

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY**

**WORKSHEET S  
PARTS I, II & III**

**PART I - COST REPORT STATUS**

Provider use only		1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	Date: 02/25/2018 Time: 10:34
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

**PART II - CERTIFICATION**

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by NORWEGIAN AMERICAN HOSPITAL (14-0206) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 10/01/2016 and ending 09/30/2017, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)  
  
\_\_\_\_\_  
Title  
  
\_\_\_\_\_  
Date

**PART III - SETTLEMENT SUMMARY**

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		219,550	-233,245			1
2	SUBPROVIDER - IPF		4,676				2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		224,226	-233,245			200

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 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

Hospital and Hospital Health Care Complex Address:

1	Street: 1044 N. FRANCISCO AVENUE	P.O. Box:			1
2	City: CHICAGO	State: IL	ZIP Code: 60622	County: COOK	2

Hospital and Hospital-Based Component Identification:

Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
0	1	2	3	4	5	6	7	8		
3	Hospital	NORWEGIAN AMERICAN HOSPITAL	14-0206	16974	1	07 / 01 / 1966	N	P	O	3
4	Subprovider - IPF	NORWEGIAN AMERICAN HOSP - PSYCH	14-S206	16974	4	10 / 01 / 2006	N	P	O	4
5	Subprovider - IRF									5
6	Subprovider - (OTHER)									6
7	Swing Beds - SNF									7
8	Swing Beds - NF									8
9	Hospital-Based SNF									9
10	Hospital-Based NF									10
11	Hospital-Based OLTC									11
12	Hospital-Based HHA									12
13	Separately Certified ASC									13
14	Hospital-Based Hospice									14
15	Hospital-Based Health Clinic - RHC									15
16	Hospital-Based Health Clinic - FQHC									16
17	Hospital-Based (CMHC)									17
18	Renal Dialysis									18
19	Other									19

20	Cost Reporting Period (mm/dd/yyyy)	From: 10 / 01 / 2016	To: 09 / 30 / 2017		20
21	Type of control (see instructions)	2			21

**Inpatient PPS Information**

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	Y	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	1	N		23

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	3,904				16,213	162	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1						26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1						27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.							35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.							37
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with the FY 2016 OPSS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N						37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:				38

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions)				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06

Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program (see instructions). Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.

	Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the IME FTE unweighted count. Enter in column 4 direct the GME FTE unweighted count.

**ACA Provisions Affecting the Health Resources and Services Administration (HRSA)**

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				62
62.01	Enter the number of FTE residents that rotated from a teaching health center (THC) into your hospital in this cost reporting period of HRSA THC program. (see instructions)				62.01

**Teaching Hospitals that Claim Residents in Nonprovider Settings**

63	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64 through 67. (see instructions)	N			63
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**WORKSHEET S-2  
PART I**

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64

Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))		
65	1	2	3	4	5		65

Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))		
67	1	2	3	4	5		67

**Inpatient Psychiatric Facility PPS**

		1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	Y			70
71	If line 70 is yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	Y	N		71

**Inpatient Rehabilitation Facility PPS**

		1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	N			75
76	If line 75 is yes: Column 1: Did 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. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				76

**Long Term Care Hospital PPS**

80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.	N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.	N		81

**TEFRA Providers**

85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.	N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.			86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.	N		87

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**WORKSHEET S-2  
PART I**

Title V and XIX Services		V	XIX	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

**Rural Providers**

		1	2	
105	Does this hospital qualify as a CAH?	N		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106
107	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 in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Physical	Occupational Speech	Respiratory 109

		1	2	
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.	1	2	111

**Miscellaneous Cost Reporting Information**

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1.	N		115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118
118.01	List amounts of malpractice premiums and paid losses:	Premiums 676,532	Paid Losses	Self Insurance 118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y		121
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N		122

**Transplant Center Information**

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2.			132
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**

**WORKSHEET S-2  
PART I**

All Providers

		1	2	
140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	N		140

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name:	Contractor's Name:		Contractor's Number:		141
142	Street:	P.O. Box:				142
143	City:	State:	ZIP Code:			143
144	Are provider based physicians' costs included in Worksheet A?	Y				144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	Y	N			145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N				147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N				148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N				149

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter 'Y' for yes or 'N' for no for each component for Part A and Part B. See 42 CFR §413.13)

		Title XVIII		Title V	Title XIX	
		Part A	Part B	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

165	Is this hospital part of a multicampus hospital that has one or more campuses in different CBSAs? Enter 'Y' for yes or 'N' for no.	N				165
166	If line 165 is yes, for each campus, enter the name in column 0, county in column 1, state in column 2, ZIP in column 3, CBSA in column 4, FTE/campus in column 5. (see instructions)					166
	Name	County	State	ZIP Code	CBSA	FTE/Campus
	0	1	2	3	4	5

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)	9.99			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01 / 01 / 2016	09 / 30 / 2017		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0		171

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

**General Instruction: Enter Y for all YES responses. Enter N for all NO responses.  
Enter all dates in the mm/dd/yyyy format.**

**COMPLETED BY ALL HOSPITALS**

		Y/N	Date		
<b>Provider Organization and Operation</b>					
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

		Y/N	Type	Date	
<b>Financial Data and Reports</b>					
4	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter 'A' for Audited, 'C' for Compiled, or 'R' for Reviewed. Submit complete copy or enter date available in column 3. (see instructions). If no, see instructions.	Y	A		4
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	Y			5

		Y/N	Y/N	
<b>Approved Educational Activities</b>				
6	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider the legal operator of the program?	N		6
7	Are costs claimed for allied health programs? If yes, see instructions.	N		7
8	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period?	N		8
9	Are costs claimed for Interns and Residents in approved GME programs claimed on the current cost report? If yes, see instructions.	Y		9
10	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10
11	Are GME costs directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11

		Y/N	
<b>Bad Debts</b>			
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12
13	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

<b>Bed Complement</b>			
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15

		Part A		Part B	
		Y/N	Date	Y/N	Date
<b>PS&amp;R Report Data</b>					
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/08/2018	Y	02/08/2018
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE**

**WORKSHEET S-2  
PART II**

**General Instruction: Enter Y for all YES responses. Enter N for all NO responses.  
Enter all dates in the mm/dd/yyyy format.**

**COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)**

Capital Related Cost			
22	Have assets been relifed for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

Interest Expense			
28	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28
29	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions.		29
30	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30
31	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31

Purchased Services			
32	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32
33	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33

Provider-Based Physicians			
34	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34
35	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35

Home Office Costs		Y/N	Date	
		1	2	
36	Are home office costs claimed on the cost report?			36
37	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37
38	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38
39	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39
40	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40

Cost Report Preparer Contact Information			
41	First name: RAJ	Last name: SHAH	Title: MANAGER
42	Employer: STRATEGIC REIMBURSEMENT GROUP LLC		
43	Phone number: 630 530-7100, X107	E-mail Address: RAJ.SHAH@SRGROUPLLC.COM	

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	161	58,765			6,494	2,766	27,237	1
2	HMO and other (see instructions)						2,843	16,213		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		161	58,765			6,494	2,766	27,237	7
8	Intensive Care Unit	31	12	4,380			1,124	241	3,301	8
8.01	NICU	31.01								8.01
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43						897	1,970	13
14	Total (see instructions)		173	63,145			7,618	3,904	32,508	14
15	CAH Visits									15
16	Subprovider - IPF	40	12	4,380			967	211	3,440	16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		185							27
28	Observation Bed Days							197	2,010	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)		10	3,650				162	209	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								493	32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA**

**WORKSHEET S-3  
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,407	660	6,458	1
2	HMO and other (see instructions)					480	3,428		2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
8.01	NICU								8.01
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)	4.26	709.97			1,407	660	6,458	14
15	CAH Visits								15
16	Subprovider - IPF		9.94			145	33	532	16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC								26
27	Total (sum of lines 14-26)	4.26	719.91						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL WAGE INDEX INFORMATION**

**WORKSHEET S-3  
PARTS II-III**

**Part II - Wage Data**

	Wkst A Line No.	Amount Reported	Reclassif- ication of Salaries (from Worksheet A-6)	Adjusted Salaries (column 2 ± column 3)	Paid Hours Related to Salaries in Column 4	Average Hourly wage (column 4 ± column 5)		
	1	2	3	4	5	6		
<b>SALARIES</b>								
1	Total salaries (see instructions)	200	47,785,046	47,785,046	1,497,414.00	31.91	1	
2	Non-physician anesthetist Part A						2	
3	Non-physician anesthetist Part B						3	
4	Physician-Part A - Administrative		487,502	487,502	3,488.00	139.77	4	
4.01	Physician-Part A - Teaching						4.01	
5	Physician-Part B		2,960,503	2,960,503	35,132.00	84.27	5	
6	Non-physician-Part B						6	
7	Interns & residents (in an approved program)	21	147,191	147,191	7,233.00	20.35	7	
7.01	Contracted interns & residents (in an approved program)						7.01	
8	Home office and/or related organization personnel						8	
9	SNF	44					9	
10	Excluded area salaries (see instructions)		1,825,997	1,825,997	52,648.00	34.68	10	
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11	Contract labor (see instructions)		3,009,001	3,009,001	45,005.00	66.86	11	
12	Contract management and administrative services						12	
13	Contract labor: Physician-Part A - Administrative						13	
14	Home office salaries & wage-related costs						14	
14.01	Home office salaries						14.01	
14.02	Related organization salaries						14.02	
15	Home office: Physician Part A - Administrative						15	
16	Home office & Contract Physicians Part A - Teaching						16	
<b>WAGE-RELATED COSTS</b>								
17	Wage-related costs (core)(see instructions)		9,450,808	9,450,808			17	
18	Wage-related costs (other)(see instructions)						18	
19	Excluded areas		382,832	382,832			19	
20	Non-physician anesthetist Part A						20	
21	Non-physician anesthetist Part B						21	
22	Physician Part A - Administrative		68,325	68,325			22	
22.01	Physician Part A - Teaching						22.01	
23	Physician Part B		459,653	459,653			23	
24	Wage-related costs (RHC/FQHC)						24	
25	Interns & residents (in an approved program)		40,443	40,443			25	
25.50	Home office wage-related						25.50	
25.51	Related organization wage-related						25.51	
25.52	Home office: Physician Part A - Administrative - wage-related						25.52	
25.53	Home office & Contract Physicians Part A - Teaching - wage-related						25.53	
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26	Employee Benefits Department		3,916,748	3,916,748	154,711.00	25.32	26	
27	Administrative & General		6,599,558	6,599,558	104,660.00	63.06	27	
28	Administrative & General under contract (see instructions)		269,765	269,765	4,146.00	65.07	28	
29	Maintenance & Repairs						29	
30	Operation of Plant		1,525,851	1,525,851	68,740.00	22.20	30	
31	Laundry & Linen Service						31	
32	Housekeeping		1,170,026	1,170,026	92,924.00	12.59	32	
33	Housekeeping under contract (see instructions)						33	
34	Dietary		799,845	-247,380	552,465	39,163.00	14.11	34
35	Dietary under contract (see instructions)		446,468		446,468	11,162.00	40.00	35
36	Cafeteria			247,380	247,380	17,537.00	14.11	36
37	Maintenance of Personnel						37	
38	Nursing Administration		1,403,555	1,403,555	32,393.00	43.33	38	
39	Central Services and Supply		537,325	537,325	22,027.00	24.39	39	
40	Pharmacy		1,316,939	1,316,939	45,068.00	29.22	40	
41	Medical Records & Medical Records Library		566,948	566,948	21,566.00	26.29	41	
42	Social Service		896,869	896,869	26,470.00	33.88	42	
43	Other General Service						43	

**Part III - Hospital Wage Index Summary**

1	Net salaries (see instructions)		45,393,585	45,393,585	1,470,357.00	30.87	1
2	Excluded area salaries (see instructions)		1,825,997	1,825,997	52,648.00	34.68	2
3	Subtotal salaries (line 1 minus line 2)		43,567,588	43,567,588	1,417,709.00	30.73	3
4	Subtotal other wages & related costs (see instructions)		3,009,001	3,009,001	45,005.00	66.86	4
5	Subtotal wage-related costs (see instructions)		9,519,133	9,519,133		21.85%	5
6	Total (sum of lines 3 through 5)		56,095,722	56,095,722	1,462,714.00	38.35	6
7	Total overhead cost (see instructions)		19,449,897	19,449,897	640,567.00	30.36	7

**KPMG LLP Compu-Max 2552-10**

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**HOSPITAL WAGE RELATED COSTS**

**WORKSHEET S-3  
PART IV**

**Part IV - Wage Related Cost**

**Part A - Core List**

		Amount Reported	
	<b>RETIREMENT COST</b>		
1	401K Employer Contributions	434,095	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)	1,658,622	4
	<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization):</b>		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	<b>HEALTH AND INSURANCE COST</b>		
8	Health Insurance (Purchased or Self Funded)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)	3,866,175	8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	231,822	10
11	Life Insurance (If employee is owner or beneficiary)	54,039	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	157,510	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	477,677	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	<b>TAXES</b>		
17	FICA-Employers Portion Only	2,639,132	17
18	Medicare Taxes - Employers Portion Only	657,706	18
19	Unemployment Insurance	79,413	19
20	State or Federal Unemployment Taxes		20
	<b>OTHER</b>		
21	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	Day Care Costs and Allowances		22
23	Tuition Reimbursement	145,870	23
24	Total Wage Related cost (Sum of lines 1-23)	10,402,061	24

**Part B - Other Than Core Related Cost**

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**HOSPITAL CONTRACT LABOR AND BENEFIT COST**

**WORKSHEET S-3  
PART V**

**Part V - Contract Labor and Benefit Cost**

**Hospital and Hospital-Based Component Identification:**

	Component	Contract Labor 1	Benefit Cost 2	
	0			
1	Total facility contract labor and benefit cost			1
2	Hospital			2
3	Subprovider - IPF			3
4	Subprovider - IRF			4
5	Subprovider - (OTHER)			5
6	Swing Beds - SNF			6
7	Swing Beds - NF			7
8	Hospital-Based SNF			8
9	Hospital-Based NF			9
10	Hospital-Based OLTC			10
11	Hospital-Based HHA			11
12	Separately Certified ASC			12
13	Hospital-Based Hospice			13
14	Hospital-Based Health Clinic - RHC			14
15	Hospital-Based Health Clinic - FQHC			15
16	Hospital-Based - CMHC			16
17	Renal Dialysis			17
18	Other			18

# KPMG LLP Compu-Max 2552-10

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## HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

### Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.293625	1
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### Medicaid (see instructions for each line)

2	Net revenue from Medicaid		37,537,959	2
3	Did you receive DSH or supplemental payments from Medicaid?		Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid			5
6	Medicaid charges		160,729,460	6
7	Medicaid cost (line 1 times line 6)		47,194,188	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		9,656,229	8

### State Children's Health Insurance Program (SCHIP)(see instructions for each line)

9	Net revenue from stand-alone SCHIP			9
10	Stand-alone SCHIP charges			10
11	Stand-alone SCHIP cost (line 1 times line 10)			11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). If line 11 is less than line 9, then enter zero.			12

### Other state or local government indigent care program (see instructions for each line)

13	Net revenue from state or local indigent care program (not included on lines 2, 5, or 9)			13
14	Charges for patients covered under state or local indigent care program (not included in lines 6 or 10)			14
15	State or local indigent care program cost (line 1 times line 14)			15
16	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13). If line 15 is less than line 13, then enter zero.			16

### Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care			17
18	Government grants, appropriations of transfers for support of hospital operations			18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		9,656,229	19

### Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	8,429,490	209,313	8,638,803	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,475,109	209,313	2,684,422	21
22	Payments received from patients for amounts previously written off as charity care	71,297	35,510	106,807	22
23	Cost of charity care (line 21 minus line 22)	2,403,812	173,803	2,577,615	23
24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit				25
26	Total bad debt expense for the entire hospital complex (see instructions)			7,124,062	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			674,726	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,038,041	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27.01)			6,086,021	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			2,150,323	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)			4,727,938	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			14,384,167	31

**KPMG LLP Compu-Max 2552-10**

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**RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES**

**WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		<b>GENERAL SERVICE COST CENTERS</b>								
1	00100	Cap Rel Costs-Bldg & Fixt		936,668	936,668	2,639,435	3,576,103	-58,035	3,518,068	1
2	00200	Cap Rel Costs-Mvble Equip				2,889,288	2,889,288		2,889,288	2
3	00300	Other Cap Rel Costs		1,618,297	1,618,297	-1,618,297			-0-	3
4	00400	Employee Benefits Department	363,517	643,699	1,007,216	-289	1,006,927	-36,364	970,563	4
4.01	00401	COMMUNICATIONS	209,210	92,218	301,428		301,428		301,428	4.01
4.02	00402	DATA PROCESSING	1,670,756	4,057,049	5,727,805	-1,151,620	4,576,185	-12,500	4,563,685	4.02
4.03	00403	ADMITTING	835,038	370,928	1,205,966	-6,593	1,199,373		1,199,373	4.03
4.04	00404	CASHIERING	838,227	895,442	1,733,669	-3,648	1,730,021	-212	1,729,809	4.04
5	00500	Administrative & General	6,599,558	15,586,816	22,186,374	-134,762	22,051,612	-10,629,990	11,421,622	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,525,851	3,483,208	5,009,059	-727,509	4,281,550		4,281,550	7
8	00800	Laundry & Linen Service				325,982	325,982		325,982	8
9	00900	Housekeeping	1,170,026	991,809	2,161,835	-333,210	1,828,625		1,828,625	9
10	01000	Dietary	799,845	1,932,104	2,731,949	-865,109	1,866,840	-397,781	1,469,059	10
11	01100	Cafeteria				835,923	835,923	-336,447	499,476	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,403,555	369,996	1,773,551	-15,237	1,758,314		1,758,314	13
14	01400	Central Services & Supply	537,325	535,170	1,072,495	-44,143	1,028,352	-29,229	999,123	14
15	01500	Pharmacy	1,316,939	2,562,775	3,879,714	-1,815,382	2,064,332		2,064,332	15
16	01600	Medical Records & Library	566,948	988,461	1,555,409	-22,877	1,532,532	-3,035	1,529,497	16
17	01700	Social Service	896,869	350,647	1,247,516	-83	1,247,433	-80,833	1,166,600	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd	147,191		147,191		147,191	-342	146,849	21
22	02200	I&R Services-Other Prgm Costs Apprvd		99,147	99,147		99,147		99,147	22
23	02300	Paramed Ed Prgm-(specify)								23
		<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	03000	Adults & Pediatrics	9,839,266	4,582,011	14,421,277	-924,744	13,496,533	-176,273	13,320,260	30
31	03100	Intensive Care Unit	1,880,092	1,546,208	3,426,300	-33,614	3,392,686	-90,000	3,302,686	31
31.01	02060	NICU								31.01
40	04000	Subprovider - IPF	839,797	332,323	1,172,120	-2,599	1,169,521	-69,600	1,099,921	40
43	04300	Nursery	805,774	235,016	1,040,790	590,196	1,630,986	-185	1,630,801	43
		<b>ANCILLARY SERVICE COST CENTERS</b>								
50	05000	Operating Room	2,072,371	3,243,835	5,316,206	-746,581	4,569,625	-745,667	3,823,958	50
52	05200	Delivery Room & Labor Room	1,704,592	1,190,342	2,894,934	-537,941	2,356,993		2,356,993	52
53	05300	Anesthesiology	404,662	1,600,499	2,005,161	-39,592	1,965,569	-1,709,389	256,180	53
54	05400	Radiology-Diagnostic	1,812,786	2,155,930	3,968,716	-259,146	3,709,570	-268,363	3,441,207	54
56.01	05601	NUCLEAR MEDICINE								56.01
60	06000	Laboratory	22,177	3,812,519	3,834,696	-997	3,833,699		3,833,699	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	757,460	376,239	1,133,699	-18,652	1,115,047		1,115,047	65
66	06600	Physical Therapy	317,903	84,472	402,375	-2,559	399,816		399,816	66
69	06900	Electrocardiology	191,046	103,452	294,498	-27,684	266,814		266,814	69
70	07000	Electroencephalography		1,352	1,352	-1,352				70
71	07100	Medical Supplies Charged to Patients				141,081	141,081		141,081	71
72	07200	Impl. Dev. Charged to Patients				1,418,069	1,418,069		1,418,069	72
73	07300	Drugs Charged to Patients				1,744,264	1,744,264		1,744,264	73
75.01	07501	ACUTE DIALYSIS		483,963	483,963		483,963		483,963	75.01
75.02	03650	CARD CATH LAB	441,806	2,283,641	2,725,447	-1,095,219	1,630,228	-265,403	1,364,825	75.02
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	09000	Clinic	3,850,772	1,862,732	5,713,504	-50,178	5,663,326	-2,674,333	2,988,993	90
90.01	09001	PH CLINIC								90.01
90.02	09002	HEALTHWORKS CLINIC	312,917	97,740	410,657	-149	410,508	-6,984	403,524	90.02
90.03	09003	DENTAL CLINIC								90.03
90.04	09004	WOUND CARE THERAPY	348,842	255,248	604,090	-12,198	591,892	-89,244	502,648	90.04
90.05	09005	FAMILY PRACTICE CLINIC		2,326	2,326	-2,326				90.05
91	09100	Emergency	2,315,728	2,777,384	5,093,112	-61,110	5,032,002	-1,193,500	3,838,502	91
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF								99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY								99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY								99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY								99.40
		<b>SPECIAL PURPOSE COST CENTERS</b>								
118		SUBTOTALS (sum of lines 1-117)	46,798,846	62,541,666	109,340,512	28,838	109,369,350	-18,873,709	90,495,641	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
190	19000	Gift, Flower, Coffee Shop & Canteen								190

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**RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES**

**WORKSHEET A**

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
192	19200	Physicians' Private Offices	337,832	187,171	525,003	-18,574	506,429		506,429	192
192.01	19201	PROHEALTH SERVICES	397,888	1,029,428	1,427,316	-8,565	1,418,751		1,418,751	192.01
192.02	19202	AUXILIARY	250,480	108,362	358,842	-1,699	357,143		357,143	192.02
200		TOTAL (sum of lines 118-199)	47,785,046	63,866,627	111,651,673		111,651,673	-18,873,709	92,777,964	200

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	PROPERTY INSURANCE	A	Cap Rel Costs-Bldg & Fixt	1		93,729	1
500	Total reclassifications					93,729	500
	Code Letter - A						
1	EQUIP DEPRECIATION	B	Cap Rel Costs-Mvble Equip	2		2,186,392	1
500	Total reclassifications					2,186,392	500
	Code Letter - B						
1	CHARGEABLE SUPPLIES	C	Medical Supplies Charged to P	71		141,081	1
2			Impl. Dev. Charged to Patient	72		1,418,069	2
3							3
4							4
500	Total reclassifications					1,559,150	500
	Code Letter - C						
1	SHARED CAFETERIA EXP	D	Cafeteria	11	247,380	588,543	1
500	Total reclassifications				247,380	588,543	500
	Code Letter - D						
1	DEPRECIATION CHARGED TO DEPTS	F	Cap Rel Costs-Bldg & Fixt	1		3,816,697	1
2							2
3							3
4							4
5							5
6							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
500	Total reclassifications					3,816,697	500
	Code Letter - F						
1	INTEREST EXPENSE	G	Cap Rel Costs-Bldg & Fixt	1		915,401	1
2			Cap Rel Costs-Mvble Equip	2		702,896	2
500	Total reclassifications					1,618,297	500
	Code Letter - G						
1	LAUNDRY EXP	H	Laundry & Linen Service	8		325,982	1
500	Total reclassifications					325,982	500
	Code Letter - H						
1	NURSERY EXP	J	Nursery	43	469,531	135,765	1
500	Total reclassifications				469,531	135,765	500
	Code Letter - J						
1	CHARGEABLE DRUGS	K	Drugs Charged to Patients	73		1,744,264	1
500	Total reclassifications					1,744,264	500
	Code Letter - K						
	GRAND TOTAL (Increases)				716,911	12,068,819	

**KPMG LLP Compu-Max 2552-10**

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	INCREASES				
		1	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.  
 Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.	
		1	6	7	8	9	10	
1	PROPERTY INSURANCE	A	Administrative & General	5		93,729	12	1
500	Total reclassifications					93,729		500
	Code letter - A							
1	EQUIP DEPRECIATION	B	Cap Rel Costs-Bldg & Fixt	1		2,186,392	9	1
500	Total reclassifications					2,186,392		500
	Code letter - B							
1	CHARGEABLE SUPPLIES	C	Operating Room	50		566,102		1
2			CARD CATH LAB	75.02		985,301		2
3			Clinic	90		7,598		3
4			HEALTHWORKS CLINIC	90.02		149		4
500	Total reclassifications					1,559,150		500
	Code letter - C							
1	SHARED CAFETERIA EXP	D	Dietary	10	247,380	588,543		1
500	Total reclassifications				247,380	588,543		500
	Code letter - D							
1	DEPRECIATION CHARGED TO DEPTS	F	Employee Benefits Department	4		289	9	1
2			DATA PROCESSING	4.02		1,151,620		2
3			ADMITTING	4.03		6,593		3
4			CASHIERING	4.04		3,648		4
5			Administrative & General	5		41,033		5
6			Operation of Plant	7		727,509		6
7			Housekeeping	9		7,228		7
8			Dietary	10		29,186		8
9			Nursing Administration	13		15,237		9
10			Central Services & Supply	14		44,143		10
11			Pharmacy	15		71,118		11
12			Medical Records & Library	16		22,877		12
13			Social Service	17		83		13
14			Adults & Pediatrics	30		319,448		14
15			Intensive Care Unit	31		33,614		15
16			Subprovider - IPF	40		2,599		16
17			Nursery	43		15,100		17
18			Operating Room	50		180,479		18
19			Delivery Room & Labor Room	52		537,941		19
20			Anesthesiology	53		39,592		20
21			Radiology-Diagnostic	54		259,146		21
22			Laboratory	60		997		22
23			Respiratory Therapy	65		18,652		23
24			Physical Therapy	66		2,559		24
25			Electrocardiology	69		27,684		25
26			Electroencephalography	70		1,352		26
27			CARD CATH LAB	75.02		109,918		27
28			Clinic	90		42,580		28
29			WOUND CARE THERAPY	90.04		12,198		29
30			FAMILY PRACTICE CLINIC	90.05		2,326		30
31			Emergency	91		61,110		31
32			Physicians' Private Offices	192		18,574		32
33			PROHEALTH SERVICES	192.01		8,565		33
34			AUXILIARY	192.02		1,699		34
500	Total reclassifications					3,816,697		500
	Code letter - F							
1	INTEREST EXPENSE	G	Other Cap Rel Costs	3		915,401	11	1
2			Other Cap Rel Costs	3		702,896	11	2
500	Total reclassifications					1,618,297		500
	Code letter - G							
1	LAUNDRY EXP	H	Housekeeping	9		325,982		1
500	Total reclassifications					325,982		500
	Code letter - H							
1	NURSERY EXP	J	Adults & Pediatrics	30	469,531	135,765		1
500	Total reclassifications				469,531	135,765		500
	Code letter - J							
1	CHARGEABLE DRUGS	K	Pharmacy	15		1,744,264		1
500	Total reclassifications					1,744,264		500
	Code letter - K							
	GRAND TOTAL (Decreases)				716,911	12,068,819		

**KPMG LLP Compu-Max 2552-10**

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**RECLASSIFICATIONS**

**WORKSHEET A-6**

		DECREASES						
EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER		Wkst A-7 Ref.	
	1	6	7	8	9		10	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.  
 Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**RECONCILIATION OF CAPITAL COST CENTERS**

**WORKSHEET A-7  
PARTS I, II & III**

**PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES**

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	4,529,913					4,529,913		1
2	Land Improvements	3,689,703					3,689,703		2
3	Buildings and Fixtures	47,905,179	2,249,806		2,249,806		50,154,985		3
4	Building Improvements								4
5	Fixed Equipment	24,164,730	551,335		551,335		24,716,065		5
6	Movable Equipment	52,927,035	2,245,852		2,245,852		55,172,887		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	133,216,560	5,046,993		5,046,993		138,263,553		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	133,216,560	5,046,993		5,046,993		138,263,553		10

**PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2**

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	936,668						936,668	1	
2	Cap Rel Costs-Mvble Equip								2	
3	Total (sum of lines 1-2)	936,668						936,668	3	

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

\* All line numbers are to be consistent with Worksheet A line numbers for capital cost centers.

**PART III - RECONCILIATION OF CAPITAL COST CENTERS**

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	78,560,752		78,560,752	0.587442					1
2	Cap Rel Costs-Mvble Equip	55,172,886		55,172,886	0.412558					2
3	Total (sum of lines 1-2)	133,733,638		133,733,638	1.000000					3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	2,566,973		857,366	93,729			3,518,068	1	
2	Cap Rel Costs-Mvble Equip	2,186,392		702,896				2,889,288	2	
3	Total (sum of lines 1-2)	4,753,365		1,560,262	93,729			6,407,356	3	

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			Wkst. A-7 Ref.
				COST CENTER	LINE#		
1	Investment income-buildings & fixtures (chapter 2)	B	-58,035	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-71,510	Administrative & General	5		7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-8,454,911				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-336,447	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-3,035	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
33.01	MISC REV	B	-12,500	DATA PROCESSING	4.02		33.01
33.02	MISC REV	B	-212	CASHIERING	4.04		33.02
33.03	MISC REV	B	-54,391	Administrative & General	5		33.03
33.05	MISC REV	B	-92,750	Dietary	10		33.05
33.06	MISC REV	B	-29,229	Central Services & Supply	14		33.06
33.10	MISC REV	B	-185	Nursery	43		33.10
33.16	MISC REV	B	-3,830	Radiology-Diagnostic	54		33.16
33.17	MISC REV	B	-292,128	Dietary	10		33.17
33.20	MISC REV- WS C	B	-12,903	Dietary	10		33.20
34							34
35	NON ALLOW EXP	A	-36,364	Employee Benefits Department	4		35
35.01	NON ALLOW EXP	A	-59,880	Administrative & General	5		35.01
35.02	NON ALLOW EXP	A	-342	I&R Services-Salary & Fringes Apprvd	21		35.02
35.03	IL MEDICAID ASSESSEMENT	A	-8,554,456	Administrative & General	5		35.03
36	CLINIC INTEGRATION EXP	A	-55,505	Administrative & General	5		36
37							37
38	LOBBYING PORTION OF DUES	A	-29,676	Administrative & General	5		38
39							39
40	LOBBYING FEES	A	-190,000	Administrative & General	5		40
41							41
42	MIDLEVEL PRACTITIONERS	A	-525,420	Clinic	90		42
43							43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-18,873,709				50

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**ADJUSTMENTS TO EXPENSES**

**WORKSHEET A-8**

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	

- (1) Description - all chapter references in this column pertain to CMS Pub. 15-1
- (2) Basis for adjustment (see instructions)
  - A. Costs - if cost, including applicable overhead, can be determined
  - B. Amount Received - if cost cannot be determined
- (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

**KPMG LLP Compu-Max 2552-10**

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**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 CLAIMED HOME OFFICE COSTS:**

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wkst. A column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	1	2	3	4	5	6	7	
1								1
2								2
3								3
4								4
5	TOTALS (sum of lines 1-4) Transfer column 6, line 5 to Worksheet A-8, column 2, line 12							5

\* The amounts on lines 1 through 4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

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

The Secretary, by virtue of the 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.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors 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	Percentage of Ownership	Related Organization(s) and/or Home Office			
				Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

(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:

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**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3	5	Administrative & Gen AGGREGATE	1,845,820	1,614,572	231,248	197,500	2,440	231,683	11,584	3
4										4
5	17	Social Service AGGREGATE	80,833	80,833						5
6	30	Adults & Pediatrics AGGREGATE	176,273	176,273						6
7	31	Intensive Care Unit AGGREGATE	90,000	90,000						7
8										8
9	40	Subprovider - IPF AGGREGATE	69,600	69,600						9
10	50	Operating Room AGGREGATE	745,667	745,667						10
11	53	Anesthesiology AGGREGATE	1,709,389	1,709,389						11
12										12
13	54	Radiology-Diagnostic AGGRGATE	264,533	264,533						13
14										14
15	75.02	CARD CATH LAB AGGREGATE	265,403	265,403						15
16										16
17	90	Clinic AGGREGATE	2,255,476	1,999,671	255,805	211,500	1,048	106,563	5,328	17
18	90.02	HEALTHWORKS CLINIC AGGREGATE	6,984	6,984						18
19	90.04	WOUND CARE THERAPY AGGREGATE	89,244	89,244						19
20										20
22	91	Emergency AGGREGATE	1,193,500	1,193,500						22
200		TOTAL	8,792,722	8,305,669	487,053		3,488	338,246	16,912	200

**KPMG LLP Compu-Max 2552-10**

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**PROVIDER-BASED PHYSICIANS ADJUSTMENTS**

**WORKSHEET A-8-2**

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3	5	Administrative & Gen AGGREGATE					231,683		1,614,572	3
4										4
5	17	Social Service AGGREGATE							80,833	5
6	30	Adults & Pediatrics AGGREGATE							176,273	6
7	31	Intensive Care Unit AGGREGATE							90,000	7
8										8
9	40	Subprovider - IPF AGGREGATE							69,600	9
10	50	Operating Room AGGREGATE							745,667	10
11	53	Anesthesiology AGGREGATE							1,709,389	11
12										12
13	54	Radiology-Diagnostic AGGREGATE							264,533	13
14										14
15	75.02	CARD CATH LAB AGGREGATE							265,403	15
16										16
17	90	Clinic AGGREGATE					106,563	149,242	2,148,913	17
18	90.02	HEALTHWORKS CLINIC AGGREGATE							6,984	18
19	90.04	WOUND CARE THERAPY AGGREGATE							89,244	19
20										20
22	91	Emergency AGGREGATE							1,193,500	22
200		TOTAL					338,246	149,242	8,454,911	200

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NON PATIENT PHONES	DATA PROCESSING	
		0	1	2	4	4.01	4.02	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt	3,518,068	3,518,068					1
2	Cap Rel Costs-Mvble Equip	2,889,288		2,889,288				2
4	Employee Benefits Department	970,563	40,854	221	1,011,638			4
4.01	COMMUNICATIONS	301,428	5,452		4,463	311,343		4.01
4.02	DATA PROCESSING	4,563,685	86,011	879,960	35,642	4,265	5,569,563	4.02
4.03	ADMITTING	1,199,373	81,357	5,038	17,814	4,265	455,692	4.03
4.04	CASHIERING	1,729,809	19,480	2,787	17,882	24,737	658,221	4.04
5	Administrative & General	11,421,622	74,444	31,354	140,788	52,884	405,059	5
6	Maintenance & Repairs							6
7	Operation of Plant	4,281,550	295,058	555,895	32,551	15,354	50,632	7
8	Laundry & Linen Service	325,982	49,810					8
9	Housekeeping	1,828,625	47,673	5,523	24,960		101,265	9
10	Dietary	1,469,059	100,864	15,404	11,786	9,383	101,265	10
11	Cafeteria	499,476	45,697	6,898	5,277	853		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,758,314	32,643	11,643	29,942	6,824		13
14	Central Services & Supply	999,123	149,673	33,730	11,463	853	303,794	14
15	Pharmacy	2,064,332	65,421	54,342	28,094	8,530	354,427	15
16	Medical Records & Library	1,529,497	67,342	17,480	12,095	18,766	50,632	16
17	Social Service	1,166,600	2,070	63	19,133	6,824		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	146,849			3,140	853		21
22	I&R Services-Other Prgm Costs Apprvd	99,147	1,623					22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	13,320,260	564,535	240,503	199,880	32,414	708,853	30
31	Intensive Care Unit	3,302,686	85,159	25,685	40,108		101,265	31
31.01	NICU							31.01
40	Subprovider - IPF	1,099,921	71,603	1,986	17,915			40
43	Nursery	1,630,801	52,434	15,129	27,206	2,559	101,265	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	3,823,958	247,345	137,905	44,210	20,472	202,530	50
52	Delivery Room & Labor Room	2,356,993	43,262	411,045	36,364	1,706	101,265	52
53	Anesthesiology	256,180	9,037	30,253	8,633	2,559		53
54	Radiology-Diagnostic	3,441,207	132,276	198,016	38,672	17,060	151,897	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	3,833,699	110,456	762	473	20,472	911,382	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,115,047	33,130	14,252	16,159	4,265	101,265	65
66	Physical Therapy	399,816	35,078	1,955	6,782	2,559	101,265	66
69	Electrocardiology	266,814	42,978	21,154	4,076	6,824	101,265	69
70	Electroencephalography		5,885	1,033			101,265	70
71	Medical Supplies Charged to Patients	141,081						71
72	Impl. Dev. Charged to Patients	1,418,069						72
73	Drugs Charged to Patients	1,744,264						73
75.01	ACUTE DIALYSIS	483,963						75.01
75.02	CARD CATH LAB	1,364,825	28,855	83,989	9,425			75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	2,988,993	106,898	13,882	82,149	5,971	303,794	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	403,524	16,234		6,675	4,265		90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	502,648	43,749	9,321	7,442	4,265		90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	3,838,502	102,163	46,695	49,401	10,236	101,265	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	90,495,641	2,896,549	2,873,903	990,600	290,018	5,569,563	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen		8,482			853		190
192	Physicians' Private Offices	506,429	613,037	14,088	7,207	16,207		192
192.01	PROHEALTH SERVICES	1,418,751			8,488	4,265		192.01

