157598	108286	103

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
 PART I

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
	10	11	14	17	25	26	27	
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT								3
4 NEW CAP REL COSTS-MVBLE EQUIP								4
5 EMPLOYEE BENEFITS								5
6 ADMINISTRATIVE & GENERAL								6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT								8
9 LAUNDRY & LINEN SERVICE								9
10 HOUSEKEEPING	152643							10
11 DIETARY	846	146463						11
12 CAFETERIA								12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION	4098		122682					14
15 CENTRAL SERVICES & SUPPLY								15
16 PHARMACY								16
17 MEDICAL RECORDS & LIBRARY	2324			103500				17
18 SOCIAL SERVICE								18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES A								22
23 I&R SERVICES-OTHER PRGM COSTS A								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	121797	146463	122682	23560	5544621		5544621	25
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM				900	167822		167822	37
41 RADIOLOGY-DIAGNOSTIC				2457	266708		266708	41
44 LABORATORY	877			6973	881065		881065	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO								46.30
49 RESPIRATORY THERAPY	1743			15001	713002		713002	49
50 PHYSICAL THERAPY	3364			2403	221432		221432	50
51 OCCUPATIONAL THERAPY	948			1650	119781		119781	51
52 SPEECH PATHOLOGY	499			732	65616		65616	52
53.01 RENAL DIALYSIS	3813			2328	297986		297986	53.01
55 MEDICAL SUPPLIES CHARGED TO PAT	7176			12987	775562		775562	55
56 DRUGS CHARGED TO PATIENTS	3955			34509	1088188		1088188	56
OUTPATIENT SERVICE COST CENTERS								
62 OBSERVATION BEDS (NON-DISTINCT								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERAPY								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS	151440	146463	122682	103500	10141783		10141783	95
NONREIMBURSABLE COST CENTERS								
100 PROVIDER RELATIONS NRCC	1203				32676		32676	100
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 TOTAL	152643	146463	122682	103500	10174459		10174459	103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	DIR ASSGND	NEW CAP	NEW CAP	CAP REL	ADMINIS-	OPERATION	LAUNDRY	HOUSE-
	CAP-REL	BLDGS &	MOVABLE	COST TO	TRATIVE &	OF PLANT	+ LINEN	KEEPING
	COSTS	FIXTURES	EQUIPMENT	BE ALLOC	GENERAL		SERVICE	
	0	3	4	4A	6	8	9	10
GENERAL SERVICE COST CENTERS								
1								1
2								2
3								3
4								4
5								5
6	3320	134958	130088	268366	268366			6
7								7
8		6374	6144	12518	4157	16675		8
9		11532	11116	22648	2719	550	25917	9
10		811	782	1593	4017	39		5649 10
11		1869	1802	3671	3819	89		31 11
12								12
13								13
14		9054	8728	17782	3020	432		152 14
15								15
16								16
17		5135	4950	10085	2608	245		86 17
18								18
20								20
21								21
22								22
23								23
24								24
INPATIENT ROUTINE SERV COST CENTERS								
25		269106	259393	528499	129256	12834	25917	4508 25
ANCILLARY SERVICE COST CENTERS								
37					4403			37
41					6970			41
44		1937	1867	3804	23010	92		32 44
46.30								46.30
49	4134	3851	3712	11697	18319	184		65 49
50		7433	7164	14597	5600	355		124 50
51		2095	2019	4114	3066	100		35 51
52		1104	1064	2168	1685	53		18 52
53.01		8424	8120	16544	7598	402		141 53.01
55	185755	15856	15284	216895	19736	756		266 55
56		8739	8424	17163	27584	417		146 56
OUTPATIENT SERVICE COST CENTERS								
62								62
63.50								63.50
63.60								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10								69.10
69.20								69.20
69.30								69.30
69.40								69.40
71								71
SPECIAL PURPOSE COST CENTERS								
85.01								85.01
85.02								85.02
85.03								85.03
95	193209	488278	470657	1152144	267567	16548	25917	5604 95
NONREIMBURSABLE COST CENTERS								
100		2658	2562	5220	799	127		45 100
101								101
102								102
103	193209	490936	473219	1157364	268366	16675	25917	5649 103

ALLOCATION OF NEW CAPITAL RELATED COSTS

WORKSHEET B  
 PART III

COST CENTER DESCRIPTION	DIETARY	NURSING ADMINIS- TRATION	MEDICAL RECORDS + LIBRARY	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
	11	14	17	25	26	27	
GENERAL SERVICE COST CENTERS							
1							1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11	7610						11
12							12
13							13
14		21386					14
15							15
16							16
17			13024				17
18							18
20							20
21							21
22							22
23							23
24							24
25	7610	21386	2964	732974		732974	25
ANCILLARY SERVICE COST CENTERS							
37			113	4516		4516	37
41			309	7279		7279	41
44			877	27815		27815	44
46.30							46.30
49			1887	32152		32152	49
50			302	20978		20978	50
51			208	7523		7523	51
52			92	4016		4016	52
53.01			293	24978		24978	53.01
55			1634	239287		239287	55
56			4345	49655		49655	56
OUTPATIENT SERVICE COST CENTERS							
62							62
63.50							63.50
63.60							63.60
OTHER REIMBURSABLE COST CENTERS							
69.10							69.10
69.20							69.20
69.30							69.30
69.40							69.40
71							71
SPECIAL PURPOSE COST CENTERS							
85.01							85.01
85.02							85.02
85.03							85.03
95	7610	21386	13024	1151173		1151173	95
NONREIMBURSABLE COST CENTERS							
100				6191		6191	100
101							101
102							102
103	7610	21386	13024	1157364		1157364	103

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	NEW CAP BLDGS & FIXTURES SQUARE FEET	NEW CAP MOVABLE EQUIPMENT SQUARE FEET	EMPLOYEE BENEFITS GROSS SALARIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY + LINEN SERVICE PATIENT DAYS	
	3	4	5	6A	6	8	9	
GENERAL SERVICE COST CENTERS								
1 OLD CAP REL COSTS-BLDG & FIXT								1
2 OLD CAP REL COSTS-MVBLE EQUIP								2
3 NEW CAP REL COSTS-BLDG & FIXT	21797							3
4 NEW CAP REL COSTS-MVBLE EQUIP		21797						4
5 EMPLOYEE BENEFITS			3423136					5
6 ADMINISTRATIVE & GENERAL	5992	5992	499293	-1722420	8452039			6
7 MAINTENANCE & REPAIRS								7
8 OPERATION OF PLANT	283	283			130918	15522		8
9 LAUNDRY & LINEN SERVICE	512	512			85636	512	5099	9
10 HOUSEKEEPING	36	36			126498	36		10
11 DIETARY	83	83	36671		120265	83		11
12 CAFETERIA								12
13 MAINTENANCE OF PERSONNEL								13
14 NURSING ADMINISTRATION	402	402	68258		95118	402		14
15 CENTRAL SERVICES & SUPPLY								15
16 PHARMACY								16
17 MEDICAL RECORDS & LIBRARY	228	228	51814		82125	228		17
18 SOCIAL SERVICE								18
20 NONPHYSICIAN ANESTHETISTS								20
21 NURSING SCHOOL								21
22 I&R SERVICES-SALARY & FRINGES								22
23 I&R SERVICES-OTHER PRGM COSTS								23
24 PARAMED ED PRGM-(SPECIFY)								24
INPATIENT ROUTINE SERV COST CENTERS								
25 ADULTS & PEDIATRICS	11948	11948	1812968		4070923	11948	5099	25
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM					138664			37
41 RADIOLOGY-DIAGNOSTIC					219516			41
44 LABORATORY	86	86			724664	86		44
46.30 BLOOD CLOTTING FACTORS ADMIN								46.30
49 RESPIRATORY THERAPY	171	171	376157		576947	171		49
50 PHYSICAL THERAPY	330	330	87247		176372	330		50
51 OCCUPATIONAL THERAPY	93	93	59682		96561	93		51
52 SPEECH PATHOLOGY	49	49	81		53072	49		52
53.01 RENAL DIALYSIS	374	374	172422		239285	374		53.01
55 MEDICAL SUPPLIES CHARGED TO P	704	704	43339		621580	704		55
56 DRUGS CHARGED TO PATIENTS	388	388	201186		868745	388		56
OUTPATIENT SERVICE COST CENTERS								
62 OBSERVATION BEDS (NON-DISTINC								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
69.10 CMHC								69.10
69.20 OUTPATIENT PHYSICAL THERAPY								69.20
69.30 OUTPATIENT OCCUPATIONAL THERA								69.30
69.40 OUTPATIENT SPEECH PATHOLOGY								69.40
71 HOME HEALTH AGENCY								71
SPECIAL PURPOSE COST CENTERS								
85.01 PANCREAS ACQUISITION								85.01
85.02 INTESTINAL ACQUISITION								85.02
85.03 ISLET CELL ACQUISITION								85.03
95 SUBTOTALS	21679	21679	3409118	-1722420	8426889	15404	5099	95
NONREIMBURSABLE COST CENTERS								
100 PROVIDER RELATIONS NRCC	118	118	14018		25150	118		100
101 CROSS FOOT ADJUSTMENTS								101
102 NEGATIVE COST CENTER								102
103 COST TO BE ALLOC PER B PT I	490936	473219	10300		1722420	157598	108286	103
104 UNIT COST MULT-WS B PT I		21.710281				10.153202		104
104 UNIT COST MULT-WS B PT I	22.523100		.003009		.203788		21.236713	104
105 COST TO BE ALLOC PER B PT II								105
106 UNIT COST MULT-WS B PT II								106
106 UNIT COST MULT-WS B PT II								106
107 COST TO BE ALLOC PER B PT III					268366	16675	25917	107
108 UNIT COST MULT-WS B PT III					.031752	1.074282		108
108 UNIT COST MULT-WS B PT III							5.082761	108

