

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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: 02/23/2019 Time: 10:53
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by NORWEGIAN AMERICAN HOSPITAL (14-0206) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 10/01/2017 and ending 09/30/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

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

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		888,808	157,387			1
2	SUBPROVIDER - IPF		28,337				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		917,145	157,387			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										
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 / 2017	To: 09 / 30 / 2018	20
21	Type of control (see instructions)	2		21

Inpatient PPS Information

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		4,718		49	12,934	97	24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.							25

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
	Prospective Payment System (PPS)-Capital	V	XVIII	XIX
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	1	2	3
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	Y	N
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N

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

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

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

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

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

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

Teaching Hospitals that Claim Residents in Nonprovider Settings

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

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

Rural Providers

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

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

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	1,184,385			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	Y			121
122	Does the cost report contain state health care related taxes as defined in §1903(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

Transplant Center Information

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

All Providers

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

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

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

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

		Title XVIII		Title V	Title XIX	
		Part A	Part B	3	4	
		1	2			
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)				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 / 2017	09 / 30 / 2018	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)			N	0	171

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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.	N			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	01/17/2019	Y	01/17/2019
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 relieved for Medicare purposes? If yes, see instructions.		22
23	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23
24	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions.		24
25	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.		27

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

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

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

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

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

**WORKSHEET S-3
PART I**

	Component	Wkst A Line No.	No. of Beds	Bed Days Available	CAH Hours	Inpatient Days / Outpatient Visits / Trips			Total All Patients	
						Title V	Title XVIII	Title XIX		
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	161	58,765			6,248	2,275	26,587	1
2	HMO and other (see instructions)						2,690	14,406		2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF									5
6	Hospital Adults & Peds. Swing Bed NF									6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		161	58,765			6,248	2,275	26,587	7
8	Intensive Care Unit	31	12	4,380			1,073	245	3,153	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						872	1,433	13
14	Total (see instructions)		173	63,145			7,321	3,392	31,173	14
15	CAH Visits									15
16	Subprovider - IPF	40	12	4,380			880	1,462	2,748	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							4	24.10
25	CMHC	99								25
26	RHC	88								26
27	Total (sum of lines 14-26)		185							27
28	Observation Bed Days							61	2,204	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)							102	139	32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

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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)					1,237	476	5,621	1
2	HMO and other (see instructions)					416	2,723		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)	10.26	697.48			1,237	476	5,621	14
15	CAH Visits								15
16	Subprovider - IPF		8.50			116	198	371	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)	10.26	705.98						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

KPMG LLP Compu-Max 2552-10

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HOSPITAL WAGE INDEX INFORMATION

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

Part II - Wage Data

	Wkst A Line No.	Amount Reported	Reclassification 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	47,563,441		47,563,441	1,468,441.00	32.39	1
2							2
3							3
4		551,634		551,634	3,823.00	144.29	4
4.01							4.01
5		2,429,076		2,429,076	26,315.00	92.31	5
6							6
7	21	153,104		153,104	6,371.00	24.03	7
7.01							7.01
8							8
9	44						9
10		1,657,790		1,657,790	46,051.00	36.00	10
OTHER WAGES & RELATED COSTS							
11		4,914,899		4,914,899	71,795.00	68.46	11
12							12
13							13
14							14
14.01							14.01
14.02							14.02
15							15
16							16
WAGE-RELATED COSTS							
17		13,065,609		13,065,609			17
18							18
19		471,809		471,809			19
20							20
21							21
22		99,574		99,574			22
22.01							22.01
23		509,874		509,874			23
24							24
25		51,439		51,439			25
25.50							25.50
25.51							25.51
25.52							25.52
25.53							25.53
OVERHEAD COSTS - DIRECT SALARIES							
26		3,971,841		3,971,841	158,034.00	25.13	26
27		7,598,956		7,598,956	122,304.00	62.13	27
28		817,816		817,816	16,614.00	49.22	28
29							29
30		1,555,232		1,555,232	64,849.00	23.98	30
31							31
32		1,249,466		1,249,466	84,751.00	14.74	32
33		86,700		86,700	1,709.00	50.73	33
34		829,390	-342,413	486,977	33,228.00	14.66	34
35		483,150		483,150	9,526.00	50.72	35
36			342,413	342,413	23,360.00	14.66	36
37							37
38		1,221,235		1,221,235	28,170.00	43.35	38
39		566,643		566,643	23,416.00	24.20	39
40		1,422,620		1,422,620	46,782.00	30.41	40
41		543,118		543,118	21,108.00	25.73	41
42		668,202		668,202	22,886.00	29.20	42
43							43

Part III - Hospital Wage Index Summary

1	Net salaries (see instructions)	46,368,927		46,368,927	1,463,604.00	31.68	1
2	Excluded area salaries (see instructions)	1,657,790		1,657,790	46,051.00	36.00	2
3	Subtotal salaries (line 1 minus line 2)	44,711,137		44,711,137	1,417,553.00	31.54	3
4	Subtotal other wages & related costs (see instructions)	4,914,899		4,914,899	71,795.00	68.46	4
5	Subtotal wage-related costs (see instructions)	13,165,183		13,165,183		29.44%	5
6	Total (sum of lines 3 through 5)	62,791,219		62,791,219	1,489,348.00	42.16	6
7	Total overhead cost (see instructions)	21,014,369		21,014,369	656,737.00	32.00	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	366,000	1
2	Tax Sheltered Annuity (TSA) Employer Contribution		2
3	Nonqualified Defined Benefit Plan Cost (see instructions)		3
4	Qualified Defined Benefit Plan Cost (see instructions)	4,816,858	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)		8
8.01	Health Insurance (Self Funded without a Third Party Administrator)		8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		8.02
8.03	Health Insurance (Purchased)	4,472,993	8.03
9	Prescription Drug Plan		9
10	Dental, Hearing and Vision Plan	200,332	10
11	Life Insurance (If employee is owner or beneficiary)	54,268	11
12	Accident Insurance (If employee is owner or beneficiary)		12
13	Disability Insurance (If employee is owner or beneficiary)	203,296	13
14	Long-Term Care Insurance (If employee is owner or beneficiary)		14
15	Workers' Compensation Insurance	614,650	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	2,642,465	17
18	Medicare Taxes - Employers Portion Only	662,424	18
19	Unemployment Insurance	59,365	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	105,653	23
24	Total Wage Related cost (Sum of lines 1-23)	14,198,304	24

Part B - Other Than Core Related Cost

25	OTHER WAGE RELATED COSTs (SPECIFY)		25
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HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

Part V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

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

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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

Uncompensated and indigent care cost computation

1	Cost to charge ratio (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.325874	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	64,146,249	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	147,550,823	6
7	Medicaid cost (line 1 times line 6)	48,082,977	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

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

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

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	13,791,907	558,244	14,350,151	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,494,424	558,244	5,052,668	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	4,494,424	558,244	5,052,668	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	4,880,835	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,034,781	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,591,972	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,288,863	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	1,628,946	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	6,681,614	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,681,614	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		1,320,447	1,320,447	2,324,097	3,644,544		3,644,544	1
2	00200	Cap Rel Costs-Mvble Equip				2,451,846	2,451,846		2,451,846	2
3	00300	Other Cap Rel Costs		1,567,570	1,567,570	-1,567,570			-0-	3
4	00400	Employee Benefits Department	428,170	652,475	1,080,645	-262	1,080,383	6,984,861	8,065,244	4
4.01	00401	COMMUNICATIONS	206,955	106,778	313,733		313,733		313,733	4.01
4.02	00402	DATA PROCESSING	1,552,079	3,345,250	4,897,329	-678,030	4,219,299	-10,080	4,209,219	4.02
4.03	00403	ADMITTING	831,079	330,904	1,161,983	-5,581	1,156,402		1,156,402	4.03
4.04	00404	CASHIERING	953,558	1,013,634	1,967,192	-2,903	1,964,289		1,964,289	4.04
5	00500	Administrative & General	7,598,956	15,708,385	23,307,341	-139,007	23,168,334	-12,087,374	11,080,960	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	1,555,232	3,580,200	5,135,432	-731,452	4,403,980	-4,413	4,399,567	7
8	00800	Laundry & Linen Service				355,834	355,834		355,834	8
9	00900	Housekeeping	1,249,466	1,044,008	2,293,474	-362,448	1,931,026		1,931,026	9
10	01000	Dietary	829,390	1,892,578	2,721,968	-1,137,055	1,584,913	-98,907	1,486,006	10
11	01100	Cafeteria				1,114,415	1,114,415	-344,162	770,253	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration	1,221,235	509,589	1,730,824	-18,484	1,712,340		1,712,340	13
14	01400	Central Services & Supply	566,643	507,851	1,074,494	-41,494	1,033,000	-32,067	1,000,933	14
15	01500	Pharmacy	1,422,620	2,809,621	4,232,241	-2,000,688	2,231,553	-7,807	2,223,746	15
16	01600	Medical Records & Library	543,118	856,453	1,399,571	-19,266	1,380,305	-1,204	1,379,101	16
17	01700	Social Service	668,202	326,003	994,205	-75	994,130	-11,215	982,915	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd	153,104		153,104		153,104	-517	152,587	21
22	02200	I&R Services-Other Prgm Costs Apprvd		97,212	97,212		97,212		97,212	22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	9,305,702	5,728,611	15,034,313	-739,934	14,294,379	-45,473	14,248,906	30
31	03100	Intensive Care Unit	1,677,722	2,028,864	3,706,586	-40,519	3,666,067	-90,000	3,576,067	31
31.01	02060	NICU								31.01
40	04000	Subprovider - IPF	796,673	1,273,670	2,070,343	-14,691	2,055,652	-961,075	1,094,577	40
43	04300	Nursery	945,515	245,022	1,190,537	393,272	1,583,809		1,583,809	43
		ANCILLARY SERVICE COST CENTERS								
50	05000	Operating Room	2,034,511	3,129,032	5,163,543	-639,774	4,523,769	-705,044	3,818,725	50
52	05200	Delivery Room & Labor Room	1,717,093	1,094,775	2,811,868	-493,567	2,318,301		2,318,301	52
53	05300	Anesthesiology	110,395	2,151,921	2,262,316	-49,272	2,213,044	-2,059,679	153,365	53
54	05400	Radiology-Diagnostic	1,915,842	2,000,555	3,916,397	-186,055	3,730,342	-292,108	3,438,234	54
56.01	05601	NUCLEAR MEDICINE								56.01
60	06000	Laboratory	5,979	3,836,838	3,842,817	-907	3,841,910		3,841,910	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	777,395	396,148	1,173,543	-14,900	1,158,643		1,158,643	65
66	06600	Physical Therapy	383,641	124,339	507,980	-6,708	501,272		501,272	66
69	06900	Electrocardiology	165,314	87,488	252,802	-37,431	215,371		215,371	69
70	07000	Electroencephalography	12,514	3,352	15,866	-859	15,007		15,007	70
71	07100	Medical Supplies Charged to Patients				714,753	714,753		714,753	71
72	07200	Impl. Dev. Charged to Patients				1,136,899	1,136,899		1,136,899	72
73	07300	Drugs Charged to Patients				1,937,423	1,937,423		1,937,423	73
75.01	07501	ACUTE DIALYSIS		636,337	636,337	-60	636,277		636,277	75.01
75.02	03650	CARD CATH LAB	455,178	1,796,570	2,251,748	-1,297,069	954,679	-239,046	715,633	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	3,731,519	2,044,181	5,775,700	-41,318	5,734,382	-2,562,303	3,172,079	90
90.01	09001	PH CLINIC								90.01
90.02	09002	HEALTHWORKS CLINIC	33,381	90,460	123,841	-449	123,392	-9,849	113,543	90.02
90.03	09003	DENTAL CLINIC								90.03
90.04	09004	WOUND CARE THERAPY	343,255	240,439	583,694	-11,067	572,627	-89,244	483,383	90.04
90.05	09005	FAMILY PRACTICE CLINIC								90.05
91	09100	Emergency	2,510,888	3,196,899	5,707,787	-107,435	5,600,352	-1,200,000	4,400,352	91
92	09200	Observation Beds (Non-Distinct Part)								92
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM								93.99
		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)	46,702,324	65,774,459	112,476,783	42,209	112,518,992	-13,866,706	98,652,286	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
192	19200	Physicians' Private Offices	528,485	278,611	807,096	-17,288	789,808		789,808	192
192.01	19201	PROHEALTH SERVICES	1,097	710,710	711,807	-8,134	703,673		703,673	192.01
192.02	19202	AUXILIARY	331,535	130,334	461,869	-16,787	445,082		445,082	192.02
200		TOTAL (sum of lines 118-199)	47,563,441	66,894,114	114,457,555		114,457,555	-13,866,706	100,590,849	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		94,162	1
500	Total reclassifications					94,162	500
	Code Letter - A						
1	EQUIP DEPRECIATION	B	Cap Rel Costs-Mvble Equip	2		1,718,109	1
500	Total reclassifications					1,718,109	500
	Code Letter - B						
1	CHARGEABLE SUPPLIES	C	Medical Supplies Charged to P	71		714,753	1
2			Impl. Dev. Charged to Patient	72		1,136,899	2
3			WOUND CARE THERAPY	90.04		22	3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
500	Total reclassifications					1,851,674	500
	Code Letter - C						
1	SHARED CAFETERIA EXP	D	Cafeteria	11	342,413	772,002	1
500	Total reclassifications				342,413	772,002	500
	Code Letter - D						
1	DEPRECIATION CHARGED TO DEPTS	F	Cap Rel Costs-Bldg & Fixt	1		3,114,211	1
2							2
3							3
4							4
5							5
6							6
7							7
8							8
9							9
10							10
11							11
12							12
13							13
14							14
15							15
16							16
17							17
18							18
19							19
20							20
21							21
22							22
23							23
24							24
25							25
26							26
27							27
28							28
29							29
30							30
31							31
32							32
33							33
34							34
35							35
500	Total reclassifications					3,114,211	500
	Code Letter - F						
1	INTEREST EXPENSE	G	Cap Rel Costs-Bldg & Fixt	1		833,833	1
2			Cap Rel Costs-Mvble Equip	2		733,737	2
500	Total reclassifications					1,567,570	500
	Code Letter - G						
1	LAUNDRY EXP	H	Laundry & Linen Service	8		355,834	1
500	Total reclassifications					355,834	500

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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION(S)		CODE (1)	INCREASES			
			COST CENTER	LINE #	SALARY	
		1	2	3	4	5
	Code Letter - H					
1	NURSERY EXP	J	Nursery	43	294,308	113,247
500	Total reclassifications				294,308	113,247
	Code Letter - J					
1	CHARGEABLE DRUGS	K	Drugs Charged to Patients	73		1,937,423
500	Total reclassifications					1,937,423
	Code Letter - K					
	GRAND TOTAL (Increases)				636,721	11,524,232

