

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

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

PART I - COST REPORT STATUS

Provider use only		1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted the cost report 4. <input checked="" type="checkbox"/> Medicare Utilization. Enter 'F' for full or 'L' for low.	Date: 02/25/2016 Time: 17:05
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by

(Signed) _____
Officer or Administrator of Provider(s)

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		625,655	80,156	31,005		1
2	SUBPROVIDER - IPF		5	402			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		625,660	80,558	31,005		200

The above amounts represent 'due to' or 'due from' the applicable program for the element of the above complex indicated.

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

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

20	Cost Reporting Period (mm/dd/yyyy)	From: 10 / 01 / 2014	To: 09 / 30 / 2015							20
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21	Type of control (see instructions)	2								21
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Inpatient PPS Information

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
	1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	12,306	343			11,158	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.						25

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	1					26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1					27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status is in effect in the cost reporting period.						35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:			36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.						37
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:			38

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

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

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	Y			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
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 Nonprovider Settings

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

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						64
Enter in lines 65-65.49 in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
65		1	2	3	4	5	65
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)						66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)							
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))	
67		1	2	3	4	5	67
Inpatient Psychiatric Facility PPS				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			Y			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			Y	N		71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.				N		81
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.				N		87

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WORKSHEET S-2 PART I

		V	XIX	
Title V and XIX Services		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/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97

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	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
		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
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.			N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2		118
		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

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

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

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

		Title XVIII		Title V	Title XIX	
		Part A	Part B			
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N	N	N	156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y			167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)				168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)	0.50			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 / 2014	09 / 30 / 2015		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)		N		171

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

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

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

		Y/N	
Bad Debts			
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

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data					
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	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	
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

**WORKSHEET S-2
PART II**

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

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

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

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

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

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

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

Cost Report Preparer Contact Information			
41	First name: RAJ	Last name: SHAH	Title: 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 Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	161	58,765			7,848	10,278	32,193	1
2	HMO and other (see instructions)						1,972	11,158		2
3	HMO IPF Subprovider						14			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			7,848	10,278	32,193	7
8	Intensive Care Unit	31	12	4,380			1,252	1,174	3,615	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						923	2,843	13
14	Total (see instructions)		173	63,145			9,100	12,375	38,651	14
15	CAH Visits									15
16	Subprovider - IPF	40	12	4,380			849	1,010	3,379	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								1,969	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)		10	3,650				274	296	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

KPMG LLP Compu-Max 2552-10

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					1,537	3,773	7,789	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	679.00			1,537	3,773	7,789	14
15	CAH Visits								15
16	Subprovider - IPF		10.00			118	137	465	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	689.00						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	Reclassi- fication 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	
SALARIES							
1	200	50,700,658	-4,777,066	45,923,592	1,515,182.00	30.31	1
2							2
3							3
4							4
4.01							4.01
5		3,264,190		3,264,190	33,202.00	98.31	5
6							6
7	21	127,127		127,127	6,423.00	19.79	7
7.01							7.01
8							8
9	44						9
10		1,931,998	-115,845	1,816,153	55,246.00	32.87	10
OTHER WAGES & RELATED COSTS							
11		5,039,061		5,039,061	88,314.00	57.06	11
12							12
13							13
14							14
15							15
16							16
WAGE-RELATED COSTS							
17		7,474,297		7,474,297			17
18							18
19		285,952		285,952			19
20							20
21		123,768		123,768			21
22							22
22.01							22.01
23		339,316		339,316			23
24							24
25		17,524		17,524			25
OVERHEAD COSTS - DIRECT SALARIES							
26		3,572,542	-178,174	3,394,368	137,010.00	24.77	26
27		6,158,240	-217,101	5,941,139	75,988.00	78.19	27
28		405,565		405,565	8,934.00	45.40	28
29							29
30		1,398,753		1,398,753	62,777.00	22.28	30
31							31
32		1,111,187		1,111,187	93,512.00	11.88	32
33							33
34		748,252	-183,754	564,498	42,219.00	13.37	34
35							35
36			183,754	183,754	13,743.00	13.37	36
37							37
38		1,224,700	-108	1,224,592	24,262.00	50.47	38
39		424,809		424,809	20,932.00	20.29	39
40		1,447,837	-20,101	1,427,736	48,173.00	29.64	40
41		639,628		639,628	23,829.00	26.84	41
42		1,014,478	-387,325	627,153	14,097.00	44.49	42
43							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	47,714,906	-4,777,066	42,937,840	1,484,491.00	28.92	1
2	Excluded area salaries (see instructions)	1,931,998	-115,845	1,816,153	55,246.00	32.87	2
3	Subtotal salaries (line 1 minus line 2)	45,782,908	-4,661,221	41,121,687	1,429,245.00	28.77	3
4	Subtotal other wages & related costs (see instructions)	5,039,061		5,039,061	88,314.00	57.06	4
5	Subtotal wage-related costs (see instructions)	7,474,297		7,474,297		18.18%	5
6	Total (sum of lines 3 through 5)	58,296,266	-4,661,221	53,635,045	1,517,559.00	35.34	6
7	Total overhead cost (see instructions)	18,145,991	-802,809	17,343,182	565,476.00	30.67	7

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HOSPITAL WAGE RELATED COSTS

**WORKSHEET S-3
PART IV**

Part IV - Wage Related Cost

Part A - Core List

		Amount Reported	
	RETIREMENT COST		
1	401K Employer Contributions		1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)	600,961	3
4	Qualified Defined Benefit Plan Cost (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA Plan Administration Fees		5
6	Legal/Accounting/Management Fees-Pension Plan		6
7	Employee Managed Care Program Administration Fees		7
	HEALTH AND INSURANCE COST		
8	Health Insurance (Purchased or Self Funded)	3,343,714	8
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	224,467	10
11	Life Insurance (If employee is owner or beneficiary)	65,585	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	113,739	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	437,731	15
16	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-Employers Portion Only	2,597,280	17
18	Medicare Taxes - Employers Portion Only	651,730	18
19	Unemployment Insurance	124,390	19
20	State or Federal Unemployment Taxes		20
	OTHER		
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	81,261	23
24	Total Wage Related cost (Sum of lines 1-23)	8,240,858	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)	47,228	25
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NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	Supporting Exhibit for Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 1: DETERMINE THE 3-YEAR AVERAGING PERIOD			
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
STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
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

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
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	DEPOSIT DATE(S)	CONTRIBUTION(S) 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 MOonths in Provider Cost Reporting Period on Line 2		15
16	Average Pension Contributions (Line 14 times Line 15)		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
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 RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

WORKSHEET S-5

RENAL DIALYSIS STATISTICS

	DESCRIPTION	Outpatient		Training		Home		
		Regular	High Flux	Hemo-dialysis	CAPD CCPD	Hemo-dialysis	CAPD CCPD	
		1	2	3	4	5	6	
1	Number of patients in program at end of cost reporting period							1
2	Number of times per week patient receives dialysis							2
3	Average patient dialysis time including setup							3
4	CAPD exchanges per day							4
5	Number of days in year dialysis furnished							5
6	Number of stations							6
7	Treatment capacity per day per station							7
8	Utilization (see instructions)							8
9	Average times dialyzers re-used							9
10	Percentage of patients re-using dialyzers							10

ESRD PPS

		1	2	
10.01	Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter 'Y' for yes or 'N' for no. (see instructions)			10.01
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter 'Y' for yes or 'N' for no. (see instructions for 'new' providers)			10.02
10.03	If you responded 'N' to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)		4	10.03

TRANSPLANT INFORMATION

11	Number of patients on transplant list			11
12	Number of patients transplanted during the cost reporting period			12

EPOETIN

13	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider			13
14	Epoetin amount from Worksheet A for home dialysis program			14
15	Number of EPO units furnished relating to the renal dialysis department			15
16	Number of EPO units furnished relating to the home dialysis department			16

ARANESP

17	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider			17
18	ARANESP amount from Worksheet A for home dialysis program			18
19	Number of ARANESP units furnished relating to the renal dialysis department			19
20	Number of ARANESP units furnished relating to the home dialysis department			20

PHYSICIAN PAYMENT METHOD (Enter 'X' for applicable method(s))

21	MCP	INITIAL METHOD	
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	Erythropoiesis-Stimulating Agents (ESA) Statistics:	ESA Description	Net Cost of ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.	
		1	2	3	4	5	
22	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						22

KPMG LLP Compu-Max 2552-10

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)		0.281858	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		32,508,716	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		104,250,683	6
7	Medicaid cost (line 1 times line 6)		29,383,889	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 care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng charity care				17
18	Government grants, appropriations of transfers for support of hospital operations				18
19	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)				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	8,272,423		8,272,423	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	2,331,649		2,331,649	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	2,331,649		2,331,649	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)			948,443	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			10,307,460	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			2,905,240	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)			5,236,889	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			5,236,889	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- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		649,044	649,044	2,735,749	3,384,793	-1,369,231	2,015,562	1
2	00200	Cap Rel Costs-Mvble Equip				3,590,199	3,590,199		3,590,199	2
3	00300	Other Cap Rel Costs		1,597,222	1,597,222	-1,597,222			-0-	3
4	00400	Employee Benefits Department	360,756	724,507	1,085,263	-488	1,084,775	-65	1,084,710	4
4.01	00401	COMMUNICATIONS	203,930	74,297	278,227		278,227		278,227	4.01
4.02	00402	DATA PROCESSING	1,348,139	4,166,686	5,514,825	-1,557,455	3,957,370	-25,700	3,931,670	4.02
4.03	00403	ADMITTING	757,732	264,002	1,021,734	-6,898	1,014,836		1,014,836	4.03
4.04	00404	CASHIERING	901,985	830,162	1,732,147	-3,112	1,729,035	-152	1,728,883	4.04
5	00500	Administrative & General	6,158,240	16,410,173	22,568,413	-137,817	22,430,596	-10,532,792	11,897,804	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,398,753	3,710,384	5,109,137	-649,204	4,459,933		4,459,933	7
8	00800	Laundry & Linen Service				395,847	395,847		395,847	8
9	00900	Housekeeping	1,111,187	923,333	2,034,520	-399,299	1,635,221	-108	1,635,113	9
10	01000	Dietary	748,252	1,838,386	2,586,638	-659,732	1,926,906	-400,343	1,526,563	10
11	01100	Cafeteria				627,243	627,243	-318,968	308,275	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,224,700	289,870	1,514,570	-10,141	1,504,429	-375	1,504,054	13
14	01400	Central Services & Supply	424,809	573,745	998,554	-53,338	945,216	-1,226	943,990	14
15	01500	Pharmacy	1,447,837	3,344,680	4,792,517	-2,370,347	2,422,170	-532	2,421,638	15
16	01600	Medical Records & Library	639,628	1,546,626	2,186,254	-10,132	2,176,122	-20,276	2,155,846	16
17	01700	Social Service	1,014,478	228,753	1,243,231	-373	1,242,858	-76,079	1,166,779	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd	127,127	79,685	206,812		206,812		206,812	21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	12,142,083	3,477,964	15,620,047	-1,054,032	14,566,015	-130,375	14,435,640	30
31	03100	Intensive Care Unit	2,533,701	1,043,429	3,577,130	-68,156	3,508,974	-90,000	3,418,974	31
31.01	02060	NICU								31.01
40	04000	Subprovider - IPF	1,041,637	340,463	1,382,100	-18,769	1,363,331	-69,600	1,293,731	40
43	04300	Nursery	711,010	214,623	925,633	580,439	1,506,072		1,506,072	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	2,161,241	3,186,469	5,347,710	-1,046,677	4,301,033	-735,970	3,565,063	50
52	05200	Delivery Room & Labor Room	2,386,965	1,351,941	3,738,906	-593,993	3,144,913		3,144,913	52
53	05300	Anesthesiology	391,035	1,411,894	1,802,929	-70,264	1,732,665	-1,512,560	220,105	53
54	05400	Radiology-Diagnostic	1,497,700	1,479,270	2,976,970	-745,166	2,231,804	-257,023	1,974,781	54
56.01	05601	NUCLEAR MEDICINE	118,250	136,890	255,140		255,140		255,140	56.01
57	05700	CT Scan	329,724	369,765	699,489	-4,939	694,550		694,550	57
58	05800	MRI		274,684	274,684		551,112		551,112	58
59	05900	Cardiac Catheterization	434,302	1,934,163	2,368,465	-1,154,952	1,213,513		1,213,513	59
60	06000	Laboratory	26,054	3,048,470	3,074,524	-39,736	3,034,788		3,034,788	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	817,675	401,778	1,219,453	-21,382	1,198,071		1,198,071	65
66	06600	Physical Therapy	324,443	60,601	385,044	-3,959	381,085		381,085	66
69	06900	Electrocardiology	211,897	65,931	277,828	-5,851	271,977		271,977	69
70	07000	Electroencephalography		3,025	3,025	-1,475	1,550		1,550	70
71	07100	Medical Supplies Charged to Patients				676,418	676,418		676,418	71
72	07200	Impl. Dev. Charged to Patients				1,249,617	1,249,617		1,249,617	72
73	07300	Drugs Charged to Patients				2,307,733	2,307,733		2,307,733	73
75.01	07501	ACUTE DIALYSIS		342,185	342,185		342,185	-340,794	1,391	75.01
75.02	03650	CARD CATH LAB						-217,947	-217,947	75.02
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
90	09000	Clinic	3,385,217	1,690,967	5,076,184	-62,252	5,013,932	-2,224,057	2,789,875	90
90.01	09001	PH CLINIC								90.01
90.02	09002	HEALTHWORKS CLINIC	182,104	72,239	254,343	-45	254,298	-25	254,273	90.02
90.03	09003	DENTAL CLINIC								90.03
90.04	09004	WOUND CARE THERAPY	416,403	268,507	684,910	-24,920	659,990	-162,510	497,480	90.04
90.05	09005	FAMILY PRACTICE CLINIC		2,690	2,690	-2,690				90.05
91	09100	Emergency	2,831,303	1,673,072	4,504,375	-53,532	4,450,843	-511,399	3,939,444	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
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
		SPECIAL PURPOSE COST CENTERS								
118		SUBTOTALS (sum of lines 1-117)	49,810,297	60,102,575	109,912,872	11,325	109,924,197	-18,998,107	90,926,090	118