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/97)

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

COST CENTER DESCRIPTION	HOUSE-KEEPING	DIETARY	NURSING ADMINIS-TRATION	MEDICAL RECORDS + LIBRARY	
	SQUARE FEET	PATIENT DAYS	NURSING FTE'S	GROSS REVENUE	
	10	11	14	17	
GENERAL SERVICE COST CENTERS					
1 OLD CAP REL COSTS-BLDG & FIXT					1
2 OLD CAP REL COSTS-MVBLE EQUIP					2
3 NEW CAP REL COSTS-BLDG & FIXT					3
4 NEW CAP REL COSTS-MVBLE EQUIP					4
5 EMPLOYEE BENEFITS					5
6 ADMINISTRATIVE & GENERAL					6
7 MAINTENANCE & REPAIRS					7
8 OPERATION OF PLANT					8
9 LAUNDRY & LINEN SERVICE					9
10 HOUSEKEEPING	14974				10
11 DIETARY	83	5099			11
12 CAFETERIA					12
13 MAINTENANCE OF PERSONNEL					13
14 NURSING ADMINISTRATION	402		35		14
15 CENTRAL SERVICES & SUPPLY					15
16 PHARMACY					16
17 MEDICAL RECORDS & LIBRARY	228			14984089	17
18 SOCIAL SERVICE					18
20 NONPHYSICIAN ANESTHETISTS					20
21 NURSING SCHOOL					21
22 I&R SERVICES-SALARY & FRINGES					22
23 I&R SERVICES-OTHER PRGM COSTS					23
24 PARAMED ED PRGM-(SPECIFY)					24
25 INPATIENT ROUTINE SERV COST CENTERS	11948	5099	35	3411096	25
ADULTS & PEDIATRICS					
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM				130261	37
41 RADIOLOGY-DIAGNOSTIC				355782	41
44 LABORATORY	86			1009619	44
46.30 BLOOD CLOTTING FACTORS ADMIN					46.30
49 RESPIRATORY THERAPY	171			2171851	49
50 PHYSICAL THERAPY	330			347930	50
51 OCCUPATIONAL THERAPY	93			238898	51
52 SPEECH PATHOLOGY	49			106051	52
53.01 RENAL DIALYSIS	374			337050	53.01
55 MEDICAL SUPPLIES CHARGED TO P	704			1880273	55
56 DRUGS CHARGED TO PATIENTS	388			4995278	56
OUTPATIENT SERVICE COST CENTERS					
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
69.10 CMHC					69.10
69.20 OUTPATIENT PHYSICAL THERAPY					69.20
69.30 OUTPATIENT OCCUPATIONAL THERA					69.30
69.40 OUTPATIENT SPEECH PATHOLOGY					69.40
71 HOME HEALTH AGENCY					71
SPECIAL PURPOSE COST CENTERS					
85.01 PANCREAS ACQUISITION					85.01
85.02 INTESTINAL ACQUISITION					85.02
85.03 ISLET CELL ACQUISITION					85.03
95 SUBTOTALS	14856	5099	35	14984089	95
NONREIMBURSABLE COST CENTERS					
100 PROVIDER RELATIONS NRCC	118				100
101 CROSS FOOT ADJUSTMENTS					101
102 NEGATIVE COST CENTER					102
103 COST TO BE ALLOC PER B PT I	152643	146463	122682	103500	103
104 UNIT COST MULT-WS B PT I	10.193869		3505.200000		104
104 UNIT COST MULT-WS B PT I		28.723867		.006907	104
105 COST TO BE ALLOC PER B PT II					105
106 UNIT COST MULT-WS B PT II					106
106 UNIT COST MULT-WS B PT II					106
107 COST TO BE ALLOC PER B PT III	5649	7610	21386	13024	107
108 UNIT COST MULT-WS B PT III	.377254		611.028571		108
108 UNIT COST MULT-WS B PT III		1.492449		.000869	108

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM VERSION: 2009.01  
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I

COST CENTER DESCRIPTION	TOTAL COST (FROM WKST B, PART I, COL 27) 1	THERAPY LIMIT ADJUSTMENT 2	TOTAL COSTS 3	RCE DISALLOWANCE 4	TOTAL COSTS 5	
25 INPATIENT ROUTINE SERV COST CENTERS						25
ADULTS & PEDIATRICS	5544621		5544621		5544621	
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	167822		167822		167822	37
41 RADIOLOGY-DIAGNOSTIC	266708		266708		266708	41
44 LABORATORY	881065		881065		881065	44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	713002		713002		713002	49
50 PHYSICAL THERAPY	221432		221432		221432	50
51 OCCUPATIONAL THERAPY	119781		119781		119781	51
52 SPEECH PATHOLOGY	65616		65616		65616	52
53.01 RENAL DIALYSIS	297986		297986		297986	53.01
55 MEDICAL SUPPLIES CHARGED TO	775562		775562		775562	55
56 DRUGS CHARGED TO PATIENTS	1088188		1088188		1088188	56
OUTPATIENT SERVICE COST CENTERS						
62 OBSERVATION BEDS (NON-DISTI						62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	10141783		10141783		10141783	101
102 LESS OBSERVATION BEDS						102
103 TOTAL	10141783		10141783		10141783	103

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (5/1999)

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
 PART I (CONT)

COST CENTER DESCRIPTION	----- CHARGES -----			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO
	INPATIENT 6	OUTPATIENT 7	TOTAL 8			
25 INPATIENT ROUTINE SERV COST CENTERS						
ADULTS & PEDIATRICS	3411096		3411096			25
ANCILLARY SERVICE COST CENTERS						
37 OPERATING ROOM	130261		130261	1.288352	1.288352	1.288352 37
41 RADIOLOGY-DIAGNOSTIC	355782		355782	.749639	.749639	.749639 41
44 LABORATORY	1009619		1009619	.872671	.872671	.872671 44
46.30 BLOOD CLOTTING FACTORS ADMI						46.30
49 RESPIRATORY THERAPY	2171851		2171851	.328292	.328292	.328292 49
50 PHYSICAL THERAPY	347930		347930	.636427	.636427	.636427 50
51 OCCUPATIONAL THERAPY	238898		238898	.501390	.501390	.501390 51
52 SPEECH PATHOLOGY	106051		106051	.618721	.618721	.618721 52
53.01 RENAL DIALYSIS	337050		337050	.884100	.884100	.884100 53.01
55 MEDICAL SUPPLIES CHARGED TO	1880273		1880273	.412473	.412473	.412473 55
56 DRUGS CHARGED TO PATIENTS	4995278		4995278	.217843	.217843	.217843 56
OUTPATIENT SERVICE COST CENTERS						
62 OBSERVATION BEDS (NON-DISTI						62
63.50 RHC						63.50
63.60 FQHC						63.60
OTHER REIMBURSABLE COST CENTERS						
101 SUBTOTAL	14984089		14984089			101
102 LESS OBSERVATION BEDS						102
103 TOTAL	14984089		14984089			103