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

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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		94,162	12	1
500	Total reclassifications					94,162		500
	Code letter - A							
1	EQUIP DEPRECIATION	B	Cap Rel Costs-Bldg & Fixt	1		1,718,109	9	1
500	Total reclassifications					1,718,109		500
	Code letter - B							
1	CHARGEABLE SUPPLIES	C	Central Services & Supply	14		1,371		1
2			Pharmacy	15		4,250		2
3			Adults & Pediatrics	30		57,818		3
4			Intensive Care Unit	31		10,586		4
5			Subprovider - IPF	40		10,507		5
6			Nursery	43		719		6
7			Operating Room	50		489,245		7
8			Delivery Room & Labor Room	52		10,634		8
9			Anesthesiology	53		9,475		9
10			Radiology-Diagnostic	54		2,104		10
11			Respiratory Therapy	65		15		11
12			ACUTE DIALYSIS	75.01		60		12
13			CARD CATH LAB	75.02		1,197,268		13
14			Clinic	90		5,304		14
15			HEALTHWORKS CLINIC	90.02		278		15
16			Emergency	91		52,040		16
500	Total reclassifications					1,851,674		500
	Code letter - C							
1	SHARED CAFETERIA EXP	D	Dietary	10	342,413	772,002		1
500	Total reclassifications				342,413	772,002		500
	Code letter - D							
1	DEPRECIATION CHARGED TO DEPTS	F	Employee Benefits Department	4		262	9	1
2			DATA PROCESSING	4.02		678,030		2
3			ADMITTING	4.03		5,581		3
4			CASHIERING	4.04		2,903		4
5			Administrative & General	5		44,845		5
6			Operation of Plant	7		731,452		6
7			Housekeeping	9		6,614		7
8			Dietary	10		22,640		8
9			Nursing Administration	13		18,484		9
10			Central Services & Supply	14		40,123		10
11			Pharmacy	15		59,015		11
12			Medical Records & Library	16		19,266		12
13			Social Service	17		75		13
14			Adults & Pediatrics	30		274,561		14
15			Intensive Care Unit	31		29,933		15
16			Subprovider - IPF	40		4,184		16
17			Nursery	43		13,564		17
18			Operating Room	50		150,529		18
19			Delivery Room & Labor Room	52		482,933		19
20			Anesthesiology	53		39,797		20
21			Radiology-Diagnostic	54		183,951		21
22			Laboratory	60		907		22
23			Respiratory Therapy	65		14,885		23
24			Physical Therapy	66		6,708		24
25			Electrocardiology	69		37,431		25
26			Electroencephalography	70		859		26
27			CARD CATH LAB	75.02		99,801		27
28			Clinic	90		33,900		28
29			HEALTHWORKS CLINIC	90.02		171		29
30			WOUND CARE THERAPY	90.04		11,089		30
31			Clinic	90		2,114		31
32			Emergency	91		55,395		32
33			Physicians' Private Offices	192		17,288		33
34			PROHEALTH SERVICES	192.01		8,134		34
35			AUXILIARY	192.02		16,787		35
500	Total reclassifications					3,114,211		500
	Code letter - F							
1	INTEREST EXPENSE	G	Other Cap Rel Costs	3		833,833	11	1
2			Other Cap Rel Costs	3		733,737	11	2
500	Total reclassifications					1,567,570		500
	Code letter - G							
1	LAUNDRY EXP	H	Housekeeping	9		355,834		1

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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	
500	Total reclassifications					355,834	500	
	Code letter - H							
1	NURSERY EXP	J	Adults & Pediatrics	30	294,308	113,247	1	
500	Total reclassifications				294,308	113,247	500	
	Code letter - J							
1	CHARGEABLE DRUGS	K	Pharmacy	15		1,937,423	1	
500	Total reclassifications					1,937,423	500	
	Code letter - K							
	GRAND TOTAL (Decreases)				636,721	11,524,232		

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

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RECONCILIATION OF CAPITAL COST CENTERS

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

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	Description	Beginning Balances	Acquisitions			Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
			Purchases	Donation	Total				
		1	2	3	4	5	6	7	
1	Land	4,529,913	311,000		311,000		4,840,913		1
2	Land Improvements	3,689,703				56	3,689,647		2
3	Buildings and Fixtures	50,154,984	2,585,985		2,585,985		52,740,969		3
4	Building Improvements								4
5	Fixed Equipment	24,716,065	2,017,245		2,017,245		26,733,310		5
6	Movable Equipment	55,172,886	1,128,372		1,128,372		56,301,258		6
7	HIT-designated Assets								7
8	Subtotal (sum of lines 1-7)	138,263,551	6,042,602		6,042,602	56	144,306,097		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	138,263,551	6,042,602		6,042,602	56	144,306,097		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	1,320,447						1,320,447	1	
2	Cap Rel Costs-Mvble Equip								2	
3	Total (sum of lines 1-2)	1,320,447						1,320,447	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	83,163,926		83,163,926	0.596306					1
2	Cap Rel Costs-Mvble Equip	56,301,258		56,301,258	0.403694					2
3	Total (sum of lines 1-2)	139,465,184		139,465,184	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	2,716,549		833,833	94,162			3,644,544	1	
2	Cap Rel Costs-Mvble Equip	1,718,109		733,737				2,451,846	2	
3	Total (sum of lines 1-2)	4,434,658		1,567,570	94,162			6,096,390	3	

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			Wkst. A-7 Ref.
				COST CENTER	LINE#		
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)						5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-71,510	Administrative & General	5		7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-10,679,590				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	-344,162	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	B	-1,204	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation						32
33							33
33.01	MISC REV	B	-10,080	DATA PROCESSING	4.02		33.01
33.03	MISC REV	B	-464,793	Administrative & General	5		33.03
33.04	MISC REV	B	-4,413	Operation of Plant	7		33.04
33.05	MISC REV	B	-53,000	Dietary	10		33.05
33.06	MISC REV	B	-32,067	Central Services & Supply	14		33.06
33.07	MISC REV	B	-7,807	Pharmacy	15		33.07
33.08	MISC REV	B	-800	Adults & Pediatrics	30		33.08
33.16	MISC REV	B	-3,450	Radiology-Diagnostic	54		33.16
33.17	MISC REV	B	-8,455	Clinic	90		33.17
33.20	MISC REV- WS C	B	-45,907	Dietary	10		33.20
34							34
35	NON ALLOW EXP	A	-8,347	Employee Benefits Department	4		35
35.01	NON ALLOW EXP	A	-73,912	Administrative & General	5		35.01
35.02	NON ALLOW EXP	A	-517	I&R Services-Salary & Fringes Apprvd	21		35.02
35.03	IL MEDICAID ASSESSEMENT	A	-8,486,885	Administrative & General	5		35.03
36	CLINIC INTEGRATION EXP	A	-54,236	Administrative & General	5		36
37							37
38	LOBBYING PORTION OF DUES	A	-29,694	Administrative & General	5		38
39							39
40	LOBBYING FEES	A	-190,000	Administrative & General	5		40
41							41
42	MIDLEVEL PRACTITIONERS	A	-289,085	Clinic	90		42
43	CURR. PERIOD PENSION COST	A	6,993,208	Employee Benefits Department	4		43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-13,866,706				50

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

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

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

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

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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	2,980,595	2,688,077	292,518	197,500	2,783	264,251	13,213	3
4										4
5	17	Social Service AGGREGATE	30,680		30,680	197,500	205	19,465	973	5
6	30	Adults & Pediatrics AGGREGATE	44,673	44,673						6
7	31	Intensive Care Unit AGGREGATE	90,000	90,000						7
8										8
9	40	Subprovider - IPF AGGREGATE	961,075	961,075						9
10	50	Operating Room AGGREGATE	705,044	705,044						10
11	53	Anesthesiology AGGREGATE	2,059,679	2,059,679						11
12										12
13	54	Radiology-Diagnostic AGGRGATE	288,658	288,658						13
14										14
15	75.02	CARD CATH LAB AGGREGATE	239,046	239,046						15
16										16
17	90	Clinic AGGREGATE	2,370,513	2,111,396	259,117	211,500	1,040	105,750	5,288	17
18	90.02	HEALTHWORKS CLINIC AGGREGATE	9,849	9,849						18
19	90.04	WOUND CARE THERAPY AGGREGATE	89,244	89,244						19
20										20
22	91	Emergency AGGREGATE	1,200,000	1,200,000						22
200		TOTAL	11,069,056	10,486,741	582,315		4,028	389,466	19,474	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					264,251	28,267	2,716,344	3
4										4
5	17	Social Service AGGREGATE					19,465	11,215	11,215	5
6	30	Adults & Pediatrics AGGREGATE							44,673	6
7	31	Intensive Care Unit AGGREGATE							90,000	7
8										8
9	40	Subprovider - IPF AGGREGATE							961,075	9
10	50	Operating Room AGGREGATE							705,044	10
11	53	Anesthesiology AGGREGATE							2,059,679	11
12										12
13	54	Radiology-Diagnostic AGGRGATE							288,658	13
14										14
15	75.02	CARD CATH LAB AGGREGATE							239,046	15
16										16
17	90	Clinic AGGREGATE					105,750	153,367	2,264,763	17
18	90.02	HEALTHWORKS CLINIC AGGREGATE							9,849	18
19	90.04	WOUND CARE THERAPY AGGREGATE							89,244	19
20										20
22	91	Emergency AGGREGATE							1,200,000	22
200		TOTAL					389,466	192,849	10,679,590	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	3,644,544	3,644,544					1
2	Cap Rel Costs-Mvble Equip	2,451,846		2,451,846				2
4	Employee Benefits Department	8,065,244	42,323	206	8,107,773			4
4.01	COMMUNICATIONS	313,733	5,648		35,599	354,980		4.01
4.02	DATA PROCESSING	4,209,219	89,103	533,848	266,975	4,863	5,104,008	4.02
4.03	ADMITTING	1,156,402	84,282	4,394	142,955	4,863	417,601	4.03
4.04	CASHIERING	1,964,289	20,181	2,286	164,022	28,204	603,201	4.04
5	Administrative & General	11,080,960	77,121	35,309	1,307,104	60,295	371,201	5
6	Maintenance & Repairs							6
7	Operation of Plant	4,399,567	305,666	575,911	267,517	17,506	46,400	7
8	Laundry & Linen Service	355,834	51,601					8
9	Housekeeping	1,931,026	49,386	5,208	214,922		92,800	9
10	Dietary	1,486,006	104,491	8,340	83,765	10,698	92,800	10
11	Cafeteria	770,253	47,340	9,486	58,899	973		11
12	Maintenance of Personnel							12
13	Nursing Administration	1,712,340	33,816	14,553	210,066	7,780		13
14	Central Services & Supply	1,000,933	155,054	31,591	97,469	973	278,400	14
15	Pharmacy	2,223,746	67,773	46,466	244,706	9,725	324,801	15
16	Medical Records & Library	1,379,101	69,763	15,169	93,422	21,396	46,400	16
17	Social Service	982,915	2,144	59	114,938	7,780		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd	152,587			26,336	973		21
22	I&R Services-Other Prgm Costs Apprvd	97,212	1,682					22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	14,248,906	584,831	212,162	1,550,046	36,957	649,601	30
31	Intensive Care Unit	3,576,067	88,220	23,568	288,587		92,800	31
31.01	NICU							31.01
40	Subprovider - IPF	1,094,577	74,178	3,294	137,037			40
43	Nursery	1,583,809	54,319	14,694	213,263	2,918	92,800	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	3,818,725	256,237	118,519	349,958	23,341	185,600	50
52	Delivery Room & Labor Room	2,318,301	44,818	380,238	295,359	1,945	92,800	52
53	Anesthesiology	153,365	9,362	31,334	18,989	2,918		53
54	Radiology-Diagnostic	3,438,234	137,032	144,834	329,546	19,451	139,200	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	3,841,910	114,427	714	1,028	23,341	835,203	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,158,643	34,321	11,720	133,720	4,863	92,800	65
66	Physical Therapy	501,272	36,339	5,282	65,990	2,918	92,800	66
69	Electrocardiology	215,371	44,523	29,471	28,436	7,780	92,800	69
70	Electroencephalography	15,007	6,096	676	2,153		92,800	70
71	Medical Supplies Charged to Patients	714,753						71
72	Impl. Dev. Charged to Patients	1,136,899						72
73	Drugs Charged to Patients	1,937,423						73
75.01	ACUTE DIALYSIS	636,277						75.01
75.02	CARD CATH LAB	715,633	29,892	78,579	78,296			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	3,172,079	110,741	28,356	641,862	6,808	278,400	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	113,543	16,817		5,742	4,863		90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	483,383	45,322	8,731	59,044	4,863		90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	4,400,352	105,836	43,615	431,900	11,671	92,800	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	98,652,286	3,000,685	2,418,613	7,959,651	330,666	5,104,008	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		8,787			973		190
192	Physicians' Private Offices	789,808	635,072	13,612	90,905	18,478		192
192.01	PROHEALTH SERVICES	703,673		6,404	189	4,863		192.01