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
192	19200	Physicians' Private Offices	239,848	67,075	306,923	-184	306,739		306,739	192
192.01	19201	PROHEALTH SERVICES	414,528	618,111	1,032,639	-9,343	1,023,296		1,023,296	192.01
192.02	19202	AUXILIARY	235,985	178,498	414,483	-1,798	412,685		412,685	192.02
200		TOTAL (sum of lines 118-199)	50,700,658	60,966,259	111,666,917		111,666,917	-18,998,107	92,668,810	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	PROPERTY INSURANCE	A	Cap Rel Costs-Bldg & Fixt	1		85,015	1
500	Total reclassifications					85,015	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		676,418	1
2			Impl. Dev. Charged to Patient	72		1,249,617	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
500	Total reclassifications					1,926,035	500
	Code Letter - C						
1	SHARED CAFETERIA EXP	D	Cafeteria	11	183,754	443,489	1
500	Total reclassifications				183,754	443,489	500
	Code Letter - D						
1	TEMPORARY HELP RECLASS	E	Employee Benefits Department	4		6,963	1
2			COMMUNICATIONS	4.01		1,401	2
3			CASHIERING	4.04		169,810	3
4			Administrative & General	5		217,101	4
5			Nursing Administration	13		108	5
6			Pharmacy	15		20,101	6
7			Social Service	17		387,325	7
8			Adults & Pediatrics	30		2,073,951	8
9			Intensive Care Unit	31		981,479	9
10			Subprovider - IPF	40		115,005	10
11			Nursery	43		14,975	11
12			Operating Room	50		130,991	12
13			Delivery Room & Labor Room	52		105,489	13
14			Physical Therapy	66		22,050	14
15			Clinic	90		44,099	15
16			Emergency	91		485,378	16
17			AUXILIARY	192.02		840	17
500	Total reclassifications					4,777,066	500
	Code Letter - E						
1	DEPRECIATION CHARGED TO DEPTS	F	Cap Rel Costs-Bldg & Fixt	1		4,648,255	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
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21							21
22							22
23							23
24							24
25							25
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27							27

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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	
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
36							36
500	Total reclassifications					4,648,255	500
	Code Letter - F						
1	INTEREST EXPENSE	G	Cap Rel Costs-Bldg & Fixt	1		913,907	1
2			Cap Rel Costs-Mvble Equip	2		678,771	2
3			Administrative & General	5		4,544	3
500	Total reclassifications					1,597,222	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	RECLASS OF MRI RELATED SALARY EXPEN	I	MRI	58	278,053		1
500	Total reclassifications				278,053		500
	Code Letter - I						
1	NURSERY EXP	J	Nursery	43	466,278	128,609	1
500	Total reclassifications				466,278	128,609	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						
	GRAND TOTAL (Increases)				928,085	19,220,699	

(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		85,015	12	1	
500	Total reclassifications					85,015		500	
	Code letter - A								
1	EQUIP DEPRECIATION	B	Cap Rel Costs-Bldg & Fixt	1		2,911,428	9	1	
500	Total reclassifications					2,911,428		500	
	Code letter - B								
1	CHARGEABLE SUPPLIES	C	Electrocardiology	69		25		1	
2			Adults & Pediatrics	30		88,491		2	
3			Intensive Care Unit	31		6,411		3	
4			Nursery	43		1,412		4	
5			Subprovider - IPF	40		12,537		5	
6			Operating Room	50		719,614		6	
7			Delivery Room & Labor Room	52		9,466		7	
8			Anesthesiology	53		17,881		8	
9			Radiology-Diagnostic	54		294		9	
10			Cardiac Catheterization	59		1,027,381		10	
11			Clinic	90		9,500		11	
12			HEALTHWORKS CLINIC	90.02		45		12	
13			WOUND CARE THERAPY	90.04		12,283		13	
14			Emergency	91		20,695		14	
500	Total reclassifications					1,926,035		500	
	Code letter - C								
1	SHARED CAFETERIA EXP	D	Dietary	10	183,754	443,489		1	
500	Total reclassifications				183,754	443,489		500	
	Code letter - D								
1	TEMPORARY HELP RECLASS	E	Employee Benefits Department	4	6,963			1	
2			COMMUNICATIONS	4.01	1,401			2	
3			CASHIERING	4.04	169,810			3	
4			Administrative & General	5	217,101			4	
5			Nursing Administration	13	108			5	
6			Pharmacy	15	20,101			6	
7			Social Service	17	387,325			7	
8			Adults & Pediatrics	30	2,073,951			8	
9			Intensive Care Unit	31	981,479			9	
10			Subprovider - IPF	40	115,005			10	
11			Nursery	43	14,975			11	
12			Operating Room	50	130,991			12	
13			Delivery Room & Labor Room	52	105,489			13	
14			Physical Therapy	66	22,050			14	
15			Clinic	90	44,099			15	
16			Emergency	91	485,378			16	
17			AUXILIARY	192.02	840			17	
500	Total reclassifications				4,777,066			500	
	Code letter - E								
1	DEPRECIATION CHARGED TO DEPTS	F	Employee Benefits Department	4		488	9	1	
2			DATA PROCESSING	4.02		1,557,455		2	
3			ADMITTING	4.03		6,898		3	
4			CASHIERING	4.04		3,112		4	
5			Administrative & General	5		57,346		5	
6			Operation of Plant	7		649,204		6	
7			Housekeeping	9		3,452		7	
8			Dietary	10		32,489		8	
9			Nursing Administration	13		10,141		9	
10			Central Services & Supply	14		53,338		10	
11			Pharmacy	15		62,614		11	
12			Medical Records & Library	16		10,132		12	
13			Social Service	17		373		13	
14			Adults & Pediatrics	30		370,654		14	
15			Intensive Care Unit	31		61,745		15	
16			Nursery	43		13,036		16	
17			Subprovider - IPF	40		6,232		17	
18			Operating Room	50		327,063		18	
19			Delivery Room & Labor Room	52		584,527		19	
20			Anesthesiology	53		52,383		20	
21			Radiology-Diagnostic	54		466,819		21	
22			CT Scan	57		4,939		22	
23			MRI	58		1,625		23	
24			Laboratory	60		39,736		24	
25			Respiratory Therapy	65		21,382		25	
26			Physical Therapy	66		3,959		26	

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RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
27			Electrocardiology	69		5,826		27
28			Electroencephalography	70		1,475		28
29			Cardiac Catheterization	59		127,571		29
30			Clinic	90		52,752		30
31			WOUND CARE THERAPY	90.04		12,637		31
32			FAMILY PRACTICE CLINIC	90.05		2,690		32
33			Emergency	91		32,837		33
34			Physicians' Private Offices	192		184		34
35			PROHEALTH SERVICES	192.01		9,343		35
36			AUXILIARY	192.02		1,798		36
500	Total reclassifications					4,648,255		500
	Code letter - F							
1	INTEREST EXPENSE	G	Other Cap Rel Costs	3		1,597,222	11	1
2							11	2
3								3
500	Total reclassifications					1,597,222		500
	Code letter - G							
1	LAUNDRY EXP	H	Housekeeping	9		395,847		1
500	Total reclassifications					395,847		500
	Code letter - H							
1	RECLASS OF MRI RELATED SALARY EXPEN	I	Radiology-Diagnostic	54	278,053			1
500	Total reclassifications				278,053			500
	Code letter - I							
1	NURSERY EXP	J	Adults & Pediatrics	30	466,278	128,609		1
500	Total reclassifications				466,278	128,609		500
	Code letter - J							
1	CHARGEABLE DRUGS	K	Pharmacy	15		2,307,733		1
500	Total reclassifications					2,307,733		500
	Code letter - K							
	GRAND TOTAL (Decreases)					5,705,151	14,443,633	

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

KPMG LLP Compu-Max 2552-10

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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		208,358	208,358		4,738,271		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	208,358	1,762,651		127,269,372		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	125,506,721	1,554,293	208,358	1,762,651		127,269,372		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	649,044						649,044	1	
2	Cap Rel Costs-Mvble Equip								2	
3	Total (sum of lines 1-2)	649,044						649,044	3	

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	Description	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	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 instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	2,385,871		-432,969	85,015	-22,355		2,015,562	1	
2	Cap Rel Costs-Mvble Equip	2,911,428		678,771				3,590,199	2	
3	Total (sum of lines 1-2)	5,297,299		245,802	85,015	-22,355		5,605,761	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.)

KPMG LLP Compu-Max 2552-10

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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
1	Investment income-buildings & fixtures (chapter 2)	B	-1,346,876	Cap Rel Costs-Bldg & Fixt	1	11	1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)	B	-1,077	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)						7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-8,622,799				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	-318,968	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients	B	-1,226	Central Services & Supply	14		16
17	Sale of drugs to other than patients	B	-532	Pharmacy	15		17
18	Sale of medical records and abstracts	B	-20,276	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						32
33	MISC REV	B	-75,941	Administrative & General	5		33
33.01	MISC REV	B	-375	Nursing Administration	13		33.01
33.02	MISC REV	B	-25,700	DATA PROCESSING	4.02		33.02
33.03	MISC REV	B	-65	Employee Benefits Department	4		33.03
33.04	MISC REV	B	-1,960	Radiology-Diagnostic	54		33.04
33.05	MISC REV	B	-343	Administrative & General	5		33.05
33.06	MISC REV	B	-11,132	Clinic	90		33.06
33.08	MISC REV	B	-25	HEALTHWORKS CLINIC	90.02		33.08
33.10	MISC REV	B	-152	CASHIERING	4.04		33.10
33.16	MISC REV	B	-108	Housekeeping	9		33.16
33.18	MISC REV	B	-19,406	Administrative & General	5		33.18
33.20	MISC REV	B	300	Adults & Pediatrics	30		33.20
33.21	MISC REV	B	-428	Adults & Pediatrics	30		33.21
34							34
34.06	MISC DIETARY	B	-400,343	Dietary	10		34.06
35							35
36							36
36.04	REAL ESTATE TAXES	A	-126,671	Administrative & General	5		36.04
36.05	REAL ESTATE TAXES	A	-22,355	Cap Rel Costs-Bldg & Fixt	1	13	36.05
36.09	CLINICAL INTEGRATION NON PHY SA	A	-30,675	Administrative & General	5		36.09
36.10	CLINICAL INTEGRATION-OTHER NON	A	-145,173	Administrative & General	5		36.10
37	LOOBYING PORTION - DUES	A	-249,422	Administrative & General	5		37
38							38
39	CHARITABLE CONTRIBUTIONS	A	-10,210	Administrative & General	5		39
40							40
41	ENTERTAINMENT EXP	A	-53,224	Administrative & General	5		41
42							42
43							43
44	STATE ASSESSMENT RECEIPTS	B	-7,512,945	Administrative & General	5		44
45							45
46							46
47							47
48							48

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-18,998,107				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	Percentage of Ownership	Related Organization(s) and/or Home Office			
				Name	Percentage of Ownership	Type of Business	
	1	2	3	4	5	6	
6							6
7							7
8							8
9							9
10							10

(1) Use the following symbols to indicate the interrelationship to related organizations:

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
- G. Other (financial Or non-financial) specify:

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1										1
2										2
3	5	Administrative & Gen AGGREGATE	2,307,705	2,307,705						3
4										4
5	17	Social Service AGGREGATE	76,079	76,079						5
6	30	Adults & Pediatrics AGGREGATE	130,247	130,247						6
7	31	Intensive Care Unit AGGREGATE	90,000	90,000						7
8										8
9	40	Subprovider - IPF AGGREGATE	69,600	69,600						9
10	50	Operating Room AGGREGATE	735,970	735,970						10
11	53	Anesthesiology AGGREGATE	1,512,560	1,512,560						11
12										12
13	54	Radiology-Diagnostic AGGREGATE	255,063	255,063						13
14	75.01	ACUTE DIALYSIS AGGREGATE	340,794	340,794						14
15	75.02	CARD CATH LAB AGGREGATE	217,947	217,947						15
16										16
17	90	Clinic AGGREGATE	2,212,925	2,212,925						17
18										18
19	90.04	WOUND CARE THERAPY AGGREGATE	162,510	162,510						19
20										20
22	91	Emergency AGGREGATE	511,399	511,399						22
200		TOTAL	8,622,799	8,622,799						200

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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1										1
2										2
3	5	Administrative & Gen	AGGREGATE						2,307,705	3
4										4
5	17	Social Service	AGGREGATE						76,079	5
6	30	Adults & Pediatrics	AGGREGATE						130,247	6
7	31	Intensive Care Unit	AGGREGATE						90,000	7
8										8
9	40	Subprovider - IPF	AGGREGATE						69,600	9
10	50	Operating Room	AGGREGATE						735,970	10
11	53	Anesthesiology	AGGREGATE						1,512,560	11
12										12
13	54	Radiology-Diagnostic	AGGREGATE						255,063	13
14	75.01	ACUTE DIALYSIS	AGGREGATE						340,794	14
15	75.02	CARD CATH LAB	AGGREGATE						217,947	15
16										16
17	90	Clinic	AGGREGATE						2,212,925	17
18										18
19	90.04	WOUND CARE THERAPY	AGGREGATE						162,510	19
20										20
22	91	Emergency	AGGREGATE						511,399	22
200		TOTAL							8,622,799	200

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	NEW CAP-REL COSTS BLDG&FIXT	NEW CAP-REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NON PATIENT PHONES	DATA PROCESSING	
		0	1	2	4	4.01	4.02	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	2,015,562	2,015,562					1
2	Cap Rel Costs-Mvble Equip	3,590,199		3,590,199				2
4	Employee Benefits Department	1,084,710	23,406	350	1,108,466			4
4.01	COMMUNICATIONS	278,227	3,123		4,927	286,277		4.01
4.02	DATA PROCESSING	3,931,670	49,277	1,215,834	32,793	17,058	5,246,632	4.02
4.03	ADMITTING	1,014,836	46,611	5,385	18,432	4,450	429,270	4.03
4.04	CASHIERING	1,728,883	11,161	2,792	17,810	22,991	620,057	4.04
5	Administrative & General	11,897,804	42,650	44,767	144,518	45,980	381,573	5
6	Maintenance & Repairs							6
7	Operation of Plant	4,459,933	169,044	506,804	34,025	13,350	47,697	7
8	Laundry & Linen Service	395,847	28,537					8
9	Housekeeping	1,635,113	27,312	2,695	27,030		95,393	9
10	Dietary	1,526,563	57,787	18,797	13,731	8,158	95,393	10
11	Cafeteria	308,275	26,181	6,567	4,470	742		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,504,054	18,702	7,917	29,788	5,933		13
14	Central Services & Supply	943,990	85,750	41,639	10,333	742	286,180	14
15	Pharmacy	2,421,638	37,481	44,991	34,730	7,417	333,877	15
16	Medical Records & Library	2,155,846	38,582	7,910	15,559	16,316	47,697	16
17	Social Service	1,166,779	1,186	291	15,255	5,933		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	206,812			3,092	742		21
22	I&R Services-Other Prgm Costs Apprvd		930					22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	14,435,640	323,432	298,177	233,546	28,183	667,753	30
31	Intensive Care Unit	3,418,974	48,789	41,428	37,758		95,393	31
31.01	NICU							31.01
40	Subprovider - IPF	1,293,731	41,023	4,865	22,540			40
43	Nursery	1,506,072	30,041	11,540	28,273	2,225	95,393	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,565,063	141,708	240,156	49,386	17,800	190,787	50
52	Delivery Room & Labor Room	3,144,913	24,786	456,313	55,497	1,483	95,393	52
53	Anesthesiology	220,105	5,177	35,004	9,512	2,225		53
54	Radiology-Diagnostic	1,974,781	44,100	215,938	29,668	8,900	95,393	54
56.01	NUCLEAR MEDICINE	255,140	4,588	22,471	2,876	742		56.01
57	CT Scan	694,550	22,089	108,164	8,021	4,450	47,697	57
58	MRI	551,112	5,007	24,531	6,764	742		58
59	Cardiac Catheterization	1,213,513			10,564			59
60	Laboratory	3,034,788	63,282	654	634	17,800	858,541	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,198,071	18,981	19,853	19,890	3,708	95,393	65
66	Physical Therapy	381,085	20,097	3,104	7,356	2,225	95,393	66
69	Electrocardiology	271,977	24,623	4,548	5,154	5,933	95,393	69
70	Electroencephalography	1,550	3,371	1,151			95,393	70
71	Medical Supplies Charged to Patients	676,418						71
72	Impl. Dev. Charged to Patients	1,249,617						72
73	Drugs Charged to Patients	2,307,733						73
75.01	ACUTE DIALYSIS	1,391						75.01
75.02	CARD CATH LAB	-217,947	16,532	99,589				75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	2,789,875	61,244	41,181	81,273	5,192	286,180	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	254,273	9,300		4,430	3,708		90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	497,480	25,065	10,932	10,129	3,708		90.04
90.05	FAMILY PRACTICE CLINIC			2,100				90.05
91	Emergency	3,939,444	58,531	25,634	57,065	8,900	95,393	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
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
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	90,926,090	1,659,486	3,574,072	1,086,829	267,736	5,246,632	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		4,860			742		190