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/97)

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D  
 PART I

CHECK [ ] TITLE V  
 APPLICABLE [XX] TITLE XVIII-PT A  
 BOXES [ ] TITLE XIX

COST CENTER DESCRIPTION	----- OLD CAPITAL -----			----- NEW CAPITAL -----		
	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST	CAPITAL RELATED COST	SWING-BED ADJUSTMENT	REDUCED CAPITAL RELATED COST
	1	2	3	4	5	6
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS				732974		732974
26 INTENSIVE CARE UNIT						
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I						
33 NURSERY						
101 TOTAL				732974		732974

COST CENTER DESCRIPTION	---- OLD CAPITAL ----			---- NEW CAPITAL ----		
	TOTAL PATIENT DAYS	INPATIENT PROGRAM DAYS	PER DIEM	INPATIENT PROGRAM CAPITAL COST	PER DIEM	INPATIENT PROGRAM CAPITAL COST
	7	8	9	10	11	12
INPAT ROUTINE SERV COST CTRS						
25 ADULTS & PEDIATRICS	5099	4567			143.75	656506
26 INTENSIVE CARE UNIT						
27 CORONARY CARE UNIT						
28 BURN INTENSIVE CARE UNIT						
29 SURGICAL INTENSIVE CARE UNIT						
30 OTHER SPECIAL CARE (SPECIFY)						
31 SUBPROVIDER I						
33 NURSERY						
101 TOTAL	5099	4567				656506

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 PERIOD FROM 12/01/2007 TO 11/30/2008

OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/96)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

WORKSHEET D  
 PART II

CHECK [ ] TITLE V [XX] HOSPITAL (15-2010) [ ] SUB III [XX] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB I [ ] SUB IV [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II

COST CENTER DESCRIPTION	OLD	NEW		INPATIENT PROGRAM CHARGES	---- OLD CAPITAL ----		---- NEW CAPITAL ----	
	CAPITAL RELATED COST	CAPITAL RELATED COST	TOTAL CHARGES		RATIO OF COST TO CHARGES	CAPITAL COSTS	RATIO OF COST TO CHARGES	CAPITAL COSTS
	1	2	3	4	5	6	7	8
ANCILLARY SERVICE COST CENTERS								
37 OPERATING ROOM		4516	130261	130261			.034669	4516 37
41 RADIOLOGY-DIAGNOSTIC		7279	355782	330817			.020459	6768 41
44 LABORATORY		27815	1009619	864306			.027550	23812 44
46.30 BLOOD CLOTTING FACTORS ADMIN								46.30
49 RESPIRATORY THERAPY		32152	2171851	1871048			.014804	27699 49
50 PHYSICAL THERAPY		20978	347930	297933			.060294	17964 50
51 OCCUPATIONAL THERAPY		7523	238898	198597			.031490	6254 51
52 SPEECH PATHOLOGY		4016	106051	89882			.037869	3404 52
53.01 RENAL DIALYSIS		24978	337050	337050			.074108	24978 53.01
55 MEDICAL SUPPLIES CHARGED TO P		239287	1880273	1704309			.127262	216894 55
56 DRUGS CHARGED TO PATIENTS		49655	4995278	4487619			.009940	44607 56
OUTPATIENT SERVICE COST CENTERS								
62 OBSERVATION BEDS (NON-DISTINC								62
63.50 RHC								63.50
63.60 FQHC								63.60
OTHER REIMBURSABLE COST CENTERS								
101 TOTAL		418199	11572993	10311822				376896 101

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART III

CHECK [ ] TITLE V  
 APPLICABLE [XX] TITLE XVIII-PT A  
 BOXES [ ] TITLE XIX

COST CENTER DESCRIPTION	NONPHYSICIAN	MEDICAL	SWING-BED	TOTAL	TOTAL	PER	INPATIENT	INPATIENT
	ANESTHETIST	EDUCATION	ADJUSTMENT					PROGRAM
	COST	COST	AMOUNT	COSTS	PATIENT	DIEM	DAYS	COSTS
	1	2	3	4	5	6	7	8
INPAT ROUTINE SERV COST CTRS								
25 ADULTS & PEDIATRICS					5099		4567	25
26 INTENSIVE CARE UNIT								26
27 CORONARY CARE UNIT								27
28 BURN INTENSIVE CARE UNIT								28
29 SURGICAL INTENSIVE CARE UNIT								29
30 OTHER SPECIAL CARE (SPECIFY)								30
31 SUBPROVIDER I								31
33 NURSERY								33
34 SKILLED NURSING FACILITY								34
35 NURSING FACILITY								35
101 TOTAL					5099		4567	101

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (9/2000)

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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (15-2010) [ ] SUB IV [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB I [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II [ ] NF  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT			N/A	N/A	N/A	TOTAL COSTS
	NONPHYSICIAN ANESTHETIST	NONPHYSICIAN ANESTHETIST	MEDICAL EDUCATION				
	COST 1	COST 1.01	COST 2				
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM				2.01	2.02	2.03	37
41 RADIOLOGY-DIAGNOSTIC							41
44 LABORATORY							44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY							49
50 PHYSICAL THERAPY							50
51 OCCUPATIONAL THERAPY							51
52 SPEECH PATHOLOGY							52
53.01 RENAL DIALYSIS							53.01
55 MEDICAL SUPPLIES CHARGED TO P							55
56 DRUGS CHARGED TO PATIENTS							56
OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL							101

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (15-2010) [ ] SUB IV [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB I [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II [ ] NF  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT	TOTAL	RATIO OF	OUTPATIENT	INPATIENT	INPATIENT	OUTPATIENT
	PASS THROUGH		COST TO	RATIO OF COST	PROGRAM	PROGRAM	
	COSTS	CHARGES	CHARGES	TO CHARGES	CHARGES	CHARGES	CHARGES
	3.01	4	5	5.01	6	7	8
ANCILLARY SERVICE COST CENTERS							
37 OPERATING ROOM		130261			130261		37
41 RADIOLOGY-DIAGNOSTIC		355782			330817		41
44 LABORATORY		1009619			864306		44
46.30 BLOOD CLOTTING FACTORS ADMIN							46.30
49 RESPIRATORY THERAPY		2171851			1871048		49
50 PHYSICAL THERAPY		347930			297933		50
51 OCCUPATIONAL THERAPY		238898			198597		51
52 SPEECH PATHOLOGY		106051			89882		52
53.01 RENAL DIALYSIS		337050			337050		53.01
55 MEDICAL SUPPLIES CHARGED TO P		1880273			1704309		55
56 DRUGS CHARGED TO PATIENTS		4995278			4487619		56
OUTPATIENT SERVICE COST CENTERS							
62 OBSERVATION BEDS (NON-DISTINC							62
63.50 RHC							63.50
63.60 FQHC							63.60
OTHER REIMBURSABLE COST CENTERS							
101 TOTAL		11572993			10311822		101

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D  
 PART IV

CHECK [ ] TITLE V [XX] HOSPITAL (15-2010) [ ] SUB IV [ ] PPS  
 APPLICABLE [XX] TITLE XVIII-PT A [ ] SUB I [ ] SNF [ ] TEFRA  
 BOXES [ ] TITLE XIX [ ] SUB II [ ] NF  
 [ ] SUB III [ ] ICF/MR

COST CENTER DESCRIPTION	OUTPATIENT PROGRAM CHARGES 8.01	OUTPATIENT PROGRAM CHARGES 8.02	OUTPATIENT PROGRAM PASS THROUGH COSTS 9	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.01	OUTPATIENT PROGRAM PASS THROUGH COSTS 9.02
ANCILLARY SERVICE COST CENTERS					
37 OPERATING ROOM					37
41 RADIOLOGY-DIAGNOSTIC					41
44 LABORATORY					44
46.30 BLOOD CLOTTING FACTORS ADMIN					46.30
49 RESPIRATORY THERAPY					49
50 PHYSICAL THERAPY					50
51 OCCUPATIONAL THERAPY					51
52 SPEECH PATHOLOGY					52
53.01 RENAL DIALYSIS					53.01
55 MEDICAL SUPPLIES CHARGED TO P					55
56 DRUGS CHARGED TO PATIENTS					56
OUTPATIENT SERVICE COST CENTERS					
62 OBSERVATION BEDS (NON-DISTINC					62
63.50 RHC					63.50
63.60 FQHC					63.60
OTHER REIMBURSABLE COST CENTERS					
101 TOTAL					101

