



NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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	DATE: 02/24/2015	TIME: 16:58
	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.		
CONTRACTOR USE ONLY	5. <input type="checkbox"/> COST REPORT STATUS	6. DATE RECEIVED: _____	10. NPR DATE: _____
	1 -AS SUBMITTED	7. CONTRACTOR NO: _____	11. CONTRACTOR'S VENDOR CODE: _____
	2 -SETTLED WITHOUT AUDIT	8. <input type="checkbox"/> INITIAL REPORT FOR THIS PROVIDER CCN	12. <input type="checkbox"/> IF LINE 5, COLUMN 1 IS 4: ENTER NUMBER OF TIMES REOPENED = 0-9.
	3 -SETTLED WITH AUDIT	9. <input type="checkbox"/> FINAL REPORT FOR THIS PROVIDER CCN	
	4 -REOPENED		
	5 -AMENDED		

**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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE STATEMENT AND THAT I HAVE EXAMINED THE ACCOMPANYING ELECTRONICALLY FILED OR MANUALLY SUBMITTED COST REPORT AND THE BALANCE SHEET AND STATEMENT OF REVENUE AND EXPENSES PREPARED BY NORWEGIAN AMERICAN HOSPITAL (14-0206) {(PROVIDER NAME(S) AND NUMBER(S))} FOR THE COST REPORTING PERIOD BEGINNING 10/01/2013 AND ENDING 09/30/2014, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT PREPARED FROM THE BOOKS AND RECORDS OF THE PROVIDER IN ACCORDANCE WITH APPLICABLE INSTRUCTIONS, EXCEPT AS NOTED. I FURTHER CERTIFY THAT I AM FAMILIAR WITH THE LAWS AND REGULATIONS REGARDING THE PROVISION OF HEALTH CARE SERVICES, AND THAT THE SERVICES IDENTIFIED IN THIS COST REPORT WERE PROVIDED IN COMPLIANCE WITH SUCH LAWS AND REGULATIONS.

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

\_\_\_\_\_  
TITLE

\_\_\_\_\_  
DATE

**PART III - SETTLEMENT SUMMARY**

		TITLE V	TITLE XVIII		HIT	TITLE XIX	
		1	PART A 2	PART B 3	4	5	
1	HOSPITAL		473,941	-25,354	197,970		1
2	SUBPROVIDER - IPF			-1			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		473,941	-25,355	197,970		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



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

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.



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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. FRANSICSO AVENUE	P.O. Box:								1	
2	City: CHICAGO	State: IL	ZIP Code: 60622	County: COOK						2	
Hospital and Hospital-Based Component Identification:											
										Payment System (P, T, O, or N)	
	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	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 / 2013	To: 09 / 30 / 2014								20
21	Type of control (see instructions)	2								21	
Inpatient PPS Information								1	2		
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)							N	N	22.01	
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 col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	16,678	1,004			4,798			24		
25	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.								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 in effect in the cost reporting period.									37	
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.				Beginning:			Ending:	38		
								1	2		



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

**WORKSHEET S-2  
PART I**

39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(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)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
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WORKSHEET S-2  
PART I

Prospective Payment System (PPS)-Capital		V	XVIII	XIX	
		1	2	3	
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	Y	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	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	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	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 Worksheet E-4. If column 2 is 'N', complete Worksheet D, Part III & IV and D-2, Part 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, section 2148? If yes, complete Worksheet D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
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 and enter in column 4 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 and enter in column 4 direct 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 Non-Provider Settings					
63	Has your facility trained residents in non-provider settings during this cost reporting period? Enter 'Y' for yes or 'N' for no. If yes, complete lines 64-67. (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 non-provider 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))	
	1	2		3	4	5	
65							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 non-provider 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))	
	1	2		3	4	5	
67							67
<b>Inpatient Psychiatric Facility PPS</b>				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 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, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.			Y	N		71
<b>Inpatient Rehabilitation Facility PPS</b>				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 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, enter 1, 2, or 3 respectively in column 3. If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5.						76
<b>Long Term Care Hospital PPS</b>							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
<b>TEFRA Providers</b>							
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

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WORKSHEET S-2  
PART I

Title V and XIX Services		V	XIX		
		1	2		
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/MR 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	
Rural Providers		1	2		
105	Does this hospital qualify as a Critical Access Hospital (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	Column 1: 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. If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes, complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter 'Y' for yes or 'N' for no in column 2.			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	
		Physical	Occupational	Speech	Respiratory
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.				109
Miscellaneous Cost Reporting Information					
115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If 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'	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	
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	1,435,000			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
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, if applicable in column 2.			126	
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			127	
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			128	
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			129	
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			130	
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			131	
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date, if applicable in column 2.			132	
133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date, if applicable 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	



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WORKSHEET S-2  
PART I

All Providers					
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)	1	2		140
		N			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141	Name:	Contractor's Name:		Contractor's Number:	
142	Street:	P.O. Box:			
143	City:	State:	ZIP Code:		
144	Are provider based physicians' costs included in Worksheet A?	Y			144
145	If costs for renal services are claimed on Worksheet A, line 74 are they costs for inpatient services only? Enter 'Y' for yes, or 'N' for no.	Y			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, section 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			
		Part A	Part B	Title V	Title XIX
			1	2	3
155	Hospital	N	N	N	N
156	Subprovider - IPF	N	N	N	N
157	Subprovider - IRF	N	N		
158	Subprovider - Other				
159	SNF	N	N		
160	HHA	N	N		
161	CMHC		N		
161.10	CORF				
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.				166
	Name	County	State	ZIP Code	CBSA
	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
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transitional factor. (see instructions)	0.75			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2013	09/30/2014		170



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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	
		1	2	3	
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
<b>FINANCIAL DATA AND REPORTS</b>					
		Y/N	TYPE	DATE	
		1	2	3	
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 ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y			5
<b>APPROVED EDUCATIONAL ACTIVITIES</b>					
		Y/N	Y/N		
		1	2		
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 INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	Y			9
10	WAS AN INTERN-RESIDENT 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
<b>BAD DEBTS</b>					
		Y/N			
		1			
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
<b>PART A</b>					
		Y/N	DATE	Y/N	DATE
		1	2	3	4
<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	16
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	12/30/2014	Y	12/30/2014
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	18
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	19
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	20



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2  
PART II

21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N		21
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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 COSTS			
22	HAVE ASSETS BEEN RELIEVED 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 CAPITALIZED 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
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
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.		
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
COST REORT PREPARER INFORMATION			
41	FIRST NAME: RAJ	LAST NAME: SHAH	TITLE: SENIOR CONSULTANT
42	EMPLOYER: STRATEGIC REIMBURSEMENT GROUP LLC		
43	PHONE NUMBER: 630 530-7100, X107	E-MAIL ADDRESS: RAJ.SHAH@SRGROUPLLC.COM	



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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 AVAILABL E	CAH HOURS	INPATIENT DAYS/OUTPATIENT VISITS/TRIPS				
						TITLE V	TITLE XVIII	TITLE XIX	TOTAL ALL PATIENTS	
						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		8,562	15,215	29,837	1	
2	HMO AND OTHER (see instructions)						4,798		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		8,562	15,215	29,837	7	
8	INTENSIVE CARE UNIT	31	12	4,380		1,074	399	3,265	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					2,068	3,064	13	
14	TOTAL (see instructions)		173	63,145		9,636	17,682	36,166	14	
15	CAH VISITS								15	
16	SUBPROVIDER - IPF	40	12	4,380		1,274	961	3,581	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							1,682	28	
29	AMBULANCE TRIPS								29	
30	EMPLOYEE DISCOUNT DAYS (see instructions)								30	
31	EMPLOYEE DISCOUNT DAYS-IRF								31	
32	LABOR & DELIVERY DAYS (see instructions)		10	3,650					32	
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32.01	
33	LTCH NON-COVERED DAYS								33	



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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	EMPLOYEE S 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)					1,727	3,773	7,370	1
2	HMO AND OTHER (see instructions)								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)	3.00	746.76			1,727	3,773	7,370	14
15	CAH VISITS								15
16	SUBPROVIDER - IPF		13.88			176	137	512	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)	3.00	760.64						27
32.01	TOTAL ANCILLARY LABOR & DELIVERY ROOM OUTPATIENT DAYS (see instructions)								32

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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	47,511,211	47,511,211	1,582,138.00	30.03	1	
2	NON-PHYSICIAN ANESTHETIST PART A						2	
3	NON-PHYSICIAN ANESTHETIST PART B		761,463	761,463	9,807.00	77.64	3	
4	PHYSICIAN-PART A - ADMINISTRATIVE						4	
4.01	PHYSICIAN-PART A - TEACHING						4.01	
5	PHYSICIAN-PART B		2,087,594	2,087,594	20,396.00	102.35	5	
6	NON-PHYSICIAN-PART B						6	
7	INTERNS & RESIDENTS (in an approved program)	21	107,811	107,811	6,152.00	17.52	7	
7.01	CONTRACTED INTERNS & RESIDENTS (in an approved program)						7.01	
8	HOME OFFICE PERSONNEL						8	
9	SNF	44					9	
10	EXCLUDED AREA SALARIES (see instructions)		1,771,952	1,771,952	61,566.00	28.78	10	
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11	CONTRACT LABOR (see instructions)		225,045	225,045	3,621.00	62.15	11	
12	CONTRACT MANAGEMENT AND ADMINISTRATIVE SERVICES						12	
13	CONTRACT LABOR: PHYSICIAN-PART A - ADMINISTRATIVE						13	
14	HOME OFFICE SALARIES & WAGE-RELATED COSTS						14	
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)		7,135,686	7,135,686			17	
18	WAGE-RELATED COSTS (other)(see instructions)						18	
19	EXCLUDED AREAS		293,343	293,343			19	
20	NON-PHYSICIAN ANESTHETIST PART A						20	
21	NON-PHYSICIAN ANESTHETIST PART B		126,967	126,967			21	
22	PHYSICIAN PART A - ADMINISTRATIVE						22	
22.01	PHYSICIAN PART A - TEACHING						22.01	
23	PHYSICIAN PART B		348,087	348,087			23	
24	WAGE-RELATED COSTS (RHC/FQHC)						24	
25	INTERNS & RESIDENTS (in an approved program)		17,977	17,977			25	
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26	EMPLOYEE BENEFITS DEPARTMENT		3,170,308	3,170,308	135,676.00	23.37	26	
27	ADMINISTRATIVE & GENERAL		5,625,611	5,625,611	89,254.00	63.03	27	
28	ADMINISTRATIVE & GENERAL UNDER CONTRACT (see instructions)		117,761	117,761	735.00	160.22	28	
29	MAINTENANCE & REPAIRS						29	
30	OPERATION OF PLANT		1,613,265	1,613,265	93,019.00	17.34	30	
31	LAUNDRY & LINEN SERVICE						31	
32	HOUSEKEEPING		966,317	966,317	119,817.00	8.06	32	
33	HOUSEKEEPING UNDER CONTRACT (see instructions)						33	
34	DIETARY		1,127,165	-291,714	835,451	41,143.00	20.31	34
35	DIETARY UNDER CONTRACT (see instructions)						35	
36	CAFETERIA			291,714	291,714	14,082.00	20.72	36
37	MAINTENANCE OF PERSONNEL						37	
38	NURSING ADMINISTRATION		1,045,242	1,045,242	23,721.00	44.06	38	
39	CENTRAL SERVICES AND SUPPLY		339,773	339,773	17,527.00	19.39	39	
40	PHARMACY		1,393,411	1,393,411	47,430.00	29.38	40	
41	MEDICAL RECORDS & MEDICAL RECORDS LIBRARY		892,856	892,856	30,604.00	29.17	41	
42	SOCIAL SERVICE		770,828	770,828	25,817.00	29.86	42	
43	OTHER GENERAL SERVICE						43	

## PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)		44,672,104	44,672,104	1,546,518.00	28.89	1
2	EXCLUDED AREA SALARIES (see instructions)		1,771,952	1,771,952	61,566.00	28.78	2
3	SUBTOTAL SALARIES (line 1 minus line 2)		42,900,152	42,900,152	1,484,952.00	28.89	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)		225,045	225,045	3,621.00	62.15	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)		7,135,686	7,135,686		16.63%	5



COMPU-MAX

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3  
PARTS II-III

6	TOTAL (sum of lines 3 through 5)		50,260,883		50,260,883	1,488,573.00	33.76	6
7	TOTAL OVERHEAD COST (see instructions)		17,062,537		17,062,537	638,825.00	26.71	7



COMPU-MAX

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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		1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)	723,952	3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		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)	3,234,669	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	205,105	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	66,448	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	157,813	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	264,793	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	2,459,429	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY	617,186	18
19	UNEMPLOYMENT INSURANCE	131,000	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	61,665	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	7,922,060	24
	<b>PART B - OTHER THAN CORE RELATED COST</b>		
25	OTHER WAGE RELATED (OTHER WAGE REL		25



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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

<b>STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD</b>				
1	WAGE INDEX FISCAL YEAR ENDING DATE			1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)			2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH			3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)			4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)			5
<b>STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)</b>				
6	EFFECTIVE DATE OF PENSION PLAN			6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE			7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)			8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

<b>STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD</b>				
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE			9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5			10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	<b>DEPOSIT DATE(S)</b>	<b>CONTRIB-UTION(S)</b>	11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)			12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD			13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)			14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2			15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)			16
<b>STEP 4: TOTAL PENSION COST FOR WAGE INDEX</b>				
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)			17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)			18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)			19