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NON PATIENT PHONES	DATA PROCESSING	
		0	1	2	4	4.01	4.02	
192	Physicians' Private Offices	306,739	351,216	173	5,834	14,091		192
192.01	PROHEALTH SERVICES	1,023,296		7,294	10,083	3,708		192.01
192.02	AUXILIARY	412,685		8,660	5,720			192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	92,668,810	2,015,562	3,590,199	1,108,466	286,277	5,246,632	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	
	GENERAL SERVICE COST CENTERS							
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	1,518,984						4.03
4.04	CASHIERING		2,403,694					4.04
5	Administrative & General			12,557,292	12,557,292			5
6	Maintenance & Repairs							6
7	Operation of Plant			5,230,853	818,885	6,049,738		7
8	Laundry & Linen Service			424,384	66,437	103,360	594,181	8
9	Housekeeping			1,787,543	279,838	98,925		9
10	Dietary			1,720,429	269,331	209,303		10
11	Cafeteria			346,235	54,203	94,826		11
12	Maintenance of Personnel							12
13	Nursing Administration			1,566,394	245,217	67,737		13
14	Central Services & Supply			1,368,634	214,258	310,586		14
15	Pharmacy			2,880,134	450,882	135,755		15
16	Medical Records & Library			2,281,910	357,231	139,741		16
17	Social Service			1,189,444	186,206	4,295		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			210,646	32,976			21
22	I&R Services-Other Prgm Costs Apprvd			930	146	3,369		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	427,983	434,217	16,848,931	2,637,657	1,171,461	190,090	30
31	Intensive Care Unit	75,523	70,099	3,787,964	593,002	176,712	25,344	31
31.01	NICU							31.01
40	Subprovider - IPF	51,208	47,530	1,460,897	228,702	148,584		40
43	Nursery	60,482	56,138	1,790,164	280,248	108,806	31,725	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	62,431	141,592	4,408,923	690,212	513,263	107,604	50
52	Delivery Room & Labor Room	55,371	64,372	3,898,128	610,248	89,773	90,534	52
53	Anesthesiology	12,257	24,602	308,882	48,355	18,752		53
54	Radiology-Diagnostic	29,146	129,479	2,527,405	395,663	159,728	24,889	54
56.01	NUCLEAR MEDICINE	7,962	13,474	307,253	48,100	16,618	2,590	56.01
57	CT Scan	19,650	64,856	969,477	151,771	80,004	12,467	57
58	MRI	5,081	14,709	607,946	95,173	18,134	2,828	58
59	Cardiac Catheterization	35,535	54,326	1,313,938	205,696			59
60	Laboratory	195,955	331,587	4,503,241	704,978	229,206		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	41,827	45,518	1,443,241	225,938	68,748		65
66	Physical Therapy	5,816	17,895	532,971	83,436	72,790	10,994	66
69	Electrocardiology	21,291	39,325	468,244	73,303	89,184		69
70	Electroencephalography	625	838	102,928	16,113	12,211		70
71	Medical Supplies Charged to Patients	2,268	6,080	684,766	107,199			71
72	Impl. Dev. Charged to Patients	19,921	29,914	1,299,452	203,428			72
73	Drugs Charged to Patients	272,810	369,705	2,950,248	461,858			73
75.01	ACUTE DIALYSIS	16,744	16,615	34,750	5,440			75.01
75.02	CARD CATH LAB			-101,826		59,877		75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	333	56,543	3,321,821	520,028	221,823	22,799	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	5	2,273	273,989	42,893	33,686	948	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	5,790	59,284	612,388	95,869	90,784	3,170	90.04
90.05	FAMILY PRACTICE CLINIC			2,100	329			90.05
91	Emergency	92,970	312,723	4,590,660	718,663	211,998	68,199	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
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
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,518,984	2,403,694	90,513,709	12,219,912	4,760,039	594,181	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			5,602	877	17,601		190
192	Physicians' Private Offices			678,053	106,149	1,272,098		192
192.01	PROHEALTH SERVICES			1,044,381	163,497			192.01

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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	
192.02	AUXILIARY			427,065	66,857			192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,518,984	2,403,694	92,668,810	12,557,292	6,049,738	594,181	202

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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	
	GENERAL SERVICE COST CENTERS							
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	2,166,306						9
10	Dietary	77,540	2,276,603					10
11	Cafeteria	35,130		530,394				11
12	Maintenance of Personnel							12
13	Nursing Administration	25,095		12,842	1,917,285			13
14	Central Services & Supply	115,063		11,080		2,019,621		14
15	Pharmacy	50,293		25,508		3,724	3,546,296	15
16	Medical Records & Library	51,770		12,622		65		16
17	Social Service	1,591		7,467		4		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			3,403		36		21
22	I&R Services-Other Prgm Costs Apprvd	1,248						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	433,991	1,873,327	185,893	971,011	194,570	326,875	30
31	Intensive Care Unit	65,466	208,442	17,215	89,921	141,207	108,539	31
31.01	NICU							31.01
40	Subprovider - IPF	55,046	194,834	10,772	56,266	5,244	25,013	40
43	Nursery	40,309		8,767	45,795	17,514	7,113	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	190,149		24,407	127,489	251,796	120,824	50
52	Delivery Room & Labor Room	33,258		38,273	199,921	98,969	117,194	52
53	Anesthesiology	6,947		2,236		25,956	7,019	53
54	Radiology-Diagnostic	59,174		17,975		11,269	195	54
56.01	NUCLEAR MEDICINE	6,157		1,872		1,173	20	56.01
57	CT Scan	29,639		9,009		5,645	98	57
58	MRI	6,718		2,038		1,280	22	58
59	Cardiac Catheterization							59
60	Laboratory	84,914		606			9,167	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	25,469		16,157		59,594	996	65
66	Physical Therapy	26,967		4,372		1,742		66
69	Electrocardiology	33,040		4,659		2,446		69
70	Electroencephalography	4,524				498		70
71	Medical Supplies Charged to Patients					283,858		71
72	Impl. Dev. Charged to Patients					546,494		72
73	Drugs Charged to Patients						2,407,241	73
75.01	ACUTE DIALYSIS							75.01
75.02	CARD CATH LAB	22,183		4,152		92,774	94,740	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	82,179		45,707	238,755	31,987	137,098	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	12,480		1,542		1,909	13,295	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	33,633		8,932		25,850	18,817	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	78,539		36,015	188,127	200,196	134,063	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
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
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,688,512	2,276,603	513,521	1,917,285	2,005,800	3,528,329	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	6,521						190
192	Physicians' Private Offices	471,273		5,309		703	2,830	192
192.01	PROHEALTH SERVICES			7,269		2,582	14,377	192.01

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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	
192.02	AUXILIARY			4,295		10,536	760	192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,166,306	2,276,603	530,394	1,917,285	2,019,621	3,546,296	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	
	GENERAL SERVICE COST CENTERS							
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	2,843,339						16
17	Social Service		1,389,007					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			247,061				21
22	I&R Services-Other Prgm Costs Apprvd				5,693			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	513,467	1,208,437	222,355	5,124	26,783,189	-227,479	30
31	Intensive Care Unit	82,926	55,560			5,352,298		31
31.01	NICU							31.01
40	Subprovider - IPF	56,228				2,241,586		40
43	Nursery	66,411				2,396,852		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	167,502	41,670			6,643,839		50
52	Delivery Room & Labor Room	76,151				5,252,449		52
53	Anesthesiology	29,104				447,251		53
54	Radiology-Diagnostic	153,172				3,349,470		54
56.01	NUCLEAR MEDICINE	15,940				399,723		56.01
57	CT Scan	76,724				1,334,834		57
58	MRI	17,401				751,540		58
59	Cardiac Catheterization	64,268				1,583,902		59
60	Laboratory	392,263				5,924,375		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	53,847				1,893,990		65
66	Physical Therapy	21,170				754,442		66
69	Electrocardiology	46,521				717,397		69
70	Electroencephalography	991				137,265		70
71	Medical Supplies Charged to Patients	7,193				1,083,016		71
72	Impl. Dev. Charged to Patients	35,388				2,084,762		72
73	Drugs Charged to Patients	437,357				6,256,704		73
75.01	ACUTE DIALYSIS	19,655				59,845		75.01
75.02	CARD CATH LAB					171,900		75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	66,890		24,706	569	4,714,362	-25,275	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	2,689				383,431		90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	70,133				959,576		90.04
90.05	FAMILY PRACTICE CLINIC					2,429		90.05
91	Emergency	369,948	83,340			6,679,748		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
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
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	2,843,339	1,389,007	247,061	5,693	88,360,175	-252,754	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					30,601		190
192	Physicians' Private Offices					2,536,415		192
192.01	PROHEALTH SERVICES					1,232,106		192.01

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COST ALLOCATION - GENERAL SERVICE COSTS

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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	
192.02	AUXILIARY					509,513		192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,843,339	1,389,007	247,061	5,693	92,668,810	-252,754	202

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
	GENERAL SERVICE COST CENTERS						
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
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	26,555,710					30
31	Intensive Care Unit	5,352,298					31
31.01	NICU						31.01
40	Subprovider - IPF	2,241,586					40
43	Nursery	2,396,852					43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,643,839					50
52	Delivery Room & Labor Room	5,252,449					52
53	Anesthesiology	447,251					53
54	Radiology-Diagnostic	3,349,470					54
56.01	NUCLEAR MEDICINE	399,723					56.01
57	CT Scan	1,334,834					57
58	MRI	751,540					58
59	Cardiac Catheterization	1,583,902					59
60	Laboratory	5,924,375					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,893,990					65
66	Physical Therapy	754,442					66
69	Electrocardiology	717,397					69
70	Electroencephalography	137,265					70
71	Medical Supplies Charged to Patients	1,083,016					71
72	Impl. Dev. Charged to Patients	2,084,762					72
73	Drugs Charged to Patients	6,256,704					73
75.01	ACUTE DIALYSIS	59,845					75.01
75.02	CARD CATH LAB	171,900					75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	4,689,087					90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	383,431					90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	959,576					90.04
90.05	FAMILY PRACTICE CLINIC	2,429					90.05
91	Emergency	6,679,748					91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
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
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	88,107,421					118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	30,601					190
192	Physicians' Private Offices	2,536,415					192
192.01	PROHEALTH SERVICES	1,232,106					192.01

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
192.02	AUXILIARY	509,513						192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	92,416,056						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 DEPARTMENT	NON PATIENT PHONES	
		0	1	2	2A	4	4.01	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department		23,406	350	23,756	23,756		4
4.01	COMMUNICATIONS		3,123		3,123	106	3,229	4.01
4.02	DATA PROCESSING		49,277	1,215,834	1,265,111	702	192	4.02
4.03	ADMITTING		46,611	5,385	51,996	395	50	4.03
4.04	CASHIERING		11,161	2,792	13,953	381	259	4.04
5	Administrative & General		42,650	44,767	87,417	3,095	520	5
6	Maintenance & Repairs							6
7	Operation of Plant		169,044	506,804	675,848	729	151	7
8	Laundry & Linen Service		28,537		28,537			8
9	Housekeeping		27,312	2,695	30,007	579		9
10	Dietary		57,787	18,797	76,584	294	92	10
11	Cafeteria		26,181	6,567	32,748	96	8	11
12	Maintenance of Personnel							12
13	Nursing Administration		18,702	7,917	26,619	638	67	13
14	Central Services & Supply		85,750	41,639	127,389	221	8	14
15	Pharmacy		37,481	44,991	82,472	744	84	15
16	Medical Records & Library		38,582	7,910	46,492	333	184	16
17	Social Service		1,186	291	1,477	327	67	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					66	8	21
22	I&R Services-Other Prgm Costs Apprvd		930		930			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		323,432	298,177	621,609	5,014	318	30
31	Intensive Care Unit		48,789	41,428	90,217	809		31
31.01	NICU							31.01
40	Subprovider - IPF		41,023	4,865	45,888	483		40
43	Nursery		30,041	11,540	41,581	606	25	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		141,708	240,156	381,864	1,058	201	50
52	Delivery Room & Labor Room		24,786	456,313	481,099	1,189	17	52
53	Anesthesiology		5,177	35,004	40,181	204	25	53
54	Radiology-Diagnostic		44,100	215,938	260,038	635	100	54
56.01	NUCLEAR MEDICINE		4,588	22,471	27,059	62	8	56.01
57	CT Scan		22,089	108,164	130,253	172	50	57
58	MRI		5,007	24,531	29,538	145	8	58
59	Cardiac Catheterization					226		59
60	Laboratory		63,282	654	63,936	14	201	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		18,981	19,853	38,834	426	42	65
66	Physical Therapy		20,097	3,104	23,201	158	25	66
69	Electrocardiology		24,623	4,548	29,171	110	67	69
70	Electroencephalography		3,371	1,151	4,522			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		16,532	99,589	116,121			75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		61,244	41,181	102,425	1,741	59	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC		9,300		9,300	95	42	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY		25,065	10,932	35,997	217	42	90.04
90.05	FAMILY PRACTICE CLINIC			2,100	2,100			90.05
91	Emergency		58,531	25,634	84,165	1,222	100	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
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
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)		1,659,486	3,574,072	5,233,558	23,292	3,020	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		4,860		4,860		8	190
192	Physicians' Private Offices		351,216	173	351,389	125	159	192
192.01	PROHEALTH SERVICES			7,294	7,294	216	42	192.01