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OPTIMIZER SYSTEMS, INC. WIN-LASH MICRO SYSTEM  
 IN LIEU OF FORM CMS-2552-96 (11/98)

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (15-2010)	SUB I	SUB II	SUB III	SUB IV	SNF	
INPATIENT DAYS	1	1	1	1	1	1	
1 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS AND SWING-BED DAYS EXCLUDING NEWBORN)	5099						1
2 INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS, EXCLUDING SWING BED AND NEWBORN DAYS)	5099						2
3 PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)							3
4 SEMI-PRIVATE ROOM DAYS (EXCLUDING SWING-BED PRIVATE ROOM DAYS)	5099						4
5 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							5
6 TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							6
7 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							7
8 TOTAL SWING-BED NF-TYPE INPATIENT DAYS (INCL PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							8
9 INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED AND NEWBORN DAYS)	4567						9
10 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							10
11 SWING-BED SNF-TYPE INPATIENT DAYS APPLICABLE TO TITLE XVIII ONLY (INCLUDING PRIVATE ROOM DAYS) AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							11
12 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							12
13 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							13
14 MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (EXCLUDING SWING-BED DAYS)							14
15 TOTAL NURSERY DAYS							15
16 TITLE V OR XIX NURSERY DAYS							16

COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART I (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART I - ALL PROVIDER COMPONENTS

	HOSPITAL (PPS) (15-2010)	SUB I	SUB II	SUB III	SUB IV	SNF	
SWING-BED ADJUSTMENT	1	1	1	1	1	1	
17 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							17
18 MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							18
19 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							19
20 MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							20
21 TOTAL GENERAL INPATIENT ROUTINE SERVICE COST	5544621						21
22 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							22
23 SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							23
24 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD							24
25 SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD							25
26 TOTAL SWING-BED COST							26
27 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	5544621						27
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT							
28 GENERAL INPATIENT ROUTINE SERVICE CHARGES (EXCLUDING SWING-BED CHARGES)	3411096						28
29 PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)							29
30 SEMI-PRIVATE ROOM CHARGES (EXCLUDING SWING-BED CHARGES)	3411096						30
31 GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO	1.625466						31
32 AVERAGE PRIVATE ROOM PER DIEM CHARGE							32
33 AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE	668.97						33
34 AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL							34
35 AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL							35
36 PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT							36
37 GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL	5544621						37

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PART II

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (15-2010)	SUB I	SUB II	SUB III	SUB IV	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1	1	1	1	1	
38 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	1087.39					38
39 PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	4966110					39
40 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM						40
41 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST	4966110					41
	TOTAL I/P COST	TOTAL I/P DAYS	AVERAGE PER DIEM	PROGRAM DAYS	PROGRAM COST	
	1	2	3	4	5	
42 NURSERY (TITLES V AND XIX ONLY)						42
INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43 INTENSIVE CARE UNIT						43
44 CORONARY CARE UNIT						44
45 BURN INTENSIVE CARE UNIT						45
46 SURGICAL INTENSIVE CARE UNIT						46
47 OTHER SPECIAL CARE (SPECIFY)						47
	HOSPITAL (PPS) (15-2010)	SUB I	SUB II	SUB III	SUB IV	
	1	1	1	1	1	
48 PROGRAM INPATIENT ANCILLARY SERVICE COST	4107683					48
49 TOTAL PROGRAM INPATIENT COSTS	9073793					49
	PASS THROUGH COST ADJUSTMENTS					
50 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES	656506					50
51 PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES	376896					51
52 TOTAL PROGRAM EXCLUDABLE COST	1033402					52
53 TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS	8040391					53

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 PART II (CONT)

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART II - HOSPITAL AND SUBPROVIDERS ONLY

	HOSPITAL (PPS) (15-2010)	SUB I	SUB II	SUB III	SUB IV	
TARGET AMOUNT AND LIMITATION COMPUTATION	1	1	1	1	1	
54 PROGRAM DISCHARGES						54
55 TARGET AMOUNT PER DISCHARGE						55
56 TARGET AMOUNT						56
57 DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT						57
58 BONUS PAYMENT						58
58.01 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED & COMPOUNDED BY THE MARKET BASKET						58.01
58.02 LESSER OF LINE 53/LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT UPDATED BY THE MARKET BASKET						58.02
58.03 IF LINE 53/LINE 54 IS LESS THAN THE LOWER OF LINES 55, 58.01 OR 58.02, THE LESSER OF 50% OF THE AMOUNT BY WHICH OPERATING COSTS ARE LESS THAN EXPECTED COSTS, OR 1% OF THE TARGET AMOUNT						58.03
58.04 RELIEF PAYMENT						58.04
59 ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT						59
59.01 ALLOWABLE INPATIENT COST PER DISCHARGE (LTCH ONLY)						59.01
59.02 PROGRAM DISCHARGES PRIOR TO JULY 1						59.02
59.03 PROGRAM DISCHARGES AFTER JULY 1						59.03
59.04 PROGRAM DISCHARGES (SEE INSTRUCTIONS)						59.04
59.05 REDUCED INPAT COST PER DISCH. FOR DISCHARGES PRIOR TO JULY 1						59.05
59.06 REDUCED INPAT COST PER DISCHARGE FOR DISCHARGES AFTER JULY 1						59.06
59.07 REDUCED INPAT COST PER DISCHARGE (SEE INSTR.) (LTCH ONLY)						59.07
59.08 REDUCED INPATIENT COST PLUS INCENTIVE PAYMENT (SEE INSTR.)						59.08
PROGRAM INPATIENT ROUTINE SWING BED COST						
60 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						60
61 MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						61
62 TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS						62
63 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD						63
64 TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD						64
65 TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS						65

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PARTS III & IV

[ ] TITLE V-INPT [XX] TITLE XVIII-PART A [ ] TITLE XIX-INPT

PART III - SKILLED NURSING FACILITY, NURSING FACILITY AND ICF/MR ONLY

SNF

1

66 SNF/NF/ICF/MR ROUTINE SERVICE COST	66
67 ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM	67
68 PROGRAM ROUTINE SERVICE COST	68
69 MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO PROGRAM	69
70 TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COSTS	70
71 CAPITAL RELATED COST ALLOCATED TO INPATIENT ROUTINE SERV COSTS	71
72 PER DIEM CAPITAL RELATED COSTS	72
73 PROGRAM CAPITAL RELATED COSTS	73
74 INPATIENT ROUTINE SERVICE COST	74
75 AGGREGATE CHARGES TO BENEFICIARIES FOR EXCESS COSTS	75
76 TOTAL PGM ROUTINE SERVICE COSTS FOR COMPARISON TO COST LIMIT	76
77 INPATIENT ROUTINE SERVICE COST PER DIEM LIMITATION	77
78 INPATIENT ROUTINE SERVICE COST LIMITATION	78
79 REASONABLE INPATIENT ROUTINE SERVICE COSTS	79
80 PROGRAM INPATIENT ANCILLARY SERVICES	80
81 UTILIZATION REVIEW--PHYSICIAN COMPENSATION	81
82 TOTAL PROGRAM INPATIENT OPERATING COSTS	82

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COMPUTATION OF INPATIENT OPERATING COST

WORKSHEET D-1  
 PARTS III & IV

[ ] TITLE V-INPT                      [XX] TITLE XVIII-PART A                      [ ] TITLE XIX-INPT

HOSPITAL    SUB I    SUB II    SUB III    SUB IV  
 (PPS)  
 (15-2010)  
           1           1           1           1           1

PART IV - COMPUTATION OF OBSERVATION BED COST

83 TOTAL OBSERVATION BEDS		83
84 ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM	1087.39	84
85 OBSERVATION BED COST		85