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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	BENEFIT COST	
	0	1	2	
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



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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)	0.292668	1
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## MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	56,023,542	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 OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	Y	4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	145,377,034	6
7	MEDICAID COST (line 1 times line 6)	42,547,206	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.		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

## UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING 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)			19	
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	14,111,652		14,111,652	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	4,130,029		4,130,029	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE				22
23	COST OF CHARITY CARE (line 21 minus line 22)	4,130,029		4,130,029	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, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	11,255,903	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	986,084	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	10,269,819	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	3,005,647	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	7,135,676	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	7,135,676	31



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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- FICATION S	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		744,957	744,957	2,600,263	3,345,220	-252,902	3,092,318	1
2	00200	CAP REL COSTS-MVBLE EQUIP				3,611,131	3,611,131		3,611,131	2
3	00300	OTHER CAP REL COSTS		1,653,275	1,653,275	-1,653,275			-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	355,473	181,028	536,501	-1,799	534,702	-105	534,597	4
4.01	00401	COMMUNICATIONS	177,111	33,619	210,730	-349	210,381	-70,471	139,910	4.01
4.02	00402	DATA PROCESSING	1,221,999	3,909,481	5,131,480	-1,470,555	3,660,925	-71,160	3,589,765	4.02
4.03	00403	ADMITTING	655,995	159,308	815,303	-7,573	807,730		807,730	4.03
4.04	00404	CASHIERING	759,730	662,502	1,422,232	-2,245	1,419,987		1,419,987	4.04
5	00500	ADMINISTRATIVE & GENERAL	5,625,611	17,794,468	23,420,079	-136,769	23,283,310	-10,456,212	12,827,098	5
6	00600	MAINTENANCE & REPAIRS								6
7	00700	OPERATION OF PLANT	1,613,265	3,842,014	5,455,279	-548,073	4,907,206		4,907,206	7
8	00800	LAUNDRY & LINEN SERVICE				395,847	395,847		395,847	8
9	00900	HOUSEKEEPING	966,317	930,559	1,896,876	-399,239	1,497,637	-48	1,497,589	9
10	01000	DIETARY	1,127,165	1,488,549	2,615,714	-702,268	1,913,446	-382,307	1,531,139	10
11	01100	CAFETERIA				668,117	668,117	-324,528	343,589	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	1,045,242	283,881	1,329,123	-7,069	1,322,054	-1,070	1,320,984	13
14	01400	CENTRAL SERVICES & SUPPLY	339,773	216,040	555,813	-76,643	479,170	-7,460	471,710	14
15	01500	PHARMACY	1,393,411	2,324,463	3,717,874	-2,370,347	1,347,527	-1,063	1,346,464	15
16	01600	MEDICAL RECORDS & LIBRARY	892,856	1,090,404	1,983,260	-7,963	1,975,297	-10,853	1,964,444	16
17	01700	SOCIAL SERVICE	770,828	246,278	1,017,106	-810	1,016,296	-77,010	939,286	17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD	107,811		107,811		107,811		107,811	21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		175,118	175,118		175,118		175,118	22
23	02300	PARAMED ED PRGM-(SPECIFY)								23
		<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	03000	ADULTS & PEDIATRICS	10,157,848	3,176,649	13,334,497	-1,063,305	12,271,192	-77,504	12,193,688	30
31	03100	INTENSIVE CARE UNIT	2,084,819	1,116,563	3,201,382	-67,001	3,134,381	-90,000	3,044,381	31
31.01	02060	NICU								31.01
40	04000	SUBPROVIDER - IPF	881,335	335,691	1,217,026	-16,326	1,200,700	-69,650	1,131,050	40
43	04300	NURSERY	765,118	229,323	994,441	611,049	1,605,490		1,605,490	43
		<b>ANCILLARY SERVICE COST CENTERS</b>								
50	05000	OPERATING ROOM	2,019,533	3,227,097	5,246,630	-1,202,896	4,043,734	-501,983	3,541,751	50
52	05200	DELIVERY ROOM & LABOR ROOM	2,239,654	1,411,097	3,650,751	-600,536	3,050,215		3,050,215	52
53	05300	ANESTHESIOLOGY	1,184,922	1,437,039	2,621,961	-70,193	2,551,768	-2,148,094	403,674	53
54	05400	RADIOLOGY-DIAGNOSTIC	1,890,539	2,166,920	4,057,459	-473,977	3,583,482	-277,420	3,306,062	54
60	06000	LABORATORY	397,065	2,883,186	3,280,251	-39,736	3,240,515	-341,945	2,898,570	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	RESPIRATORY THERAPY	731,690	456,335	1,188,025	-21,465	1,166,560		1,166,560	65
66	06600	PHYSICAL THERAPY	282,950	59,342	342,292	-3,959	338,333		338,333	66
69	06900	ELECTROCARDIOLOGY	204,927	80,902	285,829	-5,826	280,003		280,003	69
70	07000	ELECTROENCEPHALOGRAPHY		1,475	1,475					70
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				676,779	676,779		676,779	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS				1,302,963	1,302,963		1,302,963	72
73	07300	DRUGS CHARGED TO PATIENTS				2,307,733	2,307,733		2,307,733	73
75.01	07501	ACUTE DIALYSIS		301,595	301,595	-266	301,329		301,329	75.01
75.02	03650	CARD CATH LAB	422,122	1,809,905	2,232,027	-1,063,887	1,168,140	-203,849	964,291	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	3,162,302	1,642,934	4,805,236	-57,176	4,748,060	-2,544,677	2,203,383	90
90.01	09001	PH CLINIC								90.01
90.02	09002	HEALTHWORKS CLINIC	214,646	77,555	292,201	-1,893	290,308	-4,767	285,541	90.02
90.03	09003	DENTAL CLINIC								90.03
90.04	09004	WOUND CARE THERAPY	384,785	261,999	646,784	-24,585	622,199	-89,250	532,949	90.04
90.05	09005	FAMILY PRACTICE CLINIC		5,452	5,452	-5,452				90.05
91	09100	EMERGENCY	2,543,752	1,646,441	4,190,193	-54,394	4,135,799	-482,907	3,652,892	91
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92



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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- FICATION S	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>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)	46,620,594	58,063,444	104,684,038	14,557	104,698,595	-18,487,235	86,211,360	118
		<b>NONREIMBURSABLE COST CENTERS</b>								
190	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN								190
192	19200	PHYSICIANS' PRIVATE OFFICES	316,239	81,671	397,910	-1,166	396,744		396,744	192
192.0 1	19201	PROHEALTH SERVICES	426,175	574,625	1,000,800	-9,473	991,327		991,327	192.0 1
192.0 2	19202	AUXILIARY	148,203	73,199	221,402	-3,918	217,484		217,484	192.0 2
200		TOTAL (sum of lines 118-199)	47,511,211	58,792,939	106,304,150		106,304,150	-18,487,235	87,816,915	200



COMPU-MAX

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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		79,875	1
500	TOTAL RECLASSIFICATIONS					79,875	500
	CODE LETTER - A						
1	EQUIP DEPRECIATION	B	CAP REL COSTS-MVBLE EQUIP	2		2,911,428	1
500	TOTAL RECLASSIFICATIONS					2,911,428	500
	CODE LETTER - B						
1	CHARGEABLE SUPPLIES	C	MEDICAL SUPPLIES CHARGED TO P	71		676,779	1
2			IMPL. DEV. CHARGED TO PATIENT	72		1,302,963	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
500	TOTAL RECLASSIFICATIONS					1,979,742	500
	CODE LETTER - C						
1	SHARED CAFETERIA EXP	D	CAFETERIA	11	291,714	376,403	1
500	TOTAL RECLASSIFICATIONS				291,714	376,403	500
	CODE LETTER - D						
1	DEPRECIATION CHARGED TO DEPTS	F	CAP REL COSTS-BLDG & FIXT	1		4,489,727	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
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26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
500	TOTAL RECLASSIFICATIONS					4,489,727	500
	CODE LETTER - F						
1	INTEREST EXPENSE	G	CAP REL COSTS-BLDG & FIXT	1		942,089	1



COMPU-MAX

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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	
2			CAP REL COSTS-MVBLE EQUIP	2		699,703	2
3			ADMINISTRATIVE & GENERAL	5		11,483	3
500	TOTAL RECLASSIFICATIONS					1,653,275	500
	CODE LETTER - G						
1	LAUNDRY EXP	H	LAUNDRY & LINEN SERVICE	8		395,847	1
500	TOTAL RECLASSIFICATIONS					395,847	500
	CODE LETTER - H						
1	NURSERY EXP	J	NURSERY	43	487,801	137,334	1
500	TOTAL RECLASSIFICATIONS				487,801	137,334	500
	CODE LETTER - J						
1	CHARGEABLE DRUGS	K	DRUGS CHARGED TO PATIENTS	73		2,307,733	1
500	TOTAL RECLASSIFICATIONS					2,307,733	500
	CODE LETTER - K						
1	FAMILY PRACTICE CLINIC	L	CLINIC	90		2,762	1
500	TOTAL RECLASSIFICATIONS					2,762	500
	CODE LETTER - L						
	GRAND TOTAL (INCREASES)				779,515	14,334,126	

(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.



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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		79,875	12	
500	TOTAL RECLASSIFICATIONS					79,875	500	
	CODE LETTER - A							
1	EQUIP DEPRECIATION	B	CAP REL COSTS-BLDG & FIXT	1		2,911,428	9	
500	TOTAL RECLASSIFICATIONS					2,911,428	500	
	CODE LETTER - B							
1	CHARGEABLE SUPPLIES	C	CENTRAL SERVICES & SUPPLY	14		6,364	1	
2			ADULTS & PEDIATRICS	30		66,532	2	
3			INTENSIVE CARE UNIT	31		5,256	3	
4			NURSERY	43		1,050	4	
5			SUBPROVIDER - IPF	40		10,094	5	
6			OPERATING ROOM	50		872,179	6	
7			DELIVERY ROOM & LABOR ROOM	52		9,446	7	
8			ANESTHESIOLOGY	53		17,810	8	
9			RADIOLOGY-DIAGNOSTIC	54		594	9	
10			RESPIRATORY THERAPY	65		83	10	
11			CARD CATH LAB	75.02		931,890	11	
12			CLINIC	90		18,184	12	
13			HEALTHWORKS CLINIC	90.02		1,893	13	
14			WOUND CARE THERAPY	90.04		11,948	14	
15			EMERGENCY	91		26,153	15	
16			ACUTE DIALYSIS	75.01		266	16	
500	TOTAL RECLASSIFICATIONS					1,979,742	500	
	CODE LETTER - C							
1	SHARED CAFETERIA EXP	D	DIETARY	10	291,714	376,403	1	
500	TOTAL RECLASSIFICATIONS				291,714	376,403	500	
	CODE LETTER - D							
1	DEPRECIATION CHARGED TO DEPTS	F	EMPLOYEE BENEFITS DEPARTMENT	4		1,799	9	
2			COMMUNICATIONS	4.01		349	2	
3			DATA PROCESSING	4.02		1,470,555	3	
4			ADMITTING	4.03		7,573	4	
5			CASHIERING	4.04		2,245	5	
6			ADMINISTRATIVE & GENERAL	5		68,377	6	
7			OPERATION OF PLANT	7		548,073	7	
8			HOUSEKEEPING	9		3,392	8	
9			DIETARY	10		34,151	9	
10			NURSING ADMINISTRATION	13		7,069	10	
11			CENTRAL SERVICES & SUPPLY	14		70,279	11	
12			PHARMACY	15		62,614	12	
13			MEDICAL RECORDS & LIBRARY	16		7,963	13	
14			SOCIAL SERVICE	17		810	14	
15			ADULTS & PEDIATRICS	30		371,638	15	
16			INTENSIVE CARE UNIT	31		61,745	16	
17			NURSERY	43		13,036	17	
18			SUBPROVIDER - IPF	40		6,232	18	
19			OPERATING ROOM	50		330,717	19	
20			DELIVERY ROOM & LABOR ROOM	52		591,090	20	
21			ANESTHESIOLOGY	53		52,383	21	
22			RADIOLOGY-DIAGNOSTIC	54		473,383	22	
23			LABORATORY	60		39,736	23	
24			RESPIRATORY THERAPY	65		21,382	24	
25			PHYSICAL THERAPY	66		3,959	25	
26			ELECTROCARDIOLOGY	69		5,826	26	
27			ELECTROENCEPHALOGRAPHY	70		1,475	27	
28			CARD CATH LAB	75.02		131,997	28	
29			CLINIC	90		41,754	29	
30			WOUND CARE THERAPY	90.04		12,637	30	
31			FAMILY PRACTICE CLINIC	90.05		2,690	31	
32			EMERGENCY	91		28,241	32	
33			PHYSICIANS' PRIVATE OFFICES	192		1,166	33	
34			PROHEALTH SERVICES	192.01		9,473	34	
35			AUXILIARY	192.02		3,918	35	
500	TOTAL RECLASSIFICATIONS					4,489,727	500	
	CODE LETTER - F							



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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	INTEREST EXPENSE	G	OTHER CAP REL COSTS	3		1,653,275	11	
2							11	
3								
500	TOTAL RECLASSIFICATIONS					1,653,275		
	CODE LETTER - G							
1	LAUNDRY EXP	H	HOUSEKEEPING	9		395,847		
500	TOTAL RECLASSIFICATIONS					395,847		
	CODE LETTER - H							
1	NURSERY EXP	J	ADULTS & PEDIATRICS	30	487,801	137,334		
500	TOTAL RECLASSIFICATIONS				487,801	137,334		
	CODE LETTER - J							
1	CHARGEABLE DRUGS	K	PHARMACY	15		2,307,733		
500	TOTAL RECLASSIFICATIONS					2,307,733		
	CODE LETTER - K							
1	FAMILY PRACTICE CLINIC	L	FAMILY PRACTICE CLINIC	90.05		2,762		
500	TOTAL RECLASSIFICATIONS					2,762		
	CODE LETTER - L							
	GRAND TOTAL (DECREASES)				779,515	14,334,126		

(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.



