This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 31-0027 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/30/2024 10: 12 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/30/2024 Time: 10:12 am use only ] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only (3) Settled with Audit number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(4) Reopened (5) Amended

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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by TRINITAS HOSPITAL (31-0027) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1		2	SI GNATURE STATEMENT	
1	Rich	n Henwood	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Ri ch Henwood			2
3	Signatory Title	VP CORP REIMBURSEMENT			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	137, 445	725, 582	0	905, 069	1.00
2.00	SUBPROVIDER - IPF	0	-70, 766	0		0	2. 00
3.00	SUBPROVIDER - IRF	0	0	0		0	3. 00
4.00	SUBPROVI DER (OTHER)						4. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
200.00	TOTAL	0	66, 679	725, 582	0	905, 069	200. 00

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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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 the 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.

Health Financial Systems TRINITAS HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 31-0027 Peri od: Worksheet S-2 From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/30/2024 10:12 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 225 WILLIAMSON STREET 1.00 PO Box: 1.00 State: NJ 2.00 City: ELIZABETH Zip Code: 07201 County: UNION 2.00 Payment System (P, Component Name CCN CBSA Provi der Date T, O, or N)

XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal TRINITAS HOSPITAL 310027 35084 01/31/1975 Ν 3.00 Subprovider - IPF Р PSYCH EXCLUDED UNIT 4.00 4.00 31S027 35084 4 01/31/1999 Ν Т 5.00 Subprovider - IRF 5.00 Subprovider - (Other) 6.00 6.00 7.00 Swing Beds - SNF 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF SKILLED NURSING LTC 315442 35084 01/29/1998 Ρ Ν 9.00 SOUTH 5 Hospi tal -Based NF NURSING FACILITY 10.00 10.00 315442 35084 01/29/1998 N Ν 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Renal Dialysis TRINITAS RENAL DIALYSIS 35084 18.00 18.00 312318 01/01/2004 18. 01 Renal Dialysis TRINITAS LINDEN RENAL 313503 35084 01/01/1994 18.01 DI ALYSI S 18.02 Renal Dialysis TRINITAS CRANFORD RENAL 313521 35084 05/01/2019 18.02 DI ALYSI S 19.00 Other 19.00 From: To 2.00 1.00 01/01/2023 12/31/2023 20.00 Cost Reporting Period (mm/dd/yyyy) 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for 22.00 Ν disproportionate share hospital adjustment, 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 Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Ν Ν 22.01 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) Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 22. 02 22.02 Ν Ν 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. Did this hospital receive a geographic reclassification from urban to N N N 22.03 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 ves or "N" for no 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? 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, yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 3 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.

complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

Ν

58.00

Health Financial Systems TRINITAS HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 31-0027 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 10: 12 am 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. Y/N IMF Direct GME IME Direct GME 2. 00 3. 00 4.00 5.00 1 00 61.00 Did your hospital receive FTE slots under ACA Ν 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61 03 Enter the base line FTE count for primary care 61 03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary 61.05 61.05 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) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 2.00 1.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0 00 0.00 61.10 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. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 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, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00

Health Financial Systems	TRI	NITAS HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provider CO		eriod: com 01/01/2023 o 12/31/2023	Worksheet S-2 Part I Date/Time Prep 5/30/2024 10:	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2.00	3. 00	
Section 5504 of the ACA Base Yea			This base year	is your cost r	reporting	
period that begins on or after of the following seriod that begins on or after of the following seriod the number of the following seriod that the following seriod that the following seriod seriod that the following seriod s	yes, or your facili ber of unweighted no stations occurring in number of unweighte our hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. 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)	1. 00	2.00	0.00	0. 00		65. 00
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1.00	2. 00	3.00	
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Setting				
beginning on or after July 1, 20	)10					
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0. 47	30. 32  Unwei ghted	0. 015265 Ratio (col. 3/	66. 00
	Trogram Name	11 ogi alli code	FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1.00	2. 00	3. 00	4. 00	5.00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. 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)	INTERNAL MEDICINE	1400	4. 58	28. 72	0. 137538	67. 00

118. 00

118.00 s the mal practice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems			OSPI TAL				In Lie	u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	<b>\</b>	Provi der CC	N: 31-002			/01/2023 /31/2023	Worksheet S- Part I Date/Time Pr 5/30/2024 10	epared:
								1.00	-
147.00 Was there a change in the statisti	cal hasis? Enter "Y"	for v	es or "N" for	no				1.00 N	147. 0
148.00Was there a change in the order of								l N	148. 0
149.00 Was there a change to the simplifi					for r	10.		N	149. 0
			Part A	Part	В	Ti	tle V	Title XIX	
			1.00	2.00			3. 00	4. 00	
Does this facility contain a provi									
or charges? Enter "Y" for yes or '	'N" for no for each c	ompone	ent for Part A	and Part	B. (	see 42	CFR §413	8. 13) N	 155. 0
55. 00 Hospi tal 56. 00 Subprovi der - TPF			N N	N N			N	N N	156. 0
57. 00 Subprovider - TRF			N	N N			N	N N	157. 0
58. OO SUBPROVI DER			.,				14	14	158. 0
159. 00 SNF			N	N		1	N	N	159. 0
160.00 HOME HEALTH AGENCY			N	N			N	N	160. C
61. 00 CMHC				N			N	N	161. C
								1.00	
Multicampus									
65.00 s this hospital part of a Multica Enter "Y" for yes or "N" for no.	· ·	as one	<u> </u>					N	165. 0
	Name		County	State		Code	CBSA	FTE/Campus	_
66.00 f line 165 is yes, for each	0		1. 00	2. 00	3.	00	4. 00	5. 00	0 166. C
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.0	0 100. 0
								1.00	1
Health Information Technology (HI	Γ) incentive in the A	meri ca	n Recovery and	Rei nves	tment	Act			
167.00 s this provider a meaningful user								Υ	<b>167.</b> 0
68.00 If this provider is a CAH (line 10				167 is '	'Y"),	enter	the		168. C
reasonable cost incurred for the H	•		,		£		L: -		1,00
68.01 If this provider is a CAH and is rexception under §413.70(a)(6)(ii)						i narus	m b		168. 0
69.00 If this provider is a meaningful utransition factor. (see instruction	user (line 167 is "Y")	) and	is not a CAH (	line 105	is "N	l"), en	iter the	0.0	0169. 0
Transition rastor (oss instrustr	,,,,,,					Beg	i nni ng	Endi ng	
						1	. 00	2.00	
70.00 Enter in columns 1 and 2 the EHR begins period respectively (mm/dd/yyyy)	peginning date and end	ding d	ate for the re	porting					170. C
						1	. 00	2.00	
171.00  fline 167 is "Y", does this prov							N		0 171. C
section 1876 Medicare cost plans m "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, umn 1. If column 1 is	Pt.	I, line 2, col	. 6? Ente					

	Financial Systems TRINITAS F AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 31-0027	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time P 5/30/2024 1	-2 repared:
		Descr	iption	Y/N	Y/N	0. 12 (
			0	1. 00	3. 00	
0. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1. 00	2. 00	3. 00	4. 00	
1. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	DT CHILDDENS F	IOSDI TAI S)		1.00	
- +	Capital Related Cost	FI CHILDRENS I	IUSFI IALS)			
	Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22. 00
	Have changes occurred in the Medicare depreciation expense		als made dur	ing the cost	N	23. 00
3. 00	reporting period? If yes, see instructions.	duc to apprais	ar 3 made dar	ing the cost	11	25.00
4. 00	Were new leases and/or amendments to existing leases entere	d into durina	this cost re	porting period?	N	24. 00
. 50	If yes, see instructions		2 2001 10	,g po od.		50
5. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see	N	25. 00
	instructions.		J .			
6. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	e cost reporti	ng period? I	f yes, see	N	26. 00
	instructions.					
7. 00	Has the provider's capitalization policy changed during the	cost reportir	ng period? If	yes, submit	N	27. 00
ļ	сору.					
	Interest Expense					
	Were new loans, mortgage agreements or letters of credit en	itered into dur	ing the cost	reporting	N	28. 0
	period? If yes, see instructions.			<b>5</b> 1)		
9. 00	Did the provider have a funded depreciation account and/or		ebt Service R	eserve Fund)	N	29. 0
0 00	treated as a funded depreciation account? If yes, see instr		1-1-10 16		N.	20.00
0. 00	Has existing debt been replaced prior to its scheduled matu instructions.	irity with new	debt? IT yes	, see	N	30.00
1. 00	Has debt been recalled before scheduled maturity without is	suance of new	daht2 If vas	202	N	31.00
1.00	instructions.	Suarice of fiew	debt: 11 yes	, 300	11	31.00
1	Purchased Services					
	Have changes or new agreements occurred in patient care ser	vices furnishe	d through co	ntractual	N	32.00
	arrangements with suppliers of services? If yes, see instru		3			
3. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app	lied pertainir	ng to competi	tive bidding? If		33. 0
	no, see instructions.					
	Provi der-Based Physi ci ans					
4. 00	Were services furnished at the provider facility under an a	rrangement wit	h provider-b	ased physicians?	Y	34. 0
	If yes, see instructions.					
5. 00	If line 34 is yes, were there new agreements or amended exi		its with the	provi der-based	N	35. 0
	physicians during the cost reporting period? If yes, see in	ISTRUCTI ONS.		Y/N	Date	
				1.00	2. 00	
	Home Office Costs			1.00	2.00	
	Were home office costs claimed on the cost report?			Υ		36.00
	If line 36 is yes, has a home office cost statement been pr	enared by the	home office?			37. 0
7.00	If yes, see instructions.	cpared by the	nome orrice:	'		37.00
8. 00	If line 36 is yes , was the fiscal year end of the home off	ice different	from that of	N N		38.00
	the provider? If yes, enter in column 2 the fiscal year end	of the home of	office.			30.00
9. 00	If line 36 is yes, did the provider render services to othe			, N		39. 00
	see instructions.	•	•			
0. 00	If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40.00
	instructions.					
		1.	00	2.	00	
	Cost Report Preparer Contact Information			UENWOO-		
				HENWOOD		41.00
	Enter the first name, last name and the title/position	RI CHARD				III .
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RI CHARD				
1. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.		ENI TU			42.04
1. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report	RI CHARD RWJ BARNABAS H	EALTH			42.00
2. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.  Enter the employer/company name of the cost report preparer.		EALTH	RI CH. HENWOOD@R	NIBH OPG	42. 0

Heal th Fi	inancial Systems	TRINITAS H	IOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI TAL	. AND HOSPITAL HEALTH CARE REIMBURSEMENT (	QUESTI ONNAI RE	Provi der		Peri od:	Worksheet S-2	2
					From 01/01/2023 To 12/31/2023	Part II  Date/Time Pre	enared:
					12, 01, 2020	5/30/2024 10:	
			(	3. 00			
Co	ost Report Preparer Contact Information						
	nter the first name, last name and the ti		VP CORPORATE	REI MBURSEMENT			41.00
	eld by the cost report preparer in columr	ns 1, 2, and 3,					
	especti vel y.						
42. 00 Er	nter the employer/company name of the cos	st report					42. 00
	reparer.						
	nter the telephone number and email addre						43. 00
re	eport preparer in columns 1 and 2, respec	cti vel y.					