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NON PATIENT PHONES	DATA PROCESSING	
		0	1	2	4	4.01	4.02	
192.02	AUXILIARY	357,143		1,297	5,343			192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	92,777,964	3,518,068	2,889,288	1,011,638	311,343	5,569,563	202

**KPMG LLP Compu-Max 2552-10**

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	ADMITTING 4.03	CASHIERS 4.04	SUBTOTAL (cols.0-4) 4A	ADMINI- STRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY AND LINEN SERVICE 8	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	COMMUNICATIONS							4.01
4.02	DATA PROCESSING							4.02
4.03	ADMITTING	1,763,539						4.03
4.04	CASHIERING		2,452,916					4.04
5	Administrative & General			12,126,151	12,126,151			5
6	Maintenance & Repairs							6
7	Operation of Plant			5,231,040	786,497	6,017,537		7
8	Laundry & Linen Service			375,792	56,501	102,810	535,103	8
9	Housekeeping			2,008,046	301,914	98,398		9
10	Dietary			1,707,761	256,765	208,189		10
11	Cafeteria			558,201	83,927	94,322		11
12	Maintenance of Personnel							12
13	Nursing Administration			1,839,366	276,552	67,377		13
14	Central Services & Supply			1,498,636	225,323	308,932		14
15	Pharmacy			2,575,146	387,178	135,032		15
16	Medical Records & Library			1,695,812	254,969	138,997		16
17	Social Service			1,194,690	179,624	4,272		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			150,842	22,679			21
22	I&R Services-Other Prgm Costs Apprvd			100,770	15,151	3,351		22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	472,333	424,635	15,963,413	2,400,123	1,165,226	171,189	30
31	Intensive Care Unit	88,213	69,422	3,712,538	558,188	175,771	22,824	31
31.01	NICU							31.01
40	Subprovider - IPF	66,295	52,173	1,309,893	196,945	147,793		40
43	Nursery	53,203	41,870	1,924,467	289,347	108,227	28,571	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	61,444	147,134	4,684,998	704,399	510,532	96,905	50
52	Delivery Room & Labor Room	49,503	49,526	3,049,664	458,523	89,296	81,532	52
53	Anesthesiology	12,801	24,983	344,446	51,788	18,652		53
54	Radiology-Diagnostic	78,974	234,621	4,292,723	645,419	273,024	38,522	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	242,595	376,492	5,496,331	826,384	227,986		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	88,848	81,680	1,454,646	218,709	68,382		65
66	Physical Therapy	7,349	20,608	575,412	86,514	72,403	9,901	66
69	Electrocardiology	24,892	42,247	510,250	76,717	88,709		69
70	Electroencephalography	1,455	1,468	111,106	16,705	12,146		70
71	Medical Supplies Charged to Patients	6,421	11,424	158,926	23,895			71
72	Impl. Dev. Charged to Patients	34,255	42,208	1,494,532	224,706			72
73	Drugs Charged to Patients	282,743	305,234	2,332,241	350,657			73
75.01	ACUTE DIALYSIS	20,853	18,238	523,054	78,642			75.01
75.02	CARD CATH LAB	79,127	110,986	1,677,207	252,171	59,558		75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	735	36,712	3,539,134	532,116	220,642	20,533	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	3	3,064	433,765	65,217	33,507	854	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	8,226	56,013	631,664	94,972	90,301	2,854	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	83,271	302,178	4,533,711	681,653	210,869	61,418	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	1,763,539	2,452,916	89,816,374	11,680,870	4,734,704	535,103	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen			9,335	1,404	17,507		190
192	Physicians' Private Offices			1,156,968	173,952	1,265,326		192
192.01	PROHEALTH SERVICES			1,431,504	215,229			192.01
192.02	AUXILIARY			363,783	54,696			192.02
200	Cross Foot Adjustments							200

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	ADMITTING	CASHIERS	SUBTOTAL (cols.0-4)	ADMINI- STRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	
		4.03	4.04	4A	5	7	8	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,763,539	2,452,916	92,777,964	12,126,151	6,017,537	535,103	202

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9	10	11	13	14	15	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	COMMUNICATIONS							4.01
4.02	DATA PROCESSING							4.02
4.03	ADMITTING							4.03
4.04	CASHIERING							4.04
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	2,408,358						9
10	Dietary	86,204	2,258,919					10
11	Cafeteria	39,056		775,506				11
12	Maintenance of Personnel							12
13	Nursing Administration	27,898		24,944	2,236,137			13
14	Central Services & Supply	127,919		16,966		2,177,776		14
15	Pharmacy	55,913		34,716			3,187,985	15
16	Medical Records & Library	57,554		16,613				16
17	Social Service	1,769		20,394				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			5,014				21
22	I&R Services-Other Prgm Costs Apprvd	1,387						22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	482,483	1,810,766	249,666	1,125,763	82,150	292,666	30
31	Intensive Care Unit	72,781	219,456	42,038	189,553	11,266	138,111	31
31.01	NICU							31.01
40	Subprovider - IPF	61,196	228,697	15,924	71,805	18,347	16,766	40
43	Nursery	44,813		13,409	60,463	541	9,495	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	211,395		39,731	179,151		141,413	50
52	Delivery Room & Labor Room	36,974		42,807	193,021	15,258	78,179	52
53	Anesthesiology	7,723		3,252	14,664	4,667	6,469	53
54	Radiology-Diagnostic	113,051		40,596		1,731		54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	94,402		737			7,508	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	28,315		21,660	97,666	36	1,106	65
66	Physical Therapy	29,980		6,616				66
69	Electrocardiology	36,732		5,143	23,188			69
70	Electroencephalography	5,029						70
71	Medical Supplies Charged to Patients					180,479		71
72	Impl. Dev. Charged to Patients					1,813,346		72
73	Drugs Charged to Patients						2,103,652	73
75.01	ACUTE DIALYSIS						1,394	75.01
75.02	CARD CATH LAB	24,661		6,168	27,812		57,252	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	91,361		77,988			77,398	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	13,874		769			8,914	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	37,391		9,596			16,694	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	87,314		56,120	253,051	49,955	177,899	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	1,877,175	2,258,919	750,867	2,236,137	2,177,776	3,134,916	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	7,249						190
192	Physicians' Private Offices	523,934		18,952			52,536	192
192.01	PROHEALTH SERVICES			1,009			533	192.01
192.02	AUXILIARY			4,678				192.02
200	Cross Foot Adjustments							200

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9	10	11	13	14	15	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,408,358	2,258,919	775,506	2,236,137	2,177,776	3,187,985	202

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		16	17	21	22	24	25	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	COMMUNICATIONS							4.01
4.02	DATA PROCESSING							4.02
4.03	ADMITTING							4.03
4.04	CASHIERING							4.04
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	2,163,945						16
17	Social Service		1,400,749					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			178,535				21
22	I&R Services-Other Prgm Costs Apprvd				120,659			22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	374,559	1,218,652	160,681	108,593	25,605,930	-269,274	30
31	Intensive Care Unit	61,246	56,030			5,259,802		31
31.01	NICU							31.01
40	Subprovider - IPF	46,028				2,113,394		40
43	Nursery	36,938				2,516,271		43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	129,804	42,022			6,740,350		50
52	Delivery Room & Labor Room	43,693				4,088,947		52
53	Anesthesiology	22,040				473,701		53
54	Radiology-Diagnostic	206,987				5,612,053		54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	332,148				6,985,496		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	72,059				1,962,579		65
66	Physical Therapy	18,181				799,007		66
69	Electrocardiology	37,271				778,010		69
70	Electroencephalography	1,295				146,281		70
71	Medical Supplies Charged to Patients	10,078				373,378		71
72	Impl. Dev. Charged to Patients	37,237				3,569,821		72
73	Drugs Charged to Patients	269,283				5,055,833		73
75.01	ACUTE DIALYSIS	16,090				619,180		75.01
75.02	CARD CATH LAB	97,914				2,202,743		75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	32,388		17,854	12,066	4,621,480	-29,920	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	2,703				559,603		90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	49,416				932,888		90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	266,587	84,045			6,462,622		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	2,163,945	1,400,749	178,535	120,659	87,479,369	-299,194	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen					35,495		190
192	Physicians' Private Offices					3,191,668		192
192.01	PROHEALTH SERVICES					1,648,275		192.01
192.02	AUXILIARY					423,157		192.02
200	Cross Foot Adjustments							200

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		16	17	21	22	24	25	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,163,945	1,400,749	178,535	120,659	92,777,964	-299,194	202

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	TOTAL				
		26				
	<b>GENERAL SERVICE COST CENTERS</b>					
1	Cap Rel Costs-Bldg & Fixt					1
2	Cap Rel Costs-Mvble Equip					2
4	Employee Benefits Department					4
4.01	COMMUNICATIONS					4.01
4.02	DATA PROCESSING					4.02
4.03	ADMITTING					4.03
4.04	CASHIERING					4.04
5	Administrative & General					5
6	Maintenance & Repairs					6
7	Operation of Plant					7
8	Laundry & Linen Service					8
9	Housekeeping					9
10	Dietary					10
11	Cafeteria					11
12	Maintenance of Personnel					12
13	Nursing Administration					13
14	Central Services & Supply					14
15	Pharmacy					15
16	Medical Records & Library					16
17	Social Service					17
19	Nonphysician Anesthetists					19
20	Nursing School					20
21	I&R Services-Salary & Fringes Apprvd					21
22	I&R Services-Other Prgm Costs Apprvd					22
23	Paramed Ed Prgm-(specify)					23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>					
30	Adults & Pediatrics	25,336,656				30
31	Intensive Care Unit	5,259,802				31
31.01	NICU					31.01
40	Subprovider - IPF	2,113,394				40
43	Nursery	2,516,271				43
	<b>ANCILLARY SERVICE COST CENTERS</b>					
50	Operating Room	6,740,350				50
52	Delivery Room & Labor Room	4,088,947				52
53	Anesthesiology	473,701				53
54	Radiology-Diagnostic	5,612,053				54
56.01	NUCLEAR MEDICINE					56.01
60	Laboratory	6,985,496				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	1,962,579				65
66	Physical Therapy	799,007				66
69	Electrocardiology	778,010				69
70	Electroencephalography	146,281				70
71	Medical Supplies Charged to Patients	373,378				71
72	Impl. Dev. Charged to Patients	3,569,821				72
73	Drugs Charged to Patients	5,055,833				73
75.01	ACUTE DIALYSIS	619,180				75.01
75.02	CARD CATH LAB	2,202,743				75.02
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>					
90	Clinic	4,591,560				90
90.01	PH CLINIC					90.01
90.02	HEALTHWORKS CLINIC	559,603				90.02
90.03	DENTAL CLINIC					90.03
90.04	WOUND CARE THERAPY	932,888				90.04
90.05	FAMILY PRACTICE CLINIC					90.05
91	Emergency	6,462,622				91
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	CORF					99.10
99.20	OUTPATIENT PHYSICAL THERAPY					99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY					99.30
99.40	OUTPATIENT SPEECH PATHOLOGY					99.40
	<b>SPECIAL PURPOSE COST CENTERS</b>					
118	SUBTOTALS (sum of lines 1-117)	87,180,175				118
	<b>NONREIMBURSABLE COST CENTERS</b>					
190	Gift, Flower, Coffee Shop & Canteen	35,495				190
192	Physicians' Private Offices	3,191,668				192
192.01	PROHEALTH SERVICES	1,648,275				192.01
192.02	AUXILIARY	423,157				192.02
200	Cross Foot Adjustments					200

**KPMG LLP Compu-Max 2552-10**

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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	92,478,770					202

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NON PATIENT PHONES	
		0	1	2	2A	4	4.01	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		40,854	221	41,075	41,075		4
4.01	COMMUNICATIONS		5,452		5,452	181	5,633	4.01
4.02	DATA PROCESSING		86,011	879,960	965,971	1,447	77	4.02
4.03	ADMITTING		81,357	5,038	86,395	723	77	4.03
4.04	CASHIERING		19,480	2,787	22,267	726	448	4.04
5	Administrative & General		74,444	31,354	105,798	5,715	962	5
6	Maintenance & Repairs							6
7	Operation of Plant		295,058	555,895	850,953	1,321	278	7
8	Laundry & Linen Service		49,810		49,810			8
9	Housekeeping		47,673	5,523	53,196	1,013		9
10	Dietary		100,864	15,404	116,268	478	170	10
11	Cafeteria		45,697	6,898	52,595	214	15	11
12	Maintenance of Personnel							12
13	Nursing Administration		32,643	11,643	44,286	1,215	123	13
14	Central Services & Supply		149,673	33,730	183,403	465	15	14
15	Pharmacy		65,421	54,342	119,763	1,140	154	15
16	Medical Records & Library		67,342	17,480	84,822	491	340	16
17	Social Service		2,070	63	2,133	777	123	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					127	15	21
22	I&R Services-Other Prgm Costs Apprvd		1,623		1,623			22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics		564,535	240,503	805,038	8,126	586	30
31	Intensive Care Unit		85,159	25,685	110,844	1,628		31
31.01	NICU							31.01
40	Subprovider - IPF		71,603	1,986	73,589	727		40
43	Nursery		52,434	15,129	67,563	1,104	46	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room		247,345	137,905	385,250	1,795	370	50
52	Delivery Room & Labor Room		43,262	411,045	454,307	1,476	31	52
53	Anesthesiology		9,037	30,253	39,290	350	46	53
54	Radiology-Diagnostic		132,276	198,016	330,292	1,570	309	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory		110,456	762	111,218	19	370	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		33,130	14,252	47,382	656	77	65
66	Physical Therapy		35,078	1,955	37,033	275	46	66
69	Electrocardiology		42,978	21,154	64,132	165	123	69
70	Electroencephalography		5,885	1,033	6,918			70
71	Medical Supplies Charged to Patients							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75.01	ACUTE DIALYSIS							75.01
75.02	CARD CATH LAB		28,855	83,989	112,844	383		75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic		106,898	13,882	120,780	3,335	108	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC		16,234		16,234	271	77	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY		43,749	9,321	53,070	302	77	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency		102,163	46,695	148,858	2,005	185	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)		2,896,549	2,873,903	5,770,452	40,220	5,248	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen		8,482		8,482		15	190
192	Physicians' Private Offices		613,037	14,088	627,125	293	293	192
192.01	PROHEALTH SERVICES					345	77	192.01
192.02	AUXILIARY			1,297	1,297	217		192.02
200	Cross Foot Adjustments							200

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NON PATIENT PHONES	
		0	1	2	2A	4	4.01	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		3,518,068	2,889,288	6,407,356	41,075	5,633	202

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	DATA PROCESSING 4.02	ADMITTING 4.03	CASHIERS 4.04	ADMINISTRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY AND LINEN SERVICE 8	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	COMMUNICATIONS							4.01
4.02	DATA PROCESSING	967,495						4.02
4.03	ADMITTING	79,159	166,354					4.03
4.04	CASHIERING	114,340		137,781				4.04
5	Administrative & General	70,363			182,838			5
6	Maintenance & Repairs							6
7	Operation of Plant	8,795			11,859	873,206		7
8	Laundry & Linen Service				852	14,919	65,581	8
9	Housekeeping	17,591			4,552	14,279		9
10	Dietary	17,591			3,871	30,210		10
11	Cafeteria				1,265	13,687		11
12	Maintenance of Personnel							12
13	Nursing Administration				4,170	9,777		13
14	Central Services & Supply	52,772			3,397	44,829		14
15	Pharmacy	61,568			5,838	19,595		15
16	Medical Records & Library	8,795			3,844	20,170		16
17	Social Service				2,708	620		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				342			21
22	I&R Services-Other Prgm Costs Apprvd				228	486		22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	123,136	44,576	23,857	36,191	169,086	20,981	30
31	Intensive Care Unit	17,591	8,320	3,899	8,416	25,506	2,797	31
31.01	NICU							31.01
40	Subprovider - IPF		6,252	2,930	2,970	21,446		40
43	Nursery	17,591	5,018	2,352	4,363	15,705	3,502	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	35,182	5,795	8,264	10,621	74,083	11,877	50
52	Delivery Room & Labor Room	17,591	4,669	2,782	6,914	12,958	9,992	52
53	Anesthesiology		1,207	1,403	781	2,707		53
54	Radiology-Diagnostic	26,386	7,448	13,178	9,732	39,619	4,721	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	158,317	22,880	21,147	12,460	33,083		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	17,591	8,380	4,588	3,298	9,923		65
66	Physical Therapy	17,591	693	1,158	1,304	10,506	1,213	66
69	Electrocardiology	17,591	2,348	2,373	1,157	12,873		69
70	Electroencephalography	17,591	137	82	252	1,763		70
71	Medical Supplies Charged to Patients		606	642	360			71
72	Impl. Dev. Charged to Patients		3,231	2,371	3,388			72
73	Drugs Charged to Patients		26,666	17,144	5,287			73
75.01	ACUTE DIALYSIS		1,967	1,024	1,186			75.01
75.02	CARD CATH LAB		7,463	6,234	3,802	8,643		75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	52,772	69	2,062	8,023	32,017	2,516	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC			172	983	4,862	105	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY		776	3,146	1,432	13,104	350	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	17,591	7,853	16,973	10,278	30,599	7,527	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	967,495	166,354	137,781	176,124	687,055	65,581	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen				21	2,540		190
192	Physicians' Private Offices				2,623	183,611		192
192.01	PROHEALTH SERVICES				3,245			192.01
192.02	AUXILIARY				825			192.02
200	Cross Foot Adjustments							200