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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	3,112,770					3,112,770		2
3	BUILDINGS AND FIXTURES	47,045,356	208,358		208,358		47,253,714		3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	20,787,072	1,027,789		1,027,789		21,814,861		5
6	MOVABLE EQUIPMENT	50,031,610	318,146		318,146		50,349,756		6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	125,506,721	1,554,293		1,554,293		127,061,014		8
9	RECONCILING ITEMS								9
10	TOTAL (line 7 minus line 9)	125,506,721	1,554,293		1,554,293		127,061,014		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 instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	744,957						744,957	1	
2	CAP REL COSTS-MVBLE EQUIP								2	
3	TOTAL (sum of lines 1-2)	744,957						744,957	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 lines 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 instr.)	INSURANCE	TAXES	OTHER CAPITAL-RELATED COSTS	TOTAL (sum of cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	72,181,346		72,181,346	0.589086					1
2	CAP REL COSTS-MVBLE EQUIP	50,349,755		50,349,755	0.410914					2
3	TOTAL (sum of lines 1-2)	122,531,101		122,531,101	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of cols. 9 through 14)	
		DEPRECIATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL-RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	2,322,930		773,572	79,875	-84,059		3,092,318	1	
2	CAP REL COSTS-MVBLE EQUIP	2,911,428		699,703				3,611,131	2	
3	TOTAL (sum of lines 1-2)	5,234,358		1,473,275	79,875	-84,059		6,703,449	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		
				COST CENTER	LINE#	WKST A-7 REF.
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)	B	-168,517	CAP REL COSTS-BLDG & FIXT	1	11
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2	
3	INVESTMENT INCOME-OTHER (chapter 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)	B	-8,192	ADMINISTRATIVE & GENERAL	5	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	-70,108	COMMUNICATIONS	4.01	7
8	TELEVISION AND RADIO SERVICE (chapter 21)					8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-2	-8,046,669			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	-324,528	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	B	-1,063	PHARMACY	15	17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	B	-10,582	MEDICAL RECORDS & LIBRARY	16	18
19	NURSING SCHOOL (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 AND					32
33	MISC REV	B	-119,822	ADMINISTRATIVE & GENERAL	5	33
33.01	MISC REV	B	-363	COMMUNICATIONS	4.01	33.01
33.02	MISC REV	B	-41,500	DATA PROCESSING	4.02	33.02
33.03	MISC REV	B	-105	EMPLOYEE BENEFITS DEPARTMENT	4	33.03
33.04	MISC REV	B	-10,932	RADIOLOGY-DIAGNOSTIC	54	33.04
33.05	MISC REV	B	-48	HOUSEKEEPING	9	33.05
33.06	MISC REV	B	-116	CLINIC	90	33.06
33.07	MISC REV	B	-43,973	CLINIC	90	33.07
33.08	MISC REV	B	-1,070	NURSING ADMINISTRATION	13	33.08
33.10	MISC REV	B	-7,460	CENTRAL SERVICES & SUPPLY	14	33.10
33.16	MISC REV	B	-123,197	ADMINISTRATIVE & GENERAL	5	33.16
33.18	MISC REV	B	-341,945	LABORATORY	60	33.18
33.20	MISC REV	B	-20	HEALTHWORKS CLINIC	90.02	33.20
33.21	MISC REV	B	-3,459	ADULTS & PEDIATRICS	30	33.21
34						34
34.06	MISC DIETARY	B	-382,307	DIETARY	10	34.06
35						35
36	MISC T MOBILE LEASE INCOME	B	-18,960	ADMINISTRATIVE & GENERAL	5	36
36.04	REAL ESTATE TAXES	A	-15,096	ADMINISTRATIVE & GENERAL	5	36.04
36.05	REAL ESTATE TAXES	A	-84,059	CAP REL COSTS-BLDG & FIXT	1	13
36.07	OTHER MME DEP	A	-326	CAP REL COSTS-BLDG & FIXT	1	9
36.09	CLINICAL INTEGRATION NON PHY SALAR	A	-33,504	ADMINISTRATIVE & GENERAL	5	36.09
36.10	CLINICAL INTEGRATION-OTHER NON PHY	A	-117,464	ADMINISTRATIVE & GENERAL	5	36.10
37	LOOBYING PORTION - DUES	A	-249,422	ADMINISTRATIVE & GENERAL	5	37



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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	2	3	4	5
38						38
39	CHARITABLE CONTRIBUTIONS	A	-15,990	ADMINISTRATIVE & GENERAL	5	39
40						40
41	ENTERTAINMENT EXP	A	-15,767	ADMINISTRATIVE & GENERAL	5	41
42	NON PHY PART B COMP	A	-419,071	ANESTHESIOLOGY	53	42
43	NON PHY PART B COMP	A	-465,876	CLINIC	90	43
44	STATE ASSESSMENT RECEIPTS	B	-7,345,724	ADMINISTRATIVE & GENERAL	5	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)		-18,487,235			50

(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.



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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	RELATED ORGANIZATION(S) AND/OR HOME OFFICE			
			PERCENTAGE OF OWNERSHIP	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	PROFESS- IONAL COMPON- ENT	PROVIDER COMPON- ENT	RCE AMOUNT	PHYSICIAN / PROVIDER COMPON- ENT HOURS	UNADJ- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
	1	2	3	4	5	6	7	8	9	
1	4.02	DATA PROCESSING AGGREGATE	29,660	29,660						1
2										2
3	5	ADMINISTRATIVE & GEN AGGREGATE	2,393,074	2,393,074						3
4	16	MEDICAL RECORDS & LI AGGREGATE	271	271						4
5	17	SOCIAL SERVICE AGGREGATE	77,010	77,010						5
6	30	ADULTS & PEDIATRICS AGGREGATE	74,045	74,045						6
7	31	INTENSIVE CARE UNIT AGGREGATE	90,000	90,000						7
8										8
9	40	SUBPROVIDER - IPF AGGREGATE	69,650	69,650						9
10	50	OPERATING ROOM AGGREGATE	501,983	501,983						10
11	53	ANESTHESIOLOGY AGGREGATE	1,729,023	1,729,023						11
12										12
13	54	RADIOLOGY-DIAGNOSTIC AGGRGATE	266,488	266,488						13
14										14
15	75.02	CARD CATH LAB AGGREGATE	203,849	203,849						15
16										16
17	90	CLINIC AGGREGATE	2,034,712	2,034,712						17
18	90.02	HEALTHWORKS CLINIC AGGREGATE	4,747	4,747						18
19	90.04	WOUND CARE THERAPY AGGREGATE	89,250	89,250						19
20										20
22	91	EMERGENCY AGGREGATE	482,907	482,907						22
200		TOTAL	8,046,669	8,046,669						200



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATIO N	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT - ICE INSURANC E	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	4.02	DATA PROCESSING AGGREGATE							29,660	1
2										2
3	5	ADMINISTRATIVE & GEN AGGREGATE							2,393,074	3
4	16	MEDICAL RECORDS & LI AGGREGATE							271	4
5	17	SOCIAL SERVICE AGGREGATE							77,010	5
6	30	ADULTS & PEDIATRICS AGGREGATE							74,045	6
7	31	INTENSIVE CARE UNIT AGGREGATE							90,000	7
8										8
9	40	SUBPROVIDER - IPF AGGREGATE							69,650	9
10	50	OPERATING ROOM AGGREGATE							501,983	10
11	53	ANESTHESIOLOGY AGGREGATE							1,729,023	11
12										12
13	54	RADIOLOGY-DIAGNOSTIC AGGRGATE							266,488	13
14										14
15	75.02	CARD CATH LAB AGGREGATE							203,849	15
16										16
17	90	CLINIC AGGREGATE							2,034,712	17
18	90.02	HEALTHWORKS CLINIC AGGREGATE							4,747	18
19	90.04	WOUND CARE THERAPY AGGREGATE							89,250	19
20										20
22	91	EMERGENCY AGGREGATE							482,907	22
200		TOTAL							8,046,669	200



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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMEN T	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	3,092,318	3,092,318					1
2	CAP REL COSTS-MVBLE EQUIP	3,611,131		3,611,131				2
4	EMPLOYEE BENEFITS DEPARTMENT	534,597	35,910	1,447	571,954			4
4.01	COMMUNICATIONS	139,910	4,792	281	2,148	147,131		4.01
4.02	DATA PROCESSING	3,589,765	75,602	1,182,780	14,822	8,767	4,871,736	4.02
4.03	ADMITTING	807,730	71,511	6,091	7,957	2,287	398,597	4.03
4.04	CASHIERING	1,419,987	17,123	1,806	9,215	11,816	575,751	4.04
5	ADMINISTRATIVE & GENERAL	12,827,098	65,435	54,996	68,233	23,633	354,308	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	4,907,206	259,351	440,821	19,567	6,861	44,289	7
8	LAUNDRY & LINEN SERVICE	395,847	43,782					8
9	HOUSEKEEPING	1,497,589	41,903	2,728	11,720		88,577	9
10	DIETARY	1,531,139	88,658	20,356	10,133	4,193	88,577	10
11	CAFETERIA	343,589	40,167	7,112	3,538	381		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,320,984	28,693	5,686	12,678	3,049		13
14	CENTRAL SERVICES & SUPPLY	471,710	131,560	56,526	4,121	381	265,731	14
15	PHARMACY	1,346,464	57,504	50,361	16,901	3,812	310,020	15
16	MEDICAL RECORDS & LIBRARY	1,964,444	59,193	6,405	10,829	8,386	44,289	16
17	SOCIAL SERVICE	939,286	1,819	651	9,349	3,049		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD	107,811			1,308	381		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	175,118	1,427					22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	12,193,688	496,216	296,058	117,288	14,484	620,039	30
31	INTENSIVE CARE UNIT	3,044,381	74,853	49,662	25,287		88,577	31
31.01	NICU							31.01
40	SUBPROVIDER - IPF	1,131,050	62,938	5,012	10,690			40
43	NURSERY	1,605,490	46,089	13,339	15,197	1,144	88,577	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	3,541,751	217,412	265,999	24,495	9,148	177,154	50
52	DELIVERY ROOM & LABOR ROOM	3,050,215	38,027	475,420	27,165	762	88,577	52
53	ANESTHESIOLOGY	403,674	7,943	42,132	14,372	1,144		53
54	RADIOLOGY-DIAGNOSTIC	3,306,062	116,269	380,747	22,930	7,623	132,866	54
60	LABORATORY	2,898,570	97,089	31,960	4,816	9,148	797,191	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,166,560	29,121	17,198	8,875	1,906	88,577	65
66	PHYSICAL THERAPY	338,333	30,833	3,184	3,432	1,144	88,577	66
69	ELECTROCARDIOLOGY	280,003	37,777	4,686	2,486	3,049	88,577	69
70	ELECTROENCEPHALOGRAPHY		5,173	1,186			88,577	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	676,779						71
72	IMPL. DEV. CHARGED TO PATIENTS	1,302,963						72
73	DRUGS CHARGED TO PATIENTS	2,307,733						73
75.01	ACUTE DIALYSIS	301,329						75.01
75.02	CARD CATH LAB	964,291	25,363	106,167	5,120			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	2,203,383	93,961	35,748	38,356	2,668	265,731	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	285,541	14,269		2,603	1,906		90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	532,949	38,455	10,164	4,667	1,906		90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	EMERGENCY	3,652,892	89,800	22,715	30,853	4,574	88,577	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<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)	86,211,360	2,546,018	3,599,424	561,151	137,602	4,871,736	118
	<b>NONREIMBURSABLE COST CENTERS</b>							



COMPU-MAX

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B  
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMEN T	NON PATIENT PHONES	DATA PROCESSING	
		0	1	2	4	4.01	4.02	
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		7,456			381		190
192	PHYSICIANS' PRIVATE OFFICES	396,744	538,844	938	3,836	7,242		192
192.0 1	PROHEALTH SERVICES	991,327		7,619	5,169	1,906		192.0 1
192.0 2	AUXILIARY	217,484		3,150	1,798			192.0 2
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	87,816,915	3,092,318	3,611,131	571,954	147,131	4,871,736	202