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	NET EXP FOR COST ALLOCATION (from Wkst A, col.7)	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	EMPLOYEE BENEFITS DEPARTMENT	NON PATIENT PHONES	DATA PROCESSING	
		0	1	2	4	4.01	4.02	
192.02	AUXILIARY	445,082		13,217	57,028			192.02
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	100,590,849	3,644,544	2,451,846	8,107,773	354,980	5,104,008	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	1,810,497						4.03
4.04	CASHIERING		2,782,183					4.04
5	Administrative & General			12,931,990	12,931,990			5
6	Maintenance & Repairs							6
7	Operation of Plant			5,612,567	828,000	6,440,567		7
8	Laundry & Linen Service			407,435	60,107	110,037	577,579	8
9	Housekeeping			2,293,342	338,328	105,316		9
10	Dietary			1,786,100	263,496	222,824		10
11	Cafeteria			886,951	130,848	100,952		11
12	Maintenance of Personnel							12
13	Nursing Administration			1,978,555	291,888	72,113		13
14	Central Services & Supply			1,564,420	230,793	330,650		14
15	Pharmacy			2,917,217	430,365	144,525		15
16	Medical Records & Library			1,625,251	239,767	148,769		16
17	Social Service			1,107,836	163,435	4,572		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			179,896	26,539			21
22	I&R Services-Other Prgm Costs Apprvd			98,894	14,589	3,586		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	493,361	490,972	18,266,836	2,694,861	1,247,141	184,780	30
31	Intensive Care Unit	90,818	80,269	4,240,329	625,559	188,128	24,635	31
31.01	NICU							31.01
40	Subprovider - IPF	55,437	48,997	1,413,520	208,531	158,183		40
43	Nursery	44,069	38,951	2,044,823	301,665	115,835	30,839	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	72,800	164,231	4,989,411	736,068	546,422	104,598	50
52	Delivery Room & Labor Room	39,043	42,355	3,214,859	474,275	95,573	88,004	52
53	Anesthesiology	15,566	29,522	261,056	38,513	19,963		53
54	Radiology-Diagnostic	104,028	280,825	4,593,150	677,609	292,218	41,579	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	259,986	422,798	5,499,407	811,306	244,013		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	82,269	85,978	1,604,314	236,678	73,189		65
66	Physical Therapy	10,974	26,411	741,986	109,462	77,492	10,687	66
69	Electrocardiology	24,278	46,021	488,680	72,093	94,945		69
70	Electroencephalography	1,706	1,809	120,247	17,740	13,000		70
71	Medical Supplies Charged to Patients	7,573	15,054	737,380	108,783			71
72	Impl. Dev. Charged to Patients	25,805	36,516	1,199,220	176,916			72
73	Drugs Charged to Patients	279,986	347,942	2,565,351	378,456			73
75.01	ACUTE DIALYSIS	22,872	22,273	681,422	100,527			75.01
75.02	CARD CATH LAB	84,074	133,343	1,119,817	165,202	63,745		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	210	35,795	4,274,251	630,563	236,153	22,162	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC		2,337	143,302	21,141	35,862	921	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	8,587	60,790	670,720	98,949	96,649	3,081	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	87,055	368,994	5,542,223	817,622	225,693	66,293	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	1,810,497	2,782,183	97,802,758	12,520,674	5,067,548	577,579	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			9,760	1,440	18,738		190
192	Physicians' Private Offices			1,547,875	228,352	1,354,281		192
192.01	PROHEALTH SERVICES			715,129	105,500			192.01
192.02	AUXILIARY			515,327	76,024			192.02
200	Cross Foot Adjustments							200

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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	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	1,810,497	2,782,183	100,590,849	12,931,990	6,440,567	577,579	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	2,736,986						9
10	Dietary	97,967	2,370,387					10
11	Cafeteria	44,385		1,163,136				11
12	Maintenance of Personnel							12
13	Nursing Administration	31,705		33,362	2,407,623			13
14	Central Services & Supply	145,374		27,744		2,298,981		14
15	Pharmacy	63,542		55,414			3,611,063	15
16	Medical Records & Library	65,408		25,009				16
17	Social Service	2,010		27,104				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			7,540				21
22	I&R Services-Other Prgm Costs Apprvd	1,577						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	548,320	1,941,725	361,042	1,176,120	100,508	276,061	30
31	Intensive Care Unit	82,712	229,041	58,519	190,629	19,565	125,693	31
31.01	NICU							31.01
40	Subprovider - IPF	69,547	199,621	20,944	68,225	12,519	12,902	40
43	Nursery	50,928		37,797	123,126	1,014	5,621	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	240,240		63,718	207,565	5,551	133,241	50
52	Delivery Room & Labor Room	42,020		56,499	184,047	22,583	66,130	52
53	Anesthesiology	8,777		3,499	11,398	11,951	4,046	53
54	Radiology-Diagnostic	128,477		66,059		4,768	260	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	107,283					2,659	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	32,178		32,574	106,110	18	1,243	65
66	Physical Therapy	34,070		13,281				66
69	Electrocardiology	41,744		4,903	15,973	88		69
70	Electroencephalography	5,716		1,700		10		70
71	Medical Supplies Charged to Patients					659,934		71
72	Impl. Dev. Charged to Patients					1,351,376		72
73	Drugs Charged to Patients						2,482,514	73
75.01	ACUTE DIALYSIS					165	13,108	75.01
75.02	CARD CATH LAB	28,026		10,127	32,989	2,194	41,400	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	103,827		110,164		1,757	152,461	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	15,767		7,441		245	17,795	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	42,493		15,621		22,338	22,531	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	99,229		89,466	291,441	82,024	225,806	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	2,133,322	2,370,387	1,129,527	2,407,623	2,298,608	3,583,471	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	8,238						190
192	Physicians' Private Offices	595,426		21,634		320	17,097	192
192.01	PROHEALTH SERVICES					45	2,319	192.01
192.02	AUXILIARY			11,975		8	8,176	192.02
200	Cross Foot Adjustments							200

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9	10	11	13	14	15	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,736,986	2,370,387	1,163,136	2,407,623	2,298,981	3,611,063	202

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	2,104,204						16
17	Social Service		1,304,957					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			213,975				21
22	I&R Services-Other Prgm Costs Apprvd				118,646			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	371,508	1,135,313	192,577	106,781	28,603,573	-299,358	30
31	Intensive Care Unit	60,702	52,198			5,897,710		31
31.01	NICU							31.01
40	Subprovider - IPF	37,054				2,201,046		40
43	Nursery	29,456				2,741,104		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	124,198	39,149			7,190,161		50
52	Delivery Room & Labor Room	32,030				4,276,020		52
53	Anesthesiology	22,326				381,529		53
54	Radiology-Diagnostic	212,370				6,016,490		54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	319,735				6,984,403		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	65,019				2,151,323		65
66	Physical Therapy	19,973				1,006,951		66
69	Electrocardiology	34,803				753,229		69
70	Electroencephalography	1,368				159,781		70
71	Medical Supplies Charged to Patients	11,384				1,517,481		71
72	Impl. Dev. Charged to Patients	27,615				2,755,127		72
73	Drugs Charged to Patients	263,126				5,689,447		73
75.01	ACUTE DIALYSIS	16,844				812,066		75.01
75.02	CARD CATH LAB	100,838				1,564,338		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	27,070		21,398	11,865	5,591,671	-33,263	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	1,767				244,241		90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	45,971				1,018,353		90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	279,047	78,297			7,797,141		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	2,104,204	1,304,957	213,975	118,646	95,353,185	-332,621	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					38,176		190
192	Physicians' Private Offices					3,764,985		192
192.01	PROHEALTH SERVICES					822,993		192.01
192.02	AUXILIARY					611,510		192.02
200	Cross Foot Adjustments							200

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		16	17	21	22	24	25	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	2,104,204	1,304,957	213,975	118,646	100,590,849	-332,621	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	28,304,215				30
31	Intensive Care Unit	5,897,710				31
31.01	NICU					31.01
40	Subprovider - IPF	2,201,046				40
43	Nursery	2,741,104				43
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	7,190,161				50
52	Delivery Room & Labor Room	4,276,020				52
53	Anesthesiology	381,529				53
54	Radiology-Diagnostic	6,016,490				54
56.01	NUCLEAR MEDICINE					56.01
60	Laboratory	6,984,403				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	2,151,323				65
66	Physical Therapy	1,006,951				66
69	Electrocardiology	753,229				69
70	Electroencephalography	159,781				70
71	Medical Supplies Charged to Patients	1,517,481				71
72	Impl. Dev. Charged to Patients	2,755,127				72
73	Drugs Charged to Patients	5,689,447				73
75.01	ACUTE DIALYSIS	812,066				75.01
75.02	CARD CATH LAB	1,564,338				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	5,558,408				90
90.01	PH CLINIC					90.01
90.02	HEALTHWORKS CLINIC	244,241				90.02
90.03	DENTAL CLINIC					90.03
90.04	WOUND CARE THERAPY	1,018,353				90.04
90.05	FAMILY PRACTICE CLINIC					90.05
91	Emergency	7,797,141				91
92	Observation Beds (Non-Distinct Part)					92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	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)	95,020,564				118
	NONREIMBURSABLE COST CENTERS					
190	Gift, Flower, Coffee Shop & Canteen	38,176				190
192	Physicians' Private Offices	3,764,985				192
192.01	PROHEALTH SERVICES	822,993				192.01
192.02	AUXILIARY	611,510				192.02
200	Cross Foot Adjustments					200

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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	100,258,228						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		42,323	206	42,529	42,529		4
4.01	COMMUNICATIONS		5,648		5,648	187	5,835	4.01
4.02	DATA PROCESSING		89,103	533,848	622,951	1,400	80	4.02
4.03	ADMITTING		84,282	4,394	88,676	750	80	4.03
4.04	CASHIERING		20,181	2,286	22,467	860	464	4.04
5	Administrative & General		77,121	35,309	112,430	6,854	988	5
6	Maintenance & Repairs							6
7	Operation of Plant		305,666	575,911	881,577	1,403	288	7
8	Laundry & Linen Service		51,601		51,601			8
9	Housekeeping		49,386	5,208	54,594	1,127		9
10	Dietary		104,491	8,340	112,831	439	176	10
11	Cafeteria		47,340	9,486	56,826	309	16	11
12	Maintenance of Personnel							12
13	Nursing Administration		33,816	14,553	48,369	1,102	128	13
14	Central Services & Supply		155,054	31,591	186,645	511	16	14
15	Pharmacy		67,773	46,466	114,239	1,283	160	15
16	Medical Records & Library		69,763	15,169	84,932	490	352	16
17	Social Service		2,144	59	2,203	603	128	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd					138	16	21
22	I&R Services-Other Prgm Costs Apprvd		1,682		1,682			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		584,831	212,162	796,993	8,140	607	30
31	Intensive Care Unit		88,220	23,568	111,788	1,513		31
31.01	NICU							31.01
40	Subprovider - IPF		74,178	3,294	77,472	719		40
43	Nursery		54,319	14,694	69,013	1,118	48	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		256,237	118,519	374,756	1,835	384	50
52	Delivery Room & Labor Room		44,818	380,238	425,056	1,549	32	52
53	Anesthesiology		9,362	31,334	40,696	100	48	53
54	Radiology-Diagnostic		137,032	144,834	281,866	1,728	320	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory		114,427	714	115,141	5	384	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		34,321	11,720	46,041	701	80	65
66	Physical Therapy		36,339	5,282	41,621	346	48	66
69	Electrocardiology		44,523	29,471	73,994	149	128	69
70	Electroencephalography		6,096	676	6,772	11		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		29,892	78,579	108,471	411		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		110,741	28,356	139,097	3,366	112	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC		16,817		16,817	30	80	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY		45,322	8,731	54,053	310	80	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency		105,836	43,615	149,451	2,265	192	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)		3,000,685	2,418,613	5,419,298	41,752	5,435	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		8,787		8,787		16	190
192	Physicians' Private Offices		635,072	13,612	648,684	477	304	192
192.01	PROHEALTH SERVICES			6,404	6,404	1	80	192.01
192.02	AUXILIARY			13,217	13,217	299		192.02
200	Cross Foot Adjustments							200

KPMG LLP Compu-Max 2552-10

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	NEW CAP- REL COSTS BLDG&FIXT	NEW CAP- REL COSTS MOV EQUIP	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	NON PATIENT PHONES	
		0	1	2	2A	4	4.01	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		3,644,544	2,451,846	6,096,390	42,529	5,835	202

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	624,431						4.02
4.03	ADMITTING	51,090	140,596					4.03
4.04	CASHIERING	73,796		97,587				4.04
5	Administrative & General	45,413			165,685			5
6	Maintenance & Repairs							6
7	Operation of Plant	5,677			10,608	899,553		7
8	Laundry & Linen Service				770	15,369	67,740	8
9	Housekeeping	11,353			4,334	14,709		9
10	Dietary	11,353			3,376	31,122		10
11	Cafeteria				1,676	14,100		11
12	Maintenance of Personnel							12
13	Nursing Administration				3,739	10,072		13
14	Central Services & Supply	34,060			2,957	46,182		14
15	Pharmacy	39,737			5,514	20,186		15
16	Medical Records & Library	5,677			3,072	20,779		16
17	Social Service				2,094	639		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd				340			21
22	I&R Services-Other Prgm Costs Apprvd				187	501		22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	79,473	38,360	17,148	34,533	174,188	21,673	30
31	Intensive Care Unit	11,353	7,049	2,818	8,014	26,276	2,889	31
31.01	NICU							31.01
40	Subprovider - IPF		4,303	1,720	2,672	22,093		40
43	Nursery	11,353	3,421	1,367	3,865	16,179	3,617	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	22,707	5,651	5,766	9,430	76,319	12,267	50
52	Delivery Room & Labor Room	11,353	3,031	1,487	6,076	13,349	10,321	52
53	Anesthesiology		1,208	1,036	493	2,788		53
54	Radiology-Diagnostic	17,030	8,075	9,859	8,681	40,814	4,877	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	102,181	20,180	14,844	10,394	34,081		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	11,353	6,386	3,018	3,032	10,222		65
66	Physical Therapy	11,353	852	927	1,402	10,823	1,253	66
69	Electrocardiology	11,353	1,884	1,616	924	13,261		69
70	Electroencephalography	11,353	132	63	227	1,816		70
71	Medical Supplies Charged to Patients		588	529	1,394			71
72	Impl. Dev. Charged to Patients		2,003	1,282	2,267			72
73	Drugs Charged to Patients		21,733	12,216	4,849			73
75.01	ACUTE DIALYSIS		1,775	782	1,288			75.01
75.02	CARD CATH LAB		6,526	4,681	2,116	8,903		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	34,060	16	1,257	8,078	32,983	2,599	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC			82	271	5,009	108	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY		666	2,134	1,268	13,499	361	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	11,353	6,757	12,955	10,475	31,523	7,775	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	624,431	140,596	97,587	160,416	707,785	67,740	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				18	2,617		190
192	Physicians' Private Offices				2,925	189,151		192
192.01	PROHEALTH SERVICES				1,352			192.01
192.02	AUXILIARY				974			192.02
200	Cross Foot Adjustments							200

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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	
201	Negative Cost Centers	4.02	4.03	4.04	5	7	8	201
202	TOTAL (sum of lines 118-201)	624,431	140,596	97,587	165,685	899,553	67,740	202