**KPMG LLP Compu-Max 2552-10**

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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	DATA PROCESSING	ADMITTING	CASHIERS	ADMINI- STRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	
		4.02	4.03	4.04	5	7	8	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	967,495	166,354	137,781	182,838	873,206	65,581	202

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9	10	11	13	14	15	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	COMMUNICATIONS							4.01
4.02	DATA PROCESSING							4.02
4.03	ADMITTING							4.03
4.04	CASHIERING							4.04
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping	90,631						9
10	Dietary	3,244	171,832					10
11	Cafeteria	1,470		69,246				11
12	Maintenance of Personnel							12
13	Nursing Administration	1,050		2,227	62,848			13
14	Central Services & Supply	4,814		1,515		291,210		14
15	Pharmacy	2,104		3,100			213,262	15
16	Medical Records & Library	2,166		1,483				16
17	Social Service	67		1,821				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			448				21
22	I&R Services-Other Prgm Costs Apprvd	52						22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	18,157	137,741	22,292	31,640	10,985	19,578	30
31	Intensive Care Unit	2,739	16,694	3,754	5,328	1,506	9,239	31
31.01	NICU							31.01
40	Subprovider - IPF	2,303	17,397	1,422	2,018	2,453	1,122	40
43	Nursery	1,686		1,197	1,699	72	635	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	7,955		3,548	5,035		9,460	50
52	Delivery Room & Labor Room	1,391		3,822	5,425	2,040	5,230	52
53	Anesthesiology	291		290	412	624	433	53
54	Radiology-Diagnostic	4,254		3,625		232		54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	3,553		66			502	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,066		1,934	2,745	5	74	65
66	Physical Therapy	1,128		591				66
69	Electrocardiology	1,382		459	652			69
70	Electroencephalography	189						70
71	Medical Supplies Charged to Patients					24,133		71
72	Impl. Dev. Charged to Patients					242,480		72
73	Drugs Charged to Patients						140,724	73
75.01	ACUTE DIALYSIS							93
75.02	CARD CATH LAB	928		551	782		3,830	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	3,438		6,964			5,178	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	522		69			596	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	1,407		857			1,117	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	3,286		5,011	7,112	6,680	11,901	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	70,642	171,832	67,046	62,848	291,210	209,712	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen	273						190
192	Physicians' Private Offices	19,716		1,692			3,514	192
192.01	PROHEALTH SERVICES			90			36	192.01
192.02	AUXILIARY			418				192.02
200	Cross Foot Adjustments							200

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NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9	10	11	13	14	15	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	90,631	171,832	69,246	62,848	291,210	213,262	202

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		16	17	21	22	24	25	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	COMMUNICATIONS							4.01
4.02	DATA PROCESSING							4.02
4.03	ADMITTING							4.03
4.04	CASHIERING							4.04
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy							15
16	Medical Records & Library	122,111						16
17	Social Service		8,249					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			932				21
22	I&R Services-Other Prgm Costs Apprvd				2,389			22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	21,200	7,177			1,500,347		30
31	Intensive Care Unit	3,454	330			222,045		31
31.01	NICU							31.01
40	Subprovider - IPF	2,596				137,225		40
43	Nursery	2,083				124,616		43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	7,320	247			566,802		50
52	Delivery Room & Labor Room	2,464				531,092		52
53	Anesthesiology	1,243				49,077		53
54	Radiology-Diagnostic	11,673				453,039		54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	18,731				382,346		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	4,064				101,783		65
66	Physical Therapy	1,025				72,563		66
69	Electrocardiology	2,102				105,357		69
70	Electroencephalography	73				27,005		70
71	Medical Supplies Charged to Patients	568				26,309		71
72	Impl. Dev. Charged to Patients	2,100				253,570		72
73	Drugs Charged to Patients	15,186				205,007		73
75.01	ACUTE DIALYSIS	907				5,177		75.01
75.02	CARD CATH LAB	5,522				150,982		75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	1,827				239,089		90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	152				24,043		90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	2,787				78,425		90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	15,034	495			291,388		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	122,111	8,249			5,547,287		118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen					11,331		190
192	Physicians' Private Offices					838,867		192
192.01	PROHEALTH SERVICES					3,793		192.01
192.02	AUXILIARY					2,757		192.02
200	Cross Foot Adjustments			932	2,389	3,321		200

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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		16	17	21	22	24	25	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	122,111	8,249	932	2,389	6,407,356		202

**KPMG LLP Compu-Max 2552-10**

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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
4.01	COMMUNICATIONS						4.01
4.02	DATA PROCESSING						4.02
4.03	ADMITTING						4.03
4.04	CASHIERING						4.04
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	Adults & Pediatrics	1,500,347					30
31	Intensive Care Unit	222,045					31
31.01	NICU						31.01
40	Subprovider - IPF	137,225					40
43	Nursery	124,616					43
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	566,802					50
52	Delivery Room & Labor Room	531,092					52
53	Anesthesiology	49,077					53
54	Radiology-Diagnostic	453,039					54
56.01	NUCLEAR MEDICINE						56.01
60	Laboratory	382,346					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	101,783					65
66	Physical Therapy	72,563					66
69	Electrocardiology	105,357					69
70	Electroencephalography	27,005					70
71	Medical Supplies Charged to Patients	26,309					71
72	Impl. Dev. Charged to Patients	253,570					72
73	Drugs Charged to Patients	205,007					73
75.01	ACUTE DIALYSIS	5,177					75.01
75.02	CARD CATH LAB	150,982					75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic	239,089					90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	24,043					90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	78,425					90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	Emergency	291,388					91
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	<b>SPECIAL PURPOSE COST CENTERS</b>						
118	SUBTOTALS (sum of lines 1-117)	5,547,287					118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	Gift, Flower, Coffee Shop & Canteen	11,331					190
192	Physicians' Private Offices	838,867					192
192.01	PROHEALTH SERVICES	3,793					192.01
192.02	AUXILIARY	2,757					192.02
200	Cross Foot Adjustments	3,321					200

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**ALLOCATION OF CAPITAL-RELATED COSTS**

**WORKSHEET B  
PART II**

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	6,407,356						202

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET)	NEW CAP-REL COSTS MOV EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON PATIENT PHONES (NUMBER OF PHONES)	DATA PROCESSING (MACHINE TIME)	ADMITTING INPATIENT REVENUE	
	1	2	4	4.01	4.02	4.03	
<b>GENERAL SERVICE COST CENTERS</b>							
1 Cap Rel Costs-Bldg & Fixt	260,059						1
2 Cap Rel Costs-Mvble Equip		3,781,257					2
4 Employee Benefits Department	3,020	289	47,421,529				4
4.01 COMMUNICATIONS	403		209,210	365			4.01
4.02 DATA PROCESSING	6,358	1,151,620	1,670,756	5	110		4.02
4.03 ADMITTING	6,014	6,593	835,038	5	9	167,999,772	4.03
4.04 CASHIERING	1,440	3,648	838,227	29	13		4.04
5 Administrative & General	5,503	41,033	6,599,558	62	8		5
6 Maintenance & Repairs							6
7 Operation of Plant	21,811	727,509	1,525,851	18	1		7
8 Laundry & Linen Service	3,682						8
9 Housekeeping	3,524	7,228	1,170,026		2		9
10 Dietary	7,456	20,159	552,465	11	2		10
11 Cafeteria	3,378	9,027	247,380	1			11
12 Maintenance of Personnel							12
13 Nursing Administration	2,413	15,237	1,403,555	8			13
14 Central Services & Supply	11,064	44,143	537,325	1	6		14
15 Pharmacy	4,836	71,118	1,316,939	10	7		15
16 Medical Records & Library	4,978	22,877	566,948	22	1		16
17 Social Service	153	83	896,869	8			17
19 Nonphysician Anesthetists							19
20 Nursing School							20
21 I&R Services-Salary & Fringes Apprvd			147,191	1			21
22 I&R Services-Other Prgm Costs Apprvd	120						22
23 Paramed Ed Prgm-(specify)							23
<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30 Adults & Pediatrics	41,731	314,750	9,369,735	38	14	44,992,680	30
31 Intensive Care Unit	6,295	33,614	1,880,092		2	8,403,622	31
31.01 NICU							31.01
40 Subprovider - IPF	5,293	2,599	839,797			6,315,573	40
43 Nursery	3,876	19,800	1,275,305	3	2	5,068,397	43
<b>ANCILLARY SERVICE COST CENTERS</b>							
50 Operating Room	18,284	180,479	2,072,371	24	4	5,853,504	50
52 Delivery Room & Labor Room	3,198	537,941	1,704,592	2	2	4,715,933	52
53 Anesthesiology	668	39,592	404,662	3		1,219,475	53
54 Radiology-Diagnostic	9,778	259,146	1,812,786	20	3	7,523,439	54
56.01 NUCLEAR MEDICINE							56.01
60 Laboratory	8,165	997	22,177	24	18	23,110,852	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 Respiratory Therapy	2,449	18,652	757,460	5	2	8,464,143	65
66 Physical Therapy	2,593	2,559	317,903	3	2	700,122	66
69 Electrocardiology	3,177	27,684	191,046	8	2	2,371,353	69
70 Electroencephalography	435	1,352			2	138,613	70
71 Medical Supplies Charged to Patients						611,717	71
72 Impl. Dev. Charged to Patients						3,263,330	72
73 Drugs Charged to Patients						26,935,579	73
75.01 ACUTE DIALYSIS						1,986,600	75.01
75.02 CARD CATH LAB	2,133	109,918	441,806			7,538,049	75.02
76.97 CARDIAC REHABILITATION							76.97
76.98 HYPERBARIC OXYGEN THERAPY							76.98
76.99 LITHOTRIPSY							76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90 Clinic	7,902	18,167	3,850,772	7	6	70,000	90
90.01 PH CLINIC							90.01
90.02 HEALTHWORKS CLINIC	1,200		312,917	5		305	90.02
90.03 DENTAL CLINIC							90.03
90.04 WOUND CARE THERAPY	3,234	12,198	348,842	5		783,665	90.04
90.05 FAMILY PRACTICE CLINIC							90.05
91 Emergency	7,552	61,110	2,315,728	12	2	7,932,821	91
92 Observation Beds (Non-Distinct Part)							92
93.99 PARTIAL HOSPITALIZATION PROGRAM							93.99
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10 CORF							99.10
99.20 OUTPATIENT PHYSICAL THERAPY							99.20
99.30 OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40 OUTPATIENT SPEECH PATHOLOGY							99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
118 SUBTOTALS (sum of lines 1-117)	214,116	3,761,122	46,435,329	340	110	167,999,772	118
<b>NONREIMBURSABLE COST CENTERS</b>							
190 Gift, Flower, Coffee Shop & Canteen	627			1			190
192 Physicians' Private Offices	45,316	18,437	337,832	19			192
192.01 PROHEALTH SERVICES			397,888	5			192.01
192.02 AUXILIARY		1,698	250,480				192.02

**KPMG LLP Compu-Max 2552-10**

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET)	NEW CAP-REL COSTS MOV EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON PATIENT PHONES (NUMBER OF PHONES)	DATA PROCESSING (MACHINE TIME)	ADMITTING INPATIENT REVENUE	
		1	2	4	4.01	4.02	4.03	
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,518,068	2,889,288	1,011,638	311,343	5,569,563	1,763,539	202
203	Unit Cost Multiplier (Wkst. B, Part I)	13.527961	0.764108	0.021333	852.994521	50.632.390909	0.010497	203
204	Cost to be allocated (Per Wkst. B, Part II)			41,075	5,633	967,495	166,354	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000866	15.432877	8.795.409091	0.000990	205

**KPMG LLP Compu-Max 2552-10**

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CASHIERS GROSS REVENUE	RECON- CILIATION	ADMINI- STRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING  SQUARE FEET	
		4.04	5A	5	7	8	9	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	COMMUNICATIONS							4.01
4.02	DATA PROCESSING							4.02
4.03	ADMITTING							4.03
4.04	CASHIERING	296,909,751						4.04
5	Administrative & General		-12,126,151	80,651,813				5
6	Maintenance & Repairs							6
7	Operation of Plant			5,231,040	215,510			7
8	Laundry & Linen Service			375,792	3,682	309,685		8
9	Housekeeping			2,008,046	3,524		208,304	9
10	Dietary			1,707,761	7,456		7,456	10
11	Cafeteria			558,201	3,378		3,378	11
12	Maintenance of Personnel							12
13	Nursing Administration			1,839,366	2,413		2,413	13
14	Central Services & Supply			1,498,636	11,064		11,064	14
15	Pharmacy			2,575,146	4,836		4,836	15
16	Medical Records & Library			1,695,812	4,978		4,978	16
17	Social Service			1,194,690	153		153	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			150,842				21
22	I&R Services-Other Prgm Costs Apprvd			100,770	120		120	22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	51,384,876		15,963,413	41,731	99,074	41,731	30
31	Intensive Care Unit	8,403,622		3,712,538	6,295	13,209	6,295	31
31.01	NICU							31.01
40	Subprovider - IPF	6,315,573		1,309,893	5,293		5,293	40
43	Nursery	5,068,397		1,924,467	3,876	16,535	3,876	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	17,810,672		4,684,998	18,284	56,083	18,284	50
52	Delivery Room & Labor Room	5,995,161		3,049,664	3,198	47,186	3,198	52
53	Anesthesiology	3,024,151		344,446	668		668	53
54	Radiology-Diagnostic	28,401,008		4,292,723	9,778	22,294	9,778	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	45,574,575		5,496,331	8,165		8,165	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	9,887,407		1,454,646	2,449		2,449	65
66	Physical Therapy	2,494,671		575,412	2,593	5,730	2,593	66
69	Electrocardiology	5,114,013		510,250	3,177		3,177	69
70	Electroencephalography	177,692		111,106	435		435	70
71	Medical Supplies Charged to Patients	1,382,876		158,926				71
72	Impl. Dev. Charged to Patients	5,109,304		1,494,532				72
73	Drugs Charged to Patients	36,948,820		2,332,241				73
75.01	ACUTE DIALYSIS	2,207,700		523,054				75.01
75.02	CARD CATH LAB	13,434,918		1,677,207	2,133		2,133	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	4,444,065		3,539,134	7,902	11,883	7,902	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	370,948		433,765	1,200	494	1,200	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	6,780,450		631,664	3,234	1,652	3,234	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	36,578,852		4,533,711	7,552	35,545	7,552	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	296,909,751	-12,126,151	77,690,223	169,567	309,685	162,361	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen			9,335	627		627	190
192	Physicians' Private Offices			1,156,968	45,316		45,316	192
192.01	PROHEALTH SERVICES			1,431,504				192.01
192.02	AUXILIARY			363,783				192.02

**KPMG LLP Compu-Max 2552-10**

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	CASHIERS GROSS REVENUE	RECON- CILIATION	ADMINI- STRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING SQUARE FEET	
		4.04	5A	5	7	8	9	
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,452,916		12,126,151	6,017,537	535,103	2,408,358	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.008261		0.150352	27.922310	1.727894	11.561746	203
204	Cost to be allocated (Per Wkst. B, Part II)	137,781		182,838	873,206	65,581	90,631	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000464		0.002267	4.051812	0.211767	0.435090	205

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		10	11	13	14	15	16	
	<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
4.01	COMMUNICATIONS							4.01
4.02	DATA PROCESSING							4.02
4.03	ADMITTING							4.03
4.04	CASHIERING							4.04
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary	101,934						10
11	Cafeteria		48,407					11
12	Maintenance of Personnel							12
13	Nursing Administration		1,557	30,955				13
14	Central Services & Supply		1,059		1,703,061			14
15	Pharmacy		2,167			2,643,350		15
16	Medical Records & Library		1,037				296,909,751	16
17	Social Service		1,273					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		313					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	81,711	15,584	15,584	64,243	242,667	51,384,876	30
31	Intensive Care Unit	9,903	2,624	2,624	8,810	114,516	8,403,622	31
31.01	NICU							31.01
40	Subprovider - IPF	10,320	994	994	14,348	13,902	6,315,573	40
43	Nursery		837	837	423	7,873	5,068,397	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room		2,480	2,480		117,254	17,810,672	50
52	Delivery Room & Labor Room		2,672	2,672	11,932	64,823	5,995,161	52
53	Anesthesiology		203	203	3,650	5,364	3,024,151	53
54	Radiology-Diagnostic		2,534		1,354		28,401,008	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory		46			6,225	45,574,575	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,352	1,352	28	917	9,887,407	65
66	Physical Therapy		413				2,494,671	66
69	Electrocardiology		321	321			5,114,013	69
70	Electroencephalography						177,692	70
71	Medical Supplies Charged to Patients				141,138		1,382,876	71
72	Impl. Dev. Charged to Patients				1,418,069		5,109,304	72
73	Drugs Charged to Patients					1,744,264	36,948,820	73
75.01	ACUTE DIALYSIS					1,156	2,207,700	75.01
75.02	CARD CATH LAB		385	385		47,471	13,434,918	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic		4,868			64,175	4,444,065	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC		48			7,391	370,948	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY		599			13,842	6,780,450	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency		3,503	3,503	39,066	147,507	36,578,852	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
	<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	101,934	46,869	30,955	1,703,061	2,599,347	296,909,751	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices		1,183			43,561		192
192.01	PROHEALTH SERVICES		63			442		192.01
192.02	AUXILIARY		292					192.02

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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		10	11	13	14	15	16	
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,258,919	775,506	2,236,137	2,177,776	3,187,985	2,163,945	202
203	Unit Cost Multiplier (Wkst. B, Part I)	22.160604	16.020534	72.238314	1.278742	1.206040	0.007288	203
204	Cost to be allocated (Per Wkst. B, Part II)	171,832	69,246	62,848	291,210	213,262	122,111	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.685718	1.430496	2.030302	0.170992	0.080679	0.000411	205

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

COST CENTER DESCRIPTIONS	SOCIAL SERVICE (TIME SPENT)	I/R-SALARY AND FRINGES (ASSIGNED TIME)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)				
	17	21	22				