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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	1,294,173						4.03
4.04	CASHIERING		2,035,698					4.04
5	ADMINISTRATIVE & GENERAL			13,393,703	13,393,703			5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT			5,678,095	1,021,870	6,699,965		7
8	LAUNDRY & LINEN SERVICE			439,629	79,119	114,469	633,217	8
9	HOUSEKEEPING			1,642,517	295,599	109,557		9
10	DIETARY			1,743,056	313,693	231,799		10
11	CAFETERIA			394,787	71,049	105,018		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION			1,371,090	246,751	75,017		13
14	CENTRAL SERVICES & SUPPLY			930,029	167,375	343,967		14
15	PHARMACY			1,785,062	321,252	150,346		15
16	MEDICAL RECORDS & LIBRARY			2,093,546	376,769	154,760		16
17	SOCIAL SERVICE			954,154	171,716	4,757		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			109,500	19,706			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD			176,545	31,772	3,731		22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	366,883	361,833	14,466,489	2,603,472	1,297,370	202,578	30
31	INTENSIVE CARE UNIT	61,217	55,343	3,399,320	611,765	195,705	27,009	31
31.01	NICU							31.01
40	SUBPROVIDER - IPF	50,265	45,443	1,305,398	234,929	164,553		40
43	NURSERY	59,975	54,221	1,884,032	339,064	120,501	33,809	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	52,792	123,951	4,412,702	794,141	568,429	114,674	50
52	DELIVERY ROOM & LABOR ROOM	59,947	67,724	3,807,837	685,285	99,422	96,482	52
53	ANESTHESIOLOGY	10,283	19,582	499,130	89,827	20,767		53
54	RADIOLOGY-DIAGNOSTIC	47,949	192,465	4,206,911	757,105	303,987	45,585	54
60	LABORATORY	167,595	298,799	4,305,168	774,788	253,841		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	35,898	39,124	1,387,259	249,661	76,137		65
66	PHYSICAL THERAPY	4,236	15,706	485,445	87,364	80,613	11,716	66
69	ELECTROCARDIOLOGY	16,782	34,244	467,604	84,153	98,769		69
70	ELECTROENCEPHALOGRAPHY	613	890	96,439	17,356	13,524		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,855	7,194	686,828	123,606			71
72	IMPL. DEV. CHARGED TO PATIENTS	13,209	21,131	1,337,303	240,670			72
73	DRUGS CHARGED TO PATIENTS	229,629	287,186	2,824,548	508,325			73
75.01	ACUTE DIALYSIS	13,824	13,600	328,753	59,165			75.01
75.02	CARD CATH LAB	35,636	63,013	1,199,590	215,887	66,313		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	310	36,108	2,676,265	481,639	245,664	24,297	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC		1,955	306,274	55,119	37,307	1,010	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	5,389	64,397	657,927	118,405	100,541	3,378	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	EMERGENCY	58,886	231,789	4,180,086	752,278	234,783	72,679	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<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)	1,294,173	2,035,698	85,633,021	13,000,675	5,271,647	633,217	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			7,837	1,410	19,493		190



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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	
192	PHYSICIANS' PRIVATE OFFICES			947,604	170,537	1,408,825		192
192.0 1	PROHEALTH SERVICES			1,006,021	181,051			192.0 1
192.0 2	AUXILIARY			222,432	40,030			192.0 2
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,294,173	2,035,698	87,816,915	13,393,703	6,699,965	633,217	202

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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	2,047,673						9
10	DIETARY	73,294	2,361,842					10
11	CAFETERIA	33,206		604,060				11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	23,720		13,152	1,729,730			13
14	CENTRAL SERVICES & SUPPLY	108,761		9,725		1,559,857		14
15	PHARMACY	47,539		26,303		2,761	2,333,263	15
16	MEDICAL RECORDS & LIBRARY	48,935		16,970		140		16
17	SOCIAL SERVICE	1,504		14,317		9		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			3,415		21		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	1,180						22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	410,225	1,921,061	166,541	701,100	125,202	206,477	30
31	INTENSIVE CARE UNIT	61,881	210,218	31,471	132,488	96,726	160,205	31
31.01	NICU							31.01
40	SUBPROVIDER - IPF	52,031	230,563	16,013	67,410	4,533	20,434	40
43	NURSERY	38,102		34,113	143,610	23,507	9,560	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	179,736		32,337	136,131	230,511	62,993	50
52	DELIVERY ROOM & LABOR ROOM	31,437		38,739	163,085	79,276	60,938	52
53	ANESTHESIOLOGY	6,567		6,345		19,503	3,513	53
54	RADIOLOGY-DIAGNOSTIC	96,120		33,571		15,076	1,224	54
60	LABORATORY	80,264		10,302		7,896	2,984	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	24,074		15,297		53,896	545	65
66	PHYSICAL THERAPY	25,490		4,834		1,153		66
69	ELECTROCARDIOLOGY	31,231		4,926		2,996	11	69
70	ELECTROENCEPHALOGRAPHY	4,276						70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					219,119		71
72	IMPL. DEV. CHARGED TO PATIENTS					421,860		72
73	DRUGS CHARGED TO PATIENTS						1,593,085	73
75.01	ACUTE DIALYSIS					3		75.01
75.02	CARD CATH LAB	20,968		4,834		74,334	54,129	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	77,678		46,480	195,673	18,190	39,064	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	11,796		2,434		1,044	10,880	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	31,791		8,629		17,840	11,066	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	EMERGENCY	74,238		45,188	190,233	137,145	85,312	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<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)	1,596,044	2,361,842	585,936	1,729,730	1,552,741	2,322,420	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,164						190



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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	
192	PHYSICIANS' PRIVATE OFFICES	445,465		7,626		575	311	192
192.01	PROHEALTH SERVICES			7,833		4,347	10,532	192.01
192.02	AUXILIARY			2,665		2,194		192.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,047,673	2,361,842	604,060	1,729,730	1,559,857	2,333,263	202



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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	2,691,120						16
17	SOCIAL SERVICE		1,146,457					17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			132,642				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				213,228			22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	478,259	997,418	119,378	191,905	23,887,475	-311,283	30
31	INTENSIVE CARE UNIT	73,164	45,858			5,045,810		31
31.01	NICU							31.01
40	SUBPROVIDER - IPF	60,075				2,155,939		40
43	NURSERY	71,680				2,697,978		43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	163,864	34,394			6,729,912		50
52	DELIVERY ROOM & LABOR ROOM	89,532				5,152,033		52
53	ANESTHESIOLOGY	25,888				671,540		53
54	RADIOLOGY-DIAGNOSTIC	254,440				5,714,019		54
60	LABORATORY	395,014				5,830,257		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	51,722				1,858,591		65
66	PHYSICAL THERAPY	20,764				717,379		66
69	ELECTROCARDIOLOGY	45,270				734,960		69
70	ELECTROENCEPHALOGRAPHY	1,177				132,772		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	9,511				1,039,064		71
72	IMPL. DEV. CHARGED TO PATIENTS	27,935				2,027,768		72
73	DRUGS CHARGED TO PATIENTS	379,661				5,305,619		73
75.01	ACUTE DIALYSIS	17,979				405,900		75.01
75.02	CARD CATH LAB	83,304				1,719,359		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	47,735		13,264	21,323	3,887,272	-34,587	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	2,585				428,449		90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	85,134				1,034,711		90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	EMERGENCY	306,427	68,787			6,147,156		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<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)	2,691,120	1,146,457	132,642	213,228	83,323,963	-345,870	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					34,904		190



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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	
192	PHYSICIANS' PRIVATE OFFICES	16	17	21	22	24	25	192
192.0	PROHEALTH SERVICES					2,980,943		192.0
1						1,209,784		1
192.0	AUXILIARY					267,321		192.0
2								2
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,691,120	1,146,457	132,642	213,228	87,816,915	-345,870	202



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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	23,576,192				30
31	INTENSIVE CARE UNIT	5,045,810				31
31.01	NICU					31.01
40	SUBPROVIDER - IPF	2,155,939				40
43	NURSERY	2,697,978				43
	<b>ANCILLARY SERVICE COST CENTERS</b>					
50	OPERATING ROOM	6,729,912				50
52	DELIVERY ROOM & LABOR ROOM	5,152,033				52
53	ANESTHESIOLOGY	671,540				53
54	RADIOLOGY-DIAGNOSTIC	5,714,019				54
60	LABORATORY	5,830,257				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	RESPIRATORY THERAPY	1,858,591				65
66	PHYSICAL THERAPY	717,379				66
69	ELECTROCARDIOLOGY	734,960				69
70	ELECTROENCEPHALOGRAPHY	132,772				70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,039,064				71
72	IMPL. DEV. CHARGED TO PATIENTS	2,027,768				72
73	DRUGS CHARGED TO PATIENTS	5,305,619				73
75.01	ACUTE DIALYSIS	405,900				75.01
75.02	CARD CATH LAB	1,719,359				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	3,852,685				90
90.01	PH CLINIC					90.01
90.02	HEALTHWORKS CLINIC	428,449				90.02
90.03	DENTAL CLINIC					90.03
90.04	WOUND CARE THERAPY	1,034,711				90.04
90.05	FAMILY PRACTICE CLINIC					90.05
91	EMERGENCY	6,147,156				91
92	OBSERVATION BEDS (NON-DISTINCT PART)					92
	<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)	82,978,093				118
	<b>NONREIMBURSABLE COST CENTERS</b>					
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	34,904				190



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**COST ALLOCATION - GENERAL SERVICE COSTS**

**WORKSHEET B  
PART I**

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
192	PHYSICIANS' PRIVATE OFFICES	2,980,943					192
192.0 1	PROHEALTH SERVICES	1,209,784					192.0 1
192.0 2	AUXILIARY	267,321					192.0 2
200	CROSS FOOT ADJUSTMENTS						200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	87,471,045					202



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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 DEPARTMEN T	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	1,799	35,910	1,447	39,156	39,156		4
4.01	COMMUNICATIONS	349	4,792	281	5,422	147	5,569	4.01
4.02	DATA PROCESSING	1,470,555	75,602	1,182,780	2,728,937	1,014	332	4.02
4.03	ADMITTING	7,573	71,511	6,091	85,175	544	87	4.03
4.04	CASHIERING	2,245	17,123	1,806	21,174	631	447	4.04
5	ADMINISTRATIVE & GENERAL	68,377	65,435	54,996	188,808	4,669	899	5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	548,073	259,351	440,821	1,248,245	1,339	260	7
8	LAUNDRY & LINEN SERVICE		43,782		43,782			8
9	HOUSEKEEPING	3,392	41,903	2,728	48,023	802		9
10	DIETARY	25,309	88,658	20,356	134,323	693	159	10
11	CAFETERIA	8,842	40,167	7,112	56,121	242	14	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	7,069	28,693	5,686	41,448	868	115	13
14	CENTRAL SERVICES & SUPPLY	70,279	131,560	56,526	258,365	282	14	14
15	PHARMACY	62,614	57,504	50,361	170,479	1,157	144	15
16	MEDICAL RECORDS & LIBRARY	7,963	59,193	6,405	73,561	741	317	16
17	SOCIAL SERVICE	810	1,819	651	3,280	640	115	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD					89	14	21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD		1,427		1,427			22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	368,090	496,216	296,058	1,160,364	8,045	548	30
31	INTENSIVE CARE UNIT	61,745	74,853	49,662	186,260	1,730		31
31.01	NICU							31.01
40	SUBPROVIDER - IPF	6,232	62,938	5,012	74,182	732		40
43	NURSERY	16,584	46,089	13,339	76,012	1,040	43	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	330,717	217,412	265,999	814,128	1,676	346	50
52	DELIVERY ROOM & LABOR ROOM	591,090	38,027	475,420	1,104,537	1,859	29	52
53	ANESTHESIOLOGY	52,383	7,943	42,132	102,458	983	43	53
54	RADIOLOGY-DIAGNOSTIC	473,383	116,269	380,747	970,399	1,569	289	54
60	LABORATORY	39,736	97,089	31,960	168,785	330	346	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	21,382	29,121	17,198	67,701	607	72	65
66	PHYSICAL THERAPY	3,959	30,833	3,184	37,976	235	43	66
69	ELECTROCARDIOLOGY	5,826	37,777	4,686	48,289	170	115	69
70	ELECTROENCEPHALOGRAPHY	1,475	5,173	1,186	7,834			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	131,997	25,363	106,167	263,527	350		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	41,755	93,961	35,748	171,464	2,625	101	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC		14,269		14,269	178	72	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	12,637	38,455	10,164	61,256	319	72	90.04
90.05	FAMILY PRACTICE CLINIC	2,690			2,690			90.05
91	EMERGENCY	28,241	89,800	22,715	140,756	2,111	173	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<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)	4,475,171	2,546,018	3,599,424	10,620,613	38,417	5,209	118
	<b>NONREIMBURSABLE COST CENTERS</b>							



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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 DEPARTMEN T	NON PATIENT PHONES	
		0	1	2	2A	4	4.01	
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		7,456		7,456		14	190
192	PHYSICIANS' PRIVATE OFFICES	1,166	538,844	938	540,948	262	274	192
192.0 1	PROHEALTH SERVICES	9,473		7,619	17,092	354	72	192.0 1
192.0 2	AUXILIARY	3,916		3,150	7,066	123		192.0 2
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	4,489,726	3,092,318	3,611,131	11,193,175	39,156	5,569	202