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | To 12/31/2

						0 12/31/2023	5/30/2024 10:	
							I/P Days / 0/P	12 am
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH/REH Hours	Title V	
	'	Li ne No.			Avai I abl e			
		1. 00		2.00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		157	57, 305	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			157	57, 305	0.00	0	7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		25	9, 125	0.00	0	8.00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	13.00
14.00	Total (see instructions)			182	66, 430	0.00	0	14.00
15.00	CAH visits						0	15.00
15. 10	REH hours and visits					0.00	0	15. 10
16.00	SUBPROVI DER - I PF	40. 00		74	27, 010		0	16.00
17. 00	SUBPROVI DER - I RF	41. 00		0	C		0	17.00
18.00	SUBPROVI DER	42. 00		27	9, 855		0	18.00
19. 00	SKILLED NURSING FACILITY	44. 00		21	7, 665		0	19.00
20.00	NURSING FACILITY	45. 00		103	37, 595		0	20.00
21. 00	OTHER LONG TERM CARE	46. 00		0	C			21.00
22. 00	HOME HEALTH AGENCY							22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )							23.00
24.00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25.00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			407				27.00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	C			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges							33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	C		0	34. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 | 10: 12 am

						5/30/2024 10:	12 am
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Compensate	THE AVIII	THE COMM	Patients	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	7, 028	3, 921	34, 078			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)	11 221	0.770				2 00
2. 00 3. 00	HMO and other (see instructions)	11, 221	8, 778 0				2. 00 3. 00
4. 00	HMO IPF Subprovider HMO IRF Subprovider	0	ol Ol				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed SNI	٩	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	7, 028	3, 921	34, 078			7.00
7.00	beds) (see instructions)	7,020	3, 721	34, 070			7.00
8.00	INTENSIVE CARE UNIT	1, 409	530	5, 602			8. 00
9. 00	CORONARY CARE UNIT	1, 10,	000	0,002			9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1, 849	3, 332			13. 00
14. 00	Total (see instructions)	8, 437	6, 300	43, 012		1, 737. 85	14. 00
15.00	CAH visits	o	0	0			15. 00
15. 10	REH hours and visits	o	o	0			15. 10
16.00	SUBPROVIDER - IPF	2, 238	1, 593	19, 391	8. 60	97. 77	16. 00
17.00	SUBPROVI DER - I RF	0	0	0	0.00	0.00	17. 00
18.00	SUBPROVI DER		6, 065	6, 808		29. 54	18. 00
19. 00	SKILLED NURSING FACILITY	2, 325	0	4, 311		10. 13	1
20.00	NURSING FACILITY		1, 096	27, 408		64. 37	20. 00
21. 00	OTHER LONG TERM CARE			0	0.00	34. 82	
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE			•			24. 00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00 26. 00	CMHC - CMHC RURAL HEALTH CLINIC						25. 00 26. 00
26. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)	٩	٩	U	64. 09	1, 974. 48	
28. 00	Observation Bed Days		0	4, 624		1, 7/4. 40	28.00
29. 00	Ambul ance Trips	0	o <sub>l</sub>	4, 024			29.00
30.00	Employee discount days (see instruction)	٩		15			30.00
31. 00	Employee discount days (see l'histraction)			0			31.00
32. 00	Labor & delivery days (see instructions)	4	298	739			32.00
32. 01	Total ancillary labor & delivery room	"	270	.07			32. 01
	outpatient days (see instructions)			_			
33.00	LTCH non-covered days	o					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/30/2024	10: 12 am

					0 12/01/2020	5/30/2024 10:	12 am
		Full Time		Di scl	arges		
		Equi val ents	<b>-</b> 1 1.	T =1.11 \0.0111	T	<b>-</b>	
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	40.00	10.00	11.00	Pati ents	
	DADT I CTATICTICAL DATA	11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA			al		0.440	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and			0 1, 329	1, 750	8, 119	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds)			1 50-	1 705		2.00
3.00	HMO and other (see instructions) HMO IPF Subprovider			1, 597	7 1, 795 815		3.00
	· •				815		
4.00	HMO I RF Subprovi der				U U		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGI CAL INTENSI VE CARE UNI T						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00		0 1, 329	1, 750	8, 119	
15. 00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF	0.00		0 166	176	1, 886	
17. 00	SUBPROVI DER - I RF	0. 00		0	0	0	
18. 00	SUBPROVI DER	0.00		0	0	0	
19. 00	SKILLED NURSING FACILITY	0.00					19. 00
20. 00	NURSING FACILITY	0.00					20.00
21. 00	OTHER LONG TERM CARE	0.00				0	
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days				)		33.00
33. 01	LTCH site neutral days and discharges				)		33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care						34. 00

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 01/01/2023 Part II

To 12/31/2023 Date/Time Prepared: 5/30/2024 10: 12 am

						12/31/2023	5/30/2024 10:	
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.	(col.2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	A-6) 3. 00	3) 4.00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	3.00	0.00	
	SALARI ES							1
1. 00	Total salaries (see instructions)	200. 00	161, 062, 483	6, 820, 279	167, 882, 762	4, 044, 982. 40	41. 50	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part B		0	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		864, 065		864, 065	7, 356. 00		
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non Physician-Part B		923, 665 12, 774, 942			9, 454. 00 86, 657. 00		1
6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	0	4, 012, 012	4, 012, 012	117, 148. 68	34. 25	7. 00
7. 01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0. 00	7. 01
8.00	Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	296, 530 25, 916, 175		296, 530 27, 609, 097	10, 333. 44 583, 654. 01	28. 70 47. 30	
	instructions) OTHER WAGES & RELATED COSTS							-
11. 00	Contract labor: Direct Patient Care		5, 304, 663	0	5, 304, 663	43, 762. 00	121. 22	11. 00
12. 00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0. 00	12. 00
13. 00	Contract Labor: Physician-Part A - Administrative		0	0	0	0. 00	0. 00	13. 00
14. 00	Home office and/or related organization salaries and		0	0	0	0.00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		19, 283, 755	0	19, 283, 755	239, 493. 98	80. 52	14. 01
14. 02	Related organization salaries		0	0	0	0.00	0. 00	14. 02
15. 00	Home office: Physician Part A - Administrative		0	0	0	0. 00	0. 00	15. 00
16. 00	Home office and Contract		0	0	0	0.00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0. 00	0. 00	16. 01
16. 02	- Teaching Home office contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 02
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		20 021 505	0	20 021 505			17. 00
18. 00	instructions) Wage-related costs (core) (see		30, 021, 585	0	30, 021, 585			18. 00
19. 00	(see instructions) Excluded areas		5, 381, 151	0	5, 381, 151			19. 00
20. 00	Non-physician anesthetist Part A		0	0	0			20. 00
21. 00	Non-physician anesthetist Part		0	0				21. 00
22. 00	Physician Part A - Administrative		62, 296	0	62, 296			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		77, 522 759, 129	0	77, 522 759, 129			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		992, 093	0	992, 093			24. 00 25. 00
25. 50	approved program) Home office wage-related (core)		3, 586, 993	0	3, 586, 993			25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	О			25. 52

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 31-0027

Peri od: Worksheet S-3 From 01/01/2023 Part II 12/31/2023 Date/Time Prepared:

5/30/2024 10:12 am Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. (col.2 ± col. Salaries in A-6)3) col. 4 2.00 5. 00 1.00 6.00 3.00 4.00 25.53 Home office: Physicians Part A 0 25.53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 103, 038 4 00 103, 038 5, 779. 45 26.00 26.00 Employee Benefits Department 17.83 27.00 Administrative & General 5.00 16, 055, 099 4, 275, 420 20, 330, 519 584, 088. 79 34.81 27.00 28.00 Administrative & General under 488, 096 488, 096 2, 016. 00 242.11 28.00 contract (see inst.) Maintenance & Repairs 6.00 347, 089 13, 997. 59 29.00 347, 089 24. 80 29.00 Operation of Plant -104, 191 30.00 7.00 1, 853, 646 1, 749, 455 64, 002. 06 27. 33 30.00 31.00 Laundry & Linen Service 8.00 84, 407 84, 407 4, 321. 35 19. 53 31.00 173, 589. 98 32.00 Housekeepi ng 9.00 2, 972, 122 2, 972, 122 17. 12 32.00 0 33.00 Housekeeping under contract 0 C C 0.00 0.00 33.00 (see instructions) Di etary 34.00 10.00 2, 365, 039 -1, 016, 967 1, 348, 072 68, 712. 76 19. 62 34.00 Dietary under contract (see instructions) 0.00 35.00 0.00 35.00 0 47, 749. 54 36, 00 Cafeteri a 11.00 0 1, 016, 967 1, 016, 967 21. 30 36.00 Maintenance of Personnel 0.00 37.00 12.00 0.00 37.00 38.00 Nursing Administration 13.00 5, 186, 614 -128, 687 5, 057, 927 104, 143. 08 48. 57 38.00 1, 210, 445 25. 46 39.00 Central Services and Supply 14.00 1, 210, 445 47, 550. 44 39.00 49.02 3, 544, 530 -12, 303 3, 532, 227 72, 057. 83 40.00 Pharmacy 15.00 40.00 41.00 Medical Records & Medical 16.00 1, 692, 811 -20, 514 1, 672, 297 62, 453. 39 26. 78 41. 00 Records Library Social Service 17.00 21, 983. 23 49. 87 42. 00 42.00 1, 349, 814 -253, 469 1,096,345 43.00 Other General Service 0.00 43.00 18 00 0 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION In Lieu of Form CMS-2552-10
Worksheet S-3 TRINITAS HOSPITAL Provider CCN: 31-0027 Period:

HUSPII	AL WAGE INDEX INFORMATION			Provider C		From 01/01/2023 To 12/31/2023		
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4.00	5. 00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		147, 851, 972	2, 808, 267	150, 660, 23	9 3, 833, 738. 72	39. 30	1.00
	instructions)							
2.00	Excluded area salaries (see		26, 212, 705	1, 692, 922	27, 905, 62	7 593, 987. 45	46. 98	2.00
	instructions)							
3.00	Subtotal salaries (line 1		121, 639, 267	1, 115, 345	122, 754, 61	2 3, 239, 751. 27	37. 89	3.00
	minus line 2)							
4.00	Subtotal other wages & related		24, 588, 418	0	24, 588, 41	8 283, 255. 98	86. 81	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		33, 670, 874	0	33, 670, 87	4 0.00	27. 43	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		179, 898, 559	1, 115, 345	181, 013, 90	4 3, 523, 007. 25	51. 38	6.00
7.00	Total overhead cost (see		37, 252, 750	3, 756, 256	41, 009, 00	6 1, 272, 445. 49	32. 23	7. 00

instructions)

Health Financial Systems	TRINITAS HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 31-0027	Peri od: Worksheet S-3
		From 01/01/2023   Part IV
		To 12/31/2023   Data/Time Drenared

	To 12/31/2023	Date/Time Prep 5/30/2024 10:	pared: 12 am
		Amount	12 (1111
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETIREMENT COST		
1.00	401K Employer Contributions	2, 244, 385	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	350, 840	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	_	
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST	•	
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	20, 144, 300	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	0	10. 00
11.00	Life Insurance (If employee is owner or beneficiary)	275, 936	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	701, 889	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	994, 441	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		1
	TAXES		
	FICA-Employers Portion Only	11, 523, 732	
	Medicare Taxes - Employers Portion Only	164, 998	
19. 00	Unemployment Insurance	450, 322	
20. 00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		1
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		
	Day Care Cost and Allowances	0	
23. 00		442, 933	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	37, 293, 776	24. 00
25 00	Part B - Other than Core Related Cost		25 00
25. UU	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	TRINITAS HOSPITAL	In Lieu of Form CMS-255			
HOSPITAL CONTRACT LABOR AND BENEFIT COST		Period: From 01/01/2023 To 12/31/2023	Worksheet S-3 Part V Date/Time Prep 5/30/2024 10:	pared:	
Cost Center Description		Contract Labor	Benefit Cost		
		1. 00	2. 00		

			3/30/2024 10.	ız allı
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	5, 304, 663	37, 293, 776	1. 00
2.00	Hospi tal	5, 304, 663	37, 293, 776	2. 00
3.00	SUBPROVI DER - I PF	0	0	3. 00
4.00	SUBPROVI DER - I RF	0	0	4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY	0	0	8. 00
9.00	NURSING FACILITY	0	0	9. 00
10.00	OTHER LONG TERM CARE I			10.00
11. 00	Hospi tal -Based HHA			11. 00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12. 00
13.00	Hospi tal -Based Hospi ce			13. 00
14.00	Hospital-Based Health Clinic RHC			14. 00
15.00	Hospital-Based Health Clinic FQHC			15. 00
16.00	Hospi tal -Based-CMHC			16. 00
17. 00	RENAL DIALYSIS I	0	0	17. 00
18. 00	Other	0	0	18. 00

Health Financial Systems TRINITAS HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA Provider CCN: 31-0027 Peri od: Worksheet S-5 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 10:12 am Outpati ent Trai ni ng Home CAPD / CCPD Regul ar High Flux Hemodi al ysi s Hemodi al ysi s CAPD / CCPD 1.00 2.00 3.00 4.00 5.00 6.00 1.00 Number of patients in program 226 1.00 at end of cost reporting 2.00 Number of times per week 3.00 0.00 0.00 7.00 0.00 0.00 2.00 patient receives dialysis Average patient dialysis time 3.00 4.50 0.00 0.00 0.00 3.00 including setup 4.00 CAPD exchanges per day 0.00 0.00 4.00 Number of days in year 0 5.00 312 5.00 dialysis furnished Number of stations 6.00 0 0 0 6.00 52 7.00 Treatment capacity per day per 0 7.00 stati on 8.00 Utilization (see instructions) 0.00 0.00 8.00 9.00 Average times dialyzers 0.00 0.00 9.00 re-used 10.00 Percentage of patients 0 00 0 00 10.00 re-using dialyzers Y/N 1.00 ESRD PPS 10.01 Is the dialysis facility approved as a low-volume facility for this cost reporting period? Enter "Y" Ν 10.01 for yes or "N" for no. (see instructions) Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See Υ 10.02 instructions for "new" providers.) After 12/31 Prior to 1/1 1.00 2.00 10.03 If you responded "N" to line 10.02, enter in column 1 the year of transition for 10.03 periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions) TRANSPLANT INFORMATION 11.00 Number of patients on transplant list 25 11.00 12.00 12.00 Number of patients transplanted during the cost reporting period EPOETI N Net costs of Epoetin furnished to all maintenance dialysis patients by the provider. 13 00 13 00 14.00 Epoetin amount from Worksheet A for Home Dialysis program 14.00 15.00 Number of EPO units furnished relating to the renal dialysis department Number of EPO units furnished relating to the home dialysis department 16, 00 16, 00 ARANESP 17.00 Net costs of ARANESP furnished to all maintenance dialysis patients by the provider. 17.00 ARANESP amount from Worksheet A for Home Dialysis program 18.00 Number of ARANESP units furnished relating to the renal dialysis department 19.00 19.00 20.00 Number of ARANESP units furnished relating to the home dialysis department 20.00 MCP INITIAL METHOD 1. 00 2.00 PHYSICIAN PAYMENT METHOD 21.00 Enter "X" if method(s) is applicable 21.00 ESA Description Net Cost of Net Cost of Number of ESA Number of ESA ESAs for Renal ESAs for Home Units - Renal Units - Home Pati ents Dialysis Dept. Pati ents Dialysis Dept 1.00 2 00 3.00 4.00 5.00 ESAs 22.00 Enter in column 1 the ESA 0 22.00 description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of FSA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)

Health Financial Systems	TRINITAS HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA		Peri od:	Worksheet S-5	
		From 01/01/2023 To 12/31/2023		narodi
		10 12/31/2023	5/30/2024 10:	
		CCN	Treatments	
		1. 00	2. 00	
23.00 If line 10.01 is yes, enter in column 1 the CCN	l for each renal dialysis facility		0	23. 00
listed on Worksheet S-2, Part I, line 18, and i				
total treatments for each CCN. (see instruction	is)			
23.01 TRINITAS LINDEN RENAL DIALYSIS			O	23. 01
23. 02 TRINITAS CRANFORD RENAL DIALYSIS			0	23. 02

SPI TA	Financial Systems TRINITAS HOSPIT	rovi der CCI	N: 31-0027	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II Date/Time Pre 5/30/2024 10:	pare				
					1. 00					
F	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				11.00					
Ī	Uncompensated and Indigent Care Cost-to-Charge Ratio					1				
00 [	Cost to charge ratio (see instructions)				0. 234902	] 1.				
	Medicaid (see instructions for each line)									
	Net revenue from Medicaid				79, 277, 000					
	Did you receive DSH or supplemental payments from Medicaid?				Y	3.				
	If line 3 is yes, does line 2 include all DSH and/or supplementa			ni d?	N	4.				
	If line 4 is no, then enter DSH and/or supplemental payments fro	om Medicaid	l		38, 080, 251	5.				
	Medicaid charges Medicaid cost (line 1 times line 6)				474, 004, 093 111, 344, 509					
	Difference between net revenue and costs for Medicaid program (s	ee instruc	tions)		0	1				
	Children's Health Insurance Program (CHIP) (see instructions for				0	1 0				
	Net revenue from stand-alone CHIP	cach iiic	/		0	9				
	Stand-alone CHIP charges				0	10				
	Stand-alone CHIP cost (line 1 times line 10)				0	11				
00	Difference between net revenue and costs for stand-alone CHIP (s	see instruc	tions)		0	12				
(	Other state or local government indigent care program (see instr	uctions fo	r each line)							
	Net revenue from state or local indigent care program (Not inclu				0	13				
	Charges for patients covered under state or local indigent care	program (N	lot included	in lines 6 or	0	14				
	10)									
	State or local indigent care program cost (line 1 times line 14)		/		0 0					
	Difference between net revenue and costs for state or local indigent care program (see instructions)  Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see									
	nstructions for each line)	and State	710cai indig	jent care program	is (see					
	Private grants, donations, or endowment income restricted to fun	ndi ng chari	ty care		0	17				
	Government grants, appropriations or transfers for support of ho		,		0	1				
	Total unreimbursed cost for Medicaid , CHIP and state and local			(sum of lines	0	1				
	8, 12 and 16)									
			Uni nsured	Insured	Total (col. 1					
			pati ents	pati ents	+ col . 2)					
li li	Incompany to description of the cook line)		1. 00	2. 00	3. 00					
	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions)		176, 714, 20	53, 089	176, 767, 294	20				
	Cost of patients approved for charity care and uninsured discoun	nts (see	41, 510, 52							
	instructions)	113 (300	41, 510, 52	33,007	41, 303, 007	- '				
	Payments received from patients for amounts previously written o	off as		0 0	0	22				
	charity care									
00	Cost of charity care (see instructions)		41, 510, 52	20 53, 089	41, 563, 609	23				
					1. 00					
	Does the amount on line 20 col. 2, include charges for patient d		la length of	stay limit	N	24				
	imposed on patients covered by Medicaid or other indigent care p	9		'a langth of	0	2.5				
	If line 24 is use contar the charges for notiont days beyond the	e mai gent	care program	is rength of	U	25				
00	If line 24 is yes, enter the charges for patient days beyond the				_	25				
00	stay limit									
00	stay limit Charges for insured patients' liability (see instructions)				0 17. 023. 927	26				
00 01 00	stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions)				17, 023, 927	1				
00 01 00 00	stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions)				17, 023, 927 406, 194	27				
00 01 00 00 01	stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions)				17, 023, 927 406, 194 624, 913	27 27				
00 01 00 00 01 00	stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions)	unts (see i	nstructi ons)		17, 023, 927 406, 194	27 27 28				
00 01 00 00 01 00 00	stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions)	unts (see i	nstructions)		17, 023, 927 406, 194 624, 913 16, 399, 014	27 27 28 29				

SPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CC	N: 31-0027	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II Date/Time Pre 5/30/2024 10:	pare		
					1. 00			
	PART II - HOSPITAL DATA				11.00			
	Uncompensated and Indigent Care Cost-to-Charge Ratio							
00	Cost to charge ratio (see instructions)				0. 216329	1		
	Medicaid (see instructions for each line)							
00	Net revenue from Medicaid					2		
00	Did you receive DSH or supplemental payments from Medicaid?					3		
00	If line 3 is yes, does line 2 include all DSH and/or supplementa			ai d?		4		
00	If line 4 is no, then enter DSH and/or supplemental payments fro	m Medicaio	t			5		
00	Medi cai d charges					6		
00	Medicaid cost (line 1 times line 6)					7		
00	Difference between net revenue and costs for Medicaid program (s					8		
	Children's Health Insurance Program (CHIP) (see instructions for	each line	<del>)</del>	T				
00	Net revenue from stand-alone CHIP					1 9		
00	Stand-alone CHIP charges					10		
00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (s	oo instru	stions)			12		
UU	Other state or local government indigent care program (see instr			1		'-		
00	Net revenue from state or local indigent care program (Not inclu					1:		
00	Charges for patients covered under state or local indigent care					1		
00	10)	program (i	iot inciaaca	111 111103 0 01		l '		
00	State or local indigent care program cost (line 1 times line 14)					15		
00								
	Grants, donations and total unreimbursed cost for Medicaid, CHIP				s (see			
	instructions for each line)							
00	Private grants, donations, or endowment income restricted to fun					17		
00	Government grants, appropriations or transfers for support of ho					18		
00	Total unreimbursed cost for Medicaid , CHIP and state and local	indigent o	care programs	s (sum of lines		19		
	8, 12 and 16)		Uni nounced	Lacusod	Total (col. 1			
			Uni nsured pati ents	Insured patients	+ col . 2)			
		1	1.00	2. 00	3.00	$\vdash$		
	Uncompensated care cost (see instructions for each line)		1.00	2.00	0.00			
00	Charity care charges and uninsured discounts (see instructions)		156, 826, 2	41 36, 225	156, 862, 466	20		
00	Cost of patients approved for charity care and uninsured discoun	ts (see	33, 926, 0	64 36, 225	33, 962, 289	2		
	instructions)					l		
00	Payments received from patients for amounts previously written o	ff as		0 0	0	22		
	chari ty care					l		
00	Cost of charity care (see instructions)		33, 926, 0	64 36, 225	33, 962, 289	23		
					1.00			
00	D the the 20! 2 !!t ft!t			6 -4   !! 4	1.00	2		
00	Does the amount on line 20 col. 2, include charges for patient d		a rength of	stay IImit	N	24		
00	imposed on patients covered by Medicaid or other indigent care p If line 24 is yes, enter the charges for patient days beyond the		care program	n's lanath of	0	25		
UU	stay limit	i nui gent	care prograf	ıı ə i ciiyili Ul	U	25		
01	Charges for insured patients' liability (see instructions)				0	25		
00	Bad debt amount (see instructions)				16, 182, 500			
00	Medicare reimbursable bad debts (see instructions)				353, 482			
01	Medicare allowable bad debts (see instructions)				543, 818			
00	Non-Medicare bad debt amount (see instructions)				15, 638, 682			
	Cost of non Modicare and non reimburgable Modicare had debt amou				2 572 426			

3, 573, 436 37, 535, 725 37, 535, 725 31. 00

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

	Financial Systems	TRINITAS HO	DSPITAL		In Lie	u of Form CMS-:	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		eri od:	Worksheet A	
					rom 01/01/2023 o 12/31/2023	Date/Time Pre	narod:
				'	0 12/31/2023	5/30/2024 10:	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00		0.00		col . 4)	
	CENEDAL CEDVICE COCT CENTEDS	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		6, 252, 168	6, 252, 168	0	6, 252, 168	1.00
2.00	00200 CAP REL COSTS-MUBLE EQUIP		7, 377, 136			-,,	
3. 00	00300 OTHER CAP REL COSTS		7, 377, 130	7, 377, 130		0 7,030,704	1
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	103, 038	34, 136, 151	34, 239, 189	_		1
5.00	00500 ADMINISTRATIVE & GENERAL	16, 055, 099	34, 555, 832			48, 700, 960	
6.00	00600 MAI NTENANCE & REPAI RS	347, 089	2, 430, 281	2, 777, 370		2, 777, 370	6.00
7.00	00700 OPERATION OF PLANT	1, 853, 646	12, 042, 867			13, 896, 513	
8.00	00800 LAUNDRY & LINEN SERVICE	84, 407	1, 159, 935			1, 244, 342	1
9.00	00900 HOUSEKEEPI NG	2, 972, 122	2, 661, 395			5, 633, 517	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	2, 365, 039	3, 930, 853	6, 295, 892 0			
12. 00	01200 MAI NTENANCE OF PERSONNEL		0			2, 707, 234	1
13. 00	01300 NURSING ADMINISTRATION	5, 186, 614	261, 392	ľ	· ·		1
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 210, 445	2, 275, 644			3, 486, 089	
15. 00	01500 PHARMACY	3, 544, 530	15, 345, 435				
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 692, 811	1, 653, 027	3, 345, 838	0	3, 345, 838	16.00
17. 00	01700 SOCIAL SERVICE	1, 349, 814	1, 395, 006	2, 744, 820	-696, 533		
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	_		
20.00	02000 NURSING PROGRAM	3, 041, 580	987, 451	4, 029, 031			1
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	4 124 505	1, 211, 153	0 F 22F 720	.,		
22. 00 23. 00	02200   1 & R SERVI CES-OTHER PRGM COSTS APPRV   02300   PARAMED ED PRGM-(SPECIFY)	4, 124, 585	1, 211, 153			2, 709, 739	1
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	J U			0	0	23.00
30. 00	03000 ADULTS & PEDI ATRI CS	19, 688, 232	6, 086, 010	25, 774, 242	-2, 926, 300	22, 847, 942	30.00
31. 00	03100 I NTENSI VE CARE UNI T	5, 159, 408	2, 321, 652				
40.00	04000 SUBPROVI DER - I PF	12, 440, 970	802, 371				1
41.00	04100 SUBPROVI DER - I RF	0	0			0	41.00
42.00	04200 SUBPROVI DER	2, 794, 587	77, 263				
43. 00	04300 NURSERY	1, 186, 521	179, 039				1
44. 00	04400 SKILLED NURSING FACILITY	296, 530	544			297, 074	
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	5, 300, 235 2, 317, 697	2, 276, 164 241, 038			7, 566, 899 2, 561, 543	
40.00	ANCI LLARY SERVI CE COST CENTERS	2,317,097	241, 030	2, 556, 755	2, 000	2, 301, 343	46.00
50. 00	05000 OPERATING ROOM	6, 009, 322	16, 154, 691	22, 164, 013	-10, 814, 337	11, 349, 676	50.00
51.00	05100 RECOVERY ROOM	1, 315, 947	28, 143				
52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 657, 739	468, 212		-259, 680		52. 00
53.00	05300 ANESTHESI OLOGY	0	2, 427, 899				
54. 00	05400 RADI OLOGY -DI AGNOSTI C	3, 400, 297	3, 085, 437				
55. 00 56. 00	05500   RADI OLOGY-THERAPEUTI C   05600   RADI OI SOTOPE	3, 109, 780	2, 166, 395				
57. 00	05700 CT SCAN	343, 154 756, 430	422, 806 453, 981				
58. 00	05800 MRI	276, 878	181, 645				
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 090, 876	1, 567, 918				1
60.00	06000 LABORATORY	247, 037	9, 337, 632				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 245	3, 245	2, 178	5, 423	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	_	0	1
65. 00	06500 RESPI RATORY THERAPY	2, 882, 295	1, 216, 154				1
66.00	06600 PHYSI CAL THERAPY	1, 552, 715	140, 202				1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	156, 326 162, 763	54, 528 2, 054				
69.00	06900 ELECTROCARDI OLOGY	885, 775	2, 054 373, 412				1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	003,773	373, 412	1, 237, 107			
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0	Ö			1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	O	0			
74.00	07400 RENAL DIALYSIS	6, 199, 575	2, 396, 614	8, 596, 189	1, 213, 348	9, 809, 537	74.00
76. 97	07697   CARDI AC REHABI LI TATI ON	0	0	0	0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		0	0	0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	U	0	1 0	<u> </u>	78. 00
90. 00	09000 CLINIC	1, 677, 577	321, 306	1, 998, 883	-244, 726	1, 754, 157	90.00
90. 01	09016 CLINIC-NOT USED	0	0	0	0	0	1
90. 02	09001 PSYCH CLINIC	15, 140, 189	3, 763, 982	18, 904, 171	-1, 727, 489		
90. 03	09002 PSYCH CLINIC FEE BASED	0	0	0	0	0	90. 03
90. 04	09003 WORKFI RST	0	0	0	0	0	
90. 05	09004 CANCER CLINIC	0	0	0	0	0	
90.06	09005 PEDIATRIC CLINIC	811, 949	150, 615				1
90. 07 90. 08	09006 WOMENS CLINIC 09007 THERAPEUTIC SCHOOL	1, 902, 080 403, 812	305, 808 100, 094				1
90. 09	09008 AFTER SCHOOL PROGRAM	403, 812	100, 094				
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1 9		1	1	·	

Health Financial Systems	TRINITAS HOS	PI TAL	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TR	AL BALANCE OF EXPENSES	Provider CCN: 31-0027	From 01/01/2023	Worksheet A  Date/Time Prepared: 5/30/2024 10:12 am

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CC		From 01/01/2023	WOI KSHEEL A	
				To 12/31/2023	Date/Time Pre	nared:
				10 12/31/2023	5/30/2024 10:	
Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	12 (1111
oust delited besoft per on	our ur res	Other	+ col . 2)	ons (See A-6)	Trial Balance	
			1 001. 2)	0113 (300 11 0)	(col . 3 +-	
					col . 4)	
	1.00	2.00	3.00	4. 00	5. 00	
90. 10   09017   CLI NI C-NOT   USED	0	0	0.00	) 0	0.00	90, 10
90. 11 09009 PERINATAL ADDICTION	o	0			0	90. 11
90. 12 09010 THERAPEUTI C NURSERY		Ö	i		0	90. 12
90. 13 09011 CHILD DAY TREATMENT		0	l i		0	90. 13
90. 14   09012 DI ABETES CENTER		0			0	90. 13
90. 15   09013   WOUND CENTER	467, 938	323, 003	790, 94	1 -167, 298	422 442	90. 14
90. 16 09014 MI CA					623, 643 0	90. 13
	187, 249	22, 647	· ·			
90. 17   09015 BAYONNE MENTAL HEALTH CENTER	968, 923	143, 237			1, 111, 451	90. 17
90. 18   09018   CLI NI C	210, 682	53, 477	· ·		215, 321	
91. 00   09100   EMERGENCY	9, 257, 929	3, 564, 882				1
91. 01   09101   PSYCH EMERGENCY	3, 851, 141	232, 770	4, 083, 91	-135, 389	3, 948, 522	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	(	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	1, 064, 493	1, 064, 49	-346, 926	· ·	
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	(	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE		281, 628	281, 62	-281, 628	0	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	161, 041, 377	190, 468, 717	351, 510, 09	4 -31, 112	351, 478, 982	118. 00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS PRIVATE OFFICES	21, 106	4, 144, 363	4, 165, 469	9 2, 160	4, 167, 629	192. 00
193. 00 19300 NONPALD WORKERS	0	0		0	0	193. 00
194.00 07950 NON REIMBURSABLE	o	462, 562	462, 56	28, 952	491, 514	194. 00
194. 01 07951 RETAIL PHARMACY	O	2, 991, 474			2, 991, 474	194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	161, 062, 483	198, 067, 116		1	359, 129, 599	