COMPUTATION OF OBSERVATION BED PASS THROUGH COST - HOSPITAL  
 ROUTINE COST

	COST 1	(FROM LINE 27) 2	COLUMN 1 DIVIDED BY COLUMN 2 3	TOTAL OBSERVATION BED COST (FROM LINE 85) 4	OBSERVATION BED PASS-THROUGH COST COL 3 TIMES COL 4 5	
86 OLD CAPITAL-RELATED COST		5544621				86
87 NEW CAPITAL-RELATED COST	732974	5544621	.132196			87
88 NON PHYSICIAN ANESTHETIST		5544621				88
89 MEDICAL EDUCATION		5544621				89

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INPATIENT ANCILLARY COST APPORTIONMENT

WORKSHEET D-4

[ ] TITLE V [XX] HOSPITAL (15-2010) [ ] SNF [XX] PPS  
 [XX] TITLE XVIII-PT A [ ] SUB I [ ] NF [ ] TEFRA  
 [ ] TITLE XIX [ ] SUB II [ ] S/B-SNF [ ] OTHER  
 [ ] SUB III [ ] S/B-NF  
 [ ] SUB IV [ ] ICF/MR

COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES 1	INPATIENT PROGRAM CHARGES 2	INPATIENT PROGRAM COSTS 3	
INPATIENT ROUTINE SERVICE COST CENTERS				
25 ADULTS & PEDIATRICS		3100719		25
ANCILLARY SERVICE COST CENTERS				
37 OPERATING ROOM	1.288352	130261	167822	37
41 RADIOLOGY-DIAGNOSTIC	.749639	330817	247993	41
44 LABORATORY	.872671	864306	754255	44
46.30 BLOOD CLOTTING FACTORS ADMIN CO				46.30
49 RESPIRATORY THERAPY	.328292	1871048	614250	49
50 PHYSICAL THERAPY	.636427	297933	189613	50
51 OCCUPATIONAL THERAPY	.501390	198597	99575	51
52 SPEECH PATHOLOGY	.618721	89882	55612	52
53.01 RENAL DIALYSIS	.884100	337050	297986	53.01
55 MEDICAL SUPPLIES CHARGED TO PAT	.412473	1704309	702981	55
56 DRUGS CHARGED TO PATIENTS	.217843	4487619	977596	56
OUTPATIENT SERVICE COST CENTERS				
62 OBSERVATION BEDS (NON-DISTINCT OTHER REIMBURSABLE COST CENTERS				62
63.50 RHC				63.50
63.60 FQHC				63.60
101 TOTAL		10311822	4107683	101
102 LESS PBP CLINIC LAB SVCS-PGM ONLY CHARGES				102
103 NET CHARGES		10311822		103

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
DRG AMOUNT						
1 OTHER THAN OUTLIER PAYMENTS OCCURRING BEFORE OCTOBER 1						1
1.01 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER OCTOBER 1 AND BEFORE JANUARY 1						1.01
1.02 OTHER THAN OUTLIER PAYMENTS OCCURRING ON OR AFTER JAN 1 MANAGED CARE PATIENTS						1.02
1.03 PAYMENTS PRIOR TO MARCH 1 OR OCTOBER 1						1.03
1.04 PAYMENTS ON OR AFTER OCTOBER 1 AND PRIOR TO JANUARY 1						1.04
1.05 PAYMENTS ON OR AFTER JAN 1 BUT BEFORE APR 1/OCT 1						1.05
1.06 ADDITIONAL AMOUNT RECEIVED OR TO BE RECEIVED						1.06
1.07 PAYMENTS FOR DISCHARGES ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.07
1.08 SIMULATED PAYMENTS FROM THE PS&R ON OR AFTER APRIL 1, 2001 THROUGH SEPTEMBER 30, 2001						1.08
2 OUTLIER PAYMENTS PRIOR TO OCTOBER 1, 1997						2
2.01 OUTLIER PAYMENTS ON OR AFTER OCTOBER 1, 1997 INDIRECT MEDICAL EDUCATION ADJUSTMENT						2.01
3 BED DAYS AVAILABLE DIVIDED BY NO. OF DAYS IN CR PERIOD						3
3.01 NO OF INTERNS & RESIDENTS FROM WORKSHEET S-3, PART I						3.01
3.02 INDIRECT MEDICAL EDUCATION PERCENTAGE						3.02
3.03 INDIRECT MEDICAL EDUCATION ADJUSTMENT						3.03
3.04 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR THE MOST RECENT CR PERIOD ENDING ON OR BEFORE DEC 31, 1996						3.04
3.05 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS WHICH MEET THE CRITERIA FOR AN ADD-ON TO THE CAP FOR NEW PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii)						3.05
3.06 ADJUSTED FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PGMS FOR AFFILIATED PROGRAMS IN ACCORDANCE WITH SECTION 1886(d)(5)(B)(viii) [ FOR CR PERIODS ENDING ] [ ON OR AFTER 7/1/2005 ] [E-3,PT.VI,LN.15][PLUS LN.3.06]						3.06
3.07 SUM OF LINES 3.04-3.06		0.00		0.00		3.07
3.08 FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS						3.08
3.09 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING PRIOR TO OCTOBER 1						3.09
3.10 FOR CR PERIODS BEGINNING BEFORE OCTOBER 1, ENTER THE PERCENTAGE OF DISCHARGES OCCURRING ON OR AFTER OCT. 1						3.10
3.11 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.09						3.11
3.12 FTE COUNT FOR THE PERIOD IDENTIFIED IN LINE 3.10						3.12
3.13 FTE COUNT FOR RESIDENTS IN DENTAL & PODIATRIC PROGRAMS						3.13
3.14 CURRENT YEAR ALLOWABLE FTE						3.14
3.15 TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR, IF NONE BUT PRIOR YEAR TEACHING WAS IN EFFECT ENTER 1 HERE..						3.15
3.16 TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO. IF THERE WAS NO FTE COUNT IN THIS PERIOD BUT PRIOR YR TEACHING WAS IN EFFECT ENTER 1 HERE..						3.16
RES. IN INIT YRS						
3.17 SUM OF LINES 3.14 THROUGH 3.16 DIVIDED BY THE NUMBER OF THOSE LINES IN EXCESS OF ZERO			0.00			3.17

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
 PART A  
 (CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
3.18						3.18
3.19						3.19
3.20						3.20
3.21						3.21
3.22						3.22
3.23						3.23
3.24						3.24
4						4
4.01						4.01
4.02						4.02
4.03						4.03
4.04						4.04
5						5
5.01						5.01
5.02						5.02
5.03						5.03
5.04						5.04
5.05						5.05
5.06						5.06
6						6
7						7
7.01						7.01
8						8
9						9
10						10
11						11
11.01						11.01
11.02						11.02
12						12
13						13
14						14
15						15
16						16
17						17
18						18
19						19
20						20
21						21
21.01						21.01
21.02						21.02
22						22

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A  
(CONT)

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

	HOSPITAL	SUB I	SUB II	SUB III	SUB IV	
23						23
						TERMINATION OR A DECREASE IN PROGRAM UTILIZATION
24						24
						10 POINT RCC ISSUE
25						25
						AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS
26						26
						AMOUNT DUE PROVIDER
27						27
						SEQUESTRATION ADJUSTMENT
28						28
						INTERIM PAYMENTS
28.01						28.01
						TENTATIVE SETTLEMENT (FOR FI USE ONLY)
29						29
						BALANCE DUE PROVIDER (PROGRAM)
30						30
						PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2
						TO BE COMPLETED BY INTERMEDIARY
50						50
						OPERATING OUTLIER AMOUNT FROM WKST E, PART A, LINE 2.01
51						51
						CAPITAL OUTLIER AMOUNT FROM WKST L, PART I, LINE 3.01
52						52
						OPERATING OUTLIER RECONCILIATION AMOUNT (SEE INSTR.)
53						53
						CAPITAL OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)
54						54
						THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY
55						55
						TIME VALUE OF MONEY (SEE INSTRUCTIONS)
56						56
						CAPITAL TIME VALUE OF MONEY (SEE INSTRUCTIONS)