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NON PATIENT PHONES	
		0	1	2	2A	4	4.01	
192.02	AUXILIARY			8,660	8,660	123		192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		2,015,562	3,590,199	5,605,761	23,756	3,229	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	
	GENERAL SERVICE COST CENTERS							
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	1,266,005						4.02
4.03	ADMITTING	103,582	156,023					4.03
4.04	CASHIERING	149,619		164,212				4.04
5	Administrative & General	92,073			183,105			5
6	Maintenance & Repairs							6
7	Operation of Plant	11,509			11,942	700,179		7
8	Laundry & Linen Service				969	11,963	41,469	8
9	Housekeeping	23,018			4,081	11,449		9
10	Dietary	23,018			3,928	24,224		10
11	Cafeteria				790	10,975		11
12	Maintenance of Personnel							12
13	Nursing Administration				3,576	7,840		13
14	Central Services & Supply	69,055			3,125	35,946		14
15	Pharmacy	80,564			6,575	15,712		15
16	Medical Records & Library	11,509			5,210	16,173		16
17	Social Service				2,716	497		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				481			21
22	I&R Services-Other Prgm Costs Apprvd				2	390		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	161,128	43,948	29,738	38,444	135,582	13,267	30
31	Intensive Care Unit	23,018	7,758	4,786	8,648	20,452	1,769	31
31.01	NICU							31.01
40	Subprovider - IPF		5,261	3,245	3,335	17,197		40
43	Nursery	23,018	6,213	3,833	4,087	12,593	2,214	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	46,037	6,413	9,668	10,066	59,404	7,510	50
52	Delivery Room & Labor Room	23,018	5,688	4,395	8,899	10,390	6,319	52
53	Anesthesiology		1,259	1,680	705	2,170		53
54	Radiology-Diagnostic	23,018	2,994	8,841	5,770	18,486	1,737	54
56.01	NUCLEAR MEDICINE		818	920	701	1,923	181	56.01
57	CT Scan	11,509	2,019	4,428	2,213	9,259	870	57
58	MRI		522	1,004	1,388	2,099	197	58
59	Cardiac Catheterization		3,650	3,709	3,000			59
60	Laboratory	207,167	20,130	22,641	10,281	26,528		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	23,018	4,297	3,108	3,295	7,957		65
66	Physical Therapy	23,018	597	1,222	1,217	8,425	767	66
69	Electrocardiology	23,018	2,187	2,685	1,069	10,322		69
70	Electroencephalography	23,018	64	57	235	1,413		70
71	Medical Supplies Charged to Patients		233	415	1,563			71
72	Impl. Dev. Charged to Patients		2,046	2,043	2,967			72
73	Drugs Charged to Patients		28,025	25,243	6,735			73
75.01	ACUTE DIALYSIS		1,720	1,134	79			75.01
75.02	CARD CATH LAB					6,930		75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	69,055	34	3,861	7,584	25,673	1,591	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC		1	155	626	3,899	66	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY		595	4,048	1,398	10,507	221	90.04
90.05	FAMILY PRACTICE CLINIC				5			90.05
91	Emergency	23,018	9,551	21,353	10,480	24,536	4,760	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
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
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	1,266,005	156,023	164,212	178,185	550,914	41,469	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				13	2,037		190
192	Physicians' Private Offices				1,548	147,228		192
192.01	PROHEALTH SERVICES				2,384			192.01

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DATA PROCESSING	ADMITTING	CASHIERS	ADMINI- STRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY AND LINEN SERVICE	
		4.02	4.03	4.04	5	7	8	
192.02	AUXILIARY				975			192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,266,005	156,023	164,212	183,105	700,179	41,469	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	
	GENERAL SERVICE COST CENTERS							
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	69,134						9
10	Dietary	2,475	130,615					10
11	Cafeteria	1,121		45,738				11
12	Maintenance of Personnel							12
13	Nursing Administration	801		1,107	40,648			13
14	Central Services & Supply	3,672		955		240,371		14
15	Pharmacy	1,605		2,200		443	190,399	15
16	Medical Records & Library	1,652		1,088		8		16
17	Social Service	51		644				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			293		4		21
22	I&R Services-Other Prgm Costs Apprvd	40						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	13,850	107,478	16,032	20,587	23,157	17,550	30
31	Intensive Care Unit	2,089	11,959	1,484	1,906	16,806	5,827	31
31.01	NICU							31.01
40	Subprovider - IPF	1,757	11,178	929	1,193	624	1,343	40
43	Nursery	1,286		756	971	2,085	382	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,068		2,105	2,703	29,968	6,487	50
52	Delivery Room & Labor Room	1,061		3,300	4,238	11,779	6,292	52
53	Anesthesiology	222		193		3,089	377	53
54	Radiology-Diagnostic	1,888		1,550		1,341	10	54
56.01	NUCLEAR MEDICINE	196		161		140	1	56.01
57	CT Scan	946		777		672	5	57
58	MRI	214		176		152	1	58
59	Cardiac Catheterization							59
60	Laboratory	2,710		52			492	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	813		1,393		7,093	53	65
66	Physical Therapy	861		377		207		66
69	Electrocardiology	1,054		402		291		69
70	Electroencephalography	144				59		70
71	Medical Supplies Charged to Patients					33,784		71
72	Impl. Dev. Charged to Patients					65,044		72
73	Drugs Charged to Patients						129,244	73
75.01	ACUTE DIALYSIS							75.01
75.02	CARD CATH LAB	708		358		11,042	5,087	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	2,623		3,942	5,062	3,807	7,361	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	398		133		227	714	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	1,073		770		3,077	1,010	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	2,506		3,106	3,988	23,827	7,198	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
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
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	53,884	130,615	44,283	40,648	238,726	189,434	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	208						190
192	Physicians' Private Offices	15,042		458		84	152	192
192.01	PROHEALTH SERVICES			627		307	772	192.01

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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	
192.02	AUXILIARY			370		1,254	41	192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	69,134	130,615	45,738	40,648	240,371	190,399	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	
	GENERAL SERVICE COST CENTERS							
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	82,649						16
17	Social Service		5,779					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			852				21
22	I&R Services-Other Prgm Costs Apprvd				1,362			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	15,027	5,028			1,267,757		30
31	Intensive Care Unit	2,407	231			200,166		31
31.01	NICU							31.01
40	Subprovider - IPF	1,632				94,065		40
43	Nursery	1,927				101,577		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	4,862	173			574,587		50
52	Delivery Room & Labor Room	2,210				569,894		52
53	Anesthesiology	845				50,950		53
54	Radiology-Diagnostic	4,446				330,854		54
56.01	NUCLEAR MEDICINE	463				32,633		56.01
57	CT Scan	2,227				165,400		57
58	MRI	505				35,949		58
59	Cardiac Catheterization	1,865				12,450		59
60	Laboratory	11,385				365,537		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,563				91,892		65
66	Physical Therapy	614				60,689		66
69	Electrocardiology	1,350				71,726		69
70	Electroencephalography	29				29,541		70
71	Medical Supplies Charged to Patients	209				36,204		71
72	Impl. Dev. Charged to Patients	1,027				73,127		72
73	Drugs Charged to Patients	12,694				201,941		73
75.01	ACUTE DIALYSIS	570				3,503		75.01
75.02	CARD CATH LAB					140,246		75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	1,941				236,759		90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	78				15,734		90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	2,036				60,991		90.04
90.05	FAMILY PRACTICE CLINIC					2,105		90.05
91	Emergency	10,737	347			230,894		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
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
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	82,649	5,779			5,057,171		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					7,126		190
192	Physicians' Private Offices					516,185		192
192.01	PROHEALTH SERVICES					11,642		192.01

KPMG LLP Compu-Max 2552-10

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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	
192.02	AUXILIARY					11,423		192.02
200	Cross Foot Adjustments			852	1,362	2,214		200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	82,649	5,779	852	1,362	5,605,761		202

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	TOTAL					
		26					
	GENERAL SERVICE COST CENTERS						
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
	INPATIENT ROUTINE SERV COST CENTERS						
30	Adults & Pediatrics	1,267,757					30
31	Intensive Care Unit	200,166					31
31.01	NICU						31.01
40	Subprovider - IPF	94,065					40
43	Nursery	101,577					43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	574,587					50
52	Delivery Room & Labor Room	569,894					52
53	Anesthesiology	50,950					53
54	Radiology-Diagnostic	330,854					54
56.01	NUCLEAR MEDICINE	32,633					56.01
57	CT Scan	165,400					57
58	MRI	35,949					58
59	Cardiac Catheterization	12,450					59
60	Laboratory	365,537					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	91,892					65
66	Physical Therapy	60,689					66
69	Electrocardiology	71,726					69
70	Electroencephalography	29,541					70
71	Medical Supplies Charged to Patients	36,204					71
72	Impl. Dev. Charged to Patients	73,127					72
73	Drugs Charged to Patients	201,941					73
75.01	ACUTE DIALYSIS	3,503					75.01
75.02	CARD CATH LAB	140,246					75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	236,759					90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	15,734					90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	60,991					90.04
90.05	FAMILY PRACTICE CLINIC	2,105					90.05
91	Emergency	230,894					91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
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
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)	5,057,171					118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	7,126					190
192	Physicians' Private Offices	516,185					192
192.01	PROHEALTH SERVICES	11,642					192.01

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
192.02	AUXILIARY	11,423						192.02
200	Cross Foot Adjustments	2,214						200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,605,761						202

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET)	NEW CAP-REL COSTS MOV EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON PATIENT PHONES (NUMBER OF PHONES)	DATA PROCESSING (MACHINE TIME)	ADMITTING INPATIENT REVENUE	
		1	2	4	4.01	4.02	4.03	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	260,059						1
2	Cap Rel Costs-Mvble Equip		4,598,962					2
4	Employee Benefits Department	3,020	448	45,569,799				4
4.01	COMMUNICATIONS	403		202,529	386			4.01
4.02	DATA PROCESSING	6,358	1,557,455	1,348,139	23	110		4.02
4.03	ADMITTING	6,014	6,898	757,732	6	9	183,365,420	4.03
4.04	CASHIERING	1,440	3,576	732,175	31	13		4.04
5	Administrative & General	5,503	57,346	5,941,139	62	8		5
6	Maintenance & Repairs							6
7	Operation of Plant	21,811	649,204	1,398,753	18	1		7
8	Laundry & Linen Service	3,682						8
9	Housekeeping	3,524	3,452	1,111,187		2		9
10	Dietary	7,456	24,078	564,498	11	2		10
11	Cafeteria	3,378	8,412	183,754	1			11
12	Maintenance of Personnel							12
13	Nursing Administration	2,413	10,141	1,224,592	8			13
14	Central Services & Supply	11,064	53,338	424,809	1	6		14
15	Pharmacy	4,836	57,633	1,427,736	10	7		15
16	Medical Records & Library	4,978	10,132	639,628	22	1		16
17	Social Service	153	373	627,153	8			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			127,127	1			21
22	I&R Services-Other Prgm Costs Apprvd	120						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	41,731	381,958	9,601,854	38	14	51,665,390	30
31	Intensive Care Unit	6,295	53,068	1,552,222		2	9,116,787	31
31.01	NICU							31.01
40	Subprovider - IPF	5,293	6,232	926,632			6,181,582	40
43	Nursery	3,876	14,782	1,162,313	3	2	7,301,092	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	18,284	307,635	2,030,250	24	4	7,536,352	50
52	Delivery Room & Labor Room	3,198	584,527	2,281,476	2	2	6,684,119	52
53	Anesthesiology	668	44,839	391,035	3		1,479,583	53
54	Radiology-Diagnostic	5,690	276,612	1,219,647	12	2	3,518,332	54
56.01	NUCLEAR MEDICINE	592	28,785	118,250	1		961,167	56.01
57	CT Scan	2,850	138,556	329,724	6	1	2,371,984	57
58	MRI	646	31,424	278,053	1		613,397	58
59	Cardiac Catheterization			434,302			4,289,627	59
60	Laboratory	8,165	838	26,054	24	18	23,654,599	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	2,449	25,431	817,675	5	2	5,049,125	65
66	Physical Therapy	2,593	3,976	302,393	3	2	702,017	66
69	Electrocardiology	3,177	5,826	211,897	8	2	2,570,139	69
70	Electroencephalography	435	1,475			2	75,473	70
71	Medical Supplies Charged to Patients						273,829	71
72	Impl. Dev. Charged to Patients						2,404,710	72
73	Drugs Charged to Patients						32,932,157	73
75.01	ACUTE DIALYSIS						2,021,250	75.01
75.02	CARD CATH LAB	2,133	127,571					75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	7,902	52,752	3,341,118	7	6	40,217	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	1,200		182,104	5		639	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	3,234	14,004	416,403	5		698,997	90.04
90.05	FAMILY PRACTICE CLINIC		2,690					90.05
91	Emergency	7,552	32,837	2,345,925	12	2	11,222,856	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
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
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	214,116	4,578,304	44,680,278	361	110	183,365,420	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	627			1			190
192	Physicians' Private Offices	45,316	222	239,848	19			192