<b>GENERAL SERVICE COST CENTERS</b>							
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
4.01	COMMUNICATIONS						4.01
4.02	DATA PROCESSING						4.02
4.03	ADMITTING						4.03
4.04	CASHIERING						4.04
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service	100					17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd		100				21
22	I&R Services-Other Prgm Costs Apprvd			100			22
23	Paramed Ed Prgm-(specify)						23
<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	Adults & Pediatrics	87	90	90			30
31	Intensive Care Unit	4					31
31.01	NICU						31.01
40	Subprovider - IPF						40
43	Nursery						43
<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	3					50
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
56.01	NUCLEAR MEDICINE						56.01
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
75.01	ACUTE DIALYSIS						75.01
75.02	CARD CATH LAB						75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic		10	10			90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC						90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY						90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	Emergency	6					91
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
<b>SPECIAL PURPOSE COST CENTERS</b>							
118	SUBTOTALS (sum of lines 1-117)	100	100	100			118
<b>NONREIMBURSABLE COST CENTERS</b>							
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**COST ALLOCATION - STATISTICAL BASIS**

**WORKSHEET B-1**

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE (TIME SPENT)	I/R-SALARY AND FRINGES (ASSIGNED TIME)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)				
		17	21	22				
192.01	PROHEALTH SERVICES							192.01
192.02	AUXILIARY							192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,400,749	178,535	120,659				202
203	Unit Cost Multiplier (Wkst. B, Part I)	14,007.490000	1,785.350000	1,206.590000				203
204	Cost to be allocated (Per Wkst. B, Part II)	8,249	932	2,389				204
205	Unit Cost Multiplier (Wkst. B, Part II)	82.490000	9.320000	23.890000				205

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		CODE	LINE NO.	AMOUNT
	1	2	3	4

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics	25,336,656		25,336,656		25,336,656	30
31	Intensive Care Unit	5,259,802		5,259,802		5,259,802	31
31.01	NICU						31.01
40	Subprovider - IPF	2,113,394		2,113,394		2,113,394	40
43	Nursery	2,516,271		2,516,271		2,516,271	43
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	6,740,350		6,740,350		6,740,350	50
52	Delivery Room & Labor Room	4,088,947		4,088,947		4,088,947	52
53	Anesthesiology	473,701		473,701		473,701	53
54	Radiology-Diagnostic	5,612,053		5,612,053		5,612,053	54
56.01	NUCLEAR MEDICINE						56.01
60	Laboratory	6,985,496		6,985,496		6,985,496	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,962,579		1,962,579		1,962,579	65
66	Physical Therapy	799,007		799,007		799,007	66
69	Electrocardiology	778,010		778,010		778,010	69
70	Electroencephalography	146,281		146,281		146,281	70
71	Medical Supplies Charged to Patients	373,378		373,378		373,378	71
72	Impl. Dev. Charged to Patients	3,569,821		3,569,821		3,569,821	72
73	Drugs Charged to Patients	5,055,833		5,055,833		5,055,833	73
75.01	ACUTE DIALYSIS	619,180		619,180		619,180	75.01
75.02	CARD CATH LAB	2,202,743		2,202,743		2,202,743	75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic	4,591,560		4,591,560	149,242	4,740,802	90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	559,603		559,603		559,603	90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	932,888		932,888		932,888	90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	Emergency	6,462,622		6,462,622		6,462,622	91
92	Observation Beds (Non-Distinct Part)	1,741,263		1,741,263		1,741,263	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	Subtotal (sum of lines 30 thru 199)	88,921,438		88,921,438	149,242	89,070,680	200
201	Less Observation Beds	1,741,263		1,741,263		1,741,263	201
202	Total (line 200 minus line 201)	87,180,175		87,180,175		87,329,417	202

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	CHARGES			Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		Inpatient	Outpatient	Total (column 6 + column 7)				
		6	7	8				
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30	Adults & Pediatrics	44,992,680		44,992,680				30
31	Intensive Care Unit	8,403,622		8,403,622				31
31.01	NICU							31.01
40	Subprovider - IPF	6,315,573		6,315,573				40
43	Nursery	5,068,397		5,068,397				43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	5,853,504	11,957,168	17,810,672	0.378444	0.378444	0.378444	50
52	Delivery Room & Labor Room	4,715,933	1,279,228	5,995,161	0.682041	0.682041	0.682041	52
53	Anesthesiology	1,219,475	1,804,676	3,024,151	0.156639	0.156639	0.156639	53
54	Radiology-Diagnostic	7,523,439	20,877,569	28,401,008	0.197600	0.197600	0.197600	54
56.01	<b>NUCLEAR MEDICINE</b>							56.01
60	Laboratory	23,110,852	22,463,723	45,574,575	0.153276	0.153276	0.153276	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>							62.30
65	Respiratory Therapy	8,464,143	1,423,264	9,887,407	0.198493	0.198493	0.198493	65
66	Physical Therapy	700,122	1,794,549	2,494,671	0.320286	0.320286	0.320286	66
69	Electrocardiology	2,371,353	2,742,660	5,114,013	0.152133	0.152133	0.152133	69
70	Electroencephalography	138,613	39,079	177,692	0.823228	0.823228	0.823228	70
71	Medical Supplies Charged to Patients	611,717	771,159	1,382,876	0.270001	0.270001	0.270001	71
72	Impl. Dev. Charged to Patients	3,263,330	1,845,974	5,109,304	0.698690	0.698690	0.698690	72
73	Drugs Charged to Patients	26,935,579	10,013,241	36,948,820	0.136833	0.136833	0.136833	73
75.01	ACUTE DIALYSIS	1,986,600	221,100	2,207,700	0.280464	0.280464	0.280464	75.01
75.02	CARD CATH LAB	7,538,049	5,896,869	13,434,918	0.163957	0.163957	0.163957	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	70,000	4,374,065	4,444,065	1.033189	1.033189	1.066772	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	305	370,643	370,948	1.508575	1.508575	1.508575	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	783,665	5,996,785	6,780,450	0.137585	0.137585	0.137585	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	7,932,821	28,646,031	36,578,852	0.176676	0.176676	0.176676	91
92	Observation Beds (Non-Distinct Part)	335,829	6,056,367	6,392,196	0.272405	0.272405	0.272405	92
93.99	<b>PARTIAL HOSPITALIZATION PROGRAM</b>							93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	Subtotal (sum of lines 30 thru 199)	168,335,601	128,574,150	296,909,751				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	168,335,601	128,574,150	296,909,751				202

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**

**WORKSHEET D  
PART I**

Check  Title V  PPS  
 Applicable  Title XVIII, Part A  TEFRA  
 Boxes:  Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	1,500,347		1,500,347	29,247	51.30	6,494	333,142	30
31	Intensive Care Unit	222,045		222,045	3,301	67.27	1,124	75,611	31
31.01	NICU								31.01
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF	137,225		137,225	3,440	39.89	967	38,574	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	124,616		124,616	1,970	63.26			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,984,233		1,984,233	37,958		8,585	447,327	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS**

**COMPONENT CCN: 14-0206**

**WORKSHEET D  
PART II**

Check [ ] Title V [XX] Hospital [ ] SUB (Other) [XX] PPS  
 Applicable [XX] Title XVIII, Part A [ ] IPF [ ] TEFRA  
 Boxes: [ ] Title XIX [ ] IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	566,802	17,810,672	0.031824	1,716,655	54,631	50
52	Delivery Room & Labor Room	531,092	5,995,161	0.088587	21,646	1,918	52
53	Anesthesiology	49,077	3,024,151	0.016228	416,116	6,753	53
54	Radiology-Diagnostic	453,039	28,401,008	0.015952	2,854,890	45,541	54
56.01	<b>NUCLEAR MEDICINE</b>						56.01
60	Laboratory	382,346	45,574,575	0.008389	6,681,117	56,048	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>						62.30
65	Respiratory Therapy	101,783	9,887,407	0.010294	2,921,902	30,078	65
66	Physical Therapy	72,563	2,494,671	0.029087	271,458	7,896	66
69	Electrocardiology	105,357	5,114,013	0.020602	833,262	17,167	69
70	Electroencephalography	27,005	177,692	0.151976	56,059	8,520	70
71	Medical Supplies Charged to Pat	26,309	1,382,876	0.019025	218,486	4,157	71
72	Impl. Dev. Charged to Patients	253,570	5,109,304	0.049629	1,324,637	65,740	72
73	Drugs Charged to Patients	205,007	36,948,820	0.005548	7,818,233	43,376	73
75.01	ACUTE DIALYSIS	5,177	2,207,700	0.002345	1,009,800	2,368	75.01
75.02	CARD CATH LAB	150,982	13,434,918	0.011238	3,025,441	34,000	75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic	239,089	4,444,065	0.053800	17,634	949	90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	24,043	370,948	0.064815			90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	78,425	6,780,450	0.011566	195,118	2,257	90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	Emergency	291,388	36,578,852	0.007966	2,123,091	16,913	91
92	Observation Beds (Non-Distinct	103,111	6,392,196	0.016131	107,038	1,727	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	3,666,165	232,129,479		31,612,583	400,039	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**

**WORKSHEET D  
PART III**

Check  Title V  PPS  
 Applicable  Title XVIII, Part A  TEFRA  
 Boxes:  Title XIX  Other

(A)	Cost Center Description	Nursing School Post-Stepdown Adjustments 1A	Nursing School 1	Allied Health Post-Stepdown Adjustments 2A	Allied Health Cost 2	All Other Medical Education Cost 3	Swing-Bed Adjustment Amount (see instructions) 4	Total Costs (sum of cols. 1 through 3 minus col 4.) 5	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
31.01	NICU								31.01
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

Check            [ ] Title V                            [XX] PPS  
Applicable     [XX] Title XVIII, Part A        [ ] TEFRA  
Boxes:         [ ] Title XIX                       [ ] Other

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6	7	8	9			
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	29,247		6,494		30
31	Intensive Care Unit	3,301		1,124		31
31.01	NICU					31.01
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF	3,440		967		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	1,970				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	37,958		8,585		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0206**

**WORKSHEET D  
PART IV**

Check  Title V                       Hospital                       SUB (Other)                       ICF/IID                       PPS  
 Applicable  Title XVIII, Part A                       IPF                       SNF                       TEFRA  
 Boxes:  Title XIX                       IRF                       NF                       Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	<b>ANCILLARY SERVICE COST CENTERS</b>									
50	Operating Room									50
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56.01	NUCLEAR MEDICINE									56.01
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
75.01	ACUTE DIALYSIS									75.01
75.02	CARD CATH LAB									75.02
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>									
90	Clinic									90
90.01	PH CLINIC									90.01
90.02	HEALTHWORKS CLINIC									90.02
90.03	DENTAL CLINIC									90.03
90.04	WOUND CARE THERAPY									90.04
90.05	FAMILY PRACTICE CLINIC									90.05
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0206**

**WORKSHEET D  
PART IV**

Check  Title V  Hospital  SUB (Other)  ICF/IID  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  TEFRA  
 Boxes:  Title XIX  IRF  NF  Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	17,810,672			1,716,655		2,310,428		50
52	Delivery Room & Labor Room	5,995,161			21,646		8,234		52
53	Anesthesiology	3,024,151			416,116		389,449		53
54	Radiology-Diagnostic	28,401,008			2,854,890		2,342,669		54
56.01	NUCLEAR MEDICINE								56.01
60	Laboratory	45,574,575			6,681,117		1,854,304		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,887,407			2,921,902		171,523		65
66	Physical Therapy	2,494,671			271,458		11,640		66
69	Electrocardiology	5,114,013			833,262		550,868		69
70	Electroencephalography	177,692			56,059		8,929		70
71	Medical Supplies Charged to Pat	1,382,876			218,486		310,098		71
72	Impl. Dev. Charged to Patients	5,109,304			1,324,637		1,051,415		72
73	Drugs Charged to Patients	36,948,820			7,818,233		3,079,519		73
75.01	ACUTE DIALYSIS	2,207,700			1,009,800		64,350		75.01
75.02	CARD CATH LAB	13,434,918			3,025,441		3,357,722		75.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	4,444,065			17,634		1,151,072		90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	370,948							90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	6,780,450			195,118		1,343,458		90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	36,578,852			2,123,091		2,441,823		91
92	Observation Beds (Non-Distinct	6,392,196			107,038		748,503		92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	232,129,479			31,612,583		21,196,004		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0206

WORKSHEET D  
PART V

Check [ ] Title V - O/P [XX] Hospital [ ] SUB (Other) [ ] Swing Bed SNF  
 Applicable [XX] Title XVIII, Part B [ ] IPF [ ] SNF [ ] Swing Bed NF  
 Boxes: [ ] Title XIX - O/P [ ] IRF [ ] NF [ ] ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	0.378444	2,310,428			874,368			50
52	Delivery Room & Labor Room	0.682041	8,234			5,616			52
53	Anesthesiology	0.156639	389,449			61,003			53
54	Radiology-Diagnostic	0.197600	2,342,669			462,911			54
56.01	NUCLEAR MEDICINE								56.01
60	Laboratory	0.153276	1,854,304			284,220			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.198493	171,523			34,046			65
66	Physical Therapy	0.320286	11,640			3,728			66
69	Electrocardiology	0.152133	550,868			83,805			69
70	Electroencephalography	0.823228	8,929			7,351			70
71	Medical Supplies Charged to Pat	0.270001	310,098			83,727			71
72	Impl. Dev. Charged to Patients	0.698690	1,051,415			734,613			72
73	Drugs Charged to Patients	0.136833	3,079,519		7,301	421,380		999	73
75.01	ACUTE DIALYSIS	0.280464	64,350			18,048			75.01
75.02	CARD CATH LAB	0.163957	3,357,722			550,522			75.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	1.033189	1,151,072			1,189,275			90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	1.508575							90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	0.137585	1,343,458			184,840			90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	0.176676	2,441,823			431,412			91
92	Observation Beds (Non-Distinct	0.272405	748,503			203,896			92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)		21,196,004		7,301	5,634,761		999	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		21,196,004		7,301	5,634,761		999	202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S206

WORKSHEET D  
PART II

Check [ ] Title V [ ] Hospital [ ] SUB (Other) [XX] PPS  
 Applicable [XX] Title XVIII, Part A [XX] IPF [ ] TEFRA  
 Boxes: [ ] Title XIX [ ] IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	566,802	17,810,672	0.031824	12,255	390	50
52	Delivery Room & Labor Room	531,092	5,995,161	0.088587			52
53	Anesthesiology	49,077	3,024,151	0.016228	2,547	41	53
54	Radiology-Diagnostic	453,039	28,401,008	0.015952	20,944	334	54
56.01	<b>NUCLEAR MEDICINE</b>						<b>56.01</b>
60	Laboratory	382,346	45,574,575	0.008389	206,502	1,732	60
62.30	<b>BLOOD CLOTTING FOR HEMOPHILIACS</b>						<b>62.30</b>
65	Respiratory Therapy	101,783	9,887,407	0.010294	504	5	65
66	Physical Therapy	72,563	2,494,671	0.029087	3,131	91	66
69	Electrocardiology	105,357	5,114,013	0.020602	21,238	438	69
70	Electroencephalography	27,005	177,692	0.151976	771	117	70
71	Medical Supplies Charged to Pat	26,309	1,382,876	0.019025			71
72	Impl. Dev. Charged to Patients	253,570	5,109,304	0.049629			72
73	Drugs Charged to Patients	205,007	36,948,820	0.005548	334,228	1,854	73
75.01	ACUTE DIALYSIS	5,177	2,207,700	0.002345			75.01
75.02	CARD CATH LAB	150,982	13,434,918	0.011238			75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic	239,089	4,444,065	0.053800			90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	24,043	370,948	0.064815			90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	78,425	6,780,450	0.011566			90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	Emergency	291,388	36,578,852	0.007966	65,722	524	91
92	Observation Beds (Non-Distinct		6,392,196				92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	3,563,054	232,129,479		667,842	5,526	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-S206**

**WORKSHEET D  
PART IV**

Check  Title V  Hospital  SUB (Other)  ICF/IID  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  TEFRA  
 Boxes:  Title XIX  IRF  NF  Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	<b>ANCILLARY SERVICE COST CENTERS</b>									
50	Operating Room									50
52	Delivery Room & Labor Room									52
53	Anesthesiology									53
54	Radiology-Diagnostic									54
56.01	NUCLEAR MEDICINE									56.01
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
70	Electroencephalography									70
71	Medical Supplies Charged to Pat									71
72	Impl. Dev. Charged to Patients									72
73	Drugs Charged to Patients									73
75.01	ACUTE DIALYSIS									75.01
75.02	CARD CATH LAB									75.02
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>									
90	Clinic									90
90.01	PH CLINIC									90.01
90.02	HEALTHWORKS CLINIC									90.02
90.03	DENTAL CLINIC									90.03
90.04	WOUND CARE THERAPY									90.04
90.05	FAMILY PRACTICE CLINIC									90.05
91	Emergency									91
92	Observation Beds (Non-Distinct									92
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-S206**

**WORKSHEET D  
PART IV**

Check  Title V  Hospital  SUB (Other)  ICF/IID  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  TEFRA  
 Boxes:  Title XIX  IRF  NF  Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	17,810,672			12,255				50
52	Delivery Room & Labor Room	5,995,161							52
53	Anesthesiology	3,024,151			2,547				53
54	Radiology-Diagnostic	28,401,008			20,944				54
56.01	NUCLEAR MEDICINE								56.01
60	Laboratory	45,574,575			206,502				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,887,407			504				65
66	Physical Therapy	2,494,671			3,131				66
69	Electrocardiology	5,114,013			21,238				69
70	Electroencephalography	177,692			771				70
71	Medical Supplies Charged to Pat	1,382,876							71
72	Impl. Dev. Charged to Patients	5,109,304							72
73	Drugs Charged to Patients	36,948,820			334,228				73
75.01	ACUTE DIALYSIS	2,207,700							75.01
75.02	CARD CATH LAB	13,434,918							75.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	4,444,065							90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	370,948							90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	6,780,450							90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	36,578,852			65,722				91
92	Observation Beds (Non-Distinct	6,392,196							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	232,129,479			667,842				200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS**

**COMPONENT CCN: 14-S206**

**WORKSHEET D  
PART V**

Check [ ] Title V - O/P [ ] Hospital [ ] SUB (Other) [ ] Swing Bed SNF  
 Applicable [XX] Title XVIII, Part B [XX] IPF [ ] SNF [ ] Swing Bed NF  
 Boxes: [ ] Title XIX - O/P [ ] IRF [ ] NF [ ] ICF/IID