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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	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	2,730,283						4.02
4.03	ADMITTING	223,387	309,193					4.03
4.04	CASHIERING	322,670		344,922				4.04
5	ADMINISTRATIVE & GENERAL	198,566			392,942			5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	24,821			29,980	1,304,645		7
8	LAUNDRY & LINEN SERVICE				2,321	22,290	68,393	8
9	HOUSEKEEPING	49,642			8,672	21,333		9
10	DIETARY	49,642			9,203	45,137		10
11	CAFETERIA				2,084	20,450		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION				7,239	14,608		13
14	CENTRAL SERVICES & SUPPLY	148,925			4,911	66,979		14
15	PHARMACY	173,745			9,425	29,276		15
16	MEDICAL RECORDS & LIBRARY	24,821			11,054	30,136		16
17	SOCIAL SERVICE				5,038	926		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD				578			21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				932	726		22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	347,491	87,706	61,205	76,374	252,629	21,880	30
31	INTENSIVE CARE UNIT	49,642	14,622	9,381	17,948	38,108	2,917	31
31.01	NICU							31.01
40	SUBPROVIDER - IPF		12,006	7,702	6,893	32,043		40
43	NURSERY	49,642	14,325	9,190	9,948	23,464	3,652	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	99,283	12,610	21,010	23,299	110,687	12,386	50
52	DELIVERY ROOM & LABOR ROOM	49,642	14,319	11,479	20,105	19,360	10,421	52
53	ANESTHESIOLOGY		2,456	3,319	2,635	4,044		53
54	RADIOLOGY-DIAGNOSTIC	74,462	11,453	32,623	22,212	59,194	4,924	54
60	LABORATORY	446,767	40,031	50,646	22,731	49,429		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	49,642	8,574	6,631	7,325	14,826		65
66	PHYSICAL THERAPY	49,642	1,012	2,662	2,563	15,697	1,265	66
69	ELECTROCARDIOLOGY	49,642	4,008	5,804	2,469	19,233		69
70	ELECTROENCEPHALOGRAPHY	49,642	146	151	509	2,633		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		682	1,219	3,626			71
72	IMPL. DEV. CHARGED TO PATIENTS		3,155	3,582	7,061			72
73	DRUGS CHARGED TO PATIENTS		54,848	48,678	14,914			73
75.01	ACUTE DIALYSIS		3,302	2,305	1,736			75.01
75.02	CARD CATH LAB		8,512	10,681	6,334	12,913		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	148,925	74	6,120	14,131	47,837	2,624	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC			331	1,617	7,265	109	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY		1,287	10,915	3,474	19,578	365	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	EMERGENCY	49,642	14,065	39,288	22,071	45,718	7,850	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<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)	2,730,283	309,193	344,922	381,412	1,026,519	68,393	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				41	3,796		190



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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	ADMINI-STRATIVE & GENERAL 5	OPERATION OF PLANT 7	LAUNDRY AND LINEN SERVICE 8	
192	PHYSICIANS' PRIVATE OFFICES				5,003	274,330		192
192.01	PROHEALTH SERVICES				5,312			192.01
192.02	AUXILIARY				1,174			192.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	2,730,283	309,193	344,922	392,942	1,304,645	68,393	202

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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	128,472						9
10	DIETARY	4,599	243,756					10
11	CAFETERIA	2,083		80,994				11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	1,488		1,763	67,529			13
14	CENTRAL SERVICES & SUPPLY	6,824		1,304		487,604		14
15	PHARMACY	2,983		3,527		863	391,599	15
16	MEDICAL RECORDS & LIBRARY	3,070		2,275		44		16
17	SOCIAL SERVICE	94		1,920		3		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			458		7		21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD	74						22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	25,738	198,265	22,333	27,370	39,138	34,654	30
31	INTENSIVE CARE UNIT	3,882	21,696	4,220	5,172	30,236	26,888	31
31.01	NICU							31.01
40	SUBPROVIDER - IPF	3,264	23,795	2,147	2,632	1,417	3,429	40
43	NURSERY	2,391		4,574	5,607	7,348	1,605	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	11,277		4,336	5,315	72,056	10,572	50
52	DELIVERY ROOM & LABOR ROOM	1,972		5,194	6,367	24,781	10,227	52
53	ANESTHESIOLOGY	412		851		6,097	590	53
54	RADIOLOGY-DIAGNOSTIC	6,031		4,501		4,713	205	54
60	LABORATORY	5,036		1,381		2,468	501	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	1,510		2,051		16,848	91	65
66	PHYSICAL THERAPY	1,599		648		360		66
69	ELECTROCARDIOLOGY	1,959		660		937	2	69
70	ELECTROENCEPHALOGRAPHY	268						70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS					68,495		71
72	IMPL. DEV. CHARGED TO PATIENTS					131,871		72
73	DRUGS CHARGED TO PATIENTS						267,373	73
75.01	ACUTE DIALYSIS					1		75.01
75.02	CARD CATH LAB	1,316		648		23,236	9,085	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	4,874		6,232	7,639	5,686	6,556	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	740		326		326	1,826	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	1,995		1,157		5,577	1,857	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	EMERGENCY	4,658		6,059	7,427	42,871	14,318	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<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)	100,137	243,756	78,565	67,529	485,379	389,779	118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	387						190



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING 9	DIETARY 10	CAFETERIA 11	NURSING ADMINISTRATION 13	CENTRAL SERVICES & SUPPLY 14	PHARMACY 15	
192	PHYSICIANS' PRIVATE OFFICES	27,948		1,022		180	52	192
192.01	PROHEALTH SERVICES			1,050		1,359	1,768	192.01
192.02	AUXILIARY			357		686		192.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	128,472	243,756	80,994	67,529	487,604	391,599	202



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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	146,019						16
17	SOCIAL SERVICE		12,016					17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			1,146				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD				3,159			22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	25,956	10,454			2,400,150		30
31	INTENSIVE CARE UNIT	3,970	481			417,153		31
31.01	NICU							31.01
40	SUBPROVIDER - IPF	3,259				173,501		40
43	NURSERY	3,889				212,730		43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	8,891	360			1,208,232		50
52	DELIVERY ROOM & LABOR ROOM	4,858				1,285,150		52
53	ANESTHESIOLOGY	1,405				125,293		53
54	RADIOLOGY-DIAGNOSTIC	13,805				1,206,380		54
60	LABORATORY	21,432				809,883		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,806				178,684		65
66	PHYSICAL THERAPY	1,127				114,829		66
69	ELECTROCARDIOLOGY	2,456				135,744		69
70	ELECTROENCEPHALOGRAPHY	64				61,247		70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	516				74,538		71
72	IMPL. DEV. CHARGED TO PATIENTS	1,516				147,185		72
73	DRUGS CHARGED TO PATIENTS	20,599				406,412		73
75.01	ACUTE DIALYSIS	975				8,319		75.01
75.02	CARD CATH LAB	4,520				341,122		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	2,590				427,478		90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	140				27,199		90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	4,619				112,471		90.04
90.05	FAMILY PRACTICE CLINIC					2,690		90.05
91	EMERGENCY	16,626	721			414,354		91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<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)	146,019	12,016			10,290,744		118
	<b>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN					11,694		190



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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	
192	PHYSICIANS' PRIVATE OFFICES					850,019		192
192.0 1	PROHEALTH SERVICES					27,007		192.0 1
192.0 2	AUXILIARY					9,406		192.0 2
200	CROSS FOOT ADJUSTMENTS			1,146	3,159	4,305		200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	146,019	12,016	1,146	3,159	11,193,175		202



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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	2,400,150					30
31	INTENSIVE CARE UNIT	417,153					31
31.01	NICU						31.01
40	SUBPROVIDER - IPF	173,501					40
43	NURSERY	212,730					43
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM	1,208,232					50
52	DELIVERY ROOM & LABOR ROOM	1,285,150					52
53	ANESTHESIOLOGY	125,293					53
54	RADIOLOGY-DIAGNOSTIC	1,206,380					54
60	LABORATORY	809,883					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	178,684					65
66	PHYSICAL THERAPY	114,829					66
69	ELECTROCARDIOLOGY	135,744					69
70	ELECTROENCEPHALOGRAPHY	61,247					70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,538					71
72	IMPL. DEV. CHARGED TO PATIENTS	147,185					72
73	DRUGS CHARGED TO PATIENTS	406,412					73
75.01	ACUTE DIALYSIS	8,319					75.01
75.02	CARD CATH LAB	341,122					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	427,478					90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	27,199					90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	112,471					90.04
90.05	FAMILY PRACTICE CLINIC	2,690					90.05
91	EMERGENCY	414,354					91
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	<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)	10,290,744					118
	<b>NONREIMBURSABLE COST CENTERS</b>						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,694					190



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B  
PART II

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
192	PHYSICIANS' PRIVATE OFFICES	850,019					192
192.0 1	PROHEALTH SERVICES	27,007					192.0 1
192.0 2	AUXILIARY	9,406					192.0 2
200	CROSS FOOT ADJUSTMENTS	4,305					200
201	NEGATIVE COST CENTER						201
202	TOTAL (sum of lines 118-201)	11,193,175					202



NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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 T 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		4,489,726					2
4	EMPLOYEE BENEFITS DEPARTMENT	3,020	1,799	47,155,738				4
4.01	COMMUNICATIONS	403	349	177,111	386			4.01
4.02	DATA PROCESSING	6,358	1,470,555	1,221,999	23	110		4.02
4.03	ADMITTING	6,014	7,573	655,995	6	9	162,956,100	4.03
4.04	CASHIERING	1,440	2,245	759,730	31	13		4.04
5	ADMINISTRATIVE & GENERAL	5,503	68,377	5,625,611	62	8		5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT	21,811	548,073	1,613,265	18	1		7
8	LAUNDRY & LINEN SERVICE	3,682						8
9	HOUSEKEEPING	3,524	3,392	966,317		2		9
10	DIETARY	7,456	25,309	835,451	11	2		10
11	CAFETERIA	3,378	8,842	291,714	1			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	2,413	7,069	1,045,242	8			13
14	CENTRAL SERVICES & SUPPLY	11,064	70,279	339,773	1	6		14
15	PHARMACY	4,836	62,614	1,393,411	10	7		15
16	MEDICAL RECORDS & LIBRARY	4,978	7,963	892,856	22	1		16
17	SOCIAL SERVICE	153	810	770,828	8			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			107,811	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	368,090	9,670,047	38	14	46,198,428	30
31	INTENSIVE CARE UNIT	6,295	61,745	2,084,819		2	7,707,966	31
31.01	NICU							31.01
40	SUBPROVIDER - IPF	5,293	6,232	881,335			6,329,040	40
43	NURSERY	3,876	16,584	1,252,919	3	2	7,551,649	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	18,284	330,717	2,019,533	24	4	6,647,251	50
52	DELIVERY ROOM & LABOR ROOM	3,198	591,090	2,239,654	2	2	7,548,039	52
53	ANESTHESIOLOGY	668	52,383	1,184,922	3		1,294,712	53
54	RADIOLOGY-DIAGNOSTIC	9,778	473,383	1,890,539	20	3	6,037,384	54
60	LABORATORY	8,165	39,736	397,065	24	18	21,102,377	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	2,449	21,382	731,690	5	2	4,519,994	65
66	PHYSICAL THERAPY	2,593	3,959	282,950	3	2	533,335	66
69	ELECTROCARDIOLOGY	3,177	5,826	204,927	8	2	2,113,040	69
70	ELECTROENCEPHALOGRAPHY	435	1,475			2	77,226	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						359,480	71
72	IMPL. DEV. CHARGED TO PATIENTS						1,663,245	72
73	DRUGS CHARGED TO PATIENTS						28,913,229	73
75.01	ACUTE DIALYSIS						1,740,668	75.01
75.02	CARD CATH LAB	2,133	131,997	422,122			4,487,092	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	44,445	3,162,302	7	6	38,979	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	1,200		214,646	5			90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	3,234	12,637	384,785	5		678,516	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	EMERGENCY	7,552	28,241	2,543,752	12	2	7,414,450	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<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	4,475,171	46,265,121	361	110	162,956,100	118



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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 DEPARTMEN T 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>NONREIMBURSABLE COST CENTERS</b>							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	627				1		190
192	PHYSICIANS' PRIVATE OFFICES	45,316	1,166	316,239	19			192
192.0 1	PROHEALTH SERVICES		9,473	426,175	5			192.0 1
192.0 2	AUXILIARY		3,916	148,203				192.0 2
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	3,092,318	3,611,131	571,954	147,131	4,871,736	1,294,173	202
203	UNIT COST MULT-WS B PT I	11.890832	0.804310	0.012129	381.168394	44,288.509091	0.007942	203
204	COST TO BE ALLOC PER B PT II			39,156	5,569	2,730,283	309,193	204
205	UNIT COST MULT-WS B PT II			0.000830	14.427461	24,820.754545	0.001897	205



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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	283,522,790						4.04
5	ADMINISTRATIVE & GENERAL		-13,393,703	74,423,212				5
6	MAINTENANCE & REPAIRS							6
7	OPERATION OF PLANT			5,678,095	215,510			7
8	LAUNDRY & LINEN SERVICE			439,629	3,682	309,685		8
9	HOUSEKEEPING			1,642,517	3,524		208,304	9
10	DIETARY			1,743,056	7,456		7,456	10
11	CAFETERIA			394,787	3,378		3,378	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION			1,371,090	2,413		2,413	13
14	CENTRAL SERVICES & SUPPLY			930,029	11,064		11,064	14
15	PHARMACY			1,785,062	4,836		4,836	15
16	MEDICAL RECORDS & LIBRARY			2,093,546	4,978		4,978	16
17	SOCIAL SERVICE			954,154	153		153	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD			109,500				21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD			176,545	120		120	22
23	PARAMED ED PRGM-(SPECIFY)							23
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	50,393,756		14,466,489	41,731	99,074	41,731	30
31	INTENSIVE CARE UNIT	7,707,966		3,399,320	6,295	13,209	6,295	31
31.01	NICU							31.01
40	SUBPROVIDER - IPF	6,329,040		1,305,398	5,293		5,293	40
43	NURSERY	7,551,649		1,884,032	3,876	16,535	3,876	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	17,263,367		4,412,702	18,284	56,083	18,284	50
52	DELIVERY ROOM & LABOR ROOM	9,432,351		3,807,837	3,198	47,186	3,198	52
53	ANESTHESIOLOGY	2,727,322		499,130	668		668	53
54	RADIOLOGY-DIAGNOSTIC	26,805,705		4,206,911	9,778	22,294	9,778	54
60	LABORATORY	41,615,419		4,305,168	8,165		8,165	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	5,449,053		1,387,259	2,449		2,449	65
66	PHYSICAL THERAPY	2,187,522		485,445	2,593	5,730	2,593	66
69	ELECTROCARDIOLOGY	4,769,310		467,604	3,177		3,177	69
70	ELECTROENCEPHALOGRAPHY	123,997		96,439	435		435	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,001,965		686,828				71
72	IMPL. DEV. CHARGED TO PATIENTS	2,943,045		1,337,303				72
73	DRUGS CHARGED TO PATIENTS	39,998,002		2,824,548				73
75.01	ACUTE DIALYSIS	1,894,173		328,753				75.01
75.02	CARD CATH LAB	8,776,241		1,199,590	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	5,028,934		2,676,265	7,902	11,883	7,902	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	272,320		306,274	1,200	494	1,200	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	8,969,004		657,927	3,234	1,652	3,234	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	EMERGENCY	32,282,649		4,180,086	7,552	35,545	7,552	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<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)	283,522,790	-13,393,703	72,239,318	169,567	309,685	162,361	118
	<b>NONREIMBURSABLE COST CENTERS</b>							