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET)	NEW CAP-REL COSTS MOV EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON PATIENT PHONES (NUMBER OF PHONES)	DATA PROCESSING (MACHINE TIME)	ADMITTING INPATIENT REVENUE	
		1	2	4	4.01	4.02	4.03	
192.01	PROHEALTH SERVICES		9,343	414,528	5			192.01
192.02	AUXILIARY		11,093	235,145				192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,015,562	3,590,199	1,108,466	286,277	5,246,632	1,518,984	202
203	Unit Cost Multiplier (Wkst. B, Part I)	7.750403	0.780654	0.024325	741.650259	47.696.654545	0.008284	203
204	Cost to be allocated (Per Wkst. B, Part II)			23,756	3,229	1,266,005	156,023	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000521	8.365285	11,509.136364	0.000851	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	
	GENERAL SERVICE COST CENTERS							
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	312,595,554						4.04
5	Administrative & General		-12,557,292	80,213,344				5
6	Maintenance & Repairs							6
7	Operation of Plant			5,230,853	215,510			7
8	Laundry & Linen Service			424,384	3,682	309,685		8
9	Housekeeping			1,787,543	3,524		208,304	9
10	Dietary			1,720,429	7,456		7,456	10
11	Cafeteria			346,235	3,378		3,378	11
12	Maintenance of Personnel							12
13	Nursing Administration			1,566,394	2,413		2,413	13
14	Central Services & Supply			1,368,634	11,064		11,064	14
15	Pharmacy			2,880,134	4,836		4,836	15
16	Medical Records & Library			2,281,910	4,978		4,978	16
17	Social Service			1,189,444	153		153	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			210,646				21
22	I&R Services-Other Prgm Costs Apprvd			930	120		120	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	56,453,199		16,848,931	41,731	99,074	41,731	30
31	Intensive Care Unit	9,116,787		3,787,964	6,295	13,209	6,295	31
31.01	NICU							31.01
40	Subprovider - IPF	6,181,582		1,460,897	5,293		5,293	40
43	Nursery	7,301,092		1,790,164	3,876	16,535	3,876	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	18,414,927		4,408,923	18,284	56,083	18,284	50
52	Delivery Room & Labor Room	8,371,971		3,898,128	3,198	47,186	3,198	52
53	Anesthesiology	3,199,616		308,882	668		668	53
54	Radiology-Diagnostic	16,839,466		2,527,405	5,690	12,972	5,690	54
56.01	NUCLEAR MEDICINE	1,752,368		307,253	592	1,350	592	56.01
57	CT Scan	8,434,935		969,477	2,850	6,498	2,850	57
58	MRI	1,913,044		607,946	646	1,474	646	58
59	Cardiac Catheterization	7,065,474		1,313,938				59
60	Laboratory	43,124,814		4,503,241	8,165		8,165	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,919,893		1,443,241	2,449		2,449	65
66	Physical Therapy	2,327,345		532,971	2,593	5,730	2,593	66
69	Electrocardiology	5,114,446		468,244	3,177		3,177	69
70	Electroencephalography	108,942		102,928	435		435	70
71	Medical Supplies Charged to Patients	790,735		684,766				71
72	Impl. Dev. Charged to Patients	3,890,511		1,299,452				72
73	Drugs Charged to Patients	48,082,365		2,950,248				73
75.01	ACUTE DIALYSIS	2,160,834		34,750				75.01
75.02	CARD CATH LAB		101,826		2,133		2,133	75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	7,353,762		3,321,821	7,902	11,883	7,902	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	295,653		273,989	1,200	494	1,200	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	7,710,298		612,388	3,234	1,652	3,234	90.04
90.05	FAMILY PRACTICE CLINIC			2,100				90.05
91	Emergency	40,671,495		4,590,660	7,552	35,545	7,552	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
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
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	312,595,554	-12,455,466	78,058,243	169,567	309,685	162,361	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			5,602	627		627	190
192	Physicians' Private Offices			678,053	45,316		45,316	192

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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	
192.01	PROHEALTH SERVICES			1,044,381				192.01
192.02	AUXILIARY			427,065				192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,403,694		12,557,292	6,049,738	594,181	2,166,306	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.007689		0.156549	28.071728	1.918663	10.399733	203
204	Cost to be allocated (Per Wkst. B, Part II)	164,212		183,105	700,179	41,469	69,134	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000525		0.002283	3.248940	0.133907	0.331890	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	
	GENERAL SERVICE COST CENTERS							
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	118,449						10
11	Cafeteria		48,157					11
12	Maintenance of Personnel							12
13	Nursing Administration		1,166	33,326				13
14	Central Services & Supply		1,006		4,815,212			14
15	Pharmacy		2,316		8,879	3,399,704		15
16	Medical Records & Library		1,146		156		312,595,554	16
17	Social Service		678		9			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		309		86			21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	97,467	16,878	16,878	463,897	313,363	56,453,199	30
31	Intensive Care Unit	10,845	1,563	1,563	336,669	104,052	9,116,787	31
31.01	NICU							31.01
40	Subprovider - IPF	10,137	978	978	12,503	23,979	6,181,582	40
43	Nursery		796	796	41,758	6,819	7,301,092	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		2,216	2,216	600,336	115,830	18,414,927	50
52	Delivery Room & Labor Room		3,475	3,475	235,963	112,350	8,371,971	52
53	Anesthesiology		203		61,885	6,729	3,199,616	53
54	Radiology-Diagnostic		1,632		26,867	187	16,839,466	54
56.01	NUCLEAR MEDICINE		170		2,796	19	1,752,368	56.01
57	CT Scan		818		13,458	94	8,434,935	57
58	MRI		185		3,052	21	1,913,044	58
59	Cardiac Catheterization						7,065,474	59
60	Laboratory		55			8,788	43,124,814	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,467		142,084	955	5,919,893	65
66	Physical Therapy		397		4,153		2,327,345	66
69	Electrocardiology		423		5,832		5,114,446	69
70	Electroencephalography				1,188		108,942	70
71	Medical Supplies Charged to Patients				676,779		790,735	71
72	Impl. Dev. Charged to Patients				1,302,962		3,890,511	72
73	Drugs Charged to Patients					2,307,733	48,082,365	73
75.01	ACUTE DIALYSIS						2,160,834	75.01
75.02	CARD CATH LAB		377		221,193	90,824		75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic		4,150	4,150	76,264	131,431	7,353,762	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC		140		4,552	12,745	295,653	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY		811		61,631	18,039	7,710,298	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency		3,270	3,270	477,310	128,521	40,671,495	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
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
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	118,449	46,625	33,326	4,782,262	3,382,479	312,595,554	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices		482		1,675	2,713		192

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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	
192.01	PROHEALTH SERVICES		660		6,155	13,783		192.01
192.02	AUXILIARY		390		25,120	729		192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,276,603	530,394	1,917,285	2,019,621	3,546,296	2,843,339	202
203	Unit Cost Multiplier (Wkst. B, Part I)	19.220112	11.013851	57.531207	0.419425	1.043119	0.009096	203
204	Cost to be allocated (Per Wkst. B, Part II)	130,615	45,738	40,648	240,371	190,399	82,649	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.102711	0.949768	1.219708	0.049919	0.056005	0.000264	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				

GENERAL SERVICE COST CENTERS							
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
INPATIENT ROUTINE SERV COST CENTERS							
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
ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3					50
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
56.01	NUCLEAR MEDICINE						56.01
57	CT Scan						57
58	MRI						58
59	Cardiac Catheterization						59
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
OUTPATIENT SERVICE COST CENTERS							
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
OTHER REIMBURSABLE COST CENTERS							
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
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	100	100	100			118
NONREIMBURSABLE COST CENTERS							

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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				
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices							192
192.01	PROHEALTH SERVICES							192.01
192.02	AUXILIARY							192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,389,007	247,061	5,693				202
203	Unit Cost Multiplier (Wkst. B, Part I)	13,890.070000	2,470.610000	56.930000				203
204	Cost to be allocated (Per Wkst. B, Part II)	5,779	852	1,362				204
205	Unit Cost Multiplier (Wkst. B, Part II)	57.790000	8.520000	13.620000				205

KPMG LLP Compu-Max 2552-10

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	26,555,710		26,555,710		26,555,710	30
31	Intensive Care Unit	5,352,298		5,352,298		5,352,298	31
31.01	NICU						31.01
40	Subprovider - IPF	2,241,586		2,241,586		2,241,586	40
43	Nursery	2,396,852		2,396,852		2,396,852	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	6,643,839		6,643,839		6,643,839	50
52	Delivery Room & Labor Room	5,252,449		5,252,449		5,252,449	52
53	Anesthesiology	447,251		447,251		447,251	53
54	Radiology-Diagnostic	3,349,470		3,349,470		3,349,470	54
56.01	NUCLEAR MEDICINE	399,723		399,723		399,723	56.01
57	CT Scan	1,334,834		1,334,834		1,334,834	57
58	MRI	751,540		751,540		751,540	58
59	Cardiac Catheterization	1,583,902		1,583,902		1,583,902	59
60	Laboratory	5,924,375		5,924,375		5,924,375	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	1,893,990		1,893,990		1,893,990	65
66	Physical Therapy	754,442		754,442		754,442	66
69	Electrocardiology	717,397		717,397		717,397	69
70	Electroencephalography	137,265		137,265		137,265	70
71	Medical Supplies Charged to Patients	1,083,016		1,083,016		1,083,016	71
72	Impl. Dev. Charged to Patients	2,084,762		2,084,762		2,084,762	72
73	Drugs Charged to Patients	6,256,704		6,256,704		6,256,704	73
75.01	ACUTE DIALYSIS	59,845		59,845		59,845	75.01
75.02	CARD CATH LAB	171,900		171,900		171,900	75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	4,689,087		4,689,087		4,689,087	90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	383,431		383,431		383,431	90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	959,576		959,576		959,576	90.04
90.05	FAMILY PRACTICE CLINIC	2,429		2,429		2,429	90.05
91	Emergency	6,679,748		6,679,748		6,679,748	91
92	Observation Beds (Non-Distinct Part)	1,530,602		1,530,602		1,530,602	92
	OTHER REIMBURSABLE COST CENTERS						
99.10	CORF						99.10
99.20	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	OUTPATIENT SPEECH PATHOLOGY						99.40
200	Subtotal (sum of lines 30 thru 199)	89,638,023		89,638,023		89,638,023	200
201	Less Observation Beds	1,530,602		1,530,602		1,530,602	201
202	Total (line 200 minus line 201)	88,107,421		88,107,421		88,107,421	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				
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	51,665,390		51,665,390				30
31	Intensive Care Unit	9,116,787		9,116,787				31
31.01	NICU							31.01
40	Subprovider - IPF	6,181,582		6,181,582				40
43	Nursery	7,301,092		7,301,092				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,536,352	10,878,575	18,414,927	0.360786	0.360786	0.360786	50
52	Delivery Room & Labor Room	6,684,119	1,687,852	8,371,971	0.627385	0.627385	0.627385	52
53	Anesthesiology	1,479,583	1,720,033	3,199,616	0.139783	0.139783	0.139783	53
54	Radiology-Diagnostic	3,518,332	13,321,134	16,839,466	0.198906	0.198906	0.198906	54
56.01	NUCLEAR MEDICINE	961,167	791,201	1,752,368	0.228104	0.228104	0.228104	56.01
57	CT Scan	2,371,984	6,062,951	8,434,935	0.158251	0.158251	0.158251	57
58	MRI	613,397	1,299,647	1,913,044	0.392850	0.392850	0.392850	58
59	Cardiac Catheterization	4,289,627	2,775,847	7,065,474	0.224175	0.224175	0.224175	59
60	Laboratory	23,654,599	19,470,215	43,124,814	0.137377	0.137377	0.137377	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	5,049,125	870,768	5,919,893	0.319937	0.319937	0.319937	65
66	Physical Therapy	702,017	1,625,328	2,327,345	0.324164	0.324164	0.324164	66
69	Electrocardiology	2,570,139	2,544,307	5,114,446	0.140269	0.140269	0.140269	69
70	Electroencephalography	75,473	33,469	108,942	1.259982	1.259982	1.259982	70
71	Medical Supplies Charged to Patients	273,829	516,906	790,735	1.369632	1.369632	1.369632	71
72	Impl. Dev. Charged to Patients	2,404,710	1,485,801	3,890,511	0.535858	0.535858	0.535858	72
73	Drugs Charged to Patients	32,932,157	15,150,208	48,082,365	0.130125	0.130125	0.130125	73
75.01	ACUTE DIALYSIS	2,021,250	139,584	2,160,834	0.027695	0.027695	0.027695	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
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	40,217	7,313,545	7,353,762	0.637645	0.637645	0.637645	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	639	295,014	295,653	1.296895	1.296895	1.296895	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	698,997	7,011,301	7,710,298	0.124454	0.124454	0.124454	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	11,222,856	29,448,639	40,671,495	0.164237	0.164237	0.164237	91
92	Observation Beds (Non-Distinct Part)	774,995	4,012,814	4,787,809	0.319687	0.319687	0.319687	92
	OTHER REIMBURSABLE COST CENTERS							
99.10	CORF							99.10
99.20	OUTPATIENT PHYSICAL THERAPY							99.20
99.30	OUTPATIENT OCCUPATIONAL THERAPY							99.30
99.40	OUTPATIENT SPEECH PATHOLOGY							99.40
200	Subtotal (sum of lines 30 thru 199)	184,140,415	128,455,139	312,595,554				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	184,140,415	128,455,139	312,595,554				202

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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	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,267,757		1,267,757	34,162	37.11	7,848	291,239	30
31	Intensive Care Unit	200,166		200,166	3,615	55.37	1,252	69,323	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	94,065		94,065	3,379	27.84	849	23,636	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	101,577		101,577	2,843	35.73			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,663,565		1,663,565	43,999		9,949	384,198	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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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	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	574,587	18,414,927	0.031202	2,226,341	69,466	50
52	Delivery Room & Labor Room	569,894	8,371,971	0.068072	28,875	1,966	52
53	Anesthesiology	50,950	3,199,616	0.015924	438,813	6,988	53
54	Radiology-Diagnostic	330,854	16,839,466	0.019648	1,259,318	24,743	54
56.01	NUCLEAR MEDICINE	32,633	1,752,368	0.018622	288,434	5,371	56.01
57	CT Scan	165,400	8,434,935	0.019609	910,636	17,857	57
58	MRI	35,949	1,913,044	0.018792	242,343	4,554	58
59	Cardiac Catheterization	12,450	7,065,474	0.001762	1,652,002	2,911	59
60	Laboratory	365,537	43,124,814	0.008476	7,161,342	60,700	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	91,892	5,919,893	0.015523	1,483,808	23,033	65
66	Physical Therapy	60,689	2,327,345	0.026076	299,328	7,805	66
69	Electrocardiology	71,726	5,114,446	0.014024	891,300	12,500	69
70	Electroencephalography	29,541	108,942	0.271163	28,254	7,661	70
71	Medical Supplies Charged to Pat	36,204	790,735	0.045785	123,560	5,657	71
72	Impl. Dev. Charged to Patients	73,127	3,890,511	0.018796	946,952	17,799	72
73	Drugs Charged to Patients	201,941	48,082,365	0.004200	10,004,271	42,018	73
75.01	ACUTE DIALYSIS	3,503	2,160,834	0.001621	911,897	1,478	75.01
75.02	CARD CATH LAB	140,246					75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	236,759	7,353,762	0.032196	20,792	669	90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	15,734	295,653	0.053218			90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	60,991	7,710,298	0.007910	206,363	1,632	90.04
90.05	FAMILY PRACTICE CLINIC	2,105					90.05
91	Emergency	230,894	40,671,495	0.005677	2,856,450	16,216	91
92	Observation Beds (Non-Distinct	73,071	4,787,809	0.015262	217,019	3,312	92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,466,677	238,330,703		32,198,098	334,336	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6		7		8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	34,162		7,848		30
31	Intensive Care Unit	3,615		1,252		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	3,379		849		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	2,843				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	43,999		9,949		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0206

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56.01	NUCLEAR MEDICINE							56.01
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75.01	ACUTE DIALYSIS							75.01
75.02	CARD CATH LAB							75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC							90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY							90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0206