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	86,117						9
10	Dietary	3,082	162,379					10
11	Cafeteria	1,397		74,324				11
12	Maintenance of Personnel							12
13	Nursing Administration	998		2,132	66,540			13
14	Central Services & Supply	4,574		1,773		276,718		14
15	Pharmacy	1,999		3,541			186,659	15
16	Medical Records & Library	2,058		1,598				16
17	Social Service	63		1,732				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			482				21
22	I&R Services-Other Prgm Costs Apprvd	50						22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	17,252	133,014	23,072	32,503	12,098	14,270	30
31	Intensive Care Unit	2,602	15,690	3,739	5,268	2,355	6,497	31
31.01	NICU							31.01
40	Subprovider - IPF	2,188	13,675	1,338	1,886	1,507	667	40
43	Nursery	1,602		2,415	3,403	122	291	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,559		4,072	5,737	668	6,887	50
52	Delivery Room & Labor Room	1,322		3,610	5,087	2,718	3,418	52
53	Anesthesiology	276		224	315	1,438	209	53
54	Radiology-Diagnostic	4,042		4,221		574	13	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	3,376					137	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	1,012		2,081	2,933	2	64	65
66	Physical Therapy	1,072		849				66
69	Electrocardiology	1,313		313	441	11		69
70	Electroencephalography	180		109		1		70
71	Medical Supplies Charged to Patients					79,434		71
72	Impl. Dev. Charged to Patients					162,660		72
73	Drugs Charged to Patients						128,323	73
75.01	ACUTE DIALYSIS					20	678	75.01
75.02	CARD CATH LAB	882		647	912	264	2,140	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	3,267		7,039		211	7,881	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	496		475		29	920	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	1,337		998		2,689	1,165	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	3,122		5,717	8,055	9,873	11,672	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	67,121	162,379	72,177	66,540	276,674	185,232	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	259						190
192	Physicians' Private Offices	18,737		1,382		38	884	192
192.01	PROHEALTH SERVICES					5	120	192.01
192.02	AUXILIARY			765		1	423	192.02
200	Cross Foot Adjustments							200

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		9	10	11	13	14	15	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	86,117	162,379	74,324	66,540	276,718	186,659	202

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	118,958						16
17	Social Service		7,462					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			976				21
22	I&R Services-Other Prgm Costs Apprvd				2,420			22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	20,991	6,492			1,430,807		30
31	Intensive Care Unit	3,432	298			211,581		31
31.01	NICU							31.01
40	Subprovider - IPF	2,095				132,335		40
43	Nursery	1,665				119,479		43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	7,022	224			541,284		50
52	Delivery Room & Labor Room	1,811				490,220		52
53	Anesthesiology	1,262				50,093		53
54	Radiology-Diagnostic	12,008				394,108		54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	18,078				318,801		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	3,676				90,601		65
66	Physical Therapy	1,129				71,675		66
69	Electrocardiology	1,968				107,355		69
70	Electroencephalography	77				20,741		70
71	Medical Supplies Charged to Patients	644				82,589		71
72	Impl. Dev. Charged to Patients	1,561				169,773		72
73	Drugs Charged to Patients	14,877				181,998		73
75.01	ACUTE DIALYSIS	952				5,495		75.01
75.02	CARD CATH LAB	5,702				141,655		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	1,531				241,497		90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	100				24,417		90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	2,599				81,159		90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	15,778	448			287,411		91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	118,958	7,462			5,195,074		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					11,697		190
192	Physicians' Private Offices					862,582		192
192.01	PROHEALTH SERVICES					7,962		192.01
192.02	AUXILIARY					15,679		192.02
200	Cross Foot Adjustments			976	2,420	3,396		200

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	I/R-SALARY AND FRINGES	I/R-OTHER PROGRAM COSTS	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		16	17	21	22	24	25	
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	118,958	7,462	976	2,420	6,096,390		202

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	1,430,807					30
31	Intensive Care Unit	211,581					31
31.01	NICU						31.01
40	Subprovider - IPF	132,335					40
43	Nursery	119,479					43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	541,284					50
52	Delivery Room & Labor Room	490,220					52
53	Anesthesiology	50,093					53
54	Radiology-Diagnostic	394,108					54
56.01	NUCLEAR MEDICINE						56.01
60	Laboratory	318,801					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	90,601					65
66	Physical Therapy	71,675					66
69	Electrocardiology	107,355					69
70	Electroencephalography	20,741					70
71	Medical Supplies Charged to Patients	82,589					71
72	Impl. Dev. Charged to Patients	169,773					72
73	Drugs Charged to Patients	181,998					73
75.01	ACUTE DIALYSIS	5,495					75.01
75.02	CARD CATH LAB	141,655					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	241,497					90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	24,417					90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	81,159					90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	Emergency	287,411					91
92	Observation Beds (Non-Distinct Part)						92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	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)	5,195,074					118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	11,697					190
192	Physicians' Private Offices	862,582					192
192.01	PROHEALTH SERVICES	7,962					192.01
192.02	AUXILIARY	15,679					192.02
200	Cross Foot Adjustments	3,396					200

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ALLOCATION OF CAPITAL-RELATED COSTS

**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	TOTAL						
		26						
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	6,096,390						202

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NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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		3,114,040					2
4 Employee Benefits Department	3,020	262	47,135,271				4
4.01 COMMUNICATIONS	403		206,955	365			4.01
4.02 DATA PROCESSING	6,358	678,030	1,552,079	5	110		4.02
4.03 ADMITTING	6,014	5,581	831,079	5	9	167,705,863	4.03
4.04 CASHIERING	1,440	2,903	953,558	29	13		4.04
5 Administrative & General	5,503	44,845	7,598,956	62	8		5
6 Maintenance & Repairs							6
7 Operation of Plant	21,811	731,452	1,555,232	18	1		7
8 Laundry & Linen Service	3,682						8
9 Housekeeping	3,524	6,614	1,249,466		2		9
10 Dietary	7,456	10,592	486,977	11	2		10
11 Cafeteria	3,378	12,048	342,413	1			11
12 Maintenance of Personnel							12
13 Nursing Administration	2,413	18,484	1,221,235	8			13
14 Central Services & Supply	11,064	40,123	566,643	1	6		14
15 Pharmacy	4,836	59,015	1,422,620	10	7		15
16 Medical Records & Library	4,978	19,266	543,118	22	1		16
17 Social Service	153	75	668,202	8			17
19 Nonphysician Anesthetists							19
20 Nursing School							20
21 I&R Services-Salary & Fringes Apprvd			153,104	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	269,463	9,011,394	38	14	45,703,677	30
31 Intensive Care Unit	6,295	29,933	1,677,722		2	8,412,153	31
31.01 NICU							31.01
40 Subprovider - IPF	5,293	4,184	796,673			5,134,921	40
43 Nursery	3,876	18,662	1,239,823	3	2	4,082,008	43
ANCILLARY SERVICE COST CENTERS							
50 Operating Room	18,284	150,529	2,034,511	24	4	6,743,199	50
52 Delivery Room & Labor Room	3,198	482,933	1,717,093	2	2	3,616,435	52
53 Anesthesiology	668	39,797	110,395	3		1,441,853	53
54 Radiology-Diagnostic	9,778	183,951	1,915,842	20	3	9,635,814	54
56.01 NUCLEAR MEDICINE							56.01
60 Laboratory	8,165	907	5,979	24	18	24,081,730	60
62.30 BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65 Respiratory Therapy	2,449	14,885	777,395	5	2	7,620,337	65
66 Physical Therapy	2,593	6,708	383,641	3	2	1,016,510	66
69 Electrocardiology	3,177	37,431	165,314	8	2	2,248,755	69
70 Electroencephalography	435	859	12,514		2	157,987	70
71 Medical Supplies Charged to Patients						701,492	71
72 Impl. Dev. Charged to Patients						2,390,208	72
73 Drugs Charged to Patients						25,934,215	73
75.01 ACUTE DIALYSIS						2,118,600	75.01
75.02 CARD CATH LAB	2,133	99,801	455,178			7,787,502	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	36,014	3,731,519	7	6	19,424	90
90.01 PH CLINIC							90.01
90.02 HEALTHWORKS CLINIC	1,200		33,381	5		40	90.02
90.03 DENTAL CLINIC							90.03
90.04 WOUND CARE THERAPY	3,234	11,089	343,255	5		795,343	90.04
90.05 FAMILY PRACTICE CLINIC							90.05
91 Emergency	7,552	55,395	2,510,888	12	2	8,063,660	91
92 Observation Beds (Non-Distinct Part)							92
93.99 PARTIAL HOSPITALIZATION PROGRAM							93.99
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	3,071,831	46,274,154	340	110	167,705,863	118
NONREIMBURSABLE COST CENTERS							
190 Gift, Flower, Coffee Shop & Canteen	627			1			190
192 Physicians' Private Offices	45,316	17,288	528,485	19			192
192.01 PROHEALTH SERVICES		8,134	1,097	5			192.01
192.02 AUXILIARY		16,787	331,535				192.02

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	NEW CAP-REL COSTS BLDG&FIXT (SQUARE FEET)	NEW CAP-REL COSTS MOV EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT GROSS SALARIES	NON PATIENT PHONES (NUMBER OF PHONES)	DATA PROCESSING (MACHINE TIME)	ADMITTING INPATIENT REVENUE	
		1	2	4	4.01	4.02	4.03	
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	3,644,544	2,451,846	8,107,773	354,980	5,104,008	1,810,497	202
203	Unit Cost Multiplier (Wkst. B, Part I)	14.014297	0.787352	0.172011	972.547945	46,400.072727	0.010796	203
204	Cost to be allocated (Per Wkst. B, Part II)			42,529	5,835	624,431	140,596	204
205	Unit Cost Multiplier (Wkst. B, Part II)			0.000902	15.986301	5,676.645455	0.000838	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	291,587,187						4.04
5	Administrative & General		-12,931,990	87,658,859				5
6	Maintenance & Repairs							6
7	Operation of Plant			5,612,567	215,510			7
8	Laundry & Linen Service			407,435	3,682	309,685		8
9	Housekeeping			2,293,342	3,524		208,304	9
10	Dietary			1,786,100	7,456		7,456	10
11	Cafeteria			886,951	3,378		3,378	11
12	Maintenance of Personnel							12
13	Nursing Administration			1,978,555	2,413		2,413	13
14	Central Services & Supply			1,564,420	11,064		11,064	14
15	Pharmacy			2,917,217	4,836		4,836	15
16	Medical Records & Library			1,625,251	4,978		4,978	16
17	Social Service			1,107,836	153		153	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd			179,896				21
22	I&R Services-Other Prgm Costs Apprvd			98,894	120		120	22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	51,468,796		18,266,836	41,731	99,074	41,731	30
31	Intensive Care Unit	8,412,153		4,240,329	6,295	13,209	6,295	31
31.01	NICU							31.01
40	Subprovider - IPF	5,134,921		1,413,520	5,293		5,293	40
43	Nursery	4,082,008		2,044,823	3,876	16,535	3,876	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	17,211,431		4,989,411	18,284	56,083	18,284	50
52	Delivery Room & Labor Room	4,438,745		3,214,859	3,198	47,186	3,198	52
53	Anesthesiology	3,093,938		261,056	668		668	53
54	Radiology-Diagnostic	29,430,433		4,593,150	9,778	22,294	9,778	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	44,309,154		5,499,407	8,165		8,165	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	9,010,442		1,604,314	2,449		2,449	65
66	Physical Therapy	2,767,857		741,986	2,593	5,730	2,593	66
69	Electrocardiology	4,822,998		488,680	3,177		3,177	69
70	Electroencephalography	189,533		120,247	435		435	70
71	Medical Supplies Charged to Patients	1,577,673		737,380				71
72	Impl. Dev. Charged to Patients	3,826,847		1,199,220				72
73	Drugs Charged to Patients	36,464,236		2,565,351				73
75.01	ACUTE DIALYSIS	2,334,218		681,422				75.01
75.02	CARD CATH LAB	13,974,293		1,119,817	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	3,751,338		4,274,251	7,902	11,883	7,902	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	244,911		143,302	1,200	494	1,200	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	6,370,736		670,720	3,234	1,652	3,234	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	38,670,526		5,542,223	7,552	35,545	7,552	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	291,587,187	-12,931,990	84,870,768	169,567	309,685	162,361	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen			9,760	627		627	190
192	Physicians' Private Offices			1,547,875	45,316		45,316	192
192.01	PROHEALTH SERVICES			715,129				192.01
192.02	AUXILIARY			515,327				192.02

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CASHIERS GROSS REVENUE	RECON- CILIATION	ADMINI- STRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	LAUNDRY AND LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSE- KEEPING SQUARE FEET	
		4.04	5A	5	7	8	9	
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,782,183		12,931,990	6,440,567	577,579	2,736,986	202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.009542		0.147526	29,885235	1.865053	13.139383	203
204	Cost to be allocated (Per Wkst. B, Part II)	97,587		165,685	899,553	67,740	86,117	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.000335		0.001890	4.174066	0.218738	0.413420	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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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	97,893						10
11	Cafeteria		47,206					11
12	Maintenance of Personnel							12
13	Nursing Administration		1,354	29,996				13
14	Central Services & Supply		1,126		1,934,109			14
15	Pharmacy		2,249			2,818,176		15
16	Medical Records & Library		1,015				291,587,187	16
17	Social Service		1,100					17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd		306					21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	80,190	14,653	14,653	84,556	215,446	51,468,796	30
31	Intensive Care Unit	9,459	2,375	2,375	16,460	98,094	8,412,153	31
31.01	NICU							31.01
40	Subprovider - IPF	8,244	850	850	10,532	10,069	5,134,921	40
43	Nursery		1,534	1,534	853	4,387	4,082,008	43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room		2,586	2,586	4,670	103,985	17,211,431	50
52	Delivery Room & Labor Room		2,293	2,293	18,999	51,610	4,438,745	52
53	Anesthesiology		142	142	10,054	3,158	3,093,938	53
54	Radiology-Diagnostic		2,681		4,011	203	29,430,433	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory					2,075	44,309,154	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,322	1,322	15	970	9,010,442	65
66	Physical Therapy		539				2,767,857	66
69	Electrocardiology		199	199	74		4,822,998	69
70	Electroencephalography		69		8		189,533	70
71	Medical Supplies Charged to Patients				555,196		1,577,673	71
72	Impl. Dev. Charged to Patients				1,136,899		3,826,847	72
73	Drugs Charged to Patients					1,937,423	36,464,236	73
75.01	ACUTE DIALYSIS				139	10,230	2,334,218	75.01
75.02	CARD CATH LAB		411	411	1,846	32,310	13,974,293	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		4,471		1,478	118,985	3,751,338	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC		302		206	13,888	244,911	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY		634		18,793	17,584	6,370,736	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency		3,631	3,631	69,006	176,225	38,670,526	91
92	Observation Beds (Non-Distinct Part)							92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	97,893	45,842	29,996	1,933,795	2,796,642	291,587,187	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
192	Physicians' Private Offices		878		269	13,343		192
192.01	PROHEALTH SERVICES				38	1,810		192.01
192.02	AUXILIARY		486		7	6,381		192.02

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	DIETARY (MEALS SERVED)	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS)	PHARMACY (COSTED REQUIS)	MEDICAL RECORDS & LIBRARY GROSS REVENUE	
		10	11	13	14	15	16	
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	2,370,387	1,163,136	2,407,623	2,298,981	3,611,063	2,104,204	202
203	Unit Cost Multiplier (Wkst. B, Part I)	24.214060	24.639580	80.264802	1.188651	1.281348	0.007216	203
204	Cost to be allocated (Per Wkst. B, Part II)	162,379	74,324	66,540	276,718	186,659	118,958	204
205	Unit Cost Multiplier (Wkst. B, Part II)	1.658740	1.574461	2.218296	0.143073	0.066234	0.000408	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