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 10: 12 am

				5/30/2024 10:	<u>12 am</u>
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
	OFFICE A SERVICE ASST. OFFICE	6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FLXT	0	6, 252, 168		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-281, 628			2.00
3.00	00300 OTHER CAP REL COSTS	0	0	l .	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-10			4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	35, 206, 465			5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	2, 777, 370		6. 00
7.00	00700 OPERATION OF PLANT	-589, 190	13, 307, 323		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 244, 342		8. 00
9.00	00900 HOUSEKEEPI NG	0	5, 633, 517		9. 00
10.00	01000 DI ETARY	0	3, 588, 658		10.00
11. 00	01100 CAFETERI A	-829, 845	1, 877, 389		11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		12. 00
13. 00	01300 NURSING ADMINISTRATION	-17, 338	5, 401, 985		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	3, 486, 089		14. 00
15. 00	01500 PHARMACY	-5, 516			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-796			16. 00
17. 00	01700 SOCIAL SERVICE	-1, 416			17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	1,410			19.00
20. 00	02000 NURSI NG PROGRAM	-6, 419, 730			20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	-0, 417, 730	4, 012, 012		21.00
	1 1	1			1
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	-838, 493			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		23. 00
00.00	INPATIENT ROUTINE SERVICE COST CENTERS	/ 107 104	4/ 440 504	T	00.00
30.00	03000 ADULTS & PEDIATRICS	-6, 407, 421			30.00
31. 00	03100 INTENSIVE CARE UNIT	-675, 608			31.00
40. 00	04000 SUBPROVI DER – I PF	-2, 035, 907	11, 167, 277		40.00
41. 00	04100 SUBPROVI DER - I RF	0	0		41. 00
42. 00	04200 SUBPROVI DER	-1, 096			42. 00
43.00	04300 NURSERY	0	1, 301, 100		43. 00
44.00	04400 SKILLED NURSING FACILITY	0	297, 074		44. 00
45.00	04500 NURSING FACILITY	0	7, 566, 899		45. 00
46.00	04600 OTHER LONG TERM CARE	-19, 799	2, 541, 744		46. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-1, 819, 939	9, 529, 737		50. 00
51.00	05100 RECOVERY ROOM	0	1, 323, 283		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-1, 443, 201	3, 423, 070		52. 00
53. 00	05300 ANESTHESI OLOGY	-4, 595, 902	535, 925		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-1, 401, 950			54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	-32, 870			55. 00
56. 00	05600 RADI OI SOTOPE	-32, 670			56.00
57. 00	05700 CT SCAN	0			57.00
		1			
58.00	05800 MRI	100.734	440, 869	·	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	-109, 736			59.00
60.00	06000 LABORATORY	-194, 300			60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	5, 423		62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62. 30
65. 00		-287	3, 807, 518		65. 00
66. 00	1 1	-34, 518			66. 00
67. 00		-25, 440		l control of the cont	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	163, 928		68. 00
69. 00	06900 ELECTROCARDI OLOGY	-101, 586	1, 052, 267		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9, 061, 053		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	6, 949, 662		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	14, 617, 585		73. 00
74.00	07400 RENAL DIALYSIS	-265, 262	9, 544, 275		74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	О		76. 98
76. 99		0	0		76. 99
77. 00	1	0	0		77. 00
78. 00	1	Ö	o o		78. 00
55	OUTPATIENT SERVICE COST CENTERS	<u> </u>	·	·	1
90. 00	09000 CLINIC	-210, 100	1, 544, 057		90.00
90. 00	09016 CLINIC-NOT USED	210, 100	1, 544, 557		90.00
90. 01	09001 PSYCH CLINIC	-2, 139, 219	15, 037, 463		90.01
90. 02	09001 PSYCH CLINIC FEE BASED	2, 137, 219	13,037,403		90.02
90. 03	1 1				90.03
	09003 WORKFIRST				1
90. 05	09004 CANCER CLINIC	000 510	(22.42)		90.05
90.06	09005 PEDIATRIC CLINIC	-300, 560			90.06
90. 07	09006 WOMENS CLINIC	-243, 329		l control of the cont	90. 07
90. 08	09007 THERAPEUTI C SCHOOL	-341, 255	1		90. 08
90. 09	09008 AFTER SCHOOL PROGRAM	0			90. 09
90. 10	09017 CLI NI C-NOT USED	0	1		90. 10
90. 11	09009 PERINATAL ADDICTION	0	0		90. 11
	<u> </u>		<u> </u>		

Health Financial Systems TRINIT RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES TRINITAS HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 31-0027

Peri od: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared:

			5/30/2024 10:12 am
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6. 00	7. 00	
90. 12   09010   THERAPEUTI C NURSERY	0	0	90. 12
90. 13   09011   CHILD DAY TREATMENT	0	0	90. 13
90. 14   09012   DI ABETES CENTER	0	0	90. 14
90. 15   09013   WOUND CENTER	-34, 400	589, 243	90. 15
90. 16   09014 MI CA	0	0	90. 16
90. 17   09015 BAYONNE MENTAL HEALTH CENTER	-175, 243	936, 208	90. 17
90. 18   09018   CLI NI C	-780	214, 541	90. 18
91. 00   09100   EMERGENCY	-1, 133, 540	11, 098, 822	91.00
91. 01   09101   PSYCH EMERGENCY	-1, 104, 085	2, 844, 437	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
93.99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS			
95. 00 09500 AMBULANCE SERVICES	-717, 567	0	95. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0	O	102. 00
SPECIAL PURPOSE COST CENTERS			
113. 00 11300   I NTEREST EXPENSE	0	0	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	657, 603	352, 136, 585	118. 00
NONREI MBURSABLE COST CENTERS			
192. 00 19200 PHYSICIANS PRIVATE OFFICES	0	4, 167, 629	192. 00
193.00 19300 NONPALD WORKERS	0	o	193. 00
194. 00 07950 NON REIMBURSABLE	0	491, 514	194. 00
194. 01 07951 RETAIL PHARMACY	0	2, 991, 474	194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	657, 603	359, 787, 202	200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 31-0027