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	0.378444						50
52	Delivery Room & Labor Room	0.682041						52
53	Anesthesiology	0.156639						53
54	Radiology-Diagnostic	0.197600						54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	0.153276						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.198493						65
66	Physical Therapy	0.320286						66
69	Electrocardiology	0.152133						69
70	Electroencephalography	0.823228						70
71	Medical Supplies Charged to Pat	0.270001						71
72	Impl. Dev. Charged to Patients	0.698690						72
73	Drugs Charged to Patients	0.136833						73
75.01	ACUTE DIALYSIS	0.280464						75.01
75.02	CARD CATH LAB	0.163957						75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	1.033189						90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	1.508575						90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	0.137585						90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	0.176676						91
92	Observation Beds (Non-Distinct)	0.272405						92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS**

**WORKSHEET D  
PART I**

Check  Title V  
 Applicable  Title XVIII, Part A  
 Boxes:  Title XIX

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)	1,500,347		1,500,347	29,247	51.30	2,766	141,896	30
31	Intensive Care Unit	222,045		222,045	3,301	67.27	241	16,212	31
31.01	NICU								31.01
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF	137,225		137,225	3,440	39.89	211	8,417	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	124,616		124,616	1,970	63.26	897	56,744	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,984,233		1,984,233	37,958		4,115	223,269	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0206

WORKSHEET D  
PART II

Check [ ] Title V [XX] Hospital [ ] SUB (Other)  
 Applicable [ ] Title XVIII, Part A [ ] IPF  
 Boxes: [XX] Title XIX [ ] IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	566,802	17,810,672	0.031824	410,010	13,048	50
52	Delivery Room & Labor Room	531,092	5,995,161	0.088587	489,468	43,361	52
53	Anesthesiology	49,077	3,024,151	0.016228	83,171	1,350	53
54	Radiology-Diagnostic	453,039	28,401,008	0.015952	598,703	9,551	54
56.01	NUCLEAR MEDICINE						56.01
60	Laboratory	382,346	45,574,575	0.008389	2,261,471	18,971	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	101,783	9,887,407	0.010294	659,116	6,785	65
66	Physical Therapy	72,563	2,494,671	0.029087	43,753	1,273	66
69	Electrocardiology	105,357	5,114,013	0.020602	155,704	3,208	69
70	Electroencephalography	27,005	177,692	0.151976	14,507	2,205	70
71	Medical Supplies Charged to Pat	26,309	1,382,876	0.019025	47,802	909	71
72	Impl. Dev. Charged to Patients	253,570	5,109,304	0.049629	370,871	18,406	72
73	Drugs Charged to Patients	205,007	36,948,820	0.005548	2,370,990	13,154	73
75.01	ACUTE DIALYSIS	5,177	2,207,700	0.002345	33,000	77	75.01
75.02	CARD CATH LAB	150,982	13,434,918	0.011238	595,495	6,692	75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic	239,089	4,444,065	0.053800	7,063	380	90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	24,043	370,948	0.064815			90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	78,425	6,780,450	0.011566	78,402	907	90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	Emergency	291,388	36,578,852	0.007966	599,399	4,775	91
92	Observation Beds (Non-Distinct	103,111	6,392,196	0.016131	59,405	958	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	3,666,165	232,129,479		8,878,330	146,010	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS**

**WORKSHEET D  
PART III**

Check  Title V  PPS  
 Applicable  Title XVIII, Part A  TEFRA  
 Boxes:  Title XIX  Other

(A)	Cost Center Description	Nursing School Post-Stepdown Adjustments 1A	Nursing School 1	Allied Health Post-Stepdown Adjustments 2A	Allied Health Cost 2	All Other Medical Education Cost 3	Swing-Bed Adjustment Amount (see instructions) 4	Total Costs (sum of cols. 1 through 3 minus col 4.) 5	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
31.01	NICU								31.01
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D  
PART III**

Check  Title V  PPS  
 Applicable  Title XVIII, Part A  TEFRA  
 Boxes:  Title XIX  Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30	Adults & Pediatrics (General Routine Care)	29,247		2,766		30
31	Intensive Care Unit	3,301		241		31
31.01	NICU					31.01
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF	3,440		211		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	1,970		897		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	37,958		4,115		200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0206**

**WORKSHEET D  
PART IV**

Check  Title V  Hospital  SUB (Other)  ICF/IID  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  TEFRA  
 Boxes:  Title XIX  IRF  NF  Other

(A)	Cost Center Description	1	2A	2	3A	3	4	5	6
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room								50
52	Delivery Room & Labor Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
56.01	NUCLEAR MEDICINE								56.01
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
75.01	ACUTE DIALYSIS								75.01
75.02	CARD CATH LAB								75.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic								90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC								90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY								90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency								91
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)								200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-0206**

**WORKSHEET D  
PART IV**

Check  Title V  Hospital  SUB (Other)  ICF/IID  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  TEFRA  
 Boxes:  Title XIX  IRF  NF  Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	17,810,672			410,010				50
52	Delivery Room & Labor Room	5,995,161			489,468				52
53	Anesthesiology	3,024,151			83,171				53
54	Radiology-Diagnostic	28,401,008			598,703				54
56.01	NUCLEAR MEDICINE								56.01
60	Laboratory	45,574,575			2,261,471				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,887,407			659,116				65
66	Physical Therapy	2,494,671			43,753				66
69	Electrocardiology	5,114,013			155,704				69
70	Electroencephalography	177,692			14,507				70
71	Medical Supplies Charged to Pat	1,382,876			47,802				71
72	Impl. Dev. Charged to Patients	5,109,304			370,871				72
73	Drugs Charged to Patients	36,948,820			2,370,990				73
75.01	ACUTE DIALYSIS	2,207,700			33,000				75.01
75.02	CARD CATH LAB	13,434,918			595,495				75.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	4,444,065			7,063				90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	370,948							90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	6,780,450			78,402				90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	36,578,852			599,399				91
92	Observation Beds (Non-Distinct)	6,392,196			59,405				92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)	232,129,479			8,878,330				200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0206

WORKSHEET D  
PART V

Check [ ] Title V - O/P [XX] Hospital [ ] SUB (Other) [ ] Swing Bed SNF  
 Applicable [ ] Title XVIII, Part B [ ] IPF [ ] SNF [ ] Swing Bed NF  
 Boxes: [XX] Title XIX - O/P [ ] IRF [ ] NF [ ] ICF/ID

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	Operating Room	0.378444						50
52	Delivery Room & Labor Room	0.682041						52
53	Anesthesiology	0.156639						53
54	Radiology-Diagnostic	0.197600						54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	0.153276						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.198493						65
66	Physical Therapy	0.320286						66
69	Electrocardiology	0.152133						69
70	Electroencephalography	0.823228						70
71	Medical Supplies Charged to Pat	0.270001						71
72	Impl. Dev. Charged to Patients	0.698690						72
73	Drugs Charged to Patients	0.136833						73
75.01	ACUTE DIALYSIS	0.280464						75.01
75.02	CARD CATH LAB	0.163957						75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>							
90	Clinic	1.033189						90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	1.508575						90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	0.137585						90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	0.176676						91
92	Observation Beds (Non-Distinct)	0.272405						92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S206

WORKSHEET D  
PART II

Check [ ] Title V [ ] Hospital [ ] SUB (Other)  
 Applicable [ ] Title XVIII, Part A [XX] IPF  
 Boxes: [XX] Title XIX [ ] IRF

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room	566,802	17,810,672	0.031824			50
52	Delivery Room & Labor Room	531,092	5,995,161	0.088587			52
53	Anesthesiology	49,077	3,024,151	0.016228			53
54	Radiology-Diagnostic	453,039	28,401,008	0.015952	2,481	40	54
56.01	NUCLEAR MEDICINE						56.01
60	Laboratory	382,346	45,574,575	0.008389	44,823	376	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	101,783	9,887,407	0.010294			65
66	Physical Therapy	72,563	2,494,671	0.029087	2,630	76	66
69	Electrocardiology	105,357	5,114,013	0.020602	3,168	65	69
70	Electroencephalography	27,005	177,692	0.151976			70
71	Medical Supplies Charged to Pat	26,309	1,382,876	0.019025			71
72	Impl. Dev. Charged to Patients	253,570	5,109,304	0.049629			72
73	Drugs Charged to Patients	205,007	36,948,820	0.005548	54,784	304	73
75.01	ACUTE DIALYSIS	5,177	2,207,700	0.002345			75.01
75.02	CARD CATH LAB	150,982	13,434,918	0.011238			75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic	239,089	4,444,065	0.053800			90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	24,043	370,948	0.064815			90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	78,425	6,780,450	0.011566	358	4	90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	Emergency	291,388	36,578,852	0.007966	6,471	52	91
92	Observation Beds (Non-Distinct		6,392,196				92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	Total (sum of lines 50-199)	3,563,054	232,129,479		114,715	917	200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-S206**

**WORKSHEET D  
PART IV**

Check  Title V  Hospital  SUB (Other)  ICF/IID  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  TEFRA  
 Boxes:  Title XIX  IRF  NF  Other

(A)	Cost Center Description	1	2A	2	3A	3	4	5	6
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room								50
52	Delivery Room & Labor Room								52
53	Anesthesiology								53
54	Radiology-Diagnostic								54
56.01	NUCLEAR MEDICINE								56.01
60	Laboratory								60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy								65
66	Physical Therapy								66
69	Electrocardiology								69
70	Electroencephalography								70
71	Medical Supplies Charged to Pat								71
72	Impl. Dev. Charged to Patients								72
73	Drugs Charged to Patients								73
75.01	ACUTE DIALYSIS								75.01
75.02	CARD CATH LAB								75.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic								90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC								90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY								90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency								91
92	Observation Beds (Non-Distinct								92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Total (sum of lines 50-199)								200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE  
OTHER PASS THROUGH COSTS**

**COMPONENT CCN: 14-S206**

**WORKSHEET D  
PART IV**

Check  Title V  Hospital  SUB (Other)  ICF/IID  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  TEFRA  
 Boxes:  Title XIX  IRF  NF  Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
<b>ANCILLARY SERVICE COST CENTERS</b>									
50	Operating Room	17,810,672							50
52	Delivery Room & Labor Room	5,995,161							52
53	Anesthesiology	3,024,151							53
54	Radiology-Diagnostic	28,401,008			2,481				54
56.01	NUCLEAR MEDICINE								56.01
60	Laboratory	45,574,575			44,823				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,887,407							65
66	Physical Therapy	2,494,671			2,630				66
69	Electrocardiology	5,114,013			3,168				69
70	Electroencephalography	177,692							70
71	Medical Supplies Charged to Pat	1,382,876							71
72	Impl. Dev. Charged to Patients	5,109,304							72
73	Drugs Charged to Patients	36,948,820			54,784				73
75.01	ACUTE DIALYSIS	2,207,700							75.01
75.02	CARD CATH LAB	13,434,918							75.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>									
90	Clinic	4,444,065							90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	370,948							90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	6,780,450			358				90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	36,578,852			6,471				91
92	Observation Beds (Non-Distinct	6,392,196							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
<b>OTHER REIMBURSABLE COST CENTERS</b>									
200	Total (sum of lines 50-199)	232,129,479			114,715				200

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S206

WORKSHEET D  
PART V

Check [ ] Title V - O/P [ ] Hospital [ ] SUB (Other) [ ] Swing Bed SNF  
 Applicable [ ] Title XVIII, Part B [XX] IPF [ ] SNF [ ] Swing Bed NF  
 Boxes: [XX] Title XIX - O/P [ ] IRF [ ] NF [ ] ICF/ID

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	Operating Room	0.378444							50
52	Delivery Room & Labor Room	0.682041							52
53	Anesthesiology	0.156639							53
54	Radiology-Diagnostic	0.197600							54
56.01	NUCLEAR MEDICINE								56.01
60	Laboratory	0.153276							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.198493							65
66	Physical Therapy	0.320286							66
69	Electrocardiology	0.152133							69
70	Electroencephalography	0.823228							70
71	Medical Supplies Charged to Pat	0.270001							71
72	Impl. Dev. Charged to Patients	0.698690							72
73	Drugs Charged to Patients	0.136833							73
75.01	ACUTE DIALYSIS	0.280464							75.01
75.02	CARD CATH LAB	0.163957							75.02
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>								
90	Clinic	1.033189							90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	1.508575							90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	0.137585							90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	0.176676							91
92	Observation Beds (Non-Distinct	0.272405							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0206

WORKSHEET D-1  
PART I

Check [ ] Title V - I/P [XX] Hospital [ ] SUB (Other) [ ] ICF/IID [XX] PPS  
 Applicable [XX] Title XVIII, Part A [ ] IPF [ ] SNF [ ] TEFRA  
 Boxes: [ ] Title XIX - I/P [ ] IRF [ ] NF [ ] Other

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	29,247	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	29,247	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	27,237	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 (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	6,494	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 (see instructions)		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 (if calendar year, enter 0 on this line)		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 (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

**SWING-BED ADJUSTMENT**

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 (see instructions)	25,336,656	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	25,336,656	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	25,336,656	37

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0206

WORKSHEET D-1  
PART II

Check  Title V - I/P  Hospital  SUB (Other)  PPS  
 Applicable  Title XVIII, Part A  IPF  TEFRA  
 Boxes:  Title XIX - I/P  IRF  Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

							1	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
38	Adjusted general inpatient routine service cost per diem (see instructions)					866.30	38	
39	Program general inpatient routine service cost (line 9 x line 38)					5,625,752	39	
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40	
41	Total Program general inpatient routine service cost (line 39 + line 40)					5,625,752	41	
42	Nursery (Titles V and XIX only)	1	2	3	4	5	42	
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43	Intensive Care Unit	5,259,802	3,301	1,593.40	1,124	1,790,982	43	
43.01	NICU						43.01	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,441,081	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					13,857,815	49

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					408,753	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					400,039	51
52	Total Program excludable cost (sum of lines 50 and 51)					808,792	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					13,049,023	53

**TARGET AMOUNT AND LIMIT COMPUTATION**

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

**PROGRAM INPATIENT ROUTINE SWING BED COST**

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0206

WORKSHEET D-1  
PARTS III & IV

Check             Title V - I/P                             Hospital             SUB (Other)                             ICF/IID             PPS  
Applicable       Title XVIII, Part A                     IPF                     SNF                     TEFRA  
Boxes:            Title XIX - I/P                             IRF                     NF                     Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					2,010	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					866.30	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,741,263	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,500,347	25,336,656	0.059216	1,741,263	103,111	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S206

WORKSHEET D-1  
PART I

Check [ ] Title V - I/P [ ] Hospital [ ] SUB (Other) [ ] ICF/IID [XX] PPS  
 Applicable [XX] Title XVIII, Part A [XX] IPF [ ] SNF [ ] TEFRA  
 Boxes: [ ] Title XIX - I/P [ ] IRF [ ] NF [ ] Other

PART I - ALL PROVIDER COMPONENTS

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,440	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,440	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,440	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 (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	967	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 (see instructions)		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 (if calendar year, enter 0 on this line)		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 (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

**SWING-BED ADJUSTMENT**

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 (see instructions)	2,113,394	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,113,394	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,113,394	37

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-S206**

**WORKSHEET D-1  
PART II**

Check  Title V - I/P  Hospital  SUB (Other)  PPS  
 Applicable  Title XVIII, Part A  IPF  TEFRA  
 Boxes:  Title XIX - I/P  IRF  Other

**PART II - HOSPITALS AND SUBPROVIDERS ONLY**

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	614.36	38
39	Program general inpatient routine service cost (line 9 x line 38)	594,086	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	594,086	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	103,142	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	697,228	49

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	38,574	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	5,526	51
52	Total Program excludable cost (sum of lines 50 and 51)	44,100	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	653,128	53

**TARGET AMOUNT AND LIMIT COMPUTATION**

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

**PROGRAM INPATIENT ROUTINE SWING BED COST**

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-0206**

**WORKSHEET D-1  
PART I**

Check  Title V - I/P                     Hospital                     SUB (Other)                     ICF/IID                     PPS  
 Applicable  Title XVIII, Part A                     IPF                     SNF                     TEFRA  
 Boxes:  Title XIX - I/P                     IRF                     NF                     Other

**PART I - ALL PROVIDER COMPONENTS**

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	29,247	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	29,247	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	27,237	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 (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,766	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 (see instructions)		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 (if calendar year, enter 0 on this line)		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 (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	1,970	15
16	Nursery days (title V or XIX only)	897	16

**SWING-BED ADJUSTMENT**

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 (see instructions)	25,336,656	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	25,336,656	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	25,336,656	37

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-0206**

**WORKSHEET D-1  
PART II**

Check  Title V - I/P  Hospital  SUB (Other)  PPS  
 Applicable  Title XVIII, Part A  IPF  TEFRA  
 Boxes:  Title XIX - I/P  IRF  Other

**PART II - HOSPITALS AND SUBPROVIDERS ONLY**

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

							1	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
38	Adjusted general inpatient routine service cost per diem (see instructions)					866.30	38	
39	Program general inpatient routine service cost (line 9 x line 38)					2,396,186	39	
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40	
41	Total Program general inpatient routine service cost (line 39 + line 40)					2,396,186	41	
42	Nursery (Titles V and XIX only)	2,516,271	1,970	1,277.29	897	1,145,729	42	
	<b>Intensive Care Type Inpatient Hospital Units</b>							
43	Intensive Care Unit	5,259,802	3,301	1,593.40	241	384,009	43	
43.01	NICU						43.01	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,990,955	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					5,916,879	49

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					214,852	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					146,010	51
52	Total Program excludable cost (sum of lines 50 and 51)					360,862	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53

**TARGET AMOUNT AND LIMIT COMPUTATION**

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61
62	Relief payment (see instructions)						62
63	Allowable Inpatient cost plus incentive payment (see instructions)						63

**PROGRAM INPATIENT ROUTINE SWING BED COST**

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)						64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0206

WORKSHEET D-1  
PARTS III & IV

Check             Title V - I/P                             Hospital             SUB (Other)                             ICF/IID             PPS  
 Applicable     Title XVIII, Part A                     IPF                     SNF                     TEFRA  
 Boxes:         Title XIX - I/P                     IRF                     NF                     Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					2,010	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-S206**

**WORKSHEET D-1  
PART I**

Check  Title V - I/P  Hospital  SUB (Other)  ICF/IID  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  TEFRA  
 Boxes:  Title XIX - I/P  IRF  NF  Other