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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
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
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
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							
190	Gift, Flower, Coffee Shop & Canteen						190
192	Physicians' Private Offices						192

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	SOCIAL SERVICE (TIME SPENT)	I/R-SALARY AND FRINGES (ASSIGNED TIME)	I/R-OTHER PROGRAM COSTS (ASSIGNED TIME)				
		17	21	22				
192.01	PROHEALTH SERVICES							192.01
192.02	AUXILIARY							192.02
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	1,304,957	213,975	118,646				202
203	Unit Cost Multiplier (Wkst. B, Part I)	13,049.570000	2,139.750000	1,186.460000				203
204	Cost to be allocated (Per Wkst. B, Part II)	7,462	976	2,420				204
205	Unit Cost Multiplier (Wkst. B, Part II)	74.620000	9.760000	24.200000				205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		CODE	LINE NO.	AMOUNT
	1	2	3	4

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	28,304,215		28,304,215		28,304,215	30
31	Intensive Care Unit	5,897,710		5,897,710		5,897,710	31
31.01	NICU						31.01
40	Subprovider - IPF	2,201,046		2,201,046		2,201,046	40
43	Nursery	2,741,104		2,741,104		2,741,104	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,190,161		7,190,161		7,190,161	50
52	Delivery Room & Labor Room	4,276,020		4,276,020		4,276,020	52
53	Anesthesiology	381,529		381,529		381,529	53
54	Radiology-Diagnostic	6,016,490		6,016,490		6,016,490	54
56.01	NUCLEAR MEDICINE						56.01
60	Laboratory	6,984,403		6,984,403		6,984,403	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	2,151,323		2,151,323		2,151,323	65
66	Physical Therapy	1,006,951		1,006,951		1,006,951	66
69	Electrocardiology	753,229		753,229		753,229	69
70	Electroencephalography	159,781		159,781		159,781	70
71	Medical Supplies Charged to Patients	1,517,481		1,517,481		1,517,481	71
72	Impl. Dev. Charged to Patients	2,755,127		2,755,127		2,755,127	72
73	Drugs Charged to Patients	5,689,447		5,689,447		5,689,447	73
75.01	ACUTE DIALYSIS	812,066		812,066		812,066	75.01
75.02	CARD CATH LAB	1,564,338		1,564,338		1,564,338	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	5,558,408		5,558,408	153,367	5,711,775	90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	244,241		244,241		244,241	90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	1,018,353		1,018,353		1,018,353	90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	Emergency	7,797,141		7,797,141		7,797,141	91
92	Observation Beds (Non-Distinct Part)	2,166,730		2,166,730		2,166,730	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	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)	97,187,294		97,187,294	153,367	97,340,661	200
201	Less Observation Beds	2,166,730		2,166,730		2,166,730	201
202	Total (line 200 minus line 201)	95,020,564		95,020,564		95,173,931	202

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	45,703,677		45,703,677				30
31	Intensive Care Unit	8,412,153		8,412,153				31
31.01	NICU							31.01
40	Subprovider - IPF	5,134,921		5,134,921				40
43	Nursery	4,082,008		4,082,008				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,743,199	10,468,232	17,211,431	0.417755	0.417755	0.417755	50
52	Delivery Room & Labor Room	3,616,435	822,310	4,438,745	0.963340	0.963340	0.963340	52
53	Anesthesiology	1,441,853	1,652,085	3,093,938	0.123315	0.123315	0.123315	53
54	Radiology-Diagnostic	9,635,814	19,794,619	29,430,433	0.204431	0.204431	0.204431	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	24,081,730	20,227,424	44,309,154	0.157629	0.157629	0.157629	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	7,620,337	1,390,105	9,010,442	0.238759	0.238759	0.238759	65
66	Physical Therapy	1,016,510	1,751,347	2,767,857	0.363802	0.363802	0.363802	66
69	Electrocardiology	2,248,755	2,574,243	4,822,998	0.156174	0.156174	0.156174	69
70	Electroencephalography	157,987	31,546	189,533	0.843025	0.843025	0.843025	70
71	Medical Supplies Charged to Patients	701,492	876,181	1,577,673	0.961848	0.961848	0.961848	71
72	Impl. Dev. Charged to Patients	2,390,208	1,436,639	3,826,847	0.719947	0.719947	0.719947	72
73	Drugs Charged to Patients	25,934,215	10,530,021	36,464,236	0.156028	0.156028	0.156028	73
75.01	ACUTE DIALYSIS	2,118,600	215,618	2,334,218	0.347896	0.347896	0.347896	75.01
75.02	CARD CATH LAB	7,787,502	6,186,791	13,974,293	0.111944	0.111944	0.111944	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	19,424	3,731,914	3,751,338	1.481713	1.481713	1.522597	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	40	244,871	244,911	0.997264	0.997264	0.997264	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	795,343	5,575,393	6,370,736	0.159849	0.159849	0.159849	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	8,063,660	30,606,866	38,670,526	0.201630	0.201630	0.201630	91
92	Observation Beds (Non-Distinct Part)		5,765,119	5,765,119	0.375834	0.375834	0.375834	92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	167,705,863	123,881,324	291,587,187				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	167,705,863	123,881,324	291,587,187				202

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

**WORKSHEET C
PART I**

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (B Part I col 26 plus sum of cols 21 & 22)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	28,304,215		28,304,215		28,304,215	30
31	Intensive Care Unit	5,897,710		5,897,710		5,897,710	31
31.01	NICU						31.01
40	Subprovider - IPF	2,201,046		2,201,046		2,201,046	40
43	Nursery	2,741,104		2,741,104		2,741,104	43
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	7,190,161		7,190,161		7,190,161	50
52	Delivery Room & Labor Room	4,276,020		4,276,020		4,276,020	52
53	Anesthesiology	381,529		381,529		381,529	53
54	Radiology-Diagnostic	6,016,490		6,016,490		6,016,490	54
56.01	NUCLEAR MEDICINE						56.01
60	Laboratory	6,984,403		6,984,403		6,984,403	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	2,151,323		2,151,323		2,151,323	65
66	Physical Therapy	1,006,951		1,006,951		1,006,951	66
69	Electrocardiology	753,229		753,229		753,229	69
70	Electroencephalography	159,781		159,781		159,781	70
71	Medical Supplies Charged to Patients	1,517,481		1,517,481		1,517,481	71
72	Impl. Dev. Charged to Patients	2,755,127		2,755,127		2,755,127	72
73	Drugs Charged to Patients	5,689,447		5,689,447		5,689,447	73
75.01	ACUTE DIALYSIS	812,066		812,066		812,066	75.01
75.02	CARD CATH LAB	1,564,338		1,564,338		1,564,338	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	5,558,408		5,558,408	153,367	5,711,775	90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	244,241		244,241		244,241	90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	1,018,353		1,018,353		1,018,353	90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	Emergency	7,797,141		7,797,141		7,797,141	91
92	Observation Beds (Non-Distinct Part)	2,166,730		2,166,730		2,166,730	92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	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)	97,187,294		97,187,294	153,367	97,340,661	200
201	Less Observation Beds	2,166,730		2,166,730		2,166,730	201
202	Total (line 200 minus line 201)	95,020,564		95,020,564	153,367	95,173,931	202

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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COMPUTATION OF RATIO OF COST TO CHARGES - TITLE XIX (NOT AN OFFICIAL FORM CMS-2552-10 WORKSHEET)

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	45,703,677		45,703,677				30
31	Intensive Care Unit	8,412,153		8,412,153				31
31.01	NICU							31.01
40	Subprovider - IPF	5,134,921		5,134,921				40
43	Nursery	4,082,008		4,082,008				43
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	6,743,199	10,468,232	17,211,431	0.417755	0.417755	0.417755	50
52	Delivery Room & Labor Room	3,616,435	822,310	4,438,745	0.963340	0.963340	0.963340	52
53	Anesthesiology	1,441,853	1,652,085	3,093,938	0.123315	0.123315	0.123315	53
54	Radiology-Diagnostic	9,635,814	19,794,619	29,430,433	0.204431	0.204431	0.204431	54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	24,081,730	20,227,424	44,309,154	0.157629	0.157629	0.157629	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	7,620,337	1,390,105	9,010,442	0.238759	0.238759	0.238759	65
66	Physical Therapy	1,016,510	1,751,347	2,767,857	0.363802	0.363802	0.363802	66
69	Electrocardiology	2,248,755	2,574,243	4,822,998	0.156174	0.156174	0.156174	69
70	Electroencephalography	157,987	31,546	189,533	0.843025	0.843025	0.843025	70
71	Medical Supplies Charged to Patients	701,492	876,181	1,577,673	0.961848	0.961848	0.961848	71
72	Impl. Dev. Charged to Patients	2,390,208	1,436,639	3,826,847	0.719947	0.719947	0.719947	72
73	Drugs Charged to Patients	25,934,215	10,530,021	36,464,236	0.156028	0.156028	0.156028	73
75.01	ACUTE DIALYSIS	2,118,600	215,618	2,334,218	0.347896	0.347896	0.347896	75.01
75.02	CARD CATH LAB	7,787,502	6,186,791	13,974,293	0.111944	0.111944	0.111944	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	19,424	3,731,914	3,751,338	1.481713	1.481713	1.522597	90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	40	244,871	244,911	0.997264	0.997264	0.997264	90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	795,343	5,575,393	6,370,736	0.159849	0.159849	0.159849	90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	8,063,660	30,606,866	38,670,526	0.201630	0.201630	0.201630	91
92	Observation Beds (Non-Distinct Part)		5,765,119	5,765,119	0.375834	0.375834	0.375834	92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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)	167,705,863	123,881,324	291,587,187				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	167,705,863	123,881,324	291,587,187				202

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

**WORKSHEET C
PART II**

[] Title V

[XX] Title XIX

	COST CENTER DESCRIPTIONS	Total Cost (Wkst B, Part I, col. 26)	Capital Cost (Wkst B, Part II, col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	
		1	2	3	4	
	ANCILLARY SERVICE COST CENTERS					
50	Operating Room	7,190,161	541,284	6,648,877		50
52	Delivery Room & Labor Room	4,276,020	490,220	3,785,800		52
53	Anesthesiology	381,529	50,093	331,436		53
54	Radiology-Diagnostic	6,016,490	394,108	5,622,382		54
56.01	NUCLEAR MEDICINE					56.01
60	Laboratory	6,984,403	318,801	6,665,602		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	2,151,323	90,601	2,060,722		65
66	Physical Therapy	1,006,951	71,675	935,276		66
69	Electrocardiology	753,229	107,355	645,874		69
70	Electroencephalography	159,781	20,741	139,040		70
71	Medical Supplies Charged to Patients	1,517,481	82,589	1,434,892		71
72	Impl. Dev. Charged to Patients	2,755,127	169,773	2,585,354		72
73	Drugs Charged to Patients	5,689,447	181,998	5,507,449		73
75.01	ACUTE DIALYSIS	812,066	5,495	806,571		75.01
75.02	CARD CATH LAB	1,564,338	141,655	1,422,683		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	5,558,408	241,497	5,316,911		90
90.01	PH CLINIC					90.01
90.02	HEALTHWORKS CLINIC	244,241	24,417	219,824		90.02
90.03	DENTAL CLINIC					90.03
90.04	WOUND CARE THERAPY	1,018,353	81,159	937,194		90.04
90.05	FAMILY PRACTICE CLINIC					90.05
91	Emergency	7,797,141	287,411	7,509,730		91
92	Observation Beds (Non-Distinct Part)	2,166,730	109,530	2,057,200		92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
	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	58,043,219	3,410,402	54,632,817		200
201	Less Observation Beds	2,166,730	109,530	2,057,200		201
202	Total	55,876,489	3,300,872	52,575,617		202

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY

**WORKSHEET C
PART II**

[] Title V

[XX] Title XIX

COST CENTER DESCRIPTIONS		Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Wkst C, Part I, col. 8)	Outpatient Cost to Charge Ratio (col. 6 ÷ col. 7)	
		5	6	7	8	
ANCILLARY SERVICE COST CENTERS						
50	Operating Room		7,190,161	17,211,431	0.417755	50
52	Delivery Room & Labor Room		4,276,020	4,438,745	0.963340	52
53	Anesthesiology		381,529	3,093,938	0.123315	53
54	Radiology-Diagnostic		6,016,490	29,430,433	0.204431	54
56.01	NUCLEAR MEDICINE					56.01
60	Laboratory		6,984,403	44,309,154	0.157629	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy		2,151,323	9,010,442	0.238759	65
66	Physical Therapy		1,006,951	2,767,857	0.363802	66
69	Electrocardiology		753,229	4,822,998	0.156174	69
70	Electroencephalography		159,781	189,533	0.843025	70
71	Medical Supplies Charged to Patients		1,517,481	1,577,673	0.961848	71
72	Impl. Dev. Charged to Patients		2,755,127	3,826,847	0.719947	72
73	Drugs Charged to Patients		5,689,447	36,464,236	0.156028	73
75.01	ACUTE DIALYSIS		812,066	2,334,218	0.347896	75.01
75.02	CARD CATH LAB		1,564,338	13,974,293	0.111944	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		5,558,408	3,751,338	1.481713	90
90.01	PH CLINIC					90.01
90.02	HEALTHWORKS CLINIC		244,241	244,911	0.997264	90.02
90.03	DENTAL CLINIC					90.03
90.04	WOUND CARE THERAPY		1,018,353	6,370,736	0.159849	90.04
90.05	FAMILY PRACTICE CLINIC					90.05
91	Emergency		7,797,141	38,670,526	0.201630	91
92	Observation Beds (Non-Distinct Part)		2,166,730	5,765,119	0.375834	92
93.99	PARTIAL HOSPITALIZATION PROGRAM					93.99
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		58,043,219	228,254,428		200
201	Less Observation Beds		2,166,730	5,765,119		201
202	Total		55,876,489	222,489,309		202