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WORKSHEET E  
 PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (15-2010)	HOSPITAL (15-2010)	HOSPITAL (15-2010)	
	1	1.01	1.02	
1 MEDICAL AND OTHER SERVICES				1
1.01 MEDICAL AND OTHER SERVICES RENDERED ON OR AFTER AUGUST 1, 2000				1.01
1.02 PPS PAYMENTS RECEIVED INCLUDING OUTLIERS				1.02
1.03 1996 HOSPITAL SPECIFIC PAYMENT TO COST RATIO				1.03
1.04 LINE 1.01 TIMES LINE 1.03				1.04
1.05 LINE 1.02 DIVIDED BY LINE 1.04				1.05
1.06 TRANSITIONAL CORRIDOR PAYMENT				1.06
1.07 AMOUNT FROM WORKSHEET D, PART IV, COLUMN 9, LINE 101				1.07
2 INTERNS AND RESIDENTS				2
3 ORGAN ACQUISITIONS				3
4 COST OF TEACHING PHYSICIANS				4
5 TOTAL COST				5
COMPUTATION OF LESSER OF COST OR CHARGES				
REASONABLE CHARGES				
6 ANCILLARY SERVICE CHARGES				6
7 INTERNS AND RESIDENTS SERVICE CHARGES				7
8 ORGAN ACQUISITION CHARGES				8
9 CHARGES OF PROFESSIONAL SERVICES OF TEACHING PHYSICIANS				9
10 TOTAL REASONABLE CHARGES				10
CUSTOMARY CHARGES				
11 AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				11
12 AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)				12
13 RATIO OF LINE 11 TO LINE 12				13
14 TOTAL CUSTOMARY CHARGES				14
15 EXCESS OF CUSTOMARY CHGES OVER REASONABLE COST				15
16 EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES				16
17 LESSER OF COST OR CHARGES				17
17.01 TOTAL PPS PAYMENTS				17.01

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WORKSHEET E  
PART B

PART B - MEDICAL AND OTHER HEALTH SERVICES

	HOSPITAL (15-2010)	HOSPITAL (15-2010)	HOSPITAL (15-2010)	
	1	1.01	1.02	
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18				18
18.01				18.01
				LINE 17.01
19				19
20				20
21				21
22				22
23				23
24				24
25				25
				REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)
26				26
27				27
27.01				27.01
27.02				27.02
				BENEFICIARIES (SEE INSTRUCTIONS)
28				28
29				29
				RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION
30				30
30.99				30.99
				OTHER ADJUSTMENTS (MSP-LCC RECONCILIATION AMOUNT)
31				31
				AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS
32				32
33				33
34				34
34.01				34.01
35				35
36				36
				BALANCE DUE PROVIDER/PROGRAM
				PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART C

PART C - OUTPATIENT AMBULATORY SURGICAL CENTER

[ ] TITLE V            [XX] TITLE XVIII            [ ] TITLE XIX

HOSPITAL  
(15-2010)  
OCTOBER 1, 1997  
PRIOR TO    ON OR AFTER  
1            1.01

1	STANDARD OVERHEAD AMOUNTS (ASC FEES)	1
2	DEDUCTIBLES	2
3	SUBTOTAL	3
4	80 PERCENT OF LINE 3	4
5	ASC PORTION OF BLEND	5
6	OUTPATIENT ASC COST	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	HOSPITAL SPECIFIC PORTION OF BLEND	17
18	ASC BLENDED AMOUNT	18
19	LESSER OF LINES 16 OR 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	ASC PAYMENT AMOUNT	21

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART D

PART D - OUTPATIENT RADIOLOGY SERVICES

[ ] TITLE V            [XX] TITLE XVIII            [ ] TITLE XIX

HOSPITAL  
(15-2010)  
OCTOBER 1, 1997  
PRIOR TO    ON OR AFTER  
1            1.01

1	PREVAILING CHARGES	1
2	62 PERCENT OF LINE 1	2
3	DEDUCTIBLES	3
4	SUBTOTAL	4
5	BLENDED CHARGE PROPORTION	5
6	COST OF OUTPATIENT RADIOLOGY	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	COST PROPORTION	17
18	OUTPATIENT RADIOLOGY BLENDED AMOUNT	18
19	LESSER OF LINE 16 OR LINE 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	RADIOLOGY PAYMENT AMOUNT	21

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART E

PART E - OTHER OUTPATIENT DIAGNOSTIC PROCEDURES

[ ] TITLE V            [XX] TITLE XVIII            [ ] TITLE XIX

HOSPITAL  
(15-2010)  
OCTOBER 1, 1997  
PRIOR TO    ON OR AFTER  
1            1.01

1	PREVAILING CHARGES	1
2	42 PERCENT OF LINE 1	2
3	DEDUCTIBLES	3
4	SUBTOTAL	4
5	BLENDED CHARGE PROPORTION	5
6	COST OF OTHER OUTPATIENT DIAGNOSTIC PROCEDURES	6
COMPUTATION OF LESSER OF COST OR CHARGES		
7	TOTAL CHARGES	7
CUSTOMARY CHARGES		
8	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS	8
9	AMOUNTS THAT WOULD HAVE BEEN REALIZED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICE ON A CHARGE BASIS HAD SUCH PAYMENT BEEN MADE IN ACCORDANCE WITH 42 CFR 413.13(E)	9
10	RATIO OF LINE 8 TO LINE 9	10
11	TOTAL CUSTOMARY CHARGES	11
12	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST	12
13	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES	13
14	LESSER OF COST OR CHARGES	14
COMPUTATION OF REIMBURSEMENT SETTLEMENT		
15	DEDUCTIBLES AND COINSURANCE	15
16	TOTAL	16
17	COST PROPORTION	17
18	OTHER OUTPATIENT DIAGNOSTIC BLENDED AMOUNT	18
19	LESSER OF LINE 16 OR LINE 18	19
20	PART B DEDUCTIBLES AND COINSURANCE	20
21	DIAGNOSTIC PAYMENT AMOUNT	21

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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  
 HOSPITAL (15-2010)

WORKSHEET E-1

DESCRIPTION	INPATIENT		PART B		
	PART A		PART B		
	MM/DD/YYYY	AMOUNT	MM/DD/YYYY	AMOUNT	
	1	2	3	4	
1 TOTAL INTERIM PAYMENTS PAID TO PROVIDER		12191930			1
2 INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE', OR ENTER A ZERO.		NONE		NONE	2
3 LIST SEPARATELY EACH RETROACTIVE LUMP SUM					
ADJUSTMENT AMOUNT BASED ON SUBSEQUENT	PROGRAM	.02			3.01
REVISION OF THE INTERIM RATE FOR THE COST	TO	.03			3.02
REPORTING PERIOD. ALSO SHOW DATE OF EACH	PROVIDER	.04	NONE	NONE	3.03
PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.		.05			3.04
		.50	12/02/2008	5813500	3.05
	PROVIDER	.51			3.50
	TO	.52		NONE	3.51
	PROGRAM	.53			3.52
		.54			3.53
					3.54
SUBTOTAL	.99		-5813500		3.99
4 TOTAL INTERIM PAYMENTS		6378430			4
TO BE COMPLETED BY INTERMEDIARY					
5 LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAY- MENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO.	PROGRAM	.01			5.01
	TO	.02			5.02
	PROVIDER	.03			5.03
	PROVIDER	.50			5.50
	TO	.51			5.51
	PROGRAM	.52			5.52
SUBTOTAL	.99				5.99
6 DETERMINED NET SETTLEMENT AMOUNT (BALANCE DUE) BASED ON THE COST REPORT.	PROGRAM TO	.01			6.01
	PROVIDER	.02			6.02
	PROVIDER TO				
	PROGRAM				
7 TOTAL MEDICARE PROGRAM LIABILITY					7

NAME OF INTERMEDIARY:

INTERMEDIARY NUMBER:

SIGNATURE OF AUTHORIZED PERSON:

DATE (MO/DAY/YR):