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS									
50	Operating Room	18,414,927			2,226,341		2,456,660		50
52	Delivery Room & Labor Room	8,371,971			28,875		7,303		52
53	Anesthesiology	3,199,616			438,813		331,015		53
54	Radiology-Diagnostic	16,839,466			1,259,318		1,202,566		54
56.01	NUCLEAR MEDICINE	1,752,368			288,434		234,231		56.01
57	CT Scan	8,434,935			910,636		1,016,394		57
58	MRI	1,913,044			242,343		228,637		58
59	Cardiac Catheterization	7,065,474			1,652,002		1,945,382		59
60	Laboratory	43,124,814			7,161,342		2,148,078		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,919,893			1,483,808		117,250		65
66	Physical Therapy	2,327,345			299,328		95		66
69	Electrocardiology	5,114,446			891,300		675,552		69
70	Electroencephalography	108,942			28,254		15,111		70
71	Medical Supplies Charged to Pat	790,735			123,560		266,109		71
72	Impl. Dev. Charged to Patients	3,890,511			946,952		1,024,583		72
73	Drugs Charged to Patients	48,082,365			10,004,271		5,256,285		73
75.01	ACUTE DIALYSIS	2,160,834			911,897		37,393		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
OUTPATIENT SERVICE COST CENTERS									
90	Clinic	7,353,762			20,792		2,404,725		90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	295,653					973		90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	7,710,298			206,363		1,896,304		90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	40,671,495			2,856,450		2,577,881		91
92	Observation Beds (Non-Distinct)	4,787,809			217,019		853,470		92
OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)	238,330,703			32,198,098		24,695,997		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0206

WORKSHEET D
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	0.360786	2,456,660			886,329			50
52	Delivery Room & Labor Room	0.627385	7,303			4,582			52
53	Anesthesiology	0.139783	331,015			46,270			53
54	Radiology-Diagnostic	0.198906	1,202,566			239,198			54
56.01	NUCLEAR MEDICINE	0.228104	234,231			53,429			56.01
57	CT Scan	0.158251	1,016,394			160,845			57
58	MRI	0.392850	228,637			89,820			58
59	Cardiac Catheterization	0.224175	1,945,382			436,106			59
60	Laboratory	0.137377	2,148,078	188		295,097	26		60
62.30	BLOOD CLOTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.319937	117,250			37,513			65
66	Physical Therapy	0.324164	95			31			66
69	Electrocardiology	0.140269	675,552			94,759			69
70	Electroencephalography	1.259982	15,111			19,040			70
71	Medical Supplies Charged to Pat	1.369632	266,109			364,471			71
72	Impl. Dev. Charged to Patients	0.535858	1,024,583			549,031			72
73	Drugs Charged to Patients	0.130125	5,256,285		16,541	683,974		2,152	73
75.01	ACUTE DIALYSIS	0.027695	37,393			1,036			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
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	0.637645	2,404,725			1,533,361			90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	1.296895	973			1,262			90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	0.124454	1,896,304			236,003			90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	0.164237	2,577,881			423,383			91
92	Observation Beds (Non-Distinct)	0.319687	853,470			272,843			92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		24,695,997	188	16,541	6,428,383	26	2,152	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		24,695,997	188	16,541	6,428,383	26	2,152	202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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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	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	574,587	18,414,927	0.031202			50
52	Delivery Room & Labor Room	569,894	8,371,971	0.068072			52
53	Anesthesiology	50,950	3,199,616	0.015924			53
54	Radiology-Diagnostic	330,854	16,839,466	0.019648	21,657	426	54
56.01	NUCLEAR MEDICINE	32,633	1,752,368	0.018622			56.01
57	CT Scan	165,400	8,434,935	0.019609			57
58	MRI	35,949	1,913,044	0.018792			58
59	Cardiac Catheterization	12,450	7,065,474	0.001762			59
60	Laboratory	365,537	43,124,814	0.008476	208,123	1,764	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	91,892	5,919,893	0.015523	924	14	65
66	Physical Therapy	60,689	2,327,345	0.026076	1,216	32	66
69	Electrocardiology	71,726	5,114,446	0.014024	16,234	228	69
70	Electroencephalography	29,541	108,942	0.271163			70
71	Medical Supplies Charged to Pat	36,204	790,735	0.045785			71
72	Impl. Dev. Charged to Patients	73,127	3,890,511	0.018796			72
73	Drugs Charged to Patients	201,941	48,082,365	0.004200	335,042	1,407	73
75.01	ACUTE DIALYSIS	3,503	2,160,834	0.001621			75.01
75.02	CARD CATH LAB	140,246					75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	236,759	7,353,762	0.032196	1,188	38	90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	15,734	295,653	0.053218			90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	60,991	7,710,298	0.007910	1,074	8	90.04
90.05	FAMILY PRACTICE CLINIC	2,105					90.05
91	Emergency	230,894	40,671,495	0.005677	151,689	861	91
92	Observation Beds (Non-Distinct		4,787,809				92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,393,606	238,330,703		737,147	4,778	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S206

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56.01	NUCLEAR MEDICINE							56.01
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75.01	ACUTE DIALYSIS							75.01
75.02	CARD CATH LAB							75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC							90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY							90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S206

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS									
50	Operating Room	18,414,927							50
52	Delivery Room & Labor Room	8,371,971							52
53	Anesthesiology	3,199,616							53
54	Radiology-Diagnostic	16,839,466			21,657		1,303		54
56.01	NUCLEAR MEDICINE	1,752,368							56.01
57	CT Scan	8,434,935							57
58	MRI	1,913,044							58
59	Cardiac Catheterization	7,065,474							59
60	Laboratory	43,124,814			208,123				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,919,893			924				65
66	Physical Therapy	2,327,345			1,216				66
69	Electrocardiology	5,114,446			16,234		3,014		69
70	Electroencephalography	108,942							70
71	Medical Supplies Charged to Pat	790,735							71
72	Impl. Dev. Charged to Patients	3,890,511							72
73	Drugs Charged to Patients	48,082,365			335,042				73
75.01	ACUTE DIALYSIS	2,160,834							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
OUTPATIENT SERVICE COST CENTERS									
90	Clinic	7,353,762			1,188				90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	295,653							90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	7,710,298			1,074				90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	40,671,495			151,689				91
92	Observation Beds (Non-Distinct)	4,787,809							92
OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)	238,330,703			737,147		4,317		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S206

**WORKSHEET D
PART V**

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

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.360786						50
52	Delivery Room & Labor Room	0.627385						52
53	Anesthesiology	0.139783						53
54	Radiology-Diagnostic	0.198906	1,303			259		54
56.01	NUCLEAR MEDICINE	0.228104						56.01
57	CT Scan	0.158251						57
58	MRI	0.392850						58
59	Cardiac Catheterization	0.224175						59
60	Laboratory	0.137377						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.319937						65
66	Physical Therapy	0.324164						66
69	Electrocardiology	0.140269	3,014			423		69
70	Electroencephalography	1.259982						70
71	Medical Supplies Charged to Pat	1.369632						71
72	Impl. Dev. Charged to Patients	0.535858						72
73	Drugs Charged to Patients	0.130125						73
75.01	ACUTE DIALYSIS	0.027695						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
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	0.637645						90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	1.296895						90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	0.124454						90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	0.164237						91
92	Observation Beds (Non-Distinct)	0.319687						92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)		4,317			682		200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)		4,317			682		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, (col. 26))	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	1,267,757		1,267,757	34,162	37.11	10,278	381,417	30
31	Intensive Care Unit	200,166		200,166	3,615	55.37	1,174	65,004	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	94,065		94,065	3,379	27.84	1,010	28,118	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	101,577		101,577	2,843	35.73	923	32,979	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,663,565		1,663,565	43,999		13,385	507,518	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0206

WORKSHEET D
PART II

Check Title V Hospital SUB (Other)
 Applicable Title XVIII, Part A IPF
 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	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	574,587	18,414,927	0.031202			50
52	Delivery Room & Labor Room	569,894	8,371,971	0.068072			52
53	Anesthesiology	50,950	3,199,616	0.015924			53
54	Radiology-Diagnostic	330,854	16,839,466	0.019648			54
56.01	NUCLEAR MEDICINE	32,633	1,752,368	0.018622			56.01
57	CT Scan	165,400	8,434,935	0.019609			57
58	MRI	35,949	1,913,044	0.018792			58
59	Cardiac Catheterization	12,450	7,065,474	0.001762			59
60	Laboratory	365,537	43,124,814	0.008476			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	91,892	5,919,893	0.015523			65
66	Physical Therapy	60,689	2,327,345	0.026076			66
69	Electrocardiology	71,726	5,114,446	0.014024			69
70	Electroencephalography	29,541	108,942	0.271163			70
71	Medical Supplies Charged to Pat	36,204	790,735	0.045785			71
72	Impl. Dev. Charged to Patients	73,127	3,890,511	0.018796			72
73	Drugs Charged to Patients	201,941	48,082,365	0.004200			73
75.01	ACUTE DIALYSIS	3,503	2,160,834	0.001621			75.01
75.02	CARD CATH LAB	140,246					75.02
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90	Clinic	236,759	7,353,762	0.032196			90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	15,734	295,653	0.053218			90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	60,991	7,710,298	0.007910			90.04
90.05	FAMILY PRACTICE CLINIC	2,105					90.05
91	Emergency	230,894	40,671,495	0.005677			91
92	Observation Beds (Non-Distinct	73,071	4,787,809	0.015262			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,466,677	238,330,703				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

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

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
6	7	8	9			
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	34,162		10,278		30
31	Intensive Care Unit	3,615		1,174		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	3,379		1,010		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	2,843		923		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	43,999		13,385		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0206

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesth- etist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56.01	NUCLEAR MEDICINE							56.01
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75.01	ACUTE DIALYSIS							75.01
75.02	CARD CATH LAB							75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC							90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY							90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0206

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
ANCILLARY SERVICE COST CENTERS									
50	Operating Room	18,414,927							50
52	Delivery Room & Labor Room	8,371,971							52
53	Anesthesiology	3,199,616							53
54	Radiology-Diagnostic	16,839,466							54
56.01	NUCLEAR MEDICINE	1,752,368							56.01
57	CT Scan	8,434,935							57
58	MRI	1,913,044							58
59	Cardiac Catheterization	7,065,474							59
60	Laboratory	43,124,814							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,919,893							65
66	Physical Therapy	2,327,345							66
69	Electrocardiology	5,114,446							69
70	Electroencephalography	108,942							70
71	Medical Supplies Charged to Pat	790,735							71
72	Impl. Dev. Charged to Patients	3,890,511							72
73	Drugs Charged to Patients	48,082,365							73
75.01	ACUTE DIALYSIS	2,160,834							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
OUTPATIENT SERVICE COST CENTERS									
90	Clinic	7,353,762							90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	295,653							90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	7,710,298							90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	40,671,495							91
92	Observation Beds (Non-Distinct)	4,787,809							92
OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)	238,330,703							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0206

WORKSHEET D
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.360786						50
52	Delivery Room & Labor Room	0.627385						52
53	Anesthesiology	0.139783						53
54	Radiology-Diagnostic	0.198906						54
56.01	NUCLEAR MEDICINE	0.228104						56.01
57	CT Scan	0.158251						57
58	MRI	0.392850						58
59	Cardiac Catheterization	0.224175						59
60	Laboratory	0.137377						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.319937						65
66	Physical Therapy	0.324164						66
69	Electrocardiology	0.140269						69
70	Electroencephalography	1.259982						70
71	Medical Supplies Charged to Pat	1.369632						71
72	Impl. Dev. Charged to Patients	0.535858						72
73	Drugs Charged to Patients	0.130125						73
75.01	ACUTE DIALYSIS	0.027695						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
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	0.637645						90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	1.296895						90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	0.124454						90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	0.164237						91
92	Observation Beds (Non-Distinct	0.319687						92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S206

WORKSHEET D
PART II

Check Title V Hospital SUB (Other)
 Applicable Title XVIII, Part A IPF
 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
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	574,587	18,414,927	0.031202		50
52	Delivery Room & Labor Room	569,894	8,371,971	0.068072		52
53	Anesthesiology	50,950	3,199,616	0.015924		53
54	Radiology-Diagnostic	330,854	16,839,466	0.019648		54
56.01	NUCLEAR MEDICINE	32,633	1,752,368	0.018622		56.01
57	CT Scan	165,400	8,434,935	0.019609		57
58	MRI	35,949	1,913,044	0.018792		58
59	Cardiac Catheterization	12,450	7,065,474	0.001762		59
60	Laboratory	365,537	43,124,814	0.008476		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	91,892	5,919,893	0.015523		65
66	Physical Therapy	60,689	2,327,345	0.026076		66
69	Electrocardiology	71,726	5,114,446	0.014024		69
70	Electroencephalography	29,541	108,942	0.271163		70
71	Medical Supplies Charged to Pat	36,204	790,735	0.045785		71
72	Impl. Dev. Charged to Patients	73,127	3,890,511	0.018796		72
73	Drugs Charged to Patients	201,941	48,082,365	0.004200		73
75.01	ACUTE DIALYSIS	3,503	2,160,834	0.001621		75.01
75.02	CARD CATH LAB	140,246				75.02
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90	Clinic	236,759	7,353,762	0.032196		90
90.01	PH CLINIC					90.01
90.02	HEALTHWORKS CLINIC	15,734	295,653	0.053218		90.02
90.03	DENTAL CLINIC					90.03
90.04	WOUND CARE THERAPY	60,991	7,710,298	0.007910		90.04
90.05	FAMILY PRACTICE CLINIC	2,105				90.05
91	Emergency	230,894	40,671,495	0.005677		91
92	Observation Beds (Non-Distinct		4,787,809			92
	OTHER REIMBURSABLE COST CENTERS					
200	Total (sum of lines 50-199)	3,393,606	238,330,703			200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S206

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1 Non Physician Anesth- etist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 Total Outpatient Cost (sum of col. 2, 3, and 4)	
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room							50
52	Delivery Room & Labor Room							52
53	Anesthesiology							53
54	Radiology-Diagnostic							54
56.01	NUCLEAR MEDICINE							56.01
57	CT Scan							57
58	MRI							58
59	Cardiac Catheterization							59
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
70	Electroencephalography							70
71	Medical Supplies Charged to Pat							71
72	Impl. Dev. Charged to Patients							72
73	Drugs Charged to Patients							73
75.01	ACUTE DIALYSIS							75.01
75.02	CARD CATH LAB							75.02
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic							90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC							90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY							90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency							91
92	Observation Beds (Non-Distinct							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S206