Control   Cont						5/30/2024 10	
1.00			Increases				
A CAPTERIA     1 00		Cost Center	Li ne #	Sal ary	0ther		
1.00		2. 00	3.00	4.00	5. 00		
1.00							
IDIALS	1 00		11 00	1 016 967	1 690 267		1 00
1. 00	1.00		— — <del>11.</del> 00				1.00
DIRECT PARKED ID ID FAILURIS   7.3 COL     1   1,530,933   1   1,00   2   2,00   1   3,530,933   1   3,00   3,00   3   3,00   3   3,00   3   3,00   3   3,00   3   3,00   3   3,00   3   3,00   3   3,00   3   3,00   3   3,00   3   3,00   3,00   3   3,00				1,010, 707	1,090,207		
2.00 MoULE BLOOD & PACKED RED	1 00			ما	15 020 022		1 00
1. 00							1
3.00 4.00 5.00 6.00 6.00 6.00 6.00 6.00 6.00 6	2.00		62.00	O	2, 178		2.00
1,00		BLOOD CELL					
5.00			l l				1
6.00	4. 00				0		4. 00
7.00	5.00		0.00	0	0		5. 00
8.00 10.00 11.00 1	6.00		0.00	0	0		6. 00
8.00 10.00 11.00 1	7. 00		0.00	0	0		7.00
9.00 11.00 1							1
10.00			· · · · · · · · · · · · · · · · · · ·		-		1
11.00					-		1
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13.00							1
14. 00							1
15.00		1					
10.00     0.00   0   0   0   11.00							
17.00			· ·				15. 00
18. 00	16. 00		0.00		0		16. 00
1.00	17. 00		0.00		0		17. 00
1.00	18.00		0.00	o	0		18. 00
20,00					0		
22.00   0.00   0   0   0   22.00   2			· ·		0		•
22 00		1					1
23.00							
24.00   25.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   26.00   27.00   28.00   29.00   29.00   29.00   31.00   32.00   29.00   29.00   31.00   32.00   20.0							
25. 00			l l				
26.00			· •				1
27.00					0		1
28.00     0.00   0   0   0   28.00   31.00   32.00					0		
29.00     0.00   0   0   0   31.00   32.00     1.00   0   0   0   31.00   32.00     1.00   0   0   0   0   0   0   32.00							
31.00			l l		-		
1.00							
TOTALS					-		
1.00   CAP REL COSTS-MVBLE EQUIP   2.00   0   281,628   1.00	32. 00				=		32. 00
1.00   CAP REL COSTS-MABLE EQUIP   2.00   0   281,628				0	15, 833, 111		
TOTALS   D - RECLASS MED SURGICAL SUPPLIES							
D - RECLASS MED SURGICAL SUPPLIES	1. 00						1.00
1. 00 MEDICAL SUPPLIES CHARGED TO PATIENT				0	281, 628		
PATIENT RADIOI SOTOPE		D - RECLASS MED SURGICAL SUPP	PLIES				
2 00 RADI OI SOTOPE	1.00		71. 00	0	9, 061, 053		1. 00
3.00         0.00         0.00         0.00         0.00         0.00         4.00         5.00         4.00         5.00         6.00         6.00         6.00         6.00         6.00         7.00         6.00         7.00         6.00         7.00         6.00         7.00         8.00         9.00         7.00         8.00         9.00         7.00         8.00         9.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
4,00       0,00       0       0       4,00       5,00       6,00       6,00       6,00       6,00       6,00       6,00       6,00       7,00       6,00       7,00       8,00       7,00       8,00       7,00       8,00       9,00       7,00       8,00       9	2.00	RADI OI SOTOPE	56.00	0	0		2. 00
5 00         0 00         0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00		0.00	0	0		3. 00
6.00 7.00 8.00 9.00 9.00 10.00 10.00 11.00 11.00 11.00 11.00 11.00 12.00 13.00 14.00 15.00 16.00 0.00 0.00 0.00 0.00 0.00 0.00	4.00		0.00	0	0		4. 00
7.00         0.00         0         0         7.00           8.00         0.00         0         0         8.00           9.00         0.00         0         0         9.00           10.00         0.00         0         0         10.00           11.00         0.00         0         0         11.00           12.00         0.00         0         0         11.00           13.00         0.00         0         0         12.00           13.00         0.00         0         0         12.00           14.00         0.00         0         0         0         14.00           15.00         0.00         0         0         0         15.00         14.00         15.00         16.00         17.00         16.00         17.00         16.00         17.00         17.00         0         0         17.00         18.00         19.00         17.00         0         18.00         19.00         19.00         19.00         19.00         19.00         19.00         19.00         19.00         19.00         19.00         19.00         19.00         19.00         19.00         19.00         19.00         19.00	5.00		0.00	0	0		5. 00
7.00         0.00         0         0         7.00           8.00         0.00         0         0         8.00           9.00         0.00         0         0         9.00           10.00         0.00         0         0         10.00           11.00         0.00         0         0         11.00           12.00         0.00         0         0         11.00           13.00         0.00         0         0         12.00           13.00         0.00         0         0         12.00           14.00         0.00         0         0         0         14.00           15.00         0.00         0         0         0         15.00         14.00         15.00         16.00         17.00         0         0         15.00         16.00         17.00         0         0         17.00         0         17.00         0         0         17.00         0         17.00         0         18.00         19.00         0         19.00         0         19.00         0         19.00         0         19.00         0         19.00         0         0         19.00         0	6.00		0.00	0	0		6. 00
8.00       0.00       0       0       0       0       9.00       10.00       9.00       10.00       9.00       10.00       9.00       11.00       10.00       10.00       10.00       10.00       11.00       11.00       11.00       11.00       11.00       11.00       11.00       11.00       11.00       11.00       12.00       11.00       12.00       12.00       13.00       12.00       13.00       14.00       12.00       13.00       14.00       12.00       14.00       14.00       14.00       15.00       14.00       15.00       16.00       15.00       16.00       15.00       16.00       17.00       15.00       16.00       17.00       15.00       17.00       18.00       17.00       18.00       17.00       18.00       17.00       18.00       19.00       17.00       18.00       19.00	7.00		0.00	0	0		7. 00
9.00       0.00       0       0       9.00         10.00       0.00       0       0       10.00         11.00       0.00       0       0       11.00         12.00       0.00       0       0       12.00         13.00       0.00       0       0       13.00         14.00       0.00       0       0       14.00         15.00       0.00       0       0       15.00         16.00       0.00       0       0       15.00         17.00       0.00       0       0       17.00         18.00       0.00       0       0       17.00         20.00       0.00       0       0       19.00         20.00       0.00       0       0       19.00         21.00       0.00       0       0       19.00         22.00       0.00       0       0       0       21.00         23.00       0.00       0       0       0       22.00         24.00       0.00       0       0       0       22.00         25.00       0.00       0       0       0       22.00							
10.00       0.00       0       0       10.00         11.00       0.00       0       0       11.00         12.00       0.00       0       0       11.00         13.00       0.00       0       0       0       12.00         13.00       0.00       0       0       0       13.00         14.00       0.00       0       0       0       14.00         15.00       0.00       0       0       0       15.00         16.00       0.00       0       0       0       15.00         17.00       0       0.00       0       0       17.00         18.00       0       0       0       0       17.00         19.00       0       0       0       0       19.00         20.00       0       0       0       0       19.00         21.00       0       0       0       0       0       19.00         22.00       0       0       0       0       0       21.00       0         23.00       0       0       0       0       0       22.00       0         23.00 <t< td=""><td></td><td></td><td></td><td>Ō</td><td></td><td></td><td></td></t<>				Ō			
11. 00       0. 00       0       0       11. 00         12. 00       0. 00       0       0       12. 00         13. 00       0. 00       0       0       0       13. 00         14. 00       0. 00       0       0       0       14. 00         15. 00       0. 00       0       0       0       15. 00         16. 00       0. 00       0       0       0       16. 00         17. 00       0. 00       0       0       0       17. 00         18. 00       0. 00       0       0       0       18. 00         19. 00       0. 00       0       0       0       19. 00         20. 00       0. 00       0       0       0       19. 00         21. 00       0. 00       0       0       0       19. 00         21. 00       0. 00       0       0       0       20. 00         23. 00       0. 00       0       0       0       22. 00         23. 00       0. 00       0       0       0       22. 00         24. 00       0. 00       0       0       0       25. 00         26. 00       0.							
12.00       0.00       0       0       12.00         13.00       0.00       0       0       13.00         14.00       0.00       0       0       14.00         15.00       0.00       0       0       15.00         16.00       0.00       0       0       15.00         16.00       0.00       0       0       16.00         17.00       0.00       0       0       17.00         18.00       0.00       0       0       17.00         19.00       0.00       0       0       17.00         20.00       0.00       0       0       0       19.00         20.00       0.00       0       0       0       20.00       21.00       22.00       22.00       22.00       22.00       22.00       22.00       22.00       23.00       22.00       23.00       24.00       22.00       23.00       24.00       25.00       26.00       25.00       26.00       25.00       26.00       27.00       28.00       29.00       27.00       28.00       29.00       29.00       30.00       30.00       30.00       31.00       31.00       31.00       31.00							
13.00       0.00       0.00       0       0       13.00         14.00       0.00       0.00       0       0       14.00         15.00       0.00       0       0       15.00         16.00       0.00       0       0       15.00         17.00       0.00       0       0       17.00         18.00       0.00       0       0       18.00         19.00       0.00       0       0       18.00         19.00       0.00       0       0       19.00         20.00       0.00       0       0       20.00         21.00       0.00       0       0       21.00         22.00       0.00       0       0       22.00         23.00       0.00       0       0       23.00         24.00       0.00       0       0       24.00         25.00       0.00       0       0       25.00         26.00       0.00       0       0       27.00         28.00       0.00       0       0       29.00         30.00       0.00       0       0       30.00         31.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
14. 00       0.00       0       0       14. 00         15. 00       0.00       0       0       15. 00         16. 00       0.00       0       0       16. 00         17. 00       0       0       0       16. 00         18. 00       0.00       0       0       0         18. 00       0.00       0       0       18. 00         19. 00       0.00       0       0       19. 00         20. 00       0.00       0       0       0       20. 00         21. 00       0.00       0       0       0       21. 00       22. 00         22. 00       0.00       0       0       0       21. 00       22. 00       23. 00       22. 00       23. 00       24. 00       22. 00       23. 00       24. 00       24. 00       24. 00       24. 00       25. 00       26. 00       25. 00       26. 00       27. 00       28. 00       27. 00       28. 00       29. 00       29. 00       30. 00       30. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00       31. 00<							
15. 00       0.00       0       0       15. 00         16. 00       0.00       0       0       16. 00         17. 00       0.00       0       0       17. 00         18. 00       0.00       0       0       0         19. 00       0.00       0       0       0       19. 00         20. 00       0.00       0       0       0       19. 00         20. 00       0.00       0       0       0       19. 00         21. 00       0.00       0       0       0       20. 00         21. 00       0.00       0       0       0       21. 00         22. 00       0.00       0       0       0       22. 00         23. 00       0.00       0       0       0       23. 00         24. 00       0       0       0       0       24. 00         25. 00       0       0       0       0       25. 00         26. 00       0       0       0       0       27. 00         28. 00       0       0       0       0       0       28. 00         29. 00       0       0       0		1					
16. 00       0.00       0       0       16. 00         17. 00       0.00       0       0       17. 00         18. 00       0.00       0       0       18. 00         19. 00       0.00       0       0       19. 00         20. 00       0.00       0       0       0       19. 00         21. 00       0.00       0       0       0       20. 00       21. 00         22. 00       0.00       0       0       0       22. 00       22. 00       22. 00       23. 00       22. 00       23. 00       24. 00       24. 00       24. 00       24. 00       24. 00       24. 00       24. 00       24. 00       25. 00       26. 00       27. 00       26. 00       27. 00       26. 00       27. 00       28. 00       29. 00       20. 00       29. 00       29. 00       29. 00       30. 00       30. 00       31. 00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
17. 00       18. 00       0       0       0       17. 00         18. 00       0. 00       0       0       18. 00         19. 00       0. 00       0       0       19. 00         20. 00       0. 00       0       0       20. 00         21. 00       0. 00       0       0       21. 00         22. 00       0. 00       0       0       22. 00         23. 00       0. 00       0       0       0       22. 00         24. 00       0. 00       0       0       0       24. 00         25. 00       0. 00       0       0       0       25. 00         26. 00       0. 00       0       0       0       26. 00         27. 00       0       0       0       0       27. 00         28. 00       0       0       0       0       0       29. 00         30. 00       0       0       0       0       0       0       0         31. 00       0       0       0       0       0       0       0       0							
18. 00       0. 00       0       0       18. 00         19. 00       0. 00       0       0       19. 00         20. 00       0. 00       0       0       20. 00         21. 00       0. 00       0       0       21. 00         22. 00       0. 00       0       0       21. 00         23. 00       0. 00       0       0       0       23. 00         24. 00       0. 00       0       0       0       24. 00         25. 00       0. 00       0       0       0       25. 00         26. 00       0. 00       0       0       0       26. 00         27. 00       0. 00       0       0       0       27. 00         28. 00       0. 00       0       0       0       29. 00         30. 00       0. 00       0       0       0       30. 00         31. 00       0. 00       0       0       0       31. 00							
19.00       0.00       0       0       19.00         20.00       0.00       0       0       20.00         21.00       0.00       0       0       21.00         22.00       0.00       0       0       22.00         23.00       0.00       0       0       23.00         24.00       0.00       0       0       0       24.00         25.00       0.00       0       0       0       25.00         26.00       0.00       0       0       0       26.00         27.00       0.00       0       0       0       27.00         28.00       0.00       0       0       0       28.00         30.00       0.00       0       0       0       30.00         31.00       0.00       0       0       0       31.00				0			
20. 00     0. 00     0     0     20. 00       21. 00     0. 00     0     0     21. 00       22. 00     0. 00     0     0     22. 00       23. 00     0. 00     0     0     23. 00       24. 00     0. 00     0     0     24. 00       25. 00     0. 00     0     0     25. 00       26. 00     0. 00     0     0     25. 00       27. 00     0. 00     0     0     27. 00       28. 00     0. 00     0     0     28. 00       29. 00     0. 00     0     0     29. 00       30. 00     0. 00     0     0     0       31. 00     0. 00     0     0     0							
21. 00     0.00     0     0     21. 00       22. 00     0.00     0     0     0     22. 00       23. 00     0.00     0     0     0     23. 00       24. 00     0.00     0     0     0     24. 00       25. 00     0.00     0     0     0     25. 00       26. 00     0.00     0     0     0     26. 00       27. 00     0.00     0     0     0     28. 00       29. 00     0.00     0     0     0     29. 00       30. 00     0.00     0     0     0     30. 00       31. 00     0.00     0     0     0     31. 00		1		0			
22. 00       23. 00       24. 00       24. 00       25. 00       26. 00       27. 00       28. 00       29. 00       30. 00       31. 00       22. 00       23. 00       24. 00       24. 00       24. 00       25. 00       26. 00       27. 00       28. 00       29. 00       30. 00       31. 00							
23. 00     0. 00     0     0     23. 00       24. 00     0. 00     0     0     0     24. 00       25. 00     0. 00     0     0     0     25. 00       26. 00     0. 00     0     0     0     26. 00       27. 00     0. 00     0     0     0     27. 00       28. 00     0. 00     0     0     0     29. 00       30. 00     0. 00     0     0     0     30. 00       31. 00     0. 00     0     0     0     31. 00							
24.00     0.00     0     0     24.00       25.00     0.00     0     0     25.00       26.00     0.00     0     0     26.00       27.00     0.00     0     0     27.00       28.00     0.00     0     0     27.00       29.00     0.00     0     0     29.00       30.00     0.00     0     0     30.00       31.00     0.00     0     0     31.00							
24.00     0.00     0     0     24.00       25.00     0.00     0     0     25.00       26.00     0.00     0     0     26.00       27.00     0.00     0     0     27.00       28.00     0.00     0     0     27.00       29.00     0.00     0     0     29.00       30.00     0.00     0     0     30.00       31.00     0.00     0     0     31.00					0		
25. 00     0. 00     0     0     25. 00       26. 00     0. 00     0     0     26. 00       27. 00     0. 00     0     0     27. 00       28. 00     0. 00     0     0     28. 00       29. 00     0. 00     0     0     28. 00       30. 00     0. 00     0     0     30. 00       31. 00     0. 00     0     0     31. 00	24.00			o	0		
26. 00     0. 00     0     0     26. 00       27. 00     0. 00     0     0     27. 00       28. 00     0. 00     0     0     28. 00       29. 00     0. 00     0     0     29. 00       30. 00     0. 00     0     0     30. 00       31. 00     0. 00     0     0     31. 00							
27. 00     0. 00     0     0     27. 00       28. 00     0. 00     0     0     28. 00       29. 00     0. 00     0     0     29. 00       30. 00     0. 00     0     0     0       31. 00     0. 00     0     0     0							
28. 00     0. 00     0     0     28. 00       29. 00     0. 00     0     0     29. 00       30. 00     0. 00     0     0     0       31. 00     0. 00     0     0     0							
29.00     0.00     0     0     29.00       30.00     0.00     0     0     30.00       31.00     0.00     0     0     31.00							
30.00 31.00 0.00 0 0 31.00							
31.00		1					
32.00     0.00  0  0  32.00							
	JZ. UU	1	0.00	Ŋ	U		J 32. UU