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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	
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN			7,837	627		627	190
192	PHYSICIANS' PRIVATE OFFICES			947,604	45,316		45,316	192
192.0 1	PROHEALTH SERVICES			1,006,021				192.0 1
192.0 2	AUXILIARY			222,432				192.0 2
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,035,698		13,393,703	6,699,965	633,217	2,047,673	202
203	UNIT COST MULT-WS B PT I	0.007180		0.179967	31.088882	2.044713	9.830214	203
204	COST TO BE ALLOC PER B PT II	344,922		392,942	1,304,645	68,393	128,472	204
205	UNIT COST MULT-WS B PT II	0.001217		0.005280	6.053756	0.220847	0.616752	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	110,049						10
11	CAFETERIA		52,361					11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		1,140	35,616				13
14	CENTRAL SERVICES & SUPPLY		843		4,817,822			14
15	PHARMACY		2,280		8,529	3,379,946		15
16	MEDICAL RECORDS & LIBRARY		1,471		431		283,522,790	16
17	SOCIAL SERVICE		1,241		29			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD		296		65			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	89,511	14,436	14,436	386,704	299,101	50,393,756	30
31	INTENSIVE CARE UNIT	9,795	2,728	2,728	298,752	232,072	7,707,966	31
31.01	NICU							31.01
40	SUBPROVIDER - IPF	10,743	1,388	1,388	14,002	29,600	6,329,040	40
43	NURSERY		2,957	2,957	72,604	13,849	7,551,649	43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM		2,803	2,803	711,963	91,251	17,263,367	50
52	DELIVERY ROOM & LABOR ROOM		3,358	3,358	244,853	88,274	9,432,351	52
53	ANESTHESIOLOGY		550		60,239	5,089	2,727,322	53
54	RADIOLOGY-DIAGNOSTIC		2,910		46,565	1,773	26,805,705	54
60	LABORATORY		893		24,388	4,322	41,615,419	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY		1,326		166,465	789	5,449,053	65
66	PHYSICAL THERAPY		419		3,560		2,187,522	66
69	ELECTROCARDIOLOGY		427		9,255	16	4,769,310	69
70	ELECTROENCEPHALOGRAPHY						123,997	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS				676,779		1,001,965	71
72	IMPL. DEV. CHARGED TO PATIENTS				1,302,962		2,943,045	72
73	DRUGS CHARGED TO PATIENTS					2,307,733	39,998,002	73
75.01	ACUTE DIALYSIS				10		1,894,173	75.01
75.02	CARD CATH LAB		419		229,590	78,411	8,776,241	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		4,029	4,029	56,183	56,588	5,028,934	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC		211		3,225	15,760	272,320	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY		748		55,100	16,030	8,969,004	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	EMERGENCY		3,917	3,917	423,591	123,582	32,282,649	91
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	<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)	110,049	50,790	35,616	4,795,844	3,364,240	283,522,790	118
	<b>NONREIMBURSABLE COST CENTERS</b>							



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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	
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES		661		1,775	450		192
192.0 1	PROHEALTH SERVICES		679		13,425	15,256		192.0 1
192.0 2	AUXILIARY		231		6,778			192.0 2
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	2,361,842	604,060	1,729,730	1,559,857	2,333,263	2,691,120	202
203	UNIT COST MULT-WS B PT I	21.461731	11.536449	48.566094	0.323768	0.690326	0.009492	203
204	COST TO BE ALLOC PER B PT II	243,756	80,994	67,529	487,604	391,599	146,019	204
205	UNIT COST MULT-WS B PT II	2.214977	1.546838	1.896030	0.101208	0.115860	0.000515	205



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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
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
<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>							



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE (TIME SPENT) 17	I/R-SALARY AND FRINGES (ASSIGNED TIME) 21	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME) 22				
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
192.0	PROHEALTH SERVICES							192.0
1								1
192.0	AUXILIARY							192.0
2								2
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,146,457	132,642	213,228				202
203	UNIT COST MULT-WS B PT I	11,464.570000	1,326.420000	2,132.280000				203
204	COST TO BE ALLOC PER B PT II	12,016	1,146	3,159				204
205	UNIT COST MULT-WS B PT II	120.160000	11.460000	31.590000				205



COMPU-MAX

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4



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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C  
PART I

	COST CENTER DESCRIPTIONS	TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	COSTS			
				TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>						
30	ADULTS & PEDIATRICS	23,576,192		23,576,192		23,576,192	30
31	INTENSIVE CARE UNIT	5,045,810		5,045,810		5,045,810	31
31.01	NICU						31.01
40	SUBPROVIDER - IPF	2,155,939		2,155,939		2,155,939	40
43	NURSERY	2,697,978		2,697,978		2,697,978	43
	<b>ANCILLARY SERVICE COST CENTERS</b>						
50	OPERATING ROOM	6,729,912		6,729,912		6,729,912	50
52	DELIVERY ROOM & LABOR ROOM	5,152,033		5,152,033		5,152,033	52
53	ANESTHESIOLOGY	671,540		671,540		671,540	53
54	RADIOLOGY-DIAGNOSTIC	5,714,019		5,714,019		5,714,019	54
60	LABORATORY	5,830,257		5,830,257		5,830,257	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	1,858,591		1,858,591		1,858,591	65
66	PHYSICAL THERAPY	717,379		717,379		717,379	66
69	ELECTROCARDIOLOGY	734,960		734,960		734,960	69
70	ELECTROENCEPHALOGRAPHY	132,772		132,772		132,772	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,039,064		1,039,064		1,039,064	71
72	IMPL. DEV. CHARGED TO PATIENTS	2,027,768		2,027,768		2,027,768	72
73	DRUGS CHARGED TO PATIENTS	5,305,619		5,305,619		5,305,619	73
75.01	ACUTE DIALYSIS	405,900		405,900		405,900	75.01
75.02	CARD CATH LAB	1,719,359		1,719,359		1,719,359	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	3,852,685		3,852,685		3,852,685	90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	428,449		428,449		428,449	90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	1,034,711		1,034,711		1,034,711	90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	EMERGENCY	6,147,156		6,147,156		6,147,156	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	1,258,136		1,258,136		1,258,136	92
	<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 (SEE INSTRUCTIONS)	84,236,229		84,236,229		84,236,229	200
201	LESS OBSERVATION BEDS	1,258,136		1,258,136		1,258,136	201
202	TOTAL (SEE INSTRUCTIONS)	82,978,093		82,978,093		82,978,093	202

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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	9	10	11	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>							
30	ADULTS & PEDIATRICS	46,198,428		46,198,428				30
31	INTENSIVE CARE UNIT	7,707,966		7,707,966				31
31.01	NICU							31.01
40	SUBPROVIDER - IPF	6,329,040		6,329,040				40
43	NURSERY	7,551,649		7,551,649				43
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	6,647,251	10,616,116	17,263,367	0.389838	0.389838	0.389838	50
52	DELIVERY ROOM & LABOR ROOM	7,548,039	1,884,312	9,432,351	0.546209	0.546209	0.546209	52
53	ANESTHESIOLOGY	1,294,712	1,432,610	2,727,322	0.246227	0.246227	0.246227	53
54	RADIOLOGY-DIAGNOSTIC	6,037,384	20,768,321	26,805,705	0.213164	0.213164	0.213164	54
60	LABORATORY	21,102,377	20,513,042	41,615,419	0.140098	0.140098	0.140098	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	4,519,994	929,059	5,449,053	0.341085	0.341085	0.341085	65
66	PHYSICAL THERAPY	533,335	1,654,187	2,187,522	0.327941	0.327941	0.327941	66
69	ELECTROCARDIOLOGY	2,113,040	2,656,270	4,769,310	0.154102	0.154102	0.154102	69
70	ELECTROENCEPHALOGRAPHY	77,226	46,771	123,997	1.070768	1.070768	1.070768	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	359,480	642,485	1,001,965	1.037026	1.037026	1.037026	71
72	IMPL. DEV. CHARGED TO PATIENTS	1,663,245	1,279,800	2,943,045	0.689003	0.689003	0.689003	72
73	DRUGS CHARGED TO PATIENTS	28,913,229	11,084,773	39,998,002	0.132647	0.132647	0.132647	73
75.01	ACUTE DIALYSIS	1,740,668	153,505	1,894,173	0.214289	0.214289	0.214289	75.01
75.02	CARD CATH LAB	4,487,092	4,289,149	8,776,241	0.195911	0.195911	0.195911	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	38,979	4,989,955	5,028,934	0.766104	0.766104	0.766104	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC		272,320	272,320	1.573329	1.573329	1.573329	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	678,516	8,290,488	8,969,004	0.115365	0.115365	0.115365	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	EMERGENCY	7,414,450	24,868,199	32,282,649	0.190417	0.190417	0.190417	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	785,560	3,409,768	4,195,328	0.299890	0.299890	0.299890	92
	<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 (SEE INSTRUCTIONS)	163,741,660	119,781,130	283,522,790				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	163,741,660	119,781,130	283,522,790				202



NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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	8	9	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>								
30	ADULTS & PEDIATRICS (General Routine Care)	2,400,150		2,400,150	31,519	76.15	8,562	651,996	30
31	INTENSIVE CARE UNIT	417,153		417,153	3,265	127.77	1,074	137,225	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	173,501		173,501	3,581	48.45	1,274	61,725	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY	212,730		212,730	3,064	69.43			43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	3,203,534		3,203,534	41,429		10,910	850,946	200

(A) Worksheet A line numbers



NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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	1,208,232	17,263,367	0.069988	1,706,260	119,418	50
52	DELIVERY ROOM & LABOR ROOM	1,285,150	9,432,351	0.136249	22,567	3,075	52
53	ANESTHESIOLOGY	125,293	2,727,322	0.045940	310,938	14,284	53
54	RADIOLOGY-DIAGNOSTIC	1,206,380	26,805,705	0.045005	2,565,691	115,469	54
60	LABORATORY	809,883	41,615,419	0.019461	6,719,343	130,765	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	178,684	5,449,053	0.032792	1,611,284	52,837	65
66	PHYSICAL THERAPY	114,829	2,187,522	0.052493	224,607	11,790	66
69	ELECTROCARDIOLOGY	135,744	4,769,310	0.028462	867,349	24,686	69
70	ELECTROENCEPHALOGRAPHY	61,247	123,997	0.493939	37,941	18,741	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,538	1,001,965	0.074392	150,350	11,185	71
72	IMPL. DEV. CHARGED TO PATIENTS	147,185	2,943,045	0.050011	825,884	41,303	72
73	DRUGS CHARGED TO PATIENTS	406,412	39,998,002	0.010161	8,992,412	91,372	73
75.01	ACUTE DIALYSIS	8,319	1,894,173	0.004392	724,231	3,181	75.01
75.02	CARD CATH LAB	341,122	8,776,241	0.038869	1,853,680	72,051	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	427,478	5,028,934	0.085004	14,779	1,256	90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	27,199	272,320	0.099879			90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	112,471	8,969,004	0.012540	210,397	2,638	90.04
90.05	FAMILY PRACTICE CLINIC	2,690					90.05
91	EMERGENCY	414,354	32,282,649	0.012835	2,006,504	25,753	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	128,083	4,195,328	0.030530	234,927	7,172	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	TOTAL (sum of lines 50-199)	7,215,293	215,735,707		29,079,144	746,976	200

(A) Worksheet A line numbers



NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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

(A)	COST CENTER DESCRIPTION	NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
		1	2	3	4	5	
	<b>INPATIENT ROUTINE SERV 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



NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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

		TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	<b>INPATIENT ROUTINE SERV COST CENTERS</b>					
30	ADULTS & PEDIATRICS (General Routine Care)	31,519		8,562		30
31	INTENSIVE CARE UNIT	3,265		1,074		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	3,581		1,274		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	3,064				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	41,429		10,910		200

(A) Worksheet A line numbers



NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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 [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [XX] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES: [ ] TITLE XIX [ ] IRF [ ] NF