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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)	1,430,807		1,430,807	28,791	49.70	6,248	310,526	30
31	Intensive Care Unit	211,581		211,581	3,153	67.10	1,073	71,998	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	132,335		132,335	2,748	48.16	880	42,381	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	119,479		119,479	1,433	83.38			43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,894,202		1,894,202	36,125		8,201	424,905	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	541,284	17,211,431	0.031449	1,910,789	60,092	50
52	Delivery Room & Labor Room	490,220	4,438,745	0.110441	16,142	1,783	52
53	Anesthesiology	50,093	3,093,938	0.016191	458,459	7,423	53
54	Radiology-Diagnostic	394,108	29,430,433	0.013391	3,406,906	45,622	54
56.01	NUCLEAR MEDICINE						56.01
60	Laboratory	318,801	44,309,154	0.007195	7,495,484	53,930	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	90,601	9,010,442	0.010055	2,598,030	26,123	65
66	Physical Therapy	71,675	2,767,857	0.025895	378,702	9,806	66
69	Electrocardiology	107,355	4,822,998	0.022259	816,913	18,184	69
70	Electroencephalography	20,741	189,533	0.109432	51,003	5,581	70
71	Medical Supplies Charged to Pat	82,589	1,577,673	0.052349	300,267	15,719	71
72	Impl. Dev. Charged to Patients	169,773	3,826,847	0.044364	842,087	37,358	72
73	Drugs Charged to Patients	181,998	36,464,236	0.004991	7,947,698	39,667	73
75.01	ACUTE DIALYSIS	5,495	2,334,218	0.002354	937,200	2,206	75.01
75.02	CARD CATH LAB	141,655	13,974,293	0.010137	3,375,852	34,221	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	241,497	3,751,338	0.064376	11,173	719	90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	24,417	244,911	0.099697			90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	81,159	6,370,736	0.012739	294,090	3,746	90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	Emergency	287,411	38,670,526	0.007432	2,300,165	17,095	91
92	Observation Beds (Non-Distinct	109,530	5,765,119	0.018999			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,410,402	228,254,428		33,140,960	379,275	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Nursing School Post-Stepdown Adjustments 1A	Nursing School 1	Allied Health Post-Stepdown Adjustments 2A	Allied Health Cost 2	All Other Medical Education Cost 3	Swing-Bed Adjustment Amount (see instructions) 4	Total Costs (sum of cols. 1 through 3 minus col 4.) 5	
	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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)	28,791		6,248		30
31	Intensive Care Unit	3,153		1,073		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	2,748		880		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	1,433				43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	36,125		8,201		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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0206

**WORKSHEET D
PART IV**

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	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
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
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	17,211,431			1,910,789		2,094,671		50
52	Delivery Room & Labor Room	4,438,745			16,142		4,767		52
53	Anesthesiology	3,093,938			458,459		343,498		53
54	Radiology-Diagnostic	29,430,433			3,406,906		2,403,426		54
56.01	NUCLEAR MEDICINE								56.01
60	Laboratory	44,309,154			7,495,484		1,744,062		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,010,442			2,598,030		148,028		65
66	Physical Therapy	2,767,857			378,702		13,020		66
69	Electrocardiology	4,822,998			816,913		473,769		69
70	Electroencephalography	189,533			51,003		7,186		70
71	Medical Supplies Charged to Pat	1,577,673			300,267		336,957		71
72	Impl. Dev. Charged to Patients	3,826,847			842,087		577,386		72
73	Drugs Charged to Patients	36,464,236			7,947,698		3,162,964		73
75.01	ACUTE DIALYSIS	2,334,218			937,200		26,400		75.01
75.02	CARD CATH LAB	13,974,293			3,375,852		3,603,912		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	3,751,338			11,173		714,555		90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	244,911							90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	6,370,736			294,090		1,366,349		90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	38,670,526			2,300,165		2,447,023		91
92	Observation Beds (Non-Distinct	5,765,119					634,380		92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	228,254,428			33,140,960		20,102,353		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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	0.417755	2,094,671			875,059			50
52	Delivery Room & Labor Room	0.963340	4,767			4,592			52
53	Anesthesiology	0.123315	343,498			42,358			53
54	Radiology-Diagnostic	0.204431	2,403,426			491,335			54
56.01	NUCLEAR MEDICINE								56.01
60	Laboratory	0.157629	1,744,062			274,915			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.238759	148,028			35,343			65
66	Physical Therapy	0.363802	13,020			4,737			66
69	Electrocardiology	0.156174	473,769			73,990			69
70	Electroencephalography	0.843025	7,186			6,058			70
71	Medical Supplies Charged to Pat	0.961848	336,957			324,101			71
72	Impl. Dev. Charged to Patients	0.719947	577,386			415,687			72
73	Drugs Charged to Patients	0.156028	3,162,964		480	493,511		75	73
75.01	ACUTE DIALYSIS	0.347896	26,400			9,184			75.01
75.02	CARD CATH LAB	0.111944	3,603,912			403,436			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	1.481713	714,555			1,058,765			90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	0.997264							90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	0.159849	1,366,349			218,410			90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	0.201630	2,447,023			493,393			91
92	Observation Beds (Non-Distinct	0.375834	634,380			238,422			92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)		20,102,353		480	5,463,296		75	200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)		20,102,353		480	5,463,296		75	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	541,284	17,211,431	0.031449			50
52	Delivery Room & Labor Room	490,220	4,438,745	0.110441			52
53	Anesthesiology	50,093	3,093,938	0.016191			53
54	Radiology-Diagnostic	394,108	29,430,433	0.013391	27,817	372	54
56.01	NUCLEAR MEDICINE						56.01
60	Laboratory	318,801	44,309,154	0.007195	163,126	1,174	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	90,601	9,010,442	0.010055	315	3	65
66	Physical Therapy	71,675	2,767,857	0.025895	2,232	58	66
69	Electrocardiology	107,355	4,822,998	0.022259	12,876	287	69
70	Electroencephalography	20,741	189,533	0.109432			70
71	Medical Supplies Charged to Pat	82,589	1,577,673	0.052349			71
72	Impl. Dev. Charged to Patients	169,773	3,826,847	0.044364			72
73	Drugs Charged to Patients	181,998	36,464,236	0.004991	322,051	1,607	73
75.01	ACUTE DIALYSIS	5,495	2,334,218	0.002354			75.01
75.02	CARD CATH LAB	141,655	13,974,293	0.010137			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	241,497	3,751,338	0.064376			90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	24,417	244,911	0.099697			90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	81,159	6,370,736	0.012739			90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	Emergency	287,411	38,670,526	0.007432	36,362	270	91
92	Observation Beds (Non-Distinct		5,765,119				92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,300,872	228,254,428		564,779	3,771	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S206

**WORKSHEET D
PART IV**

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

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	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
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
93.99	PARTIAL HOSPITALIZATION PROGRAM									93.99
	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	17,211,431							50
52	Delivery Room & Labor Room	4,438,745							52
53	Anesthesiology	3,093,938							53
54	Radiology-Diagnostic	29,430,433			27,817				54
56.01	NUCLEAR MEDICINE								56.01
60	Laboratory	44,309,154			163,126				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,010,442			315				65
66	Physical Therapy	2,767,857			2,232				66
69	Electrocardiology	4,822,998			12,876				69
70	Electroencephalography	189,533							70
71	Medical Supplies Charged to Pat	1,577,673							71
72	Impl. Dev. Charged to Patients	3,826,847							72
73	Drugs Charged to Patients	36,464,236			322,051				73
75.01	ACUTE DIALYSIS	2,334,218							75.01
75.02	CARD CATH LAB	13,974,293							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	3,751,338							90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	244,911							90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	6,370,736							90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	38,670,526			36,362				91
92	Observation Beds (Non-Distinct	5,765,119							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	228,254,428			564,779				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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	0.417755							50
52	Delivery Room & Labor Room	0.963340							52
53	Anesthesiology	0.123315							53
54	Radiology-Diagnostic	0.204431							54
56.01	NUCLEAR MEDICINE								56.01
60	Laboratory	0.157629							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.238759							65
66	Physical Therapy	0.363802							66
69	Electrocardiology	0.156174							69
70	Electroencephalography	0.843025							70
71	Medical Supplies Charged to Pat	0.961848							71
72	Impl. Dev. Charged to Patients	0.719947							72
73	Drugs Charged to Patients	0.156028							73
75.01	ACUTE DIALYSIS	0.347896							75.01
75.02	CARD CATH LAB	0.111944							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	1.481713							90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	0.997264							90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	0.159849							90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	0.201630							91
92	Observation Beds (Non-Distinct)	0.375834							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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)	1,430,807		1,430,807	28,791	49.70	2,275	113,068	30
31	Intensive Care Unit	211,581		211,581	3,153	67.10	245	16,440	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	132,335		132,335	2,748	48.16	1,462	70,410	40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery	119,479		119,479	1,433	83.38	872	72,707	43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	1,894,202		1,894,202	36,125		4,854	272,625	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0206

**WORKSHEET D
PART II**

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	541,284	17,211,431	0.031449	525,435	16,524	50
52	Delivery Room & Labor Room	490,220	4,438,745	0.110441	455,455	50,301	52
53	Anesthesiology	50,093	3,093,938	0.016191	99,183	1,606	53
54	Radiology-Diagnostic	394,108	29,430,433	0.013391	903,812	12,103	54
56.01	NUCLEAR MEDICINE						56.01
60	Laboratory	318,801	44,309,154	0.007195	2,417,457	17,394	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	90,601	9,010,442	0.010055	601,642	6,050	65
66	Physical Therapy	71,675	2,767,857	0.025895	66,084	1,711	66
69	Electrocardiology	107,355	4,822,998	0.022259	176,043	3,919	69
70	Electroencephalography	20,741	189,533	0.109432	17,651	1,932	70
71	Medical Supplies Charged to Pat	82,589	1,577,673	0.052349	46,086	2,413	71
72	Impl. Dev. Charged to Patients	169,773	3,826,847	0.044364	240,492	10,669	72
73	Drugs Charged to Patients	181,998	36,464,236	0.004991	2,320,731	11,583	73
75.01	ACUTE DIALYSIS	5,495	2,334,218	0.002354	117,150	276	75.01
75.02	CARD CATH LAB	141,655	13,974,293	0.010137	466,947	4,733	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	241,497	3,751,338	0.064376			90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	24,417	244,911	0.099697			90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	81,159	6,370,736	0.012739	85,920	1,095	90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	Emergency	287,411	38,670,526	0.007432	664,792	4,941	91
92	Observation Beds (Non-Distinct	109,530	5,765,119	0.018999			92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,410,402	228,254,428		9,204,880	147,250	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

**WORKSHEET D
PART III**

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

(A)	Cost Center Description	Nursing School Post-Stepdown Adjustments 1A	Nursing School 1	Allied Health Post-Stepdown Adjustments 2A	Allied Health Cost 2	All Other Medical Education Cost 3	Swing-Bed Adjustment Amount (see instructions) 4	Total Costs (sum of cols. 1 through 3 minus col 4.) 5	
	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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)	28,791		2,275		30
31	Intensive Care Unit	3,153		245		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	2,748		1,462		40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery	1,433		872		43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	36,125		4,854		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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-0206

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1	2A	2	3A	3	4	5	6
	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
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
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	17,211,431			525,435				50
52	Delivery Room & Labor Room	4,438,745			455,455				52
53	Anesthesiology	3,093,938			99,183				53
54	Radiology-Diagnostic	29,430,433			903,812				54
56.01	NUCLEAR MEDICINE								56.01
60	Laboratory	44,309,154			2,417,457				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,010,442			601,642				65
66	Physical Therapy	2,767,857			66,084				66
69	Electrocardiology	4,822,998			176,043				69
70	Electroencephalography	189,533			17,651				70
71	Medical Supplies Charged to Pat	1,577,673			46,086				71
72	Impl. Dev. Charged to Patients	3,826,847			240,492				72
73	Drugs Charged to Patients	36,464,236			2,320,731				73
75.01	ACUTE DIALYSIS	2,334,218			117,150				75.01
75.02	CARD CATH LAB	13,974,293			466,947				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	3,751,338							90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	244,911							90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	6,370,736			85,920				90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	38,670,526			664,792				91
92	Observation Beds (Non-Distinct	5,765,119							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	228,254,428			9,204,880				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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0206

WORKSHEET D
PART V

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

(A)	Cost Center Description	Program Charges				Program Cost		
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	Operating Room	0.417755						50
52	Delivery Room & Labor Room	0.963340						52
53	Anesthesiology	0.123315						53
54	Radiology-Diagnostic	0.204431						54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	0.157629						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.238759						65
66	Physical Therapy	0.363802						66
69	Electrocardiology	0.156174						69
70	Electroencephalography	0.843025						70
71	Medical Supplies Charged to Pat	0.961848						71
72	Impl. Dev. Charged to Patients	0.719947						72
73	Drugs Charged to Patients	0.156028						73
75.01	ACUTE DIALYSIS	0.347896						75.01
75.02	CARD CATH LAB	0.111944						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	1.481713						90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	0.997264						90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	0.159849						90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	0.201630						91
92	Observation Beds (Non-Distinct	0.375834						92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S206

WORKSHEET D
PART II

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

(A)	Cost Center Description	Capital Related Cost (from Wkst. B, Part II (col. 26))	Total Charges (from Wkst. C, Part I, (col. 8))	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	Operating Room	541,284	17,211,431	0.031449			50
52	Delivery Room & Labor Room	490,220	4,438,745	0.110441			52
53	Anesthesiology	50,093	3,093,938	0.016191			53
54	Radiology-Diagnostic	394,108	29,430,433	0.013391			54
56.01	NUCLEAR MEDICINE						56.01
60	Laboratory	318,801	44,309,154	0.007195			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	90,601	9,010,442	0.010055			65
66	Physical Therapy	71,675	2,767,857	0.025895			66
69	Electrocardiology	107,355	4,822,998	0.022259			69
70	Electroencephalography	20,741	189,533	0.109432			70
71	Medical Supplies Charged to Pat	82,589	1,577,673	0.052349			71
72	Impl. Dev. Charged to Patients	169,773	3,826,847	0.044364			72
73	Drugs Charged to Patients	181,998	36,464,236	0.004991			73
75.01	ACUTE DIALYSIS	5,495	2,334,218	0.002354			75.01
75.02	CARD CATH LAB	141,655	13,974,293	0.010137			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	241,497	3,751,338	0.064376			90
90.01	PH CLINIC						90.01
90.02	HEALTHWORKS CLINIC	24,417	244,911	0.099697			90.02
90.03	DENTAL CLINIC						90.03
90.04	WOUND CARE THERAPY	81,159	6,370,736	0.012739			90.04
90.05	FAMILY PRACTICE CLINIC						90.05
91	Emergency	287,411	38,670,526	0.007432			91
92	Observation Beds (Non-Distinct		5,765,119				92
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	3,300,872	228,254,428				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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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**APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS**