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 10:12 am Provider CCN: 31-0027

					10 12/31	5/30/2024 10: 12 am
		Increases				
	Cost Center	Li ne # 3.00	Sal ary	Other 5 00		
33. 00	2. 00	0.00	4.00	5. 00		33.00
34. 00		0.00	Ö	Ö		34.00
	TOTALS — — — — —			9, 061, 053		
	E - RECLASS MALPRACTICE					
1.00	ADULTS & PEDIATRICS	30.00	0	43, 949		1. 00
2.00	SUBPROVI DER - I PF	40.00	0	23, 596		2.00
3. 00 4. 00	SUBPROVIDER OTHER LONG TERM CARE	42. 00 46. 00	0	5, 266 2, 808		3.00
5. 00	RESPIRATORY THERAPY	65.00	0	2, 606		5.00
6. 00	CLINIC	90.00	o	2, 896		6.00
7. 00	PSYCH CLINIC	90. 02	o	27, 702		7. 00
8.00	THERAPEUTIC SCHOOL	90. 08	0	373		8. 00
9.00	PSYCH CLINIC	90. 02	0	2, 191		9. 00
10.00	MI CA	90. 16	0	586		10.00
11. 00	BAYONNE MENTAL HEALTH CENTER	90. 17	0	4 040		11.00
12. 00	PSYCH_EMERGENCY	91.01		<u>4, 969</u> 114, 357		12.00
	F - IMPLANTABLE DEVICES	L	<u> </u>	114, 557		
1.00	I MPL. DEV. CHARGED TO	72. 00	0	6, 949, 662		1.00
	PATI ENTS					
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3.00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6. 00		0.00	0	0		6.00
7. 00		0.00	o	0		7.00
8.00		0.00	o	Ö		8.00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12.00
13. 00 14. 00		0. 00 0. 00	0	0		13. 00 14. 00
14.00	TOTALS — — — — —			6, 949, 662		14.00
	G - PUB RELATIONS TO NON REIN	MB	<u> </u>	0, , , , , , 002		
1.00	NON REIMBURSABLE	194. 00	0	28, 952		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4. 00
5.00	TOTAL C — — — — —	0.00	0	0		5. 00
	TOTALS H - RECLASS AMBULANCE TO EMER	CENCY	U	28, 952		
1.00	EMERGENCY	91.00	0	345, 968		1.00
	TOTALS			345, 968		
	I - RECLASS EPOTEIN					
1.00	RENAL DI ALYSI S	74.00	0	<u>1, 213, 3</u> 48		1. 00
	TOTALS	NI C	0	1, 213, 348		
1. 00	J - RECLASS MICA TO PSYCH CLI PSYCH CLINIC	90. 02	187, 249	18, 477		1.00
1.00	TOTALS		187, 249	18, 477		1.00
	K - CANCER CENTER PHYSICIAN		1077217	.0,		
1.00	PHYSICIANS PRIVATE OFFICES	192. 00	0	2, 160		1.00
	TOTALS		0	2, 160		
4 00	L - PSYCH ADMIN TO CLINICS	40.00	400 440			1.00
1. 00 2. 00	SUBPROVI DER - I PF SUBPROVI DER	40. 00 42. 00	188, 410 65, 534	0		1.00
3. 00	PSYCH EMERGENCY	91. 01	73, 726			3.00
3.00	TOTALS	— <u> </u>	327, 670	0		3.00
	Q - FRINGE GRANT FUNDED	1		-		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 489, 354		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3.00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
5. 00 6. 00		0.00	0	0		6.00
5.00	TOTALS — — — — —			2, 489, 354		0.00
	S - PROPERTY & AUTO INSURANCE			_,,		
1.00		0.00	0	0		1.00
	TOTALS		0	0		
1 00	T - TEACHING RECLASS	00.00	272 447			
1. 00	I&R SERVICES-OTHER PRGM COSTS APPRV	22. 00	278, 167	0		1.00
2.00	OOSIS ALLKY	0.00	0	0		2. 00
3. 00		0.00	o	Ö		3.00
		·		I		1 2 2

Health Financial Systems RECLASSIFICATIONS Provider CCN: 31-0027 

					10   12/31/2023   Date/11 me Pl   5/30/2024 10	
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
	TOTALS		278, 167	0		_
1 00	V - I&R SALARY RECLASS	21 00	4 012 012	0		1 00
1. 00	I &R SERVICES-SALARY & FRINGES APPRV	21. 00	4, 012, 012	U		1. 00
2.00	I KINGLS AFFRY	0.00	0	0		2. 00
3. 00		0.00	0	ő		3. 00
4. 00		0.00	0	ő		4. 00
5. 00		0.00	0	0		5. 00
3.00	TOTALS — — — —		4, 012, 012	— — <u> </u>		3.00
	W - ANESTHESIA FEES		1,012,012			
1.00	ANESTHESI OLOGY	53.00	0	3, 013, 220		1. 00
	TOTALS			3, 013, 220		
	X - I&R SUPERVISION	<u> </u>				
1.00	I&R SERVICES-OTHER PRGM	22. 00	815, 269	0		1. 00
	COSTS APPRV					
2.00		0.00	0	0		2. 00
	TOTALS		815, 269	0		_
	Y - CONTRACT LABOR					
1.00	ADULTS & PEDIATRICS	30. 00	0	747, 841		1. 00
2.00	INTENSIVE CARE UNIT	31. 00	0	5, 540		2. 00
3.00	DELIVERY ROOM & LABOR ROOM	5200	•_	<u>2, 6</u> 64		3. 00
	TOTALS		0	756, 045		_
	Z - WAGE INDEX					
1. 00	ADMINISTRATIVE & GENERAL	5. 00	4, 705, 080	0		1. 00
2.00	OPERATION OF PLANT	7.00	0	104, 191		2. 00
3.00	NURSI NG ADMI NI STRATI ON	13.00	0	128, 687		3. 00
4.00	PHARMACY	15.00	0	12, 303		4. 00
5.00	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	16.00	O O	20, 514		5. 00
6. 00 7. 00	NURSING PROGRAM	17. 00 20. 00	0	253, 469 58, 500		6. 00 7. 00
8. 00	ADULTS & PEDIATRICS	30.00	0	89, 567		8. 00
9. 00	INTENSIVE CARE UNIT	31. 00	o	107, 224		9. 00
10. 00	SUBPROVI DER	42.00	0	35, 094		10.00
11. 00	NURSERY	43. 00	0	99, 087		11. 00
12. 00	NURSING FACILITY	45. 00	0	81, 580		12. 00
13. 00	OPERATING ROOM	50.00	0	176, 346		13. 00
14. 00	DELIVERY ROOM & LABOR ROOM	52.00	o	306, 860		14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	Ö	80, 127		15. 00
16.00	RADI OLOGY-THERAPEUTI C	55. 00	2, 502, 679	0		16. 00
17.00	CARDIAC CATHETERIZATION	59. 00	0	5, 035		17. 00
18.00	RESPIRATORY THERAPY	65. 00	0	50, 080		18. 00
19.00	ELECTROCARDI OLOGY	69. 00	0	31, 524		19. 00
20.00	RENAL DIALYSIS	74. 00	0	102, 655		20. 00
21.00	CLINIC	90.00	0	20, 833		21. 00
22. 00	PSYCH CLINIC	90. 02	0	124, 399		22. 00
23. 00	WOUND CENTER	90. 15	0	25, 384		23. 00
24. 00	CLINIC	90. 18	0	1, 138		24. 00
25. 00	EMERGENCY	91.00	0	116, 373		25. 00
26. 00	PSYCH EMERGENCY	91. 01	0	55, 950		26. 00
27. 00	PHYSICIANS PRIVATE OFFICES	192.00	1, 699, 440	0		27. 00
	TOTALS		8, 907, 199	2, 086, 920		_
4 66	ZZ - PHYSI CI AN RECLASS	22 5-1	400 //-	04 / 507		4
1.00	ADULTS & PEDIATRICS	30.00	429, 660	816, 587		1.00
2. 00	PSYCH CLINIC	90.02	0	16, 787		2. 00
500.00	TOTALS Grand Total: Increases		429, 660 15, 974, 193	833, 374 44, 717, 896		500. 00
500.00	pranu rotar. Thereases		10, 7/4, 193	44, / 1 / , 890		1 300. 00