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
 PART I

MEDICARE PART A SERVICES - TEFRA		HOSPITAL (15-2010)	SUB I	SUB II	SUB III	SUB IV	
1	INPATIENT HOSPITAL SERVICES						1
1.01	HOSPITAL SPECIFIC AMOUNT (SEE INSTRUCTIONS)						1.01
1.02	NET FEDERAL PPS PAYMENTS (SEE INSTRUCTIONS)	5695792					1.02
1.03	MEDICARE SSI RATIO (IRF PPS ONLY) (SEE INSTR.)						1.03
1.04	INPATIENT REHAB LIP PAYMENTS (SEE INSTRUCTIONS)						1.04
1.05	OUTLIER PAYMENTS	395626					1.05
1.06	TOTAL PPS PAYMENTS	6091418					1.06
1.07	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT						1.07
INPATIENT PSYCHIATRIC FACILITY (IPF)							
1.08	NET FEDERAL IPF PPS PAYMENTS (EXCLUDING OUTLIER, STOP-LOSS, ECT, AND TEACHING ADJUSTMENT)						1.08
1.09	NET IPF PPS OUTLIER PAYMENTS						1.09
1.10	NET IPF PPS ECT PAYMENTS						1.10
1.11	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR LATEST COST REPORT FILED PRIOR TO NOVEMBER 15, 2004. (SEE INSTRUCTIONS)						1.11
1.12	NEW TEACHING PROGRAM ADJUSTMENT (SEE INSTR.)						1.12
1.13	CURRENT YEAR'S UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM'. (SEE INSTR.)						1.13
1.14	CURRENT YEAR'S UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A 'NEW TEACHING PROGRAM'. (SEE INSTR.)						1.14
1.15	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (SEE INSTRUCTIONS)						1.15
1.16	AVERAGE DAILY CENSUS (SEE INSTRUCTIONS)						1.16
1.17	MEDICAL EDUCATION ADJUSTMENT FACTOR						1.17
1.18	MEDICAL EDUCATION ADJUSTMENT						1.18
1.19	ADJUSTED NET IPF PPS PAYMENTS						1.19
1.20	STOP LESS PAYMENT FLOOR						1.20
1.21	ADJUSTED NET PAYMENT FLOOR						1.21
1.22	STOP LOSS ADJUSTMENT						1.22
1.23	TOTAL IPF PPS PAYMENTS						1.23
INPATIENT REHABILITATION FACILITY (IRF)							
1.35	UNWEIGHTED INTERN AND RESIDENT FTE COUNT FOR COST REPORT PERIODS ENDING ON/OR PRIOR TO NOVEMBER 15, 2004. (SEE INSTRUCTIONS)						1.35
1.36	NEW TEACHING PROGRAM ADJUSTMENT. (SEE INSTR.)						1.36
1.37	CURRENT YEAR'S UNWEIGHTED FTE COUNT OF I&R OTHER THAN FTES IN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INSTRUCTIONS)						1.37
1.38	CURRENT YEAR'S UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE FIRST 3 YEARS OF A "NEW TEACHING PROGRAM". (SEE INSTRUCTIONS)						1.38
1.39	INTERN AND RESIDENT COUNT FOR IRF PPS MEDICAL EDUCATION ADJUSTMENT. (SEE INSTRUCTIONS)						1.39
1.40	AVERAGE DAILY CENSUS. (SEE INSTRUCTIONS)						1.40
1.41	MEDICAL EDUCATION ADJUSTMENT FACTOR						1.41
1.42	MEDICAL EDUCATION ADJUSTMENT						1.42
2	ORGAN ACQUISITION						2
3	COST OF TEACHING PHYSICIANS						3
4	SUBTOTAL	6091418					4
5	PRIMARY PAYER PAYMENTS						5
6	SUBTOTAL	6091418					6
7	DEDUCTIBLES	11104					7
8	SUBTOTAL	6080314					8
9	COINSURANCE	277528					9
10	SUBTOTAL	5802786					10
11	REIMBURSABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	44986					11
11.01	REDUCED REIMBURSABLE BAD DEBTS	31490					11.01
11.02	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (SEE INSTRUCTIONS)						11.02
12	SUBTOTAL	5834276					12
13	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS						13

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E-3  
PART I

MEDICARE PART A SERVICES - TEFRA		HOSPITAL (15-2010)	SUB I	SUB II	SUB III	SUB IV	
13.01	OTHER PASS THROUGH COSTS (SEE INSTRUCTIONS)						13.01
14	RECOVERY OF EXCESS DEPRECIATION RESULTING FROM PROVIDER TERMINATION OR A DECREASE IN PROGRAM UTILIZATION						14
15	10 POINT RCC ISSUE	921372					15
16	AMOUNTS APPLICABLE TO PRIOR COST REPORTING PERIODS RESULTING FROM DISPOSITION OF DEPRECIABLE ASSETS						16
17	TOTAL AMOUNT PAYABLE TO THE PROVIDER	6755648					17
18	SEQUESTRATION ADJUSTMENT						18
19	INTERIM PAYMENTS	6378430					19
19.01	TENTATIVE SETTLEMENT (FOR FI USE ONLY)						19.01
20	BALANCE DUE PROVIDER/PROGRAM	377218					20
21	PROTESTED AMOUNTS (NONALLOWABLE COST REPORT ITEMS) IN ACCORDANCE WITH CMS PUB 15-II, SECTION 115.2	167099					21
TO BE COMPLETED BY INTERMEDIARY							
50	ORIGINAL OUTLIER AMOUNT						50
51	OUTLIER RECONCILIATION AMOUNT (SEE INSTRUCTIONS)						51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY						52
53	OPERATING TIME VALUE OF MONEY (SEE INSTRUCTIONS)						53



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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

	GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4
1 FUND BALANCES AT BEGINNING OF PERIOD	-1466634			1
2 NET INCOME (LOSS)	-3000624			2
3 TOTAL	-4467258			3
4 ADDITIONS (CREDIT ADJUSTMENTS)				4
5 FUND BALANCE RECON	-1184922			5
6				6
7				7
8				8
9				9
10 TOTAL ADDITIONS	-1184922			10
11 SUBTOTAL	-5652180			11
12 DEDUCTIONS (DEBIT ADJUSTMENTS)				12
13				13
14				14
15				15
16				16
17				17
18 TOTAL DEDUCTIONS				18
19 FUND BALANCE AT END OF PERIOD PER BALANCE SHEET	-5652180			19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2  
 PARTS I & II

PART I - PATIENT REVENUES

REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
1 GENERAL INPATIENT ROUTINE CARE SERVICES				
1 HOSPITAL	3411096		3411096	1
2 SUBPROVIDER I				2
4 SWING BED - SNF				4
5 SWING BED - NF				5
6 SKILLED NURSING FACILITY				6
7 NURSING FACILITY				7
8 OTHER LONG TERM CARE				8
9 TOTAL GENERAL INPATIENT CARE SERVICES	3411096		3411096	9
INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
10 INTENSIVE CARE UNIT				10
11 CORONARY CARE UNIT				11
12 BURN INTENSIVE CARE UNIT				12
13 SURGICAL INTENSIVE CARE UNIT				13
14 OTHER SPECIAL CARE (SPECIFY)				14
15 TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICE				15
16 TOTAL INPATIENT ROUTINE CARE SERVICES	3411096		3411096	16
17 ANCILLARY SERVICES	11572993		11572993	17
18 OUTPATIENT SERVICES				18
18.50 RHC				18.50
18.60 FQHC				18.60
19 HOME HEALTH AGENCY				19
20 AMBULANCE				20
21 CORF				21
22 ASC				22
23 HOSPICE				23
24				24
25 TOTAL PATIENT REVENUES	14984089		14984089	25

PART II - OPERATING EXPENSES

	1	2	
26 OPERATING EXPENSES		10535585	26
27 ADD (SPECIFY)			27
28			28
29			29
30			30
31			31
32			32
33 TOTAL ADDITIONS			33
34 DEDUCT (SPECIFY)			34
35			35
36			36
37			37
38			38
39 TOTAL DEDUCTIONS			39
40 TOTAL OPERATING EXPENSES		10535585	40

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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