COMPONENT CCN: 14-S206

**WORKSHEET D
PART IV**

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

(A)	Cost Center Description	1	2A	2	3A	3	4	5	6
	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
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
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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)	
	ANCILLARY SERVICE COST CENTERS								
50	Operating Room	17,211,431							50
52	Delivery Room & Labor Room	4,438,745							52
53	Anesthesiology	3,093,938							53
54	Radiology-Diagnostic	29,430,433							54
56.01	NUCLEAR MEDICINE								56.01
60	Laboratory	44,309,154							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	9,010,442							65
66	Physical Therapy	2,767,857							66
69	Electrocardiology	4,822,998							69
70	Electroencephalography	189,533							70
71	Medical Supplies Charged to Pat	1,577,673							71
72	Impl. Dev. Charged to Patients	3,826,847							72
73	Drugs Charged to Patients	36,464,236							73
75.01	ACUTE DIALYSIS	2,334,218							75.01
75.02	CARD CATH LAB	13,974,293							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	3,751,338							90
90.01	PH CLINIC								90.01
90.02	HEALTHWORKS CLINIC	244,911							90.02
90.03	DENTAL CLINIC								90.03
90.04	WOUND CARE THERAPY	6,370,736							90.04
90.05	FAMILY PRACTICE CLINIC								90.05
91	Emergency	38,670,526							91
92	Observation Beds (Non-Distinct)	5,765,119							92
93.99	PARTIAL HOSPITALIZATION PROGRAM								93.99
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	228,254,428							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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	0.417755						50
52	Delivery Room & Labor Room	0.963340						52
53	Anesthesiology	0.123315						53
54	Radiology-Diagnostic	0.204431						54
56.01	NUCLEAR MEDICINE							56.01
60	Laboratory	0.157629						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.238759						65
66	Physical Therapy	0.363802						66
69	Electrocardiology	0.156174						69
70	Electroencephalography	0.843025						70
71	Medical Supplies Charged to Pat	0.961848						71
72	Impl. Dev. Charged to Patients	0.719947						72
73	Drugs Charged to Patients	0.156028						73
75.01	ACUTE DIALYSIS	0.347896						75.01
75.02	CARD CATH LAB	0.111944						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	1.481713						90
90.01	PH CLINIC							90.01
90.02	HEALTHWORKS CLINIC	0.997264						90.02
90.03	DENTAL CLINIC							90.03
90.04	WOUND CARE THERAPY	0.159849						90.04
90.05	FAMILY PRACTICE CLINIC							90.05
91	Emergency	0.201630						91
92	Observation Beds (Non-Distinct	0.375834						92
93.99	PARTIAL HOSPITALIZATION PROGRAM							93.99
	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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)	28,791	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,791	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)	26,587	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	6,248	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)	28,304,215	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)	28,304,215	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)	28,304,215	37

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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)					983.09	38	
39	Program general inpatient routine service cost (line 9 x line 38)					6,142,346	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)					6,142,346	41	
42	Nursery (Titles V and XIX only)						42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	5,897,710	3,153	1,870.51	1,073	2,007,057	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)					7,043,854	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					15,193,257	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					382,524	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					379,275	51
52	Total Program excludable cost (sum of lines 50 and 51)					761,799	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)					14,431,458	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0206

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					2,204	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					983.09	88
89	Observation bed cost (line 87 x line 88) (see instructions)					2,166,730	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	1,430,807	28,304,215	0.050551	2,166,730	109,530	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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)	2,748	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,748	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)	2,748	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)	880	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)	2,201,046	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)	2,201,046	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)	2,201,046	37

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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)	800.96	38
39	Program general inpatient routine service cost (line 9 x line 38)	704,845	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)	704,845	41
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	91,879	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)	796,724	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	42,381	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,771	51
52	Total Program excludable cost (sum of lines 50 and 51)	46,152	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)	750,572	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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)	28,791	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	28,791	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)	26,587	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	2,275	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)	1,433	15
16	Nursery days (title V or XIX only)	872	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)	28,304,215	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)	28,304,215	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)	28,304,215	37

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0206

**WORKSHEET D-1
PART II**

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

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
38	Adjusted general inpatient routine service cost per diem (see instructions)					983.09	38	
39	Program general inpatient routine service cost (line 9 x line 38)					2,236,530	39	
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40	
41	Total Program general inpatient routine service cost (line 39 + line 40)					2,236,530	41	
42	Nursery (Titles V and XIX only)	2,741,104	1,433	1,912.84	872	1,667,996	42	
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit	5,897,710	3,153	1,870.51	245	458,275	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)					2,266,753	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					6,629,554	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					202,215	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					147,250	51
52	Total Program excludable cost (sum of lines 50 and 51)					349,465	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0206

WORKSHEET D-1
PARTS III & IV

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

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					2,204	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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 [XX] IPF [] SNF [] TEFRA
 Boxes: [XX] Title XIX - I/P [] IRF [] NF [XX] Other

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,748	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,748	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)	2,748	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)	1,462	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)	2,201,046	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)	2,201,046	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)	2,201,046	37

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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)	800.96	38
39	Program general inpatient routine service cost (line 9 x line 38)	1,171,004	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)	1,171,004	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)	1,171,004	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	70,410	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)	70,410	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0206

WORKSHEET D-3

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

(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		10,996,428		30
31	Intensive Care Unit		2,893,845		31
31.01	NICU				31.01
40	Subprovider - IPF				40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.417755	1,910,789	798,242	50
52	Delivery Room & Labor Room	0.963340	16,142	15,550	52
53	Anesthesiology	0.123315	458,459	56,535	53
54	Radiology-Diagnostic	0.204431	3,406,906	696,477	54
56.01	NUCLEAR MEDICINE				56.01
60	Laboratory	0.157629	7,495,484	1,181,506	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.238759	2,598,030	620,303	65
66	Physical Therapy	0.363802	378,702	137,773	66
69	Electrocardiology	0.156174	816,913	127,581	69
70	Electroencephalography	0.843025	51,003	42,997	70
71	Medical Supplies Charged to Patients	0.961848	300,267	288,811	71
72	Impl. Dev. Charged to Patients	0.719947	842,087	606,258	72
73	Drugs Charged to Patients	0.156028	7,947,698	1,240,063	73
75.01	ACUTE DIALYSIS	0.347896	937,200	326,048	75.01
75.02	CARD CATH LAB	0.111944	3,375,852	377,906	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	1.522597	11,173	17,012	90
90.01	PH CLINIC				90.01
90.02	HEALTHWORKS CLINIC	0.997264			90.02
90.03	DENTAL CLINIC				90.03
90.04	WOUND CARE THERAPY	0.159849	294,090	47,010	90.04
90.05	FAMILY PRACTICE CLINIC				90.05
91	Emergency	0.201630	2,300,165	463,782	91
92	Observation Beds (Non-Distinct Part)	0.375834			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		33,140,960	7,043,854	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		33,140,960		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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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/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				30
31	Intensive Care Unit				31
31.01	NICU				31.01
40	Subprovider - IPF		1,605,076		40
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.417755			50
52	Delivery Room & Labor Room	0.963340			52
53	Anesthesiology	0.123315			53
54	Radiology-Diagnostic	0.204431	27,817	5,687	54
56.01	NUCLEAR MEDICINE				56.01
60	Laboratory	0.157629	163,126	25,713	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.238759	315	75	65
66	Physical Therapy	0.363802	2,232	812	66
69	Electrocardiology	0.156174	12,876	2,011	69
70	Electroencephalography	0.843025			70
71	Medical Supplies Charged to Patients	0.961848			71
72	Impl. Dev. Charged to Patients	0.719947			72
73	Drugs Charged to Patients	0.156028	322,051	50,249	73
75.01	ACUTE DIALYSIS	0.347896			75.01
75.02	CARD CATH LAB	0.111944			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	1.522597			90
90.01	PH CLINIC				90.01
90.02	HEALTHWORKS CLINIC	0.997264			90.02
90.03	DENTAL CLINIC				90.03
90.04	WOUND CARE THERAPY	0.159849			90.04
90.05	FAMILY PRACTICE CLINIC				90.05
91	Emergency	0.201630	36,362	7,332	91
92	Observation Beds (Non-Distinct Part)	0.375834			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		564,779	91,879	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		564,779		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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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		3,823,845		30
31	Intensive Care Unit		683,232		31
31.01	NICU				31.01
40	Subprovider - IPF				40
43	Nursery		2,013,893		43
	ANCILLARY SERVICE COST CENTERS				
50	Operating Room	0.417755	525,435	219,503	50
52	Delivery Room & Labor Room	0.963340	455,455	438,758	52
53	Anesthesiology	0.123315	99,183	12,231	53
54	Radiology-Diagnostic	0.204431	903,812	184,767	54
56.01	NUCLEAR MEDICINE				56.01
60	Laboratory	0.157629	2,417,457	381,061	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.238759	601,642	143,647	65
66	Physical Therapy	0.363802	66,084	24,041	66
69	Electrocardiology	0.156174	176,043	27,493	69
70	Electroencephalography	0.843025	17,651	14,880	70
71	Medical Supplies Charged to Patients	0.961848	46,086	44,328	71
72	Impl. Dev. Charged to Patients	0.719947	240,492	173,141	72
73	Drugs Charged to Patients	0.156028	2,320,731	362,099	73
75.01	ACUTE DIALYSIS	0.347896	117,150	40,756	75.01
75.02	CARD CATH LAB	0.111944	466,947	52,272	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	1.481713			90
90.01	PH CLINIC				90.01
90.02	HEALTHWORKS CLINIC	0.997264			90.02
90.03	DENTAL CLINIC				90.03
90.04	WOUND CARE THERAPY	0.159849	85,920	13,734	90.04
90.05	FAMILY PRACTICE CLINIC				90.05
91	Emergency	0.201630	664,792	134,042	91
92	Observation Beds (Non-Distinct Part)	0.375834			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		9,204,880	2,266,753	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		9,204,880		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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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	0.417755			50
52	Delivery Room & Labor Room	0.963340			52
53	Anesthesiology	0.123315			53
54	Radiology-Diagnostic	0.204431			54
56.01	NUCLEAR MEDICINE				56.01
60	Laboratory	0.157629			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.238759			65
66	Physical Therapy	0.363802			66
69	Electrocardiology	0.156174			69
70	Electroencephalography	0.843025			70
71	Medical Supplies Charged to Patients	0.961848			71
72	Impl. Dev. Charged to Patients	0.719947			72
73	Drugs Charged to Patients	0.156028			73
75.01	ACUTE DIALYSIS	0.347896			75.01
75.02	CARD CATH LAB	0.111944			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	1.481713			90
90.01	PH CLINIC				90.01
90.02	HEALTHWORKS CLINIC	0.997264			90.02
90.03	DENTAL CLINIC				90.03
90.04	WOUND CARE THERAPY	0.159849			90.04
90.05	FAMILY PRACTICE CLINIC				90.05
91	Emergency	0.201630			91
92	Observation Beds (Non-Distinct Part)	0.375834			92
93.99	PARTIAL HOSPITALIZATION PROGRAM				93.99
	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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)	10,851,686			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)	284,690			2
2.01	Outlier reconciliation amount				2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)				2.02
2.03	Outlier payment for discharges occurring prior to October 1 (see instructions)				2.03
2.04	Outlier payment for discharges occurring on or after October 1 (see instructions)				2.04
3	Managed care simulated payments	3,491,057			3
4	Bed days available divided by number of days in the cost reporting period (see instructions)	166.95			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	7.26			10
11	FTE count for residents in dental and podiatric programs	3.00			11
12	Current year allowable FTE (see instructions)	10.26			12
13	Total allowable FTE count for the prior year	4.26			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	5.84			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	5.84			18
19	Current year resident to bed ratio (line 18 divided by line 4)	0.034981			19
20	Prior year resident to bed ratio (see instructions)	0.024185			20
21	Enter the lesser of lines 19 or 20 (see instructions)	0.024185			21
22	IME payment adjustment (see instructions)	142,472			22
22.01	IME payment adjustment - Managed Care (see instructions)	45,834			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)	-6.12			24
25	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)				25
26	Resident to bed ratio (divide line 25 by line 4)				26
27	IME payments adjustment factor (see instructions)				27
28	IME add-on adjustment amount (see instructions)				28
28.01	IME add-on adjustment amount - Managed Care (see instructions)				28.01
29	Total IME payment (sum of lines 22 and 28)	142,472			29
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	45,834			29.01
	Disproportionate Share Adjustment				
30	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	0.2735			30
31	Percentage of Medicaid patient days to total patient days (see instructions)	0.5684			31
32	Sum of lines 30 and 31	0.8419			32
33	Allowable disproportionate share percentage (see instructions)	0.5867			33
34	Disproportionate share adjustment (see instructions)	1,591,671			34
		Prior to		On or after	
	Uncompensated Care Adjustment	October 1 (1.00)	(1.01)	October 1 (2.00)	
35	Total uncompensated care amount (see instructions)			6,766,695,164	35
35.01	Factor 3 (see instructions)	0.000000000		0.000501449	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)			3,393,153	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)			3,393,153	35.03
36	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	3,393,153			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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

**WORKSHEET E
PART A**

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
45	Average weekly cost for dialysis treatments (see instructions)				45
46	Total additional payment (line 45 times line 44 times line 41.01)				46
47	Subtotal (see instructions)	16,263,672			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)	16,309,506			49
50	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	1,078,097			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)	139,307			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)	17,526,910			59
60	Primary payer payments				60
61	Total amount payable for program beneficiaries (line 59 minus line 60)	17,526,910			61
62	Deductibles billed to program beneficiaries	969,620			62
63	Coinsurance billed to program beneficiaries	159,039			63
64	Allowable bad debts (see instructions)	1,057,648			64
65	Adjusted reimbursable bad debts (see instructions)	687,471			65
66	Allowable bad debts for dual eligible beneficiaries (see instructions)	589,013			66
67	Subtotal (line 61 plus line 65 minus lines 62 and 63)	17,085,722			67
68	Credits received from manufacturers for replaced devices for applicable MS-DRGs (see instructions)				68
69	Outlier payments reconciliation (sum of lines 93, 95 and 96) (for SCH see instructions)				69
70	Other adjustments (OTHER ADJUSTMENT)				70
70.93	HVBP payment adjustment amount (see instructions)	471			70.93
70.94	HRR adjustment amount (see instructions)	-55,344			70.94
71	Amount due provider (see instructions)	17,030,849			71
71.01	Sequestration adjustment (see instructions)	340,617			71.01
71.02	Demonstration payment adjustment amount after sequestration				71.02
72	Interim payments	15,801,424			72
73	Tentative settlement (for contractor use only)				73
74	Balance due provider (Program) (line 71 minus lines 71.01, 72 and 73)	888,808			74
75	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2	2,485,034			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
HVBP Adjustment for HSP Bonus Payment		Prior to 10/1	On or After 10/1		
101	HVBP adjustment factor (see instructions)	0.000000000	0.000000000		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