WORKSHEET D
PART IV

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

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
7	8	9	10	11	12	13			
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	18,414,927							50
52	Delivery Room & Labor Room	8,371,971							52
53	Anesthesiology	3,199,616							53
54	Radiology-Diagnostic	16,839,466							54
56.01	NUCLEAR MEDICINE	1,752,368							56.01
57	CT Scan	8,434,935							57
58	MRI	1,913,044							58
59	Cardiac Catheterization	7,065,474							59
60	Laboratory	43,124,814							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	5,919,893							65
66	Physical Therapy	2,327,345							66
69	Electrocardiology	5,114,446							69
70	Electroencephalography	108,942							70
71	Medical Supplies Charged to Pat	790,735							71
72	Impl. Dev. Charged to Patients	3,890,511							72
73	Drugs Charged to Patients	48,082,365							73
75.01	ACUTE DIALYSIS	2,160,834							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
	OUTPATIENT SERVICE COST CENTERS								
90	Clinic	7,353,762							90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	295,653							90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	7,710,298							90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	40,671,495							91
92	Observation Beds (Non-Distinct)	4,787,809							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	238,330,703							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S206

WORKSHEET D
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.360786						50
52	Delivery Room & Labor Room	0.627385						52
53	Anesthesiology	0.139783						53
54	Radiology-Diagnostic	0.198906						54
56.01	NUCLEAR MEDICINE	0.228104						56.01
57	CT Scan	0.158251						57
58	MRI	0.392850						58
59	Cardiac Catheterization	0.224175						59
60	Laboratory	0.137377						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.319937						65
66	Physical Therapy	0.324164						66
69	Electrocardiology	0.140269						69
70	Electroencephalography	1.259982						70
71	Medical Supplies Charged to Pat	1.369632						71
72	Impl. Dev. Charged to Patients	0.535858						72
73	Drugs Charged to Patients	0.130125						73
75.01	ACUTE DIALYSIS	0.027695						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
	OUTPATIENT SERVICE COST CENTERS							
90	Clinic	0.637645						90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	1.296895						90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	0.124454						90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	0.164237						91
92	Observation Beds (Non-Distinct	0.319687						92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)							200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)							202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0206

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	34,162	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	34,162	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)	32,193	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	7,848	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	26,555,710	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	26,555,710	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	26,555,710	37

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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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	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
38	Adjusted general inpatient routine service cost per diem (see instructions)					777.35	38	
39	Program general inpatient routine service cost (line 9 x line 38)					6,100,643	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)					6,100,643	41	
42	Nursery (Titles V and XIX only)						42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	5,352,298	3,615	1,480.58	1,252	1,853,686	43	
43.01	NICU						43.01	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,105,979	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					14,060,308	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					360,562	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					334,336	51
52	Total Program excludable cost (sum of lines 50 and 51)					694,898	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					13,365,410	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0206

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,969	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					777.35	88
89	Observation bed cost (line 87 x line 88) (see instructions)					1,530,602	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,267,757	26,555,710	0.047740	1,530,602	73,071	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S206

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,379	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,379	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)	3,379	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	849	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	2,241,586	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,241,586	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,241,586	37

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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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) [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] 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)	663.39	38
39	Program general inpatient routine service cost (line 9 x line 38)	563,218	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)	563,218	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	105,268	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	668,486	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	23,636	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	4,778	51
52	Total Program excludable cost (sum of lines 50 and 51)	28,414	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	640,072	53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0206

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	34,162	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	34,162	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)	32,193	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	10,278	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	2,843	15
16	Nursery days (title V or XIX only)	923	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)	26,555,710	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	26,555,710	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	26,555,710	37

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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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) [] PPS
 Applicable [] Title XVIII, Part A [] IPF [] TEFRA
 Boxes: [XX] Title XIX - I/P [] IRF [XX] Other

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
38	Adjusted general inpatient routine service cost per diem (see instructions)					777.35	38	
39	Program general inpatient routine service cost (line 9 x line 38)					7,989,603	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)					7,989,603	41	
42	Nursery (Titles V and XIX only)	2,396,852	2,843	843.07	923	778,154	42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	5,352,298	3,615	1,480.58	1,174	1,738,201	43	
43.01	NICU						43.01	
44	Coronary Care Unit						44	
45	Burn Intensive Care Unit						45	
46	Surgical Intensive Care Unit						46	
47	Other Special Care (specify)						47	

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					10,505,958	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					479,400	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					479,400	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0206

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					1,969	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S206

**WORKSHEET D-1
PART I**

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,379	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,379	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)	3,379	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,010	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		20
21	Total general inpatient routine service cost (see instructions)	2,241,586	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		25
26	Total swing-bed cost (see instructions)		26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,241,586	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,241,586	37

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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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)	663.39	38
39	Program general inpatient routine service cost (line 9 x line 38)	670,024	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)	670,024	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	670,024	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	28,118	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51
52	Total Program excludable cost (sum of lines 50 and 51)	28,118	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

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

PROGRAM INPATIENT ROUTINE SWING BED COST

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

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0206

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		12,305,932		30
31	Intensive Care Unit		3,433,276		31
31.01	NICU				31.01
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.360786	2,226,341	803,233	50
52	Delivery Room & Labor Room	0.627385	28,875	18,116	52
53	Anesthesiology	0.139783	438,813	61,339	53
54	Radiology-Diagnostic	0.198906	1,259,318	250,486	54
56.01	NUCLEAR MEDICINE	0.228104	288,434	65,793	56.01
57	CT Scan	0.158251	910,636	144,109	57
58	MRI	0.392850	242,343	95,204	58
59	Cardiac Catheterization	0.224175	1,652,002	370,338	59
60	Laboratory	0.137377	7,161,342	983,804	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.319937	1,483,808	474,725	65
66	Physical Therapy	0.324164	299,328	97,031	66
69	Electrocardiology	0.140269	891,300	125,022	69
70	Electroencephalography	1.259982	28,254	35,600	70
71	Medical Supplies Charged to Patients	1.369632	123,560	169,232	71
72	Impl. Dev. Charged to Patients	0.535858	946,952	507,432	72
73	Drugs Charged to Patients	0.130125	10,004,271	1,301,806	73
75.01	ACUTE DIALYSIS	0.027695	911,897	25,255	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
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.637645	20,792	13,258	90
90.01	PH CLINIC				90.01
90.02	HEALTHWORKS CLINIC	1.296895			90.02
90.03	DENTAL CLINIC				90.03
90.04	WOUND CARE THERAPY	0.124454	206,363	25,683	90.04
90.05	FAMILY PRACTICE CLINIC				90.05
91	Emergency	0.164237	2,856,450	469,135	91
92	Observation Beds (Non-Distinct Part)	0.319687	217,019	69,378	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		32,198,098	6,105,979	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		32,198,098		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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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 [XX] PPS
 Applicable [XX] Title XVIII, Part A [XX] IPF [] SNF [] Swing Bed NF [] TEFRA
 Boxes: [] Title XIX [] IRF [] NF [] ICF/IID [] Other

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
31.01	NICU				31.01
40	Subprovider - IPF		1,499,541		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.360786			50
52	Delivery Room & Labor Room	0.627385			52
53	Anesthesiology	0.139783			53
54	Radiology-Diagnostic	0.198906	21,657	4,308	54
56.01	NUCLEAR MEDICINE	0.228104			56.01
57	CT Scan	0.158251			57
58	MRI	0.392850			58
59	Cardiac Catheterization	0.224175			59
60	Laboratory	0.137377	208,123	28,591	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.319937	924	296	65
66	Physical Therapy	0.324164	1,216	394	66
69	Electrocardiology	0.140269	16,234	2,277	69
70	Electroencephalography	1.259982			70
71	Medical Supplies Charged to Patients	1.369632			71
72	Impl. Dev. Charged to Patients	0.535858			72
73	Drugs Charged to Patients	0.130125	335,042	43,597	73
75.01	ACUTE DIALYSIS	0.027695			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
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.637645	1,188	758	90
90.01	PH CLINIC				90.01
90.02	HEALTHWORKS CLINIC	1.296895			90.02
90.03	DENTAL CLINIC				90.03
90.04	WOUND CARE THERAPY	0.124454	1,074	134	90.04
90.05	FAMILY PRACTICE CLINIC				90.05
91	Emergency	0.164237	151,689	24,913	91
92	Observation Beds (Non-Distinct Part)	0.319687			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		737,147	105,268	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		737,147		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0206

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
31.01	NICU				31.01
40	Subprovider - IPF				40
43	Nursery				43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.360786			50
52	Delivery Room & Labor Room	0.627385			52
53	Anesthesiology	0.139783			53
54	Radiology-Diagnostic	0.198906			54
56.01	NUCLEAR MEDICINE	0.228104			56.01
57	CT Scan	0.158251			57
58	MRI	0.392850			58
59	Cardiac Catheterization	0.224175			59
60	Laboratory	0.137377			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.319937			65
66	Physical Therapy	0.324164			66
69	Electrocardiology	0.140269			69
70	Electroencephalography	1.259982			70
71	Medical Supplies Charged to Patients	1.369632			71
72	Impl. Dev. Charged to Patients	0.535858			72
73	Drugs Charged to Patients	0.130125			73
75.01	ACUTE DIALYSIS	0.027695			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
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.637645			90
90.01	PH CLINIC				90.01
90.02	HEALTHWORKS CLINIC	1.296895			90.02
90.03	DENTAL CLINIC				90.03
90.04	WOUND CARE THERAPY	0.124454			90.04
90.05	FAMILY PRACTICE CLINIC				90.05
91	Emergency	0.164237			91
92	Observation Beds (Non-Distinct Part)	0.319687			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S206

WORKSHEET D-3

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

(A)	COST CENTER DESCRIPTION	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
31	Intensive Care Unit				31
31.01	NICU				31.01
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.360786			50
52	Delivery Room & Labor Room	0.627385			52
53	Anesthesiology	0.139783			53
54	Radiology-Diagnostic	0.198906			54
56.01	NUCLEAR MEDICINE	0.228104			56.01
57	CT Scan	0.158251			57
58	MRI	0.392850			58
59	Cardiac Catheterization	0.224175			59
60	Laboratory	0.137377			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.319937			65
66	Physical Therapy	0.324164			66
69	Electrocardiology	0.140269			69
70	Electroencephalography	1.259982			70
71	Medical Supplies Charged to Patients	1.369632			71
72	Impl. Dev. Charged to Patients	0.535858			72
73	Drugs Charged to Patients	0.130125			73
75.01	ACUTE DIALYSIS	0.027695			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
	OUTPATIENT SERVICE COST CENTERS				
90	Clinic	0.637645			90
90.01	PH CLINIC				90.01
90.02	HEALTHWORKS CLINIC	1.296895			90.02
90.03	DENTAL CLINIC				90.03
90.04	WOUND CARE THERAPY	0.124454			90.04
90.05	FAMILY PRACTICE CLINIC				90.05
91	Emergency	0.164237			91
92	Observation Beds (Non-Distinct Part)	0.319687			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG amounts other than outlier payments				1
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)				1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	10,945,374			1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)				1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)				1.04
2	Outlier payments for discharges (see instructions)	255,026			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
3	Managed care simulated payments				3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	177.61			4
	Indirect Medical Education Adjustment Calculation for Hospitals				
5	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions)	2.68			5
6	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)				6
7	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)				7
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2). If the cost report straddles July 1, 2011 then see instructions.	1.74			7.01
8	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR §413.75(b), §413.79(c)(2)(iv) 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).				8
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.				8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	12.44			8.02
9	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line 8 plus lines (8.01 and 8.02) (see instructions)	13.38			9
10	FTE count for allopathic and osteopathic programs in the current year from your records				10
11	FTE count for residents in dental 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)	0.016891			19
20	Prior year resident to bed ratio (see instructions)	0.016817			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.016817			21
22	IME payment adjustment (see instructions)	100,139			22
22.01	IME payment adjustment - Managed Care (see instructions)				22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA				
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 factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	100,139			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)				29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.2844			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.6113			31
32	Sum of lines 30 and 31	0.8957			32
33	Allowable disproportionate share percentage (see instructions)	0.6311			33
34	Disproportionate share adjustment (see instructions)	1,726,907			34
		Prior to October 1	On or after October 1		
	Uncompensated Care Adjustment				
35	Total uncompensated care amount (see instructions)		7,647,644,885		35
35.01	Factor 3 (see instructions)		0.000637118		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		4,872,452		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		4,872,452		35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	4,872,452			36
	Additional Payment for High Percentage of ESRD Beneficiary Discharges (lines 40 through 46)				
40	Total Medicare discharges, excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				40
41	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				41.01
42	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)				42
43	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				43
44	Ratio of average length of stay to one week (line 43 divided by line 41.01 divided by 7 days)				44
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
47	Subtotal (see instructions)	17,899,898			47
48	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	Total payment for inpatient operating costs (see instructions)	17,899,898			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,086,575			50
51	Exception payment for inpatient program capital (Wkst. L, Pt. III) (see instructions)				51
52	Direct graduate medical education payment (from Wkst. E-4, line 49) (see instructions)	48,955			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 Pt. III, col. 1, line 69)				55
56	Cost of physicians' services in a teaching hospital (see instructions)				56
57	Routine service other pass through costs (from Wkst. D, Pt. III, col. 9, lines 30 through 35).				57
58	Ancillary service other pass through costs (from Wkst. D, Pt. IV, col. 11, line 200)				58
59	Total (sum of amounts on lines 49 through 58)	19,035,428			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	19,035,428			61
62	Deductibles billed to program beneficiaries	1,078,344			62
63	Coinsurance billed to program beneficiaries	201,100			63
64	Allowable bad debts (see instructions)	998,950			64
65	Adjusted reimbursable bad debts (see instructions)	649,318			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	805,935			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	18,405,302			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (OTHER ADJUSTMENT - PSR)				70
70.93	HVBP payment adjustment amount (see instructions)	-44,876			70.93
70.94	HRR adjustment amount (see instructions)	3,800			70.94
71	Amount due provider (see instructions)	18,364,226			71
71.01	Sequestration adjustment (see instructions)	367,285			71.01
72	Interim payments	17,371,286			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	625,655			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	133,370			75

TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)

90	Operating outlier amount from Wkst. E, Pt. A line 2 (see instructions)				90
91	Capital outlier from Wkst. L, Pt. I, line 2				91
92	Operating outlier reconciliation adjustment amount (see instructions)				92
93	Capital outlier reconciliation adjustment amount (see instructions)				93
94	The rate used to calculate the time value of money (see instructions)				94
95	Time value of money for operating expenses (see instructions)				95
96	Time value of money for capital related expenses (see instructions)				96

HSP Bonus Payment Amount

Prior to 10/1 On or After 10/1

100	HSP bonus amount (see instructions)				100
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HVBP Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

101	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000		101
102	HVBP adjustment amount for HSP bonus payment (see instructions)				102

HRR Adjustment for HSP Bonus Payment

Prior to 10/1 On or After 10/1

103	HRR adjustment factor (see instructions)	0.0000	0.0000		103
104	HRR adjustment amount for HSP bonus payment (see instructions)				104