**PART I - ALL PROVIDER COMPONENTS**

**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,440	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,440	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	3,440	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 (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	211	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 (see instructions)		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 (if calendar year, enter 0 on this line)		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 (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

**SWING-BED ADJUSTMENT**

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 (see instructions)	2,113,394	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,113,394	27

**PRIVATE ROOM DIFFERENTIAL ADJUSTMENT**

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,113,394	37

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**COMPUTATION OF INPATIENT OPERATING COST**

**COMPONENT CCN: 14-S206**

**WORKSHEET D-1  
PART II**

Check  Title V - I/P  Hospital  SUB (Other)  PPS  
 Applicable  Title XVIII, Part A  IPF  TEFRA  
 Boxes:  Title XIX - I/P  IRF  Other

**PART II - HOSPITALS AND SUBPROVIDERS ONLY**

**PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS**

1

38	Adjusted general inpatient routine service cost per diem (see instructions)	614.36	38
39	Program general inpatient routine service cost (line 9 x line 38)	129,630	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40
41	Total Program general inpatient routine service cost (line 39 + line 40)	129,630	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	17,372	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	147,002	49

**PASS THROUGH COST ADJUSTMENTS**

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	8,417	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	917	51
52	Total Program excludable cost (sum of lines 50 and 51)	9,334	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

**TARGET AMOUNT AND LIMIT COMPUTATION**

54	Program discharges		54
55	Target amount per discharge		55
56	Target amount (line 54 x line 55)		56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57
58	Bonus payment (see instructions)		58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.		59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.		60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61
62	Relief payment (see instructions)		62
63	Allowable Inpatient cost plus incentive payment (see instructions)		63

**PROGRAM INPATIENT ROUTINE SWING BED COST**

64	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)		64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)		65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)		66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0206

WORKSHEET D-3

Check  Title V  Hospital  SUB (Other)  Swing Bed SNF  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  Swing Bed NF  TEFRA  
 Boxes:  Title XIX  IRF  NF  ICF/ID  Other

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		10,466,871		30
31	Intensive Care Unit		2,992,898		31
31.01	NICU				31.01
40	Subprovider - IPF				40
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.378444	1,716,655	649,658	50
52	Delivery Room & Labor Room	0.682041	21,646	14,763	52
53	Anesthesiology	0.156639	416,116	65,180	53
54	Radiology-Diagnostic	0.197600	2,854,890	564,126	54
56.01	NUCLEAR MEDICINE				56.01
60	Laboratory	0.153276	6,681,117	1,024,055	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.198493	2,921,902	579,977	65
66	Physical Therapy	0.320286	271,458	86,944	66
69	Electrocardiology	0.152133	833,262	126,767	69
70	Electroencephalography	0.823228	56,059	46,149	70
71	Medical Supplies Charged to Patients	0.270001	218,486	58,991	71
72	Impl. Dev. Charged to Patients	0.698690	1,324,637	925,511	72
73	Drugs Charged to Patients	0.136833	7,818,233	1,069,792	73
75.01	ACUTE DIALYSIS	0.280464	1,009,800	283,213	75.01
75.02	CARD CATH LAB	0.163957	3,025,441	496,042	75.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90	Clinic	1.066772	17,634	18,811	90
90.01	PH CLINIC				90.01
90.02	HEALTHWORKS CLINIC	1.508575			90.02
90.03	DENTAL CLINIC				90.03
90.04	WOUND CARE THERAPY	0.137585	195,118	26,845	90.04
90.05	FAMILY PRACTICE CLINIC				90.05
91	Emergency	0.176676	2,123,091	375,099	91
92	Observation Beds (Non-Distinct Part)	0.272405	107,038	29,158	92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		31,612,583	6,441,081	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		31,612,583		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S206

WORKSHEET D-3

Check  Title V  Hospital  SUB (Other)  Swing Bed SNF  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  Swing Bed NF  TEFRA  
 Boxes:  Title XIX  IRF  NF  ICF/IID  Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
1	2	3			
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
31.01	NICU				31.01
40	Subprovider - IPF		1,759,483		40
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.378444	12,255	4,638	50
52	Delivery Room & Labor Room	0.682041			52
53	Anesthesiology	0.156639	2,547	399	53
54	Radiology-Diagnostic	0.197600	20,944	4,139	54
56.01	NUCLEAR MEDICINE				56.01
60	Laboratory	0.153276	206,502	31,652	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.198493	504	100	65
66	Physical Therapy	0.320286	3,131	1,003	66
69	Electrocardiology	0.152133	21,238	3,231	69
70	Electroencephalography	0.823228	771	635	70
71	Medical Supplies Charged to Patients	0.270001			71
72	Impl. Dev. Charged to Patients	0.698690			72
73	Drugs Charged to Patients	0.136833	334,228	45,733	73
75.01	ACUTE DIALYSIS	0.280464			75.01
75.02	CARD CATH LAB	0.163957			75.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90	Clinic	1.066772			90
90.01	PH CLINIC				90.01
90.02	HEALTHWORKS CLINIC	1.508575			90.02
90.03	DENTAL CLINIC				90.03
90.04	WOUND CARE THERAPY	0.137585			90.04
90.05	FAMILY PRACTICE CLINIC				90.05
91	Emergency	0.176676	65,722	11,612	91
92	Observation Beds (Non-Distinct Part)	0.272405			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		667,842	103,142	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		667,842		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0206

WORKSHEET D-3

Check  Title V  Hospital  SUB (Other)  Swing Bed SNF  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  Swing Bed NF  TEFRA  
 Boxes:  Title XIX  IRF  NF  ICF/IID  Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics		4,471,147		30
31	Intensive Care Unit		609,232		31
31.01	NICU				31.01
40	Subprovider - IPF				40
43	Nursery		1,725,606		43
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.378444	410,010	155,166	50
52	Delivery Room & Labor Room	0.682041	489,468	333,837	52
53	Anesthesiology	0.156639	83,171	13,028	53
54	Radiology-Diagnostic	0.197600	598,703	118,304	54
56.01	NUCLEAR MEDICINE				56.01
60	Laboratory	0.153276	2,261,471	346,629	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.198493	659,116	130,830	65
66	Physical Therapy	0.320286	43,753	14,013	66
69	Electrocardiology	0.152133	155,704	23,688	69
70	Electroencephalography	0.823228	14,507	11,943	70
71	Medical Supplies Charged to Patients	0.270001	47,802	12,907	71
72	Impl. Dev. Charged to Patients	0.698690	370,871	259,124	72
73	Drugs Charged to Patients	0.136833	2,370,990	324,430	73
75.01	ACUTE DIALYSIS	0.280464	33,000	9,255	75.01
75.02	CARD CATH LAB	0.163957	595,495	97,636	75.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90	Clinic	1.033189	7,063	7,297	90
90.01	PH CLINIC				90.01
90.02	HEALTHWORKS CLINIC	1.508575			90.02
90.03	DENTAL CLINIC				90.03
90.04	WOUND CARE THERAPY	0.137585	78,402	10,787	90.04
90.05	FAMILY PRACTICE CLINIC				90.05
91	Emergency	0.176676	599,399	105,899	91
92	Observation Beds (Non-Distinct Part)	0.272405	59,405	16,182	92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		8,878,330	1,990,955	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		8,878,330		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S206

WORKSHEET D-3

Check  Title V  Hospital  SUB (Other)  Swing Bed SNF  PPS  
 Applicable  Title XVIII, Part A  IPF  SNF  Swing Bed NF  TEFRA  
 Boxes:  Title XIX  IRF  NF  ICF/IID  Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
1		2	3		
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
31.01	NICU				31.01
40	Subprovider - IPF		385,957		40
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	Operating Room	0.378444			50
52	Delivery Room & Labor Room	0.682041			52
53	Anesthesiology	0.156639			53
54	Radiology-Diagnostic	0.197600	2,481	490	54
56.01	NUCLEAR MEDICINE				56.01
60	Laboratory	0.153276	44,823	6,870	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.198493			65
66	Physical Therapy	0.320286	2,630	842	66
69	Electrocardiology	0.152133	3,168	482	69
70	Electroencephalography	0.823228			70
71	Medical Supplies Charged to Patients	0.270001			71
72	Impl. Dev. Charged to Patients	0.698690			72
73	Drugs Charged to Patients	0.136833	54,784	7,496	73
75.01	ACUTE DIALYSIS	0.280464			75.01
75.02	CARD CATH LAB	0.163957			75.02
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>				
90	Clinic	1.033189			90
90.01	PH CLINIC				90.01
90.02	HEALTHWORKS CLINIC	1.508575			90.02
90.03	DENTAL CLINIC				90.03
90.04	WOUND CARE THERAPY	0.137585	358	49	90.04
90.05	FAMILY PRACTICE CLINIC				90.05
91	Emergency	0.176676	6,471	1,143	91
92	Observation Beds (Non-Distinct Part)	0.272405			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	Total (sum of lines 50-94, and 96-98)		114,715	17,372	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		114,715		202

(A) Worksheet A line numbers

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**WORKSHEET E  
PART A**

**PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	8,670,019			1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	2,890,006			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	164,744			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments	3,463,408			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	176.14			4
	<b>Indirect Medical Education Adjustment Calculation for Hospitals</b>				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)	2.68			5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.	1.74			7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	12.44			8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)	13.38			9
10	FTE count for allopathic and osteopathic programs in the current year from your records	1.26			10
11	FTE count for residents in dental and podiatric programs	3.00			11
12	Current year allowable FTE (see instructions)	4.26			12
13	Total allowable FTE count for the prior year	3.00			13
14	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero	3.00			14
15	Sum of lines 12 through 14 divided by 3	3.42			15
16	Adjustment for residents in initial years of the program				16
17	Adjustment for residents displaced by program or hospital closure				17
18	Adjusted rolling average FTE count	3.42			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.019416			19
20	Prior year resident to bed ratio (see instructions)	0.016900			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.016900			21
22	IME payment adjustment (see instructions)	106,283			22
22.01	IME payment adjustment - Managed Care (see instructions)	31,843			22.01
	<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105(f)(1)(iv)(C)				23
24	IME FTE resident count over cap (see instructions)	-12.12			24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	106,283			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	31,843			29.01
	<b>Disproportionate Share Adjustment</b>				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.2964			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.6198			31
32	Sum of lines 30 and 31	0.9162			32
33	Allowable disproportionate share percentage (see instructions)	0.6480			33
34	Disproportionate share adjustment (see instructions)	1,872,724			34
		<b>Prior to</b>		<b>On or after</b>	
	<b>Uncompensated Care Adjustment</b>	<b>October 1 (1.00)</b>	<b>(1.01)</b>	<b>October 1 (2.00)</b>	
35	Total uncompensated care amount (see instructions)				35
35.01	Factor 3 (see instructions)				35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			3,783,169	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			3,783,169	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	3,783,169			36
	<b>Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)</b>				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**WORKSHEET E  
PART A**

**PART A - INPATIENT HOSPITAL SERVICES UNDER PPS**

		1	1.01	1.02	
47	Subtotal (see instructions)	17,486,945			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	17,518,788			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,142,162			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)	76,956			52
53	Nursing and allied health managed care payment				53
54	Special add-on payments for new technologies	2,071			54
55	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	18,739,977			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	18,739,977			61
62	Deductibles billed to program beneficiaries	1,076,824			62
63	Coinsurance billed to program beneficiaries	188,104			63
64	Allowable bad debts (see instructions)	723,971			64
65	Adjusted reimbursable bad debts (see instructions)	470,581			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	584,808			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	17,945,630			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (OTHER ADJUSTMENT)				70
70.93	HVBP payment adjustment amount (see instructions)	-85,285			70.93
70.94	HRR adjustment amount (see instructions)	-65,904			70.94
71	Amount due provider (see instructions)	17,794,441			71
71.01	Sequestration adjustment (see instructions)	355,889			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	17,219,002			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	219,550			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	2,000,890			75
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96
<b>HSP Bonus Payment Amount</b>		<b>Prior to 10/1</b>	<b>On or After 10/1</b>		
100	HSP bonus amount (see instructions)				100
<b>HVBP Adjustment for HSP Bonus Payment</b>		<b>Prior to 10/1</b>	<b>On or After 10/1</b>		
101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102
<b>HRR Adjustment for HSP Bonus Payment</b>		<b>Prior to 10/1</b>	<b>On or After 10/1</b>		
103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**CALCULATION OF REIMBURSEMENT SETTLEMENT**

**COMPONENT CCN: 14-0206**

**WORKSHEET E  
PART B**

Check applicable box:       Hospital       IPF       IRF       SUB (Other)       SNF

**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)	999			1
2	Medical and other services reimbursed under OPPTS (see instructions)	5,634,761			2
3	OPPTS payments	3,713,421			3
4	Outlier payment (see instructions)	50,479			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)	0.836			5
6	Line 2 times line 5	4,710,660			6
7	Sum of lines 3, 4, and 4.01, divided by line 6	0.7990			7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	999			11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	<b>REASONABLE CHARGES</b>				
12	Ancillary service charges	7,301			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	7,301			14
	<b>CUSTOMARY CHARGES</b>				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	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)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)	7,301			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions))	6,302			19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions))				20
21	Lesser of cost or charges (line 11 minus line 20) (see instructions)	999			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	3,763,900			24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	750,162			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	3,014,737			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	29,798			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	3,044,535			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	3,044,535			32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	306,737			34
35	Adjusted reimbursable bad debts (see instructions)	199,379			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	218,710			36
37	Subtotal (see instructions)	3,243,914			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (OTHER ADJ - PS&R)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	3,243,914			40
40.01	Sequestration adjustment (see instructions)	64,878			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	3,412,281			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-233,245			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

**TO BE COMPLETED BY CONTRACTOR**

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S206

WORKSHEET E  
PART B

Check applicable box:         Hospital         IPF         IRF         SUB (Other)         SNF

**PART B - MEDICAL AND OTHER HEALTH SERVICES**

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPTS (see instructions)				2
3	OPPTS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
	<b>REASONABLE CHARGES</b>				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	<b>CUSTOMARY CHARGES</b>				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	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)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)	1.000000			17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions))				19
20	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18 (see instructions))				20
21	Lesser of cost or charges (line 11 minus line 20) (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)				34
35	Adjusted reimbursable bad debts (see instructions)				35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)				36
37	Subtotal (see instructions)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ( )				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

**TO BE COMPLETED BY CONTRACTOR**

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (see instructions)				91
92	The rate used to calculate the Time Value of Money				92
93	Time Value of Money (see instructions)				93
94	Total (sum of lines 91 and 93)				94

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0206

WORKSHEET E-1  
PART I

Check  Hospital  SUB (Other)  
 Applicable  IPF  SNF  
 Boxes:  IRF  Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B			
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4		
1	Total interim payments paid to provider		17,165,099		3,295,998	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					2	
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01	05/04/2017	53,903	05/04/2017	116,283	3.01
		.02					3.02
	Program	.03					3.03
	to	.04					3.04
	Provider	.05					3.05
		.06					3.06
		.07					3.07
		.08					3.08
		.09					3.09
		.10					3.10
		.50					3.50
		.51					3.51
	Provider	.52					3.52
	to	.53					3.53
	Program	.54					3.54
		.55					3.55
		.56					3.56
		.57					3.57
		.58					3.58
		.59					3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99		53,903		116,283	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			17,219,002		3,412,281	4
<b>TO BE COMPLETED BY CONTRACTOR</b>							
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01					5.01
		.02					5.02
	Program	.03					5.03
	to	.04					5.04
	Provider	.05					5.05
		.06					5.06
		.07					5.07
		.08					5.08
		.09					5.09
		.10					5.10
		.50					5.50
		.51					5.51
	Provider	.52					5.52
	to	.53					5.53
	Program	.54					5.54
		.55					5.55
		.56					5.56
		.57					5.57
		.58					5.58
		.59					5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99					5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01		219,550			6.01
		.02				-233,245	6.02
7	Total Medicare program liability (see instructions)			17,438,552		3,179,036	7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)		8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-S206

WORKSHEET E-1  
PART I

Check  Hospital  SUB (Other)  
Applicable  IPF  SNF  
Boxes:  IRF  Swing Bed SNF

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		771,723		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				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		771,723		4
<b>TO BE COMPLETED BY CONTRACTOR</b>					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			5.01
		.02			5.02
	Program	.03			5.03
	to	.04			5.04
	Provider	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	Provider	.52			5.52
	to	.53			5.53
	Program	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	4,676		6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		776,399		7
8	Name of Contractor		Contractor Number	NPR Date (Month/Day/Year)	8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S206

WORKSHEET E-3  
PART II

Check [ ] Hospital  
Applicable [XX] Subprovider IPF  
Box:

**PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS**

1	Net Federal IPF PPS payment (excluding outlier, ECT, and medical education payments)	885,338	1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment		3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)	2.00	4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)	9.424658	9
10	Teaching adjustment factor $\{(1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1\}$		10
11	Teaching adjustment (line 1 multiplied by line 10)		11
12	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	885,338	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	885,338	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	885,338	18
19	Deductibles	69,328	19
20	Subtotal (line 18 minus line 19)	816,010	20
21	Coinsurance	28,532	21
22	Subtotal (line 20 minus line 21)	787,478	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	7,333	23
24	Adjusted reimbursable bad debts (see instructions)	4,766	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	201	25
26	Subtotal (sum of lines 22 and 24)	792,244	26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (for freestanding IPF only)		27
28	Other pass through costs (see instructions)		28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	792,244	31
31.01	Sequestration adjustment (see instructions)	15,845	31.01
31.02	Demonstration payment adjustment amount after sequestration		31.02
32	Interim payments	771,723	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	4,676	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35

**TO BE COMPLETED BY CONTRACTOR**

50	Original outlier amount from Worksheet E-3, Part II, line 2 (see instructions)		50
51	Outlier reconciliation adjustment amount (see instructions)		51
52	The rate used to calculate the time value of money (see instructions)		52
53	Time value of money (see instructions)		53

**KPMG LLP Compu-Max 2552-10**

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0206

WORKSHEET E-3  
PART VII

Check  Title V  Hospital  NF  PPS  
 Applicable  Title XIX  SUB (Other)  ICF/IID  TEFRA  
 Boxes:  SNF  Other

**PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES**

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>			
1	Inpatient hospital/SNF/NF services	5,916,879	1
2	Medical and other services		2
3	Organ acquisition (certified transplant centers only)		3
4	Subtotal (sum of lines 1, 2 and 3)	5,916,879	4
5	Inpatient primary payer payments		5
6	Outpatient primary payer payments		6
7	Subtotal (line 4 less sum of lines 5 and 6)	5,916,879	7
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
<b>REASONABLE CHARGES</b>			
8	Routine service charges	6,805,985	8
9	Ancillary service charges	8,878,330	9
10	Organ acquisition charges, net of revenue		10
11	Incentive from target amount computation		11
12	Total reasonable charges (sum of lines 8-11)	15,684,315	12
<b>CUSTOMARY CHARGES</b>			
13	Amount actually collected from patients liable for payment for services on a cahрге basis		13
14	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(c)		14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	15
16	Total customary charges (see instructions)	15,684,315	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	9,767,436	17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		18
19	Interns and residents (see instructions)		19
20	Cost of physicians' services in a teaching hospital (see instructions)		20
21	Cost of covered services (lesser of line 4 or line 16)	5,916,879	21
<b>PROSPECTIVE PAYMENT AMOUNT</b>			
22	Other than outlier payments		22
23	Outlier payments		23
24	Program capital payments		24
25	Capital exception payments (see instructions)		25
26	Routine and ancillary service other pass through costs		26
27	Subtotal (sum of lines 22 through 26)		27
28	Customary charges (Titles V or XIX PPS covered services only)		28
29	Titles V or XIX (sum of lines 21 and 27)	5,916,879	29
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
30	Excess of reasonable cost (from line 18)		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	5,916,879	31
32	Deductibles		32
33	Coinsurance		33
34	Allowable bad debts (see instructions)		34
35	Utilization review		35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	5,916,879	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		37
38	Subtotal (line 36 ± line 37)	5,916,879	38
39	Direct graduate medical education payments (from Wkst. E-4)		39
40	Total amount payable to the provider (sum of lines 38 and 39)	5,916,879	40
41	Interim payments	5,916,879	41
42	Balance due provider/program (line 40 minus line 41)		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		43

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S206

WORKSHEET E-3  
PART VII

Check  Title V  Hospital  NF  PPS  
 Applicable  Title XIX  Subprovider IPF  ICF/IID  TEFRA  
 Boxes:  SNF  Other

**PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES**

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
<b>COMPUTATION OF NET COST OF COVERED SERVICES</b>			
1 Inpatient hospital/SNF/NF services	147,002		1
2 Medical and other services			2
3 Organ acquisition (certified transplant centers only)			3
4 Subtotal (sum of lines 1, 2 and 3)	147,002		4
5 Inpatient primary payer payments			5
6 Outpatient primary payer payments			6
7 Subtotal (line 4 less sum of lines 5 and 6)	147,002		7
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
<b>REASONABLE CHARGES</b>			
8 Routine service charges	385,957		8
9 Ancillary service charges	114,715		9
10 Organ acquisition charges, net of revenue			10
11 Incentive from target amount computation			11
12 Total reasonable charges (sum of lines 8-11)	500,672		12
<b>CUSTOMARY CHARGES</b>			
13 Amount actually collected from patients liable for payment for services on a cahrgre basis			13
14 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)			14
15 Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16 Total customary charges (see instructions)	500,672		16
17 Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	353,670		17
18 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19 Interns and residents (see instructions)			19
20 Cost of physicians' services in a teaching hospital (see instructions)			20
21 Cost of covered services (lesser of line 4 or line 16)	147,002		21
<b>PROSPECTIVE PAYMENT AMOUNT</b>			
22 Other than outlier payments			22
23 Outlier payments			23
24 Program capital payments			24
25 Capital exception payments (see instructions)			25
26 Routine and ancillary service other pass through costs			26
27 Subtotal (sum of lines 22 through 26)			27
28 Customary charges (Titles V or XIX PPS covered services only)			28
29 Titles V or XIX (sum of lines 21 and 27)	147,002		29
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
30 Excess of reasonable cost (from line 18)			30
31 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	147,002		31
32 Deductibles			32
33 Coinsurance			33
34 Allowable bad debts (see instructions)			34
35 Utilization review			35
36 Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	147,002		36
37 OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38 Subtotal (line 36 ± line 37)	147,002		38
39 Direct graduate medical education payments (from Wkst. E-4)			39
40 Total amount payable to the provider (sum of lines 38 and 39)	147,002		40
41 Interim payments	147,002		41
42 Balance due provider/program (line 40 minus line 41)			42
43 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

**KPMG LLP Compu-Max 2552-10**

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2016 To: 09/30/2017	Run Date: 02/25/2018 Run Time: 10:34 Version: 2018.01 (02/13/2018)
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**DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS**

**WORKSHEET E-4**

Check [ ] Title V  
 Applicable [XX] Title XVIII  
 Box: [ ] Title XIX

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1.98	1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			1.29	3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			12.44	4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			13.13	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			1.26	6
7	Enter the lesser of line 5 or line 6			1.26	7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	1.26	0.00	1.26	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	1.26	0.00	1.26	9
10	Weighted dental and podiatric resident FTE count for the current year		3.00		10
10.01	Unweighted dental and podiatric resident FTE count for the current year		3.00		10.01
11	Total weighted FTE count	1.26	3.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	3.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	3.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.42	3.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count	0.42	3.00		17
18	Per resident amount	96,780.95	96,780.95		18
19	Approved amount for resident costs	40,648	290,343	330,991	19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)			330,991	25
COMPUTATION OF PROGRAM PATIENT LOAD					
		Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	8,585	2,843		26
27	Total inpatient days (see instructions)	34,187	34,187		27
28	Ratio of inpatient days to total inpatient days	0.251119	0.083160		28
29	Program direct GME amount	83,118	27,525		29
30	Reduction for direct GME payments for Medicare Advantage		3,889		30
31	Net Program direct GME amount			106,754	31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)					
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME					
Part A Reasonable Cost					
37	Reasonable cost (see instructions)			14,555,043	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			14,555,043	41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)			5,635,760	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			5,635,760	44
45	Total reasonable cost (sum of lines 41 and 44)			20,190,803	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.720875	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.279125	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)			106,754	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			76,956	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			29,798	50

**KPMG LLP Compu-Max 2552-10**

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**DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS**

**WORKSHEET E-4**

Check  Title V  
 Applicable  Title XVIII  
 Box:  Title XIX

<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>				
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)			2
3	Amount of reduction to Direct GME cap under §422 of MMA			3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			6
7	Enter the lesser of line 5 or line 6			7
		Primary Care	Other	Total
		1	2	3
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00
10	Weighted dental and podiatric resident FTE count for the current year		0.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year			
11	Total weighted FTE count	0.00	0.00	
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00	
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00	
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00	
15	Adjustment for residents in initial years of new programs	0.00	0.00	
15.01	Unweighted adjustment for residents in initial years of new programs			
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure			
17	Adjusted rolling average FTE count	0.00	0.00	
18	Per resident amount	0.00	0.00	
19	Approved amount for resident costs			
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			
21	Direct GME FTE unweighted resident count over cap (see instructions)			
22	Allowable additional direct GME FTE resident count (see instructions)			
23	Enter the locality adjustment national average per resident amount (see instructions)			
24	Multiply line 22 times line 23			
25	Total direct GME amount (sum of lines 19 and 24)			
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>				
		Inpatient Part A	Managed Care	
26	Inpatient days (see instructions)	3,380	16,213	26
27	Total inpatient days (see instructions)	34,187	34,187	27
28	Ratio of inpatient days to total inpatient days	0.098868	0.474245	28
29	Program direct GME amount			29
30	Reduction for direct GME payments for Medicare Advantage			30
31	Net Program direct GME amount			31
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			34
35	Medicare outpatient ESRD charges (see instructions)			35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			36
<b>APPORTIONMENT OF MEDICARE REASONABLE COST OF GME</b>				
<b>Part A Reasonable Cost</b>				
37	Reasonable cost (see instructions)			37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)			38
39	Cost of physicians' services in a teaching hospital (see instructions)			39
40	Primary payer payments (see instructions)			40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			41
<b>Part B Reasonable Cost</b>				
42	Reasonable cost (see instructions)			42
43	Primary payer payments (see instructions)			43
44	Total Part B reasonable cost (line 42 minus line 43)			44
45	Total reasonable cost (sum of lines 41 and 44)			45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			47
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48	Total program GME payment (line 31)			48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			50

**KPMG LLP Compu-Max 2552-10**

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**BALANCE SHEET**

**WORKSHEET G**

(If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

<b>Assets</b> (Omit Cents)		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund
		1	2	3	4
<b>CURRENT ASSETS</b>					
1	Cash on hand and in banks	27,723,991			1
2	Temporary investments	16,321,754			2
3	Notes receivable				3
4	Accounts receivable	19,298,332			4
5	Other receivables				5
6	Allowances for uncollectible notes and accounts receivable	-6,176,940			6
7	Inventory	1,253,875			7
8	Prepaid expenses	1,079,130			8
9	Other current assets	2,272,216			9
10	Due from other funds				10
11	Total current assets (sum of lines 1-10)	61,772,358			11
<b>FIXED ASSETS</b>					
12	Land	4,529,913			12
13	Land improvements	3,689,703			13
14	Accumulated depreciation	-3,210,000			14
15	Buildings	50,154,984			15
16	Accumulated depreciation	-36,978,114			16
17	Leasehold improvements				17
18	Accumulated depreciation				18
19	Fixed equipment	24,716,065			19
20	Accumulated depreciation	-17,796,218			20
21	Automobiles and trucks				21
22	Accumulated depreciation				22
23	Major movable equipment	55,172,886			23
24	Accumulated depreciation	-48,097,434			24
25	Minor equipment depreciable				25
26	Accumulated depreciation				26
27	HIT designated assets				27
28	Accumulated depreciation				28
29	Minor equipment-nondepreciable				29
30	Total fixed assets (sum of lines 12-29)	32,181,785			30
<b>OTHER ASSETS</b>					
31	Investments				31
32	Deposits on leases				32
33	Due from owners/officers				33
34	Other assets	15,201,486			34
35	Total other assets (sum of lines 31-34)	15,201,486			35
36	Total assets (sum of lines 11, 30 and 35)	109,155,629			36
<b>Liabilities and Fund Balances</b> (Omit Cents)					
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund
		1	2	3	4
<b>CURRENT LIABILITIES</b>					
37	Accounts payable	7,822,818			37
38	Salaries, wages and fees payable				38
39	Payroll taxes payable	557,095			39
40	Notes and loans payable (short term)				40
41	Deferred income				41
42	Accelerated payments				42
43	Due to other funds				43
44	Other current liabilities	10,349,698			44
45	Total current liabilities (sum of lines 37 thru 44)	18,729,611			45
<b>LONG TERM LIABILITIES</b>					
46	Mortgage payable				46
47	Notes payable	23,258,624			47
48	Unsecured loans				48
49	Other long term liabilities	26,914,469			49
50	Total long term liabilities (sum of lines 46 thru 49)	50,173,093			50
51	Total liabilities (sum of lines 45 and 50)	68,902,704			51
<b>CAPITAL ACCOUNTS</b>					
52	General fund balance	40,252,925			52
53	Specific purpose fund				53
54	Donor created - endowment fund balance - restricted				54
55	Donor created - endowment fund balance - unrestricted				55
56	Governing body created - endowment fund balance				56
57	Plant fund balance - invested in plant				57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion				58
59	Total fund balances (sum of lines 52 thru 58)	40,252,925			59
60	Total liabilities and fund balances (sum of lines 51 and 59)	109,155,629			60

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**STATEMENT OF CHANGES IN FUND BALANCES**

**WORKSHEET G-1**

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		40,659,445		1
2	Net income (loss) (from Worksheet G-3, line 29)		-1,977,003		2
3	Total (sum of line 1 and line 2)		38,682,442		3
4	Additions (credit adjustments) (specify)				4
5	NET CHANGE IN FUND BALANCE - CY	1,570,483			5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)		1,570,483		10
11	Subtotal (line 3 plus line 10)		40,252,925		11
12	Deductions (debit adjustments) (specify)				12
13					13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		40,252,925		19

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	Fund balances at beginning of period				1
2	Net income (loss) (from Worksheet G-3, line 29)				2
3	Total (sum of line 1 and line 2)				3
4	Additions (credit adjustments) (specify)				4
5	NET CHANGE IN FUND BALANCE - CY				5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)				11
12	Deductions (debit adjustments) (specify)				12
13					13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)				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	
	<b>GENERAL INPATIENT ROUTINE CARE SERVICES</b>				
1	Hospital	48,434,439		48,434,439	1
2	Subprovider IPF	6,315,573		6,315,573	2
3	Subprovider IRF				3
5	Swing Bed - SNF				5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	54,750,012		54,750,012	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
11	Intensive Care Unit	8,526,770		8,526,770	11
11.01	NICU				11.01
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	8,526,770		8,526,770	16
17	Total inpatient routine care services (sum of lines 10 and 16)	63,276,782		63,276,782	17
18	Ancillary services	106,214,230		106,214,230	18
19	Outpatient services		138,698,019	138,698,019	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	169,491,012	138,698,019	308,189,031	28

**PART II - OPERATING EXPENSES**

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		111,651,673	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35	<b>ROUNDING</b>			35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		111,651,673	43

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## STATEMENT OF REVENUES AND EXPENSES

## WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	308,189,031	1
2	Less contractual allowances and discounts on patients' accounts	208,049,539	2
3	Net patient revenues (line 1 minus line 2)	100,139,492	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	111,651,673	4
5	Net income from service to patients (line 3 minus line 4)	-11,512,181	5

### OTHER INCOME

6	Contributions, donations, bequests, etc.	58,035	6
7	Income from investments		7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses		11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	336,447	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to other than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	3,035	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hospital space		22
23	Governmental appropriations		23
24	Other (HIT INCENTIVE PAYMENTS)	411,805	24
24.01	Other (CLINICAL INTEGRATION REV)	1,411,650	24.01
24.02	Other (INVESTMENT GAIN)	2,130,875	24.02
24.03	Other (RENTAL INCOME)	292,333	24.03
24.04	Other (DIETARY MISC REV)	384,932	24.04
24.05	Other (UNREALIZED GAIN ON INVESTMENT)	658,415	24.05
24.06	Other (ACA ACCESS REV)	9,720,033	24.06
24.07	Other (PEDIATRIC CARE A VAN CONTRIBUTION)	358,841	24.07
24.08	Other (FAMILY PRACTICE RESIDENCY REV)	141,000	24.08
24.09	Other (MISC REV)	607,777	24.09
25	Total other income (sum of lines 6-24)	16,515,178	25
26	Total (line 5 plus line 25)	5,002,997	26
27	Other expenses (LOSS ON FHN INVESTMENT)	6,980,000	27
28	Total other expenses (sum of line 27 and subscripts)	6,980,000	28
29	Net income (or loss) for the period (line 26 minus line 28)	-1,977,003	29

**KPMG LLP Compu-Max 2552-10**

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**CALCULATION OF CAPITAL PAYMENT**

**COMPONENT CCN: 14-0206**

**WORKSHEET L**

Check  Title V  Hospital  PPS  
 Applicable  Title XVIII, Part A  SUB (Other)  Cost Method  
 Boxes:  Title XIX

**PART I - FULLY PROSPECTIVE METHOD**

CAPITAL FEDERAL AMOUNT			
1	Capital DRG other than outlier	935,663	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	4,957	2
2.01	Model 4 BPCI Capital DRG outlier payments		2.01
3	Total inpatient days divided by number of days in the cost reporting period (see instructions)	84.24	3
4	Number of interns & residents (see instructions)	3.42	4
5	Indirect medical education percentage (see instructions)	1.16	5
6	Indirect medical education adjustment (see instructions)	10,854	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.2964	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.6198	8
9	Sum of lines 7 and 8	0.9162	9
10	Allowable disproportionate share percentage (see instructions)	0.2038	10
11	Disproportionate share adjustment (see instructions)	190,688	11
12	Total prospective capital payments (see instructions)	1,142,162	12

**PART II - PAYMENT UNDER REASONABLE COST**

1	Program inpatient routine capital cost (see instructions)		1
2	Program inpatient ancillary capital cost (see instructions)		2
3	Total inpatient program capital cost (line 1 plus line 2)		3
4	Capital cost payment factor (see instructions)		4
5	Total inpatient program capital cost (line 3 times line 4)		5

**PART III - COMPUTATION OF EXCEPTION PAYMENTS**

1	Program inpatient capital costs (see instructions)		1
2	Program inpatient capital costs for extraordinary circumstances (see instructions)		2
3	Net program inpatient capital costs (line 1 minus line 2)		3
4	Applicable exception percentage (see instructions)		4
5	Capital cost for comparison to payments (line 3 x line 4)		5
6	Percentage adjustment for extraordinary circumstances (see instructions)		6
7	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		7
8	Capital minimum payment level (line 5 plus line 7)		8
9	Current year capital payments (from Part I, line 12 as applicable)		9
10	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		10
11	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		11
12	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		12
13	Current year exception payment (if line 12 is positive, enter the amount on this line)		13
14	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		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 (see instructions)		17

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**ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES**

**WORKSHEET L-1  
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	<b>GENERAL SERVICE COST CENTERS</b>						
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
4.01	COMMUNICATIONS						4.01
4.02	DATA PROCESSING						4.02
4.03	ADMITTING						4.03
4.04	CASHIERING						4.04
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy						15
16	Medical Records & Library						16
17	Social Service						17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
	<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
31.01	NICU						31.01
40	Subprovider - IPF						40
43	Nursery						43
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	Operating Room						50
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
56.01	NUCLEAR MEDICINE						56.01
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
69	Electrocardiology						69
70	Electroencephalography						70
71	Medical Supplies Charged to Patients						71
72	Impl. Dev. Charged to Patients						72
73	Drugs Charged to Patients						73
75.01	ACUTE DIALYSIS						75.01
75.02	CARD CATH LAB						75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	<b>OUTPATIENT SERVICE COST CENTERS</b>						
90	Clinic						90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC						90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY						90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
	<b>SPECIAL PURPOSE COST CENTERS</b>						
118	SUBTOTALS (sum of lines 1-117)						118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
192.01	PROHEALTH SERVICES						192.01
192.02	AUXILIARY						192.02
200	Cross Foot Adjustments						200

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1  
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
		0	2A	24	25	26		
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202