DESCRIPTION		
1	TOTAL PATIENT REVENUES	14984089
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	7285260
3	NET PATIENT REVENUES	7698829
4	LESS - TOTAL OPERATING EXPENSES	10535585
5	NET INCOME FROM SERVICE TO PATIENTS	-2836756
6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	
7	INCOME FROM INVESTMENTS	
8	REVENUE FROM TELEPHONE AND TELEGRAPH SERVICE	
9	REVENUE FROM TELEVISION AND RADIO SERVICE	
10	PURCHASE DISCOUNTS	
11	REBATES AND REFUNDS OF EXPENSES	
12	PARKING LOT RECEIPTS	
13	REVENUE FROM LAUNDRY AND LINEN SERVICE	
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	
15	REVENUE FROM RENTAL OF LIVING QUARTERS	
16	REV FROM SALE OF MED & SURG SUPP TO OTHER THAN PATIENTS	
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS	
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	2378
19	TUITION (FEES, SALE OF TEXTBOOKS, UNIFORMS, ETC.)	
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN	
21	RENTAL OF VENDING MACHINES	
22	RENTAL OF HOSPITAL SPACE	
23	GOVERNMENTAL APPROPRIATIONS	
24	OTHER REVENUE	3600
25	TOTAL OTHER INCOME	5978
26	TOTAL	-2830778
27	ADDITIONAL HOME OFFICE EXPENSE	169846
28		
29		
30	TOTAL OTHER EXPENSES	169846
31	NET INCOME (OR LOSS) FOR THE PERIOD	-3000624

CALCULATION OF CAPITAL PAYMENT - TITLE XVIII - FULLY PROSPECTIVE METHOD

WORKSHEET L

	HOSPITAL	HOSPITAL	SUB I	SUB II	SUB III
	1	1.01			
PART I - FULLY PROSPECTIVE METHOD					
1	CAPITAL HOSPITAL SPECIFIC RATE PAYMENTS				1
	CAPITAL FEDERAL AMOUNT				
2	CAPITAL DRG OTHER THAN OUTLIER				2
3	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED PRIOR TO OCTOBER 1, 1997				3
3.01	CAPITAL DRG OUTLIER PAYMENTS FOR SERVICES RENDERED ON OR AFTER OCTOBER 1, 1997				3.01
	INDIRECT MEDICAL EDUCATION ADJUSTMENT				
4	TOTAL INPAT DAYS DIVIDED BY NO OF DAYS IN CR PERIOD [ E-3,PT VI,LN.18] [E,PT A,LN.3.17][x E-3,PT VI,LN.1]				4
4.01	NO. OF INTERNS & RESIDENTS	0.00		0.00	4.01
4.02	INDIRECT MEDICAL EDUCATION PERCENTAGE				4.02
4.03	INDIRECT MEDICAL EDUCATION ADJUSTMENT DISPROPORTIONATE SHARE ADJUSTMENT				4.03
5	% OF SSI RECIPIENT PAT DAYS TO MEDICARE PART A PAT DAYS				5
5.01	% OF MEDICAID PAT DAYS TO TOTAL DAYS ON WKST S-3, PART I				5.01
5.02	SUM OF LINES 5 AND 5.01				5.02
5.03	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE				5.03
5.04	DISPROPORTIONATE SHARE ADJUSTMENT				5.04
6	TOTAL PROSPECTIVE CAPITAL PAYMENTS				6
PART II - HOLD HARMLESS METHOD					
1	NEW CAPITAL				1
2	OLD CAPITAL				2
3	TOTAL CAPITAL				3
4	RATIO OF NEW CAPITAL TO TOTAL CAPITAL				4
5	TOTAL CAPITAL PAYMENTS UNDER 100% FEDERAL RATE				5
6	REDUCTION FACTOR FOR HOLD HARMLESS PAYMENT				6
7	REDUCED OLD CAPITAL AMOUNT				7
8	HOLD HARMLESS PAYMENT FOR NEW CAPITAL				8
9	SUBTOTAL				9
10	PAYMENT UNDER HOLD HARMLESS (GREATER OF LINE 5 OR LINE 9)				10
PART III - PAYMENT UNDER REASONABLE COST					
1	PROGRAM INPATIENT ROUTINE CAPITAL COST				1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST				2
3	TOTAL INPATIENT PROGRAM CAPITAL				3
4	CAPITAL COST PAYMENT FACTOR				4
5	TOTAL INPATIENT PROGRAM CAPITAL COST				5
PART IV - COMPUTATION OF EXCEPTION PAYMENTS					
1	PROGRAM INPATIENT CAPITAL COSTS				1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES				2
3	NET PROGRAM INPATIENT CAPITAL COSTS				3
4	APPLICABLE EXCEPTION PERCENTAGE				4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS				5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES				6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES				7
8	CAPITAL MINIMUM PAYMENT LEVEL				8
9	CURRENT YEAR CAPITAL PAYMENTS				9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS				10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT				11
12	NET COMPARISON OF CAPITAL MINIMUM PYMNT LEVEL TO CAPITAL PYMNTS				12
13	CURRENT YEAR EXCEPTION PAYMENT				13
14	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT FOR FOLLOWING PERIOD				14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (SEE INSTRUCTIONS)				15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (SEE INSTRUCTIONS)				16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT				17

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ALLOCATION OF ALLOWABLE CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1  
 PART I

COST CENTER DESCRIPTION	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL 4A	SUBTOTAL 25	I&R COST & POST STEP- DOWN ADJS 26	TOTAL 27	
GENERAL SERVICE COST CENTERS						
1	OLD CAP REL COSTS-BLDG & FIXT					1
2	OLD CAP REL COSTS-MVBLE EQUIP					2
3	NEW CAP REL COSTS-BLDG & FIXT					3
4	NEW CAP REL COSTS-MVBLE EQUIP					4
5	EMPLOYEE BENEFITS					5
6	ADMINISTRATIVE & GENERAL					6
7	MAINTENANCE & REPAIRS					7
8	OPERATION OF PLANT					8
9	LAUNDRY & LINEN SERVICE					9
10	HOUSEKEEPING					10
11	DIETARY					11
12	CAFETERIA					12
13	MAINTENANCE OF PERSONNEL					13
14	NURSING ADMINISTRATION					14
15	CENTRAL SERVICES & SUPPLY					15
16	PHARMACY					16
17	MEDICAL RECORDS & LIBRARY					17
18	SOCIAL SERVICE					18
20	NONPHYSICIAN ANESTHETISTS					20
21	NURSING SCHOOL					21
22	I&R SERVICES-SALARY & FRINGES A					22
23	I&R SERVICES-OTHER PRGM COSTS A					23
24	PARAMED ED PRGM-(SPECIFY)					24
INPATIENT ROUTINE SERV COST CENTERS						
25	ADULTS & PEDIATRICS					25
ANCILLARY SERVICE COST CENTERS						
37	OPERATING ROOM					37
41	RADIOLOGY-DIAGNOSTIC					41
44	LABORATORY					44
46.30	BLOOD CLOTTING FACTORS ADMIN CO					46.30
49	RESPIRATORY THERAPY					49
50	PHYSICAL THERAPY					50
51	OCCUPATIONAL THERAPY					51
52	SPEECH PATHOLOGY					52
53.01	RENAL DIALYSIS					53.01
55	MEDICAL SUPPLIES CHARGED TO PAT					55
56	DRUGS CHARGED TO PATIENTS					56
OUTPATIENT SERVICE COST CENTERS						
62	OBSERVATION BEDS (NON-DISTINCT					62
63.50	RHC					63.50
63.60	FQHC					63.60
OTHER REIMBURSABLE COST CENTERS						
69.10	CMHC					69.10
69.20	OUTPATIENT PHYSICAL THERAPY					69.20
69.30	OUTPATIENT OCCUPATIONAL THERAPY					69.30
69.40	OUTPATIENT SPEECH PATHOLOGY					69.40
71	HOME HEALTH AGENCY					71
SPECIAL PURPOSE COST CENTERS						
85.01	PANCREAS ACQUISITION					85.01
85.02	INTESTINAL ACQUISITION					85.02
85.03	ISLET CELL ACQUISITION					85.03
95	SUBTOTALS					95
NONREIMBURSABLE COST CENTERS						
00	PROVIDER RELATIONS NRCC					00
101	CROSS FOOT ADJUSTMENTS					101
102	NEGATIVE COST CENTER					102
103	TOTAL					103
104	TOTAL STATISTICAL BASIS					104
105	UNIT COST MULTIPLIER					105
105	UNIT COST MULTIPLIER					105

\*\*\*FINGERPRINT Line 1 2LskXky.NxayEqORn54DAWRVMUpwT0  
 \*\*\*FINGERPRINT Line 2 E00aZ0lFAce:N16fSafRMC6ol2vW4L  
 \*\*\*FINGERPRINT Line 3 Lg004rjPhk0tt4BN