Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	27D0042084	08/31/2018
Name of Provider or Supplier	**Street Address, City, State**	
Northern Montana Hospital	30 13th Street, Havre, MT	

For information on the provider's plan to correct this deficiency, please contact the provider or the state survey agency.

(X4) ID Prefix Tag	Summary Statement of Deficiencies
No Tags	No deficiency details available.