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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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)	2,178			1
2	Medical and other services reimbursed under OPPTS (see instructions)	6,428,383			2
3	PPS payments	4,815,750			3
4	Outlier payment (see instructions)	59,831			4
5	Enter the hospital specific payment to cost ratio (see instructions)	0.836			5
6	Line 2 times line 5	5,374,128			6
7	Sum of line 3 and line 4 divided by line 6	0.9072			7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	2,178			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	16,729			12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)	16,729			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)	16,729			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	14,551			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)	2,178			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	4,875,581			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	26,630			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	939,361			26
27	Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)	3,911,768			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	21,376			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	3,933,144			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	3,933,144			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	460,192			34
35	Adjusted reimbursable bad debts (see instructions)	299,125			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	328,934			36
37	Subtotal (see instructions)	4,232,269			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	4,232,269			40
40.01	Sequestration adjustment (see instructions)	84,645			40.01
41	Interim payments	4,067,468			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	80,156			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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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)	682			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 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	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 physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)	555			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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 minus 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
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
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
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	433			40
40.01	Sequestration adjustment (see instructions)	9			40.01
41	Interim payments	22			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	402			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0206

WORKSHEET E-1
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B		
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4	
1	Total interim payments paid to provider		17,359,991		4,186,380	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01 09/17/2015	11,295			3.01
		.02				3.02
	Program	.03				3.03
	to	.04				3.04
	Provider	.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51		09/17/2015	118,912	3.51
	Provider	.52				3.52
	to	.53				3.53
	Program	.54				3.54
		.55				3.55
		.56				3.56
		.57				3.57
		.58				3.58
		.59				3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99	11,295		-118,912	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		17,371,286		4,067,468	4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01				5.01
		.02				5.02
	Program	.03				5.03
	to	.04				5.04
	Provider	.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
	Provider	.52				5.52
	to	.53				5.53
	Program	.54				5.54
		.55				5.55
		.56				5.56
		.57				5.57
		.58				5.58
		.59				5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99				5.99
6	Determined net settlement amount (balance due) based on the cost report (1)	.01	625,655		80,156	6.01
		.02				6.02
7	Total Medicare program liability (see instructions)		17,996,941		4,147,624	7
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)		8

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

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-S206

WORKSHEET E-1
PART I

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

	DESCRIPTION	INPATIENT PART A		PART B	
		mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider		659,124		22 1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	Program to Provider	.01 .02 .03 .04 .05 .06 .07 .08 .09 .10 .50 .51 .52 to .53 Program .54 .55 .56 .57 .58 .59		3.01 3.02 3.03 3.04 3.05 3.06 3.07 3.08 3.09 3.10 3.50 3.51 3.52 3.53 3.54 3.55 3.56 3.57 3.58 3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		659,124		22 4
TO BE COMPLETED BY CONTRACTOR					
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	Program to Provider	.01 .02 .03 .04 .05 .06 .07 .08 .09 .10 .50 .51 .52 to .53 Program .54 .55 .56 .57 .58 .59		5.01 5.02 5.03 5.04 5.05 5.06 5.07 5.08 5.09 5.10 5.50 5.51 5.52 5.53 5.54 5.55 5.56 5.57 5.58 5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99		5.99
6	Determined net settlement amount (balance due) based on the cost report (1)		.01 .02	5	402 6.01 6.02
7	Total Medicare program liability (see instructions)		659,129		424 7
8	Name of Contractor	Contractor Number		NPR Date (Month/Day/Year)	
					8

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

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

**WORKSHEET E-1
PART II**

Check applicable box: Hospital CAH

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 (Wkst. S-3, Pt. I, col. 15, line 14)	7,789	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	9,100	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	1,972	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	35,808	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	312,595,554	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	8,272,423	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)		7
8	Calculation of the HIT incentive payment (see instructions)	528,487	8
9	Sequestration adjustment amount (see instructions)	10,570	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	517,917	10

INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH

30	Initial/interim HIT payment(s)	486,912	30
31	OTHER ADJUSTMENTS ()		31
32	Balance due provider (line 8 or line 10 minus line 30 and line 31) (see instructions)	31,005	32

(*) This worksheet is completed by the contractor for standard and non-standard cost reporting periods at cost report settlement. Providers may complete this worksheet for a standard cost reporting period.

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2014 To: 09/30/2015	Run Date: 02/25/2016 Run Time: 17:05 Version: 2015.10 (01/29/2016)
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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)	750,942	1
2	Net IPF PPS Outlier payment		2
3	Net IPF PPS ECT payment		3
4	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions)	2.00	4
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) OR (2) (see instructions)		4.01
5	New teaching program adjustment (see instructions)		5
6	Current year unweighted FTE count of I&R excluding FTEs in the new program growth period of a 'new teaching program' (see instructions)		6
7	Current year unweighted I&R FTE count for residents within the new program growth period of a 'new teaching program' (see instructions)		7
8	Intern and resident count for IPF PPS medical education adjustment (see instructions)		8
9	Average daily census (see instructions)	9.257534	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)	750,942	12
13	Nursing and allied health managed care payment (see instructions)		13
14	Organ acquisition DO NOT USE THIS LINE		14
15	Cost of physicians' services in a teaching hospital (see instructions)		15
16	Subtotal (see instructions)	750,942	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	750,942	18
19	Deductibles	64,948	19
20	Subtotal (line 18 minus line 19)	685,994	20
21	Coinsurance	13,413	21
22	Subtotal (line 20 minus line 21)	672,581	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)	672,581	26
27	Direct graduate medical education payments (from Wkst. E-4, line 49) (for freestanding IPF only)		27
28	Other pass through costs (see instructions)		28
29	Outlier payments reconciliation		29
30	Other adjustments (specify) (see instructions)		30
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		30.50
31	Total amount payable to the provider (see instructions)	672,581	31
31.01	Sequestration adjustment (see instructions)	13,452	31.01
32	Interim payments	659,124	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)	5	34
35	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		35

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0206

WORKSHEET E-3
PART VII

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

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

	INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
COMPUTATION OF NET COST OF COVERED SERVICES			
1	Inpatient hospital/SNF/NF services	10,505,958	1
2	Medical and other services		2
3	Organ acquisition (certified transplant centers only)		3
4	Subtotal (sum of lines 1, 2 and 3)	10,505,958	4
5	Inpatient primary payer payments		5
6	Outpatient primary payer payments		6
7	Subtotal (line 4 less sum of lines 5 and 6)	10,505,958	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	Routine service charges		8
9	Ancillary service charges		9
10	Organ acquisition charges, net of revenue		10
11	Incentive from target amount computation		11
12	Total reasonable charges (sum of lines 8-11)		12
CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis		13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(c)		14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	15
16	Total customary charges (see instructions)		16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	10,505,958	18
19	Interns and residents (see instructions)		19
20	Cost of physicians' services in a teaching hospital (see instructions)		20
21	Cost of covered services (lesser of line 4 or line 16)		21
PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments		22
23	Outlier payments		23
24	Program capital payments		24
25	Capital exception payments (see instructions)		25
26	Routine and ancillary service other pass through costs		26
27	Subtotal (sum of lines 22 through 26)		27
28	Customary charges (Titles V or XIX PPS covered services only)		28
29	Titles V or XIX (sum of lines 21 and 27)		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)	10,505,958	30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		31
32	Deductibles		32
33	Coinsurance		33
34	Allowable bad debts (see instructions)		34
35	Utilization review		35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		37
38	Subtotal (line 36 ± line 37)		38
39	Direct graduate medical education payments (from Wkst. E-4)		39
40	Total amount payable to the provider (sum of lines 38 and 39)		40
41	Interim payments		41
42	Balance due provider/program (line 40 minus line 41)		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		43

KPMG LLP Compu-Max 2552-10

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

WORKSHEET E-4

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1.98	1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			1.29	3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cal (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			12.44	4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			13.13	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)				6
7	Enter the lesser of line 5 or line 6				7
		Primary Care 1	Other 2	Total 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 through 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	93,905.86	93,805.86		18
19	Approved amount for resident costs		238,267	238,267	19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)			238,267	25
COMPUTATION OF PROGRAM PATIENT LOAD					
26	Inpatient days (see instructions)	9,949	1,986		26
27	Total inpatient days (see instructions)	39,483	39,483		27
28	Ratio of inpatient days to total inpatient days	0.251982	0.050300		28
29	Program direct GME amount	60,039	11,985		29
30	Reduction for direct GME payments for Medicare Advantage		1,693		30
31	Net Program direct GME amount			70,331	31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)					
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME					
Part A Reasonable Cost					
37	Reasonable cost (see instructions)			14,728,794	37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			14,728,794	41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)			6,431,243	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			6,431,243	44
45	Total reasonable cost (sum of lines 41 and 44)			21,160,037	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.696067	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.303933	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)			70,331	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			48,955	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			21,376	50

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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

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	
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)			2	
3	Amount of reduction to Direct GME cap under §422 of MMA			3	
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			3.01	
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))			4	
4.01	ACA §5503 increase to the direct GME FTE cal (see instructions for cost reporting periods straddling 7/1/2011)			4.01	
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02	
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			5	
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			6	
7	Enter the lesser of line 5 or line 6			7	
		Primary Care 1	Other 2	Total 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		0.00		10
11	Total weighted FTE count	0.00	0.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00		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	0.00		17
18	Per resident amount	0.00	0.00		18
19	Approved amount for resident costs				19
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)				20
21	Direct GME FTE unweighted resident count over cap (see instructions)				21
22	Allowable additional direct GME FTE resident count (see instructions)				22
23	Enter the locality adjustment national average per resident amount (see instructions)				23
24	Multiply line 22 times line 23				24
25	Total direct GME amount (sum of lines 19 and 24)				25
COMPUTATION OF PROGRAM PATIENT LOAD					
		Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	12,736	11,158		26
27	Total inpatient days (see instructions)	39,483	39,483		27
28	Ratio of inpatient days to total inpatient days	0.322569	0.282603		28
29	Program direct GME amount				29
30	Reduction for direct GME payments for Medicare Advantage				30
31	Net Program direct GME amount				31
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)					
32	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)				32
33	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)				33
34	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)				34
35	Medicare outpatient ESRD charges (see instructions)				35
36	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)				36
APPORTIONMENT OF MEDICARE REASONABLE COST OF GME					
Part A Reasonable Cost					
37	Reasonable cost (see instructions)				37
38	Organ acquisition costs (Wkst. D-4, Pt. III, col 1, line 69)				38
39	Cost of physicians' services in a teaching hospital (see instructions)				39
40	Primary payer payments (see instructions)				40
41	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)				41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)				42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)				44
45	Total reasonable cost (sum of lines 41 and 44)				45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)				46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)				47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)				48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)				49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)				50

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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	
CURRENT ASSETS						
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
FIXED ASSETS						
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 depreciation					18
19	Fixed equipment	21,814,862				19
20	Accumulated depreciation	-15,123,892				20
21	Audomobiles 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
OTHER ASSETS						
31	Investments	17,293,461				31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets	18,122,861				34
35	Total other assets (sum of lines 31-34)	35,416,322				35
36	Total assets (sum of lines 11, 30 and 35)	106,706,037				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	5,886,579				37
38	Salaries, wages and fees payable	3,378,746				38
39	Payroll taxes payable	82,832				39
40	Notes and 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
LONG TERM LIABILITIES						
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
CAPITAL ACCOUNTS						
52	General fund balance	38,720,199				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	38,720,199				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	106,706,037				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)		2,958,663		2
3	Total (sum of line 1 and line 2)		37,910,394		3
4	Additions (credit adjustments) (specify)				4
5	MIN PENSION LIAB. ADJ.	447,066			5
6		362,740			6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)		809,806		10
11	Subtotal (line 3 plus line 10)		38,720,200		11
12	Deductions (debit adjustments) (specify)				12
13					13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		38,720,200		19

		ENDOWMENT FUND		PLANT FUND	
		5	6	7	8
1	Fund balances at beginning of period				1
2	Net income (loss) (from Worksheet G-3, line 29)				2
3	Total (sum of line 1 and line 2)				3
4	Additions (credit adjustments) (specify)				4
5	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) (specify)				12
13					13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)				19

KPMG LLP Compu-Max 2552-10

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

**WORKSHEET G-2
PARTS I & II**

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
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
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
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	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	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)		111,666,917	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)		111,666,917	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	188,914,812	2
3	Net patient revenues (line 1 minus line 2)	109,839,141	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	111,666,917	4
5	Net income from service to patients (line 3 minus line 4)	-1,827,776	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, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hospital space		22
23	Governmental appropriations		23
24	Other (HIT INCENTIVE PAYMENTS)	1,476,967	24
24.01	Other (CLINICAL INTEGRATION REV)	1,818,931	24.01
24.03	Other (RENTAL INCOME)	39,500	24.03
24.04	Other (DIETARY MISC REV)	382,307	24.04
24.05	Other (CAPITATION REVENUE)	108,485	24.05
24.06	Other (LAB ADMIN REV)	341,528	24.06
24.07	Other (OTHER MISC REV)	700,273	24.07
25	Total other income (sum of lines 6-24)	6,893,374	25
26	Total (line 5 plus line 25)	5,065,598	26
27.01	Other expenses (ADJUST OTHER RECEIVABLES)	2,106,935	27.01
28	Total other expenses (sum of line 27 and subscripts)	2,106,935	28
29	Net income (or loss) for the period (line 26 minus line 28)	2,958,663	29

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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0206

WORKSHEET L

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

PART I - FULLY PROSPECTIVE METHOD

CAPITAL FEDERAL AMOUNT			
1	Capital DRG other than outlier	875,079	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	29,917	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)	98.92	3
4	Number of interns & residents (see instructions)	3.00	4
5	Indirect medical education percentage (see instructions)	0.86	5
6	Indirect medical education adjustment (see instructions)	7,526	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.2844	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.6113	8
9	Sum of lines 7 and 8	0.8957	9
10	Allowable disproportionate share percentage (see instructions)	0.1989	10
11	Disproportionate share adjustment (see instructions)	174,053	11
12	Total prospective capital payments (see instructions)	1,086,575	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	
	GENERAL SERVICE COST CENTERS						
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
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics						30
31	Intensive Care Unit						31
31.01	NICU						31.01
40	Subprovider - IPF						40
43	Nursery						43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room						50
52	Delivery Room & Labor Room						52
53	Anesthesiology						53
54	Radiology-Diagnostic						54
56.01	NUCLEAR MEDICINE						56.01
57	CT Scan						57
58	MRI						58
59	Cardiac Catheterization						59
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
	OUTPATIENT SERVICE COST CENTERS						
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
	OTHER REIMBURSABLE COST CENTERS						
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
	SPECIAL PURPOSE COST CENTERS						
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192
192.01	PROHEALTH SERVICES						192.01

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP- DOWN ADJS	TOTAL	
		0	2A	24	25	26	
192.02	AUXILIARY						192.02
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)						202