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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)	75			1
2	Medical and other services reimbursed under OPPTS (see instructions)	5,463,296			2
3	OPPTS payments	3,973,996			3
4	Outlier payment (see instructions)	16,258			4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)	0.836			5
6	Line 2 times line 5	4,567,315			6
7	Sum of lines 3, 4, and 4.01, divided by line 6	0.8737			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)	75			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges	480			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)	480			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)	480			18
19	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11 (see instructions)	405			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 (see instructions)	75			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	3,990,254			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	774,106			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)	3,216,223			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)	47,598			28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	3,263,821			30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)	3,263,821			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)	489,845			34
35	Adjusted reimbursable bad debts (see instructions)	318,399			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	310,518			36
37	Subtotal (see instructions)	3,582,220			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (OTHER ADJ - PS&R)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	3,582,220			40
40.01	Sequestration adjustment (see instructions)	71,644			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	3,353,189			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	157,387			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

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S206

WORKSHEET E
PART B

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

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	Medical and other services (see instructions)				1
2	Medical and other services reimbursed under OPPTS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)				11
	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 (see instructions)				21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)				25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)				26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)				27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)				30
31	Primary payer payments				31
32	Subtotal (line 30 minus line 31)				32
	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)				37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments ()				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)				40
40.01	Sequestration adjustment (see instructions)				40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments				41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)				43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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		15,983,114		3,496,797	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		.01			3.01		
	rate for the cost reporting period. Also show date of		.02			3.02		
	each payment. If none, write 'NONE' or enter a zero. (1)	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	04/19/2018	181,690	04/19/2018	143,608	3.50
			.51				3.51	
		Provider	.52				3.52	
		to	.53				3.53	
		Program	.54				3.54	
			.55				3.55	
			.56				3.56	
			.57				3.57	
			.58				3.58	
			.59				3.59	
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99		-181,690		-143,608	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)				15,801,424		3,353,189	4
TO BE COMPLETED BY CONTRACTOR								
5	List separately each tentative settlement payment		.01					5.01
	after desk review. Also show date of each payment.		.02					5.02
	If none, write 'NONE' or enter a zero. (1)	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		888,808		157,387	6.01
			.02					6.02
7	Total Medicare program liability (see instructions)				16,690,232		3,510,576	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: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	Total interim payments paid to provider		703,542		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero				2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)				
		.01			3.01
		.02			3.02
	Program	.03			3.03
	to	.04			3.04
	Provider	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
	Provider	.52			3.52
	to	.53			3.53
	Program	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		703,542		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	28,337		6.01
		.02			6.02
7	Total Medicare program liability (see instructions)		731,879		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

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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)	824,899	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)		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)	7,528,767	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)	824,899	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)	824,899	16
17	Primary payer payments		17
18	Subtotal (line 16 less line 17)	824,899	18
19	Deductibles	79,992	19
20	Subtotal (line 18 minus line 19)	744,907	20
21	Coinsurance	27,003	21
22	Subtotal (line 20 minus line 21)	717,904	22
23	Allowable bad debts (exclude bad debts for professional services) (see instructions)	44,479	23
24	Adjusted reimbursable bad debts (see instructions)	28,911	24
25	Allowable bad debts for dual eligible beneficiaries (see instructions)	22	25
26	Subtotal (sum of lines 22 and 24)	746,815	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)	746,815	31
31.01	Sequestration adjustment (see instructions)	14,936	31.01
31.02	Demonstration payment adjustment amount after sequestration		31.02
32	Interim payments	703,542	32
33	Tentative settlement (for contractor use only)		33
34	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	28,337	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

NORWEGIAN AMERICAN HOSPITAL Provider CCN: 14-0206	In Lieu of Form CMS-2552-10	Period : From: 10/01/2017 To: 09/30/2018	Run Date: 02/23/2019 Run Time: 10:53 Version: 2018.12 (02/01/2019)
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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	6,629,554	1
2	Medical and other services		2
3	Organ acquisition (certified transplant centers only)		3
4	Subtotal (sum of lines 1, 2 and 3)	6,629,554	4
5	Inpatient primary payer payments		5
6	Outpatient primary payer payments		6
7	Subtotal (line 4 less sum of lines 5 and 6)	6,629,554	7
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
8	Routine service charges	6,520,970	8
9	Ancillary service charges	9,204,880	9
10	Organ acquisition charges, net of revenue		10
11	Incentive from target amount computation		11
12	Total reasonable charges (sum of lines 8-11)	15,725,850	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)	15,725,850	16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	9,096,296	17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		18
19	Interns and residents (see instructions)		19
20	Cost of physicians' services in a teaching hospital (see instructions)		20
21	Cost of covered services (lesser of line 4 or line 16)	6,629,554	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)	6,629,554	29
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)		30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	6,629,554	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)	6,629,554	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		37
38	Subtotal (line 36 ± line 37)	6,629,554	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)	6,629,554	40
41	Interim payments	6,629,554	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

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

WORKSHEET E-4

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

COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996			1.98	1
2	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e) (see instructions)				2
3	Amount of reduction to Direct GME cap under §422 of MMA				3
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79(m). (see instructions for cost reporting periods straddling 7/1/2011)			1.29	3.01
4	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and §413.79(f))				4
4.01	ACA §5503 increase to the direct GME FTE cap (see instructions for cost reporting periods straddling 7/1/2011)				4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			12.44	4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			13.13	5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			7.26	6
7	Enter the lesser of line 5 or line 6			7.26	7
		Primary Care	Other	Total	
		1	2	3	
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	7.26	0.00	7.26	8
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	7.26	0.00	7.26	9
10	Weighted dental and podiatric resident FTE count for the current year		3.00		10
10.01	Unweighted dental and podiatric resident FTE count for the current year		3.00		10.01
11	Total weighted FTE count	7.26	3.00		11
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	1.26	3.00		12
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	3.00		13
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	2.84	3.00		14
15	Adjustment for residents in initial years of new programs	0.00	0.00		15
15.01	Unweighted adjustment for residents in initial years of new programs				15.01
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16
16.01	Unweighted adjustment for residents displaced by program or hospital closure				16.01
17	Adjusted rolling average FTE count	2.84	3.00		17
18	Per resident amount	99,345.13	99,345.13		18
19	Approved amount for resident costs	282,140	298,035	580,175	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)			580,175	25
COMPUTATION OF PROGRAM PATIENT LOAD					
		Inpatient Part A	Managed Care		
26	Inpatient days (see instructions)	8,201	2,690		26
27	Total inpatient days (see instructions)	32,627	32,627		27
28	Ratio of inpatient days to total inpatient days	0.251356	0.082447		28
29	Program direct GME amount	145,830	47,834		29
30	Reduction for direct GME payments for Medicare Advantage		6,759		30
31	Net Program direct GME amount			186,905	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)			15,989,981	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)			15,989,981	41
Part B Reasonable Cost					
42	Reasonable cost (see instructions)			5,463,371	42
43	Primary payer payments (see instructions)				43
44	Total Part B reasonable cost (line 42 minus line 43)			5,463,371	44
45	Total reasonable cost (sum of lines 41 and 44)			21,453,352	45
46	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.745337	46
47	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.254663	47
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48	Total program GME payment (line 31)			186,905	48
49	Part A Medicare GME payment (line 46 x line 48) (title XVIII only) (see instructions)			139,307	49
50	Part B Medicare GME payment (line 47 x line 48) (title XVIII only) (see instructions)			47,598	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 cap (see instructions for cost reporting periods straddling 7/1/2011)			4.01
4.02	ACA §5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			4.02
5	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 and 4.02 plus applicable subscripts)			5
6	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			6
7	Enter the lesser of line 5 or line 6			7
		Primary Care	Other	Total
		1	2	3
8	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year	0.00	0.00	0.00
9	If line 6 is less than line 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6	0.00	0.00	0.00
10	Weighted dental and podiatric resident FTE count for the current year		0.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year			
11	Total weighted FTE count	0.00	0.00	
12	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00	
13	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00	
14	Rolling average FTE count (sum of lines 11 through 13 divided by 3)	0.00	0.00	
15	Adjustment for residents in initial years of new programs	0.00	0.00	
15.01	Unweighted adjustment for residents in initial years of new programs			
16	Adjustment for residents displaced by program or hospital closure	0.00	0.00	
16.01	Unweighted adjustment for residents displaced by program or hospital closure			
17	Adjusted rolling average FTE count	0.00	0.00	
18	Per resident amount	0.00	0.00	
19	Approved amount for resident costs			
20	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 §413.79(c)(4)			
21	Direct GME FTE unweighted resident count over cap (see instructions)			
22	Allowable additional direct GME FTE resident count (see instructions)			
23	Enter the locality adjustment national average per resident amount (see instructions)			
24	Multiply line 22 times line 23			
25	Total direct GME amount (sum of lines 19 and 24)			
COMPUTATION OF PROGRAM PATIENT LOAD				
		Inpatient Part A	Managed Care	
26	Inpatient days (see instructions)	4,084	14,406	26
27	Total inpatient days (see instructions)	32,627	32,627	27
28	Ratio of inpatient days to total inpatient days	0.125172	0.441536	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)

Assets (Omit Cents)		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund
		1	2	3	4
CURRENT ASSETS					
1	Cash on hand and in banks	21,066,476			1
2	Temporary investments	16,533,280			2
3	Notes receivable				3
4	Accounts receivable	23,970,702			4
5	Other receivables	1,233,105			5
6	Allowances for uncollectible notes and accounts receivable	-5,913,444			6
7	Inventory	1,394,436			7
8	Prepaid expenses	1,160,964			8
9	Other current assets	960,412			9
10	Due from other funds				10
11	Total current assets (sum of lines 1-10)	60,405,931			11
FIXED ASSETS					
12	Land	4,840,913			12
13	Land improvements	3,689,647			13
14	Accumulated depreciation	-3,245,074			14
15	Buildings	52,740,969			15
16	Accumulated depreciation	-38,444,609			16
17	Leasehold improvements				17
18	Accumulated depreciation				18
19	Fixed equipment	26,733,310			19
20	Accumulated depreciation	-18,838,375			20
21	Automobiles and trucks				21
22	Accumulated depreciation				22
23	Major movable equipment	56,301,258			23
24	Accumulated depreciation	-49,477,960			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)	34,300,079			30
OTHER ASSETS					
31	Investments				31
32	Deposits on leases				32
33	Due from owners/officers				33
34	Other assets	13,194,536			34
35	Total other assets (sum of lines 31-34)	13,194,536			35
36	Total assets (sum of lines 11, 30 and 35)	107,900,546			36
Liabilities and Fund Balances (Omit Cents)					
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund
		1	2	3	4
CURRENT LIABILITIES					
37	Accounts payable	9,081,442			37
38	Salaries, wages and fees payable	4,064,970			38
39	Payroll taxes payable	588,029			39
40	Notes and loans payable (short term)	3,012,226			40
41	Deferred income				41
42	Accelerated payments				42
43	Due to other funds				43
44	Other current liabilities	5,200,330			44
45	Total current liabilities (sum of lines 37 thru 44)	21,946,997			45
LONG TERM LIABILITIES					
46	Mortgage payable				46
47	Notes payable	29,809,162			47
48	Unsecured loans				48
49	Other long term liabilities	16,339,809			49
50	Total long term liabilities (sum of lines 46 thru 49)	46,148,971			50
51	Total liabilities (sum of lines 45 and 50)	68,095,968			51
CAPITAL ACCOUNTS					
52	General fund balance	39,804,578			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)	39,804,578			59
60	Total liabilities and fund balances (sum of lines 51 and 59)	107,900,546			60

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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND	
		1	2	3	4
1	Fund balances at beginning of period		40,872,531		1
2	Net income (loss) (from Worksheet G-3, line 29)		-1,067,953		2
3	Total (sum of line 1 and line 2)		39,804,578		3
4	Additions (credit adjustments) (specify)				4
5					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)		39,804,578		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)		39,804,578		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					5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)				11
12	Deductions (debit adjustments) (specify)				12
13					13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)				19

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

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

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	47,979,972		47,979,972	1
2	Subprovider IPF	5,134,921		5,134,921	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)	53,114,893		53,114,893	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit	8,484,879		8,484,879	11
11.01	NICU				11.01
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)	8,484,879		8,484,879	16
17	Total inpatient routine care services (sum of lines 10 and 16)	61,599,772		61,599,772	17
18	Ancillary services	107,457,828		107,457,828	18
19	Outpatient services		136,862,972	136,862,972	19
20	Rural Health Clinic (RHC)				20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	169,057,600	136,862,972	305,920,572	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		114,457,555	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)		114,457,555	43

KPMG LLP Compu-Max 2552-10

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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)	305,920,572	1
2	Less contractual allowances and discounts on patients' accounts	231,770,587	2
3	Net patient revenues (line 1 minus line 2)	74,149,985	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	114,457,555	4
5	Net income from service to patients (line 3 minus line 4)	-40,307,570	5

OTHER INCOME

6	Contributions, donations, bequests, etc.		6
7	Income from investments	121,264	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	344,162	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	1,204	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 hosptial space		22
23	Governmental appropriations		23
24	Other (HOSPITAL ASSESSMENT RECEIPTS)	30,972,645	24
24.01	Other (ACA ACCESS REV)	7,704,996	24.01
24.02	Other (MEDIAL EDUCATION REV)	1,814,988	24.02
24.03	Other (RENTAL INCOME)	352,134	24.03
24.04	Other (MISC REV)	257,534	24.04
24.05	Other (PEDIATRIC CARE A VAN OPERATION CONT)	427,767	24.05
25	Total other income (sum of lines 6-24)	41,996,694	25
26	Total (line 5 plus line 25)	1,689,124	26
27	Other expenses (LOSS ON FHN INVESTMENT)	2,400,763	27
27.01	Other expenses (GEN INVEST LOSS)	260,483	27.01
27.02	Other expenses (GEN REV CHANGE SWAP)	95,831	27.02
28	Total other expenses (sum of line 27 and subscripts)	2,757,077	28
29	Net income (or loss) for the period (line 26 minus line 28)	-1,067,953	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	883,815	1
1.01	Model 4 BPCI Capital DRG other than outlier		1.01
2	Capital DRG outlier payments	12,040	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)	81.86	3
4	Number of interns & residents (see instructions)	5.84	4
5	Indirect medical education percentage (see instructions)	2.03	5
6	Indirect medical education adjustment (see instructions)	17,941	6
7	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, Part A line 30) (see instructions)	0.2735	7
8	Percentage of Medicaid patient days to total days (see instructions)	0.5684	8
9	Sum of lines 7 and 8	0.8419	9
10	Allowable disproportionate share percentage (see instructions)	0.1859	10
11	Disproportionate share adjustment (see instructions)	164,301	11
12	Total prospective capital payments (see instructions)	1,078,097	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
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
93.99	PARTIAL HOSPITALIZATION PROGRAM						93.99
	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
192.02	AUXILIARY						192.02
200	Cross Foot Adjustments						200

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

**WORKSHEET L-1
PART I**

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