(A)	COST CENTER DESCRIPTION	NON PHYSICIAN ANESTHETIST COST	NURSING SCHOOL	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)	
		1	2	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
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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 [XX] HOSPITAL [ ] SUB (OTHER) [ ] ICF/MR [XX] PPS  
 APPLICABLE [XX] TITLE XVIII, PART A [ ] IPF [ ] SNF [ ] TEFRA  
 BOXES: [ ] TITLE XIX [ ] IRF [ ] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
<b>ANCILLARY SERVICE COST CENTERS</b>								
50	OPERATING ROOM	17,263,367			1,706,260		2,436,780	50
52	DELIVERY ROOM & LABOR ROOM	9,432,351			22,567		16,148	52
53	ANESTHESIOLOGY	2,727,322			310,938		299,175	53
54	RADIOLOGY-DIAGNOSTIC	26,805,705			2,565,691		2,596,036	54
60	LABORATORY	41,615,419			6,719,343		1,640,022	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	5,449,053			1,611,284		119,594	65
66	PHYSICAL THERAPY	2,187,522			224,607			66
69	ELECTROCARDIOLOGY	4,769,310			867,349		566,275	69
70	ELECTROENCEPHALOGRAPHY	123,997			37,941		10,330	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,001,965			150,350		225,109	71
72	IMPL. DEV. CHARGED TO PATIENTS	2,943,045			825,884		627,745	72
73	DRUGS CHARGED TO PATIENTS	39,998,002			8,992,412		3,473,934	73
75.01	ACUTE DIALYSIS	1,894,173			724,231		25,748	75.01
75.02	CARD CATH LAB	8,776,241			1,853,680		1,871,004	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	5,028,934			14,779		2,378,643	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	272,320					2,376	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	8,969,004			210,397		2,007,595	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	EMERGENCY	32,282,649			2,006,504		2,381,191	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	4,195,328			234,927		926,922	92
<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	TOTAL (sum of lines 50-199)	215,735,707			29,079,144		21,604,627	200

(A) Worksheet A line numbers



COMPU-MAX

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST			
			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.)	
	<b>ANCILLARY SERVICE COST CENTERS</b>								
50	OPERATING ROOM	0.389838	2,436,780			949,949			50
52	DELIVERY ROOM & LABOR ROOM	0.546209	16,148			8,820			52
53	ANESTHESIOLOGY	0.246227	299,175			73,665			53
54	RADIOLOGY-DIAGNOSTIC	0.213164	2,596,036			553,381			54
60	LABORATORY	0.140098	1,640,022	179		229,764	25		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	RESPIRATORY THERAPY	0.341085	119,594			40,792			65
66	PHYSICAL THERAPY	0.327941							66
69	ELECTROCARDIOLOGY	0.154102	566,275			87,264			69
70	ELECTROENCEPHALOGRAPHY	1.070768	10,330			11,061			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.037026	225,109	42,680		233,444	44,260		71
72	IMPL. DEV. CHARGED TO PATIENTS	0.689003	627,745	4,972		432,518	3,426		72
73	DRUGS CHARGED TO PATIENTS	0.132647	3,473,934		19,105	460,807		2,534	73
75.01	ACUTE DIALYSIS	0.214289	25,748			5,518			75.01
75.02	CARD CATH LAB	0.195911	1,871,004			366,550			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	0.766104	2,378,643			1,822,288			90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	1.573329	2,376			3,738			90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	0.115365	2,007,595			231,606			90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	EMERGENCY	0.190417	2,381,191			453,419			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.299890	926,922			277,975			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>								
200	SUBTOTAL (see instructions)		21,604,627	47,831	19,105	6,242,559	47,711	2,534	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		21,604,627	47,831	19,105	6,242,559	47,711	2,534	202

(A) Worksheet A line numbers



NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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	1,208,232	17,263,367	0.069988			50
52	DELIVERY ROOM & LABOR ROOM	1,285,150	9,432,351	0.136249			52
53	ANESTHESIOLOGY	125,293	2,727,322	0.045940			53
54	RADIOLOGY-DIAGNOSTIC	1,206,380	26,805,705	0.045005	28,816	1,297	54
60	LABORATORY	809,883	41,615,419	0.019461	295,713	5,755	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	RESPIRATORY THERAPY	178,684	5,449,053	0.032792	471	15	65
66	PHYSICAL THERAPY	114,829	2,187,522	0.052493	5,621	295	66
69	ELECTROCARDIOLOGY	135,744	4,769,310	0.028462	24,629	701	69
70	ELECTROENCEPHALOGRAPHY	61,247	123,997	0.493939			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	74,538	1,001,965	0.074392	619	46	71
72	IMPL. DEV. CHARGED TO PATIENTS	147,185	2,943,045	0.050011			72
73	DRUGS CHARGED TO PATIENTS	406,412	39,998,002	0.010161	455,395	4,627	73
75.01	ACUTE DIALYSIS	8,319	1,894,173	0.004392			75.01
75.02	CARD CATH LAB	341,122	8,776,241	0.038869			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	427,478	5,028,934	0.085004	296	25	90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	27,199	272,320	0.099879			90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	112,471	8,969,004	0.012540			90.04
90.05	FAMILY PRACTICE CLINIC	2,690					90.05
91	EMERGENCY	414,354	32,282,649	0.012835	194,627	2,498	91
92	OBSERVATION BEDS (NON-DISTINCT PART)		4,195,328				92
	<b>OTHER REIMBURSABLE COST CENTERS</b>						
200	TOTAL (sum of lines 50-199)	7,087,210	215,735,707		1,006,187	15,259	200

(A) Worksheet A line numbers



NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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/MR  PPS  
 APPLICABLE  TITLE XVIII, PART A  IPF  SNF  TEFRA  
 BOXES:  TITLE XIX  IRF  NF

(A)	COST CENTER DESCRIPTION	1	2	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
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
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	TOTAL (sum of lines 50-199)							200

(A) Worksheet A line numbers



NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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/MR [XX] PPS  
 APPLICABLE [XX] TITLE XVIII, PART A [XX] IPF [ ] SNF [ ] TEFRA  
 BOXES: [ ] TITLE XIX [ ] IRF [ ] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	17,263,367						50
52	DELIVERY ROOM & LABOR ROOM	9,432,351						52
53	ANESTHESIOLOGY	2,727,322						53
54	RADIOLOGY-DIAGNOSTIC	26,805,705			28,816		1,303	54
60	LABORATORY	41,615,419			295,713			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	5,449,053			471			65
66	PHYSICAL THERAPY	2,187,522			5,621			66
69	ELECTROCARDIOLOGY	4,769,310			24,629		3,014	69
70	ELECTROENCEPHALOGRAPHY	123,997						70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,001,965			619			71
72	IMPL. DEV. CHARGED TO PATIENTS	2,943,045						72
73	DRUGS CHARGED TO PATIENTS	39,998,002			455,395			73
75.01	ACUTE DIALYSIS	1,894,173						75.01
75.02	CARD CATH LAB	8,776,241						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	5,028,934			296			90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	272,320						90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	8,969,004						90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	EMERGENCY	32,282,649			194,627			91
92	OBSERVATION BEDS (NON-DISTINCT PART)	4,195,328						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	TOTAL (sum of lines 50-199)	215,735,707			1,006,187		4,317	200

(A) Worksheet A line numbers



COMPU-MAX

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			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.)
	<b>ANCILLARY SERVICE COST CENTERS</b>							
50	OPERATING ROOM	0.389838						50
52	DELIVERY ROOM & LABOR ROOM	0.546209						52
53	ANESTHESIOLOGY	0.246227						53
54	RADIOLOGY-DIAGNOSTIC	0.213164	1,303			278		54
60	LABORATORY	0.140098						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	RESPIRATORY THERAPY	0.341085						65
66	PHYSICAL THERAPY	0.327941						66
69	ELECTROCARDIOLOGY	0.154102	3,014			464		69
70	ELECTROENCEPHALOGRAPHY	1.070768						70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.037026						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.689003						72
73	DRUGS CHARGED TO PATIENTS	0.132647						73
75.01	ACUTE DIALYSIS	0.214289						75.01
75.02	CARD CATH LAB	0.195911						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	0.766104						90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	1.573329						90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	0.115365						90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	EMERGENCY	0.190417						91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.299890						92
	<b>OTHER REIMBURSABLE COST CENTERS</b>							
200	SUBTOTAL (see instructions)		4,317			742		200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)		4,317			742		202

(A) Worksheet A line numbers



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NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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/MR [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)	31,519	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	31,519	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)	29,837	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	8,562	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	23,576,192	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	23,576,192	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 - line 36)	23,576,192	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0206

WORKSHEET D-1  
PART II

CHECK [ ] TITLE V - I/P [XX] HOSPITAL [ ] SUB (OTHER) [XX] PPS  
 APPLICABLE [XX] 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)						748.00	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)						6,404,376	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)						6,404,376	41
		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		
42	NURSERY (Titles V and XIX only)							42
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS</b>							
43	INTENSIVE CARE UNIT	5,045,810	3,265	1,545.42	1,074	1,659,781		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

							1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						5,964,100	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)						14,028,257	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)						789,221	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						746,976	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)						1,536,197	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						12,492,060	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



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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/MR  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)					1,682	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					748.00	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					1,258,136	89
		COST	ROUTINE COST (from line 27)	column 1 ÷ column 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	2,400,150	23,576,192	0.101804	1,258,136	128,083	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



COMPU-MAX

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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/MR [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)	3,581	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	3,581	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)	3,581	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	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	1,274	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 Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title 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)	2,155,939	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	2,155,939	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 - line 36)	2,155,939	37



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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)	602.05	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	767,012	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)	767,012	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	151,707	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	918,719	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	61,725	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	15,259	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	76,984	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	841,735	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



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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/MR  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		13,051,522		30
31	INTENSIVE CARE UNIT		2,986,740		31
31.01	NICU				31.01
40	SUBPROVIDER - IPF				40
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	OPERATING ROOM	0.389838	1,706,260	665,165	50
52	DELIVERY ROOM & LABOR ROOM	0.546209	22,567	12,326	52
53	ANESTHESIOLOGY	0.246227	310,938	76,561	53
54	RADIOLOGY-DIAGNOSTIC	0.213164	2,565,691	546,913	54
60	LABORATORY	0.140098	6,719,343	941,367	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.341085	1,611,284	549,585	65
66	PHYSICAL THERAPY	0.327941	224,607	73,658	66
69	ELECTROCARDIOLOGY	0.154102	867,349	133,660	69
70	ELECTROENCEPHALOGRAPHY	1.070768	37,941	40,626	70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.037026	150,350	155,917	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.689003	825,884	569,037	72
73	DRUGS CHARGED TO PATIENTS	0.132647	8,992,412	1,192,816	73
75.01	ACUTE DIALYSIS	0.214289	724,231	155,195	75.01
75.02	CARD CATH LAB	0.195911	1,853,680	363,156	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	0.766104	14,779	11,322	90
90.01	PH CLINIC				90.01
90.02	HEALTHWORKS CLINIC	1.573329			90.02
90.03	DENTAL CLINIC				90.03
90.04	WOUND CARE THERAPY	0.115365	210,397	24,272	90.04
90.05	FAMILY PRACTICE CLINIC				90.05
91	EMERGENCY	0.190417	2,006,504	382,072	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.299890	234,927	70,452	92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	TOTAL (sum of lines 50-94, and 96-98)		29,079,144	5,964,100	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		29,079,144		202

(A) Worksheet A line numbers



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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/MR  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		2,189,243		40
	<b>ANCILLARY SERVICE COST CENTERS</b>				
50	OPERATING ROOM	0.389838			50
52	DELIVERY ROOM & LABOR ROOM	0.546209			52
53	ANESTHESIOLOGY	0.246227			53
54	RADIOLOGY-DIAGNOSTIC	0.213164	28,816	6,143	54
60	LABORATORY	0.140098	295,713	41,429	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	RESPIRATORY THERAPY	0.341085	471	161	65
66	PHYSICAL THERAPY	0.327941	5,621	1,843	66
69	ELECTROCARDIOLOGY	0.154102	24,629	3,795	69
70	ELECTROENCEPHALOGRAPHY	1.070768			70
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	1.037026	619	642	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.689003			72
73	DRUGS CHARGED TO PATIENTS	0.132647	455,395	60,407	73
75.01	ACUTE DIALYSIS	0.214289			75.01
75.02	CARD CATH LAB	0.195911			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	0.766104	296	227	90
90.01	PH CLINIC				90.01
90.02	HEALTHWORKS CLINIC	1.573329			90.02
90.03	DENTAL CLINIC				90.03
90.04	WOUND CARE THERAPY	0.115365			90.04
90.05	FAMILY PRACTICE CLINIC				90.05
91	EMERGENCY	0.190417	194,627	37,060	91
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.299890			92
	<b>OTHER REIMBURSABLE COST CENTERS</b>				
200	TOTAL (sum of lines 50-94, and 96-98)		1,006,187	151,707	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		1,006,187		202

(A) Worksheet A line numbers



NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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## CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

CHECK  HOSPITAL  
 APPLICABLE BOX:

## PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS	11,859,972			1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)				1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)				1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	179,648			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS				3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	178.39			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) AND VOL. 64 FEDERAL REGISTER, MAY 12, 1998, PAGE 26340 AND VOL. 67 FEDERAL REGISTER, PAGE 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 LINES (8, 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				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS	3.00			11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)	3.00			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	3.00			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	3.00			18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)	0.016817			19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)	0.019525			20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)	0.016817			21
22	IME PAYMENT ADJUSTMENT (see instructions)	108,507			22
	<b>INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON</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)	-13.38			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 (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)	108,507			29
	<b>DISPROPORTIONATE SHARE ADJUSTMENT</b>				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)	0.2555			30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)	0.6216			31
32	SUM OF LINES 30 AND 31	0.8771			32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.6157			33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)	1,825,546			34
		PRIOR TO	ON OR AFTER		
	<b>UNCOMPENSATED CARE ADJUSTMENT</b>	OCTOBER 1	OCTOBER 1		



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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

CHECK  HOSPITAL  
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)		9,046,380,143		35
35.01	FACTOR 3 (see instructions)		0.000671155		35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)		6,071,523		35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)		6,071,523		35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)	6,071,523			36
	<b>ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES</b>				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I 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
47	SUBTOTAL (see instructions)	20,045,196			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 SCH AND MDH ONLY (see instructions)	20,045,196			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	1,145,065			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)	49,678			52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES				54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)				58
59	TOTAL (sum of amounts on lines 49 through 58)	21,239,939			59
60	PRIMARY PAYER PAYMENTS	6,209			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	21,233,730			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	1,096,512			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	245,464			63
64	ALLOWABLE BAD DEBTS (see instructions)	1,014,922			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	659,699			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	903,327			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	20,551,453			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (OTHER ADJUSTMENT - PSR)				70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	-41,817			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-7,114			70.94
71	AMOUNT DUE PROVIDER (see instructions)	20,502,522			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	410,050			71.01
72	INTERIM PAYMENTS	19,618,531			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	473,941			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2	646,063			75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART 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



COMPU-MAX

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E  
PART A

CHECK [XX] HOSPITAL  
 APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (see instructions)				96



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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)	50,245		1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)	6,242,559		2
3	PPS PAYMENTS	4,281,631		3
4	OUTLIER PAYMENT (see instructions)	75,599		4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)	0,836		5
6	LINE 2 TIMES LINE 5	5,218,779		6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6	0,8349		7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)			8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200			9
10	ORGAN ACQUISITION			10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	50,245		11
	<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>			
	REASONABLE CHARGES			
12	ANCILLARY SERVICE CHARGES	66,936		12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)			13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	66,936		14
	CUSTOMARY CHARGES			
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)	66,936		18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))	16,691		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) (for CAH, see instructions)	50,245		21
22	INTERNS AND RESIDENTS (see instructions)			22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)			23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	4,357,230		24
	<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>			
25	DEDUCTIBLES AND COINSURANCE (see instructions)	9,586		25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	950,587		26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	3,447,302		27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)	20,926		28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)			29
30	SUBTOTAL (sum of lines 27 through 29)	3,468,228		30
31	PRIMARY PAYER PAYMENTS			31
32	SUBTOTAL (line 30 minus line 31)	3,468,228		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)	502,130		34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	326,385		35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	449,670		36
37	SUBTOTAL (see instructions)	3,794,613		37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R			38
39	OTHER ADJUSTMENTS ( )			39
40	SUBTOTAL (see instructions)	3,794,613		40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	75,892		40.01
41	INTERIM PAYMENTS	3,744,075		41
42	TENTATIVE SETTLEMENT (for contractor use only)			42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-25,354		43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 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



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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)	742			2
3	PPS PAYMENTS	555			3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART 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>				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
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) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	555			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)	122			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	433			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)	433			30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)	433			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)	433			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS ( )				39
40	SUBTOTAL (see instructions)	433			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	9			40.01
41	INTERIM PAYMENTS	425			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	-1			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 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







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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1  
PART II

CHECK [XX] HOSPITAL [ ] CAH  
APPLICABLE BOX:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	7,370	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	9,636	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2		3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	33,102	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	283,522,790	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	14,111,652	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	745,274	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	14,905	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	730,369	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	532,399	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	197,970	32



COMPU-MAX

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form <b>CMS-2552-10</b>	Period : From: 10/01/2013 To: 09/30/2014	Run Date: 02/24/2015 Run Time: 16:58 Version: 2014.10
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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)	1,095,200	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	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 §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)	9,810,959	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)	1,095,200	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		15
16	SUBTOTAL (see instructions)	1,095,200	16
17	PRIMARY PAYER PAYMENTS		17
18	SUBTOTAL (line 16 less line 17)	1,095,200	18
19	DEDUCTIBLES	99,104	19
20	SUBTOTAL (line 18 minus line 19)	996,096	20
21	COINSURANCE	9,528	21
22	SUBTOTAL (line 20 minus line 21)	986,568	22
23	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)		23
24	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)		24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)		25
26	SUBTOTAL (sum of lines 22 and 24)	986,568	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet 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
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	986,568	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	19,731	31.01
32	INTERIM PAYMENTS	966,837	32
33	TENTATIVE SETTLEMENT (for contractor use only)		33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)		34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 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



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## DIRECT GRADUATE MEDICAL EDUCATION (GME) &amp; 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)(1) (see instructions)				2
3	AMOUNT OF REDUCTION TO DIRECT GME CAP UNDER SECTION 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 SECTION 5503 INCREASE TO THE DIRECT GME FTE CAP (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA SECTION 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)				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	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	0.00	0.00	0.00	9
10	WEIGHTED DENTAL AND PODIATRIC RESIDENT FTE COUNT FOR THE CURRENT YEAR		2.63		10
11	TOTAL WEIGHTED FTE COUNT	0.00	2.63		11
12	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PRIOR COST REPORTING YEAR (see instructions)	0.00	2.50		12
13	TOTAL WEIGHTED RESIDENT FTE COUNT FOR THE PENULTIMATE COST REPORTING YEAR (see instructions)	0.00	2.50		13
14	ROLLING AVERAGE FTE COUNT (sum of lines 11-13 divided by 3)	0.00	2.54		14
15	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF NEW PROGRAMS	0.00	0.00		15
16	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE	0.00	0.00		16
17	ADJUSTED ROLLING AVERAGE FTE COUNT	0.00	2.54		17
18	PER RESIDENT AMOUNT	93,461.79	93,461.79		18
19	APPROVED AMOUNT FOR RESIDENT COSTS		237,393	237,393	19
20	ADDITIONAL UNWEIGHTED ALLOPATHIC AND OSTEOPATHIC DIRECT GME FTE RESIDENT CAP SLOTS RECEIVED UNDER 42 SEC. 413.79(c)(4)				20
21	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)			237,393	25
		INPATIENT PART A	MANAGED CARE		
26	INPATIENT DAYS	10,910			26
27	TOTAL INPATIENT DAYS (see instructions)	36,683			27
28	RATIO OF INPATIENT DAYS TO TOTAL INPATIENT DAYS	0.297413	0.000000		28
29	PROGRAM DIRECT GME AMOUNT	70,604			29
30	REDUCTION FOR DIRECT GME PAYMENTS FOR MEDICARE MANAGED CARE				30
31	NET PROGRAM DIRECT GME AMOUNT			70,604	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 Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)				32
33	RENAL DIALYSIS AND HOME DIALYSIS TOTAL CHARGES (Worksheet C, Part I, column 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)			14,946,976	37
38	ORGAN ACQUISITION COSTS (Worksheet D-4, Part III, column 1, line 69)				38
39	COST OF TEACHING PHYSICIANS (Worksheet D-5, Part II, column 3, line 20)				39
40	PRIMARY PAYER PAYMENTS (see instructions)			6,209	40
41	TOTAL PART A REASONABLE COST (sum of lines 37-39 minus line 40)			14,940,767	41
	<b>PART B REASONABLE COST</b>				
42	REASONABLE COST (see instructions)			6,293,546	42
43	PRIMARY PAYER PAYMENTS (see instructions)				43
44	TOTAL PART B REASONABLE COST (line 42 minus line 43)			6,293,546	44
45	TOTAL REASONABLE COST (sum of lines 41 and 44)			21,234,313	45
46	RATIO OF PART A REASONABLE COST TO TOTAL REASONABLE COST (line 41 ÷ line 45)			0.703614	46



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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

47	RATIO OF PART B REASONABLE COST TO TOTAL REASONABLE COST (line 44 ÷ line 45)	0.296386	47
	<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>		
48	TOTAL PROGRAM GME PAYMENT (line 31)	70,604	48
49	PART A MEDICARE GME PAYMENT (line 46 x line 48) (Title XVIII only) (see instructions)	49,678	49
50	PART B MEDICARE GME PAYMENT (line 47 x line 48) (Title XVIII only) (see instructions)	20,926	50

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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)

	ASSETS (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	14,477,515				1
2	TEMPORARY INVESTMENTS					2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	27,479,313				4
5	OTHER RECEIVABLES	1,111,005				5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-10,480,663				6
7	INVENTORY	1,027,308				7
8	PREPAID EXPENSES	829,291				8
9	OTHER CURRENT ASSETS	87,768				9
10	DUE FROM OTHER FUNDS	1,119,815				10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	35,651,352				11
<b>FIXED ASSETS</b>						
12	LAND	4,529,913				12
13	LAND IMPROVEMENTS	3,112,770				13
14	ACCUMULATED DEPRECIATION	-3,056,245				14
15	BUILDINGS	47,253,714				15
16	ACCUMULATED DEPRECIATION	-32,795,645				16
17	LEASEHOLD IMPROVEMENTS					17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT	21,814,862				19
20	ACCUMULATED DEPRECIATION	-15,123,892				20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	50,349,755				23
24	ACCUMULATED DEPRECIATION	-40,446,869				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)	35,638,363				30
<b>OTHER ASSETS</b>						
31	INVESTMENTS	17,293,461				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	15,975,957				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	33,269,418				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	104,559,133				36

	LIABILITIES AND FUND BALANCES (Omit Cents)	GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
		1	2	3	4	
<b>CURRENT LIABILITIES</b>						
37	ACCOUNTS PAYABLE	5,886,579				37
38	SALARIES, WAGES & FEES PAYABLE	3,378,746				38
39	PAYROLL TAXES PAYABLE	82,832				39
40	NOTES & LOANS PAYABLE (short term)	1,414,871				40
41	DEFERRED INCOME	2,013,014				41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	6,915,040				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	19,691,082				45
<b>LONG TERM LIABILITIES</b>						
46	MORTGAGE PAYABLE					46
47	NOTES PAYABLE	18,891,830				47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	29,402,926				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	48,294,756				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	67,985,838				51
<b>CAPITAL ACCOUNTS</b>						
52	GENERAL FUND BALANCE	36,573,295				52
53	SPECIFIC PURPOSE FUND BALANCE					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



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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)

		GENERAL FUND	SPECIFIC PURPOSE FUND	ENDOWMENT FUND	PLANT FUND	
	ASSETS (Omit Cents)	1	2	3	4	
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 52-58)	36,573,295				59
60	TOTAL LIABILITIES AND FUND BALANCES (sum of lines 51 and 59)	104,559,133				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		34,951,731		1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		1,174,498		2
3	TOTAL (sum of line 1 and line 2)		36,126,229		3
4	ADDITIONS (credit adjustments)				4
5	MIN PENSION LIAB. ADJ.	447,066			5
6					6
7					7
8					8
9					9
10	TOTAL ADDITIONS (sum of lines 4-9)		447,066		10
11	SUBTOTAL (line 3 plus line 10)		36,573,295		11
12	DEDUCTIONS (debit adjustments)				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)		36,573,295		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)				4
5	MIN PENSION LIAB. ADJ.				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)				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	50,268,985		50,268,985	1
2	SUBPROVIDER IPF	6,329,040		6,329,040	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)	56,598,025		56,598,025	10
	<b>INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES</b>				
11	INTENSIVE CARE UNIT	7,743,326		7,743,326	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)	7,743,326		7,743,326	16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	64,341,351		64,341,351	17
18	ANCILLARY SERVICES	101,687,925		101,687,925	18
19	OUTPATIENT SERVICES		132,724,677	132,724,677	19
20	RHC				20
21	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)	166,029,276	132,724,677	298,753,953	28

## PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		106,304,150	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35	ROUNDING			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)		106,304,150	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)	298,753,953	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	199,058,944	2
3	NET PATIENT REVENUES (line 1 minus line 2)	99,695,009	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	106,304,150	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-6,609,141	5

## OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.	220,446	6
7	INCOME FROM INVESTMENTS	1,468,764	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	324,528	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	1,063	17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	10,582	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES		21
22	RENTAL OF HOSPITAL SPACE		22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (HIT INCENTIVE PAYMENTS)	1,476,967	24
24.0	OTHER (CLINICAL INTEGRATION REV)	1,818,931	24.0
1			1
24.0	OTHER (FHN POOL DISTRIBUTION)	890,265	24.0
2			2
24.0	OTHER (RENTAL INCOME)	39,500	24.0
3			3
24.0	OTHER (DIETARY MISC REV)	382,307	24.0
4			4
24.0	OTHER (CAPITATION REVENUE)	108,485	24.0
5			5
24.0	OTHER (LAB ADMIN REV)	341,528	24.0
6			6
24.0	OTHER (OTHER MISC REV)	700,273	24.0
7			7
25	TOTAL OTHER INCOME (sum of lines 6-24)	7,783,639	25
26	TOTAL (line 5 plus line 25)	1,174,498	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	1,174,498	29



COMPU-MAX

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0206

WORKSHEET L

CHECK [ ] TITLE V [XX] HOSPITAL [XX] PPS  
 APPLICABLE [XX] 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	947,763	1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS	4,243	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)	90.69	3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)	3.00	4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)	0.94	5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)	8,909	6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)	0.2555	7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)	0.6216	8
9	SUM OF LINES 7 AND 8	0.8771	9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)	0.1943	10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)	184,150	11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)	1,145,065	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 SERV 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
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
	<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



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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) 2A	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL		
192	PHYSICIANS' PRIVATE OFFICES	0	2A	24	25	26		192
192.0 1	PROHEALTH SERVICES							192.0 1
192.0 2	AUXILIARY							192.0 2
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202