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 10: 12 am

		D				5/30/2024 10	. 12 alli
		Decreases	6.1	011			
	Cost Center	Li ne #	Salary	Other 0.00	Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10. 00		
1 00	A - CAFETERIA	10.00	1 01/ 0/7	1 (00 0/7			1 00
1. 00	DI ETARY		<u>1, 016, 967</u>	<u>1, 690, 267</u>			1. 00
			1, 016, 967	1, 690, 267			-
1 00	B - DRUGS CHARGED TO PATIENTS PHARMACY		٥	15, 100, 222			1 00
1.00		15.00	0				1.00
2.00	NURSING PROGRAM	20.00	0	244			2.00
3.00	ADULTS & PEDIATRICS	30.00	0	215, 104			3. 00
4.00	I NTENSI VE CARE UNI T	31.00	0	69, 675			4. 00
5.00	SUBPROVI DER - I PF	40. 00	0	10, 045			5. 00
6.00	SUBPROVI DER	42. 00	0	1, 037			6. 00
7. 00	NURSERY	43. 00	0	2, 074			7. 00
8.00	OPERATING ROOM	50.00	0	89, 016	0		8. 00
9.00	RECOVERY ROOM	51.00	0	5, 024	0		9. 00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	O	25, 158	0		10.00
11.00	ANESTHESI OLOGY	53.00	o	28, 467	0		11.00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	o	8, 312			12. 00
13. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	25, 878			13. 00
14. 00	RADI OI SOTOPE	56.00	0	440			14. 00
15. 00	CT SCAN	57.00	0	1, 825			15. 00
16. 00	MRI	58. 00	0	1, 269			16. 00
17. 00	CARDIAC CATHETERIZATION	59.00	0	4, 939			17. 00
18. 00	LABORATORY	60.00	0	2, 673			18. 00
		· · · · · · · · · · · · · · · · · · ·	0				1
19.00	RESPIRATORY THERAPY	65.00	0	21, 963			19. 00
20. 00	PHYSI CAL THERAPY	66.00	0	320			20. 00
21. 00	ELECTROCARDI OLOGY	69. 00	0	1, 431			21. 00
22. 00	CLINIC	90.00	0	639			22. 00
23.00	PSYCH CLINIC	90. 02	0	2, 176	0		23. 00
24.00	PEDIATRIC CLINIC	90.06	0	32, 285	0		24. 00
25.00	WOMENS CLINIC	90. 07	0	499	0		25. 00
26.00	WOUND CENTER	90. 15	o	1, 240	0		26. 00
27.00	EMERGENCY	91.00	o	178, 010			27. 00
28. 00	PSYCH EMERGENCY	91.01	0	10			28. 00
29. 00	AMBULANCE SERVICES	95. 00	0	958			29. 00
31. 00	ANESTHESI OLOGY	53.00	Ö	106			31. 00
32. 00	LABORATORY	60.00	Ö	2, 072			32. 00
32.00	TOTALS		— — — <del>ў</del>	<u>2, 0, 2</u> 15, 833, 111			32.00
	C - INTEREST EXPENSE		U	15, 655, 111			+
1.00	INTEREST EXPENSE	113. 00	0	281, 628	11		1. 00
1.00	TOTALS	113.00	— — —	281, 628			1.00
	D - RECLASS MED SURGICAL SUPP	DITEC	U <sub>I</sub>	201, 020			-
1.00	PHARMACY	15. 00	O	262, 567	0		1. 00
2.00	NURSI NG PROGRAM	20.00	0	21, 650			2. 00
	l .	· · · · · · · · · · · · · · · · · · ·	0				1
3.00	I &R SERVICES-OTHER PRGM	22. 00	U	886	1		3. 00
4 00	COSTS APPRV	20.00		704 5/4			4 00
4.00	ADULTS & PEDIATRICS	30.00	0	791, 561	0		4. 00
5.00	I NTENSI VE CARE UNI T	31.00	0	387, 249			5. 00
6.00	SUBPROVI DER - I PF	40. 00	0	156, 830			6. 00
7. 00	SUBPROVI DER	42. 00	0	66, 259	0		7. 00
8.00	NURSERY	43.00	0	62, 386	0		8. 00
9.00	OPERATING ROOM	50.00	0	4, 370, 092	0		9. 00
10.00	RECOVERY ROOM	51.00	0	15, 783	0		10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	237, 186	0		11. 00
12.00	ANESTHESI OLOGY	53.00	0	280, 585	0		12. 00
13.00	RADI OLOGY-DI AGNOSTI C	54.00	o	339, 093	0		13.00
14.00	RADI OLOGY-THERAPEUTI C	55. 00	o	105, 568			14.00
15. 00	RADI OI SOTOPE	56.00	0	131, 975			15. 00
16. 00	CT SCAN	57.00	0	57, 729			16. 00
17. 00	MRI	58.00	0	16, 359			17. 00
18. 00	CARDIAC CATHETERIZATION	59.00	0	443, 624			18. 00
19. 00	LABORATORY	60.00	0	9, 167			19. 00
	RESPIRATORY THERAPY	· · · · · · · · · · · · · · · · · · ·	0				20. 00
20.00	l control of the cont	65.00		268, 513			1
21. 00	PHYSI CAL THERAPY	66.00	O S	22, 976			21. 00
22. 00	OCCUPATIONAL THERAPY	67.00	٥	118			22. 00
23. 00	SPEECH PATHOLOGY	68.00	O	889			23. 00
24. 00	ELECTROCARDI OLOGY	69.00	O	26, 942			24. 00
25. 00	CLINIC	90.00	0	16, 130			25. 00
26. 00	PSYCH CLINIC	90. 02	0	13, 631			26. 00
27.00	PEDIATRIC CLINIC	90.06	0	6, 829	0		27. 00
28.00	WOMENS CLINIC	90. 07	0	27, 525	0		28. 00
29. 00	WOUND CENTER	90. 15	O	135, 986	0		29. 00
30.00	MI CA	90. 16	ol	4, 756	0		30. 00
31.00	BAYONNE MENTAL HEALTH CENTER	90. 17	o	713			31.00
32.00	EMERGENCY	91.00	O	750, 939			32. 00
33. 00	PSYCH EMERGENCY	91. 01	o	28, 557			33. 00
	1	731	9	20,007		I .	1 22.00

Health Financial Systems RECLASSIFICATIONS

In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 10:12 am Provider CCN: 31-0027

					10	5/30/2024 1	
		Decreases					
	Cost Center	Li ne #	Salary		Wkst. A-7 Ref.		
24.00	6. 00	7. 00	8. 00	9. 00	10.00		24.00
34. 00	AMBULANCE SERVICES TOTALS	95.00	0	<u>0</u> 9, 061, 053			34. 00
	E - RECLASS MALPRACTICE		U <sub>I</sub>	7,001,033			
1.00	ADMI NI STRATI VE & GENERAL	5.00	O	114, 357	O		1.00
2.00		0.00	0	0			2. 00
3.00		0.00	o	0	o		3. 00
4.00		0.00	0	0	0		4. 00
5.00		0.00	0	0	0		5. 00
6.00		0.00	0	0	0		6. 00
7.00		0.00	0	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0	0		8. 00 9. 00
10. 00		0.00	0	0	0		10.00
11. 00		0.00	Ö	0	o		11. 00
12. 00		0.00	O	0	o		12. 00
	TOTALS			114, 357			
	F - IMPLANTABLE DEVICES						
1.00	ADULTS & PEDIATRICS	30.00	0	1, 080	0		1. 00
2.00	INTENSIVE CARE UNIT	31.00	0	1, 396	l I		2.00
3. 00 4. 00	OPERATING ROOM ANESTHESIOLOGY	50. 00 53. 00	0	6, 355, 229 134	0		3. 00 4. 00
5. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	127, 672	0		5. 00
6. 00	RADI OLOGY-THERAPEUTI C	55.00	0	18, 817	0		6. 00
7. 00	RADI OI SOTOPE	56.00	Ö	17	o		7. 00
8.00	MRI	58. 00	0	26	o		8. 00
9.00	CARDIAC CATHETERIZATION	59.00	О	406, 822	o		9. 00
10.00	RESPI RATORY THERAPY	65. 00	0	185	0		10. 00
11. 00	ELECTROCARDI OLOGY	69. 00	0	646	0		11. 00
12. 00	WOUND CENTER	90. 15	0	30, 072	0		12. 00
13.00	EMERGENCY	91.00	0	7, 468			13.00
14. 00	PSYCH EMERGENCY	<u>91.</u> 01	0	98 6, 949, 662	<u> </u>		14. 00
	G - PUB RELATIONS TO NON REIM	IR	<u> </u>	0, 747, 002			
1.00	PEDIATRIC CLINIC	90.06	0	199	0		1.00
2.00	WOMENS CLINIC	90. 07	O	199			2. 00
3.00	NURSING FACILITY	45. 00	О	9, 500	o		3. 00
4.00	ADMINISTRATIVE & GENERAL	5. 00	0	8, 649	O		4. 00
5.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1 <u>0, 4</u> 05	0		5. 00
	TOTALS	2511014	0	28, 952			_
1 00	H - RECLASS AMBULANCE TO EMER		ما	245 040			1 00
1. 00	AMBULANCE SERVICES TOTALS	9500	0	34 <u>5, 9</u> 68 345, 968			1.00
	I - RECLASS EPOTEIN		U <sub>I</sub>	343, 700			
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1, 213, 348	0		1.00
	TOTALS			1, 213, 348			
	J - RECLASS MICA TO PSYCH CLI	NI C					
1.00	MI CA	<u>90.</u> 16	187, 249	1 <u>8, 4</u> 77			1. 00
	TOTALS		187, 249	18, 477			_
4 00	K - CANCER CENTER PHYSICIAN	FF 00	ما	0.440			
1. 00	RADI OLOGY-THERAPEUTI C TOTALS	<u>55.</u> 00	9	2, 160			1. 00
	L - PSYCH ADMIN TO CLINICS		U <sub>I</sub>	2, 160			
1.00	PSYCH CLINIC	90. 02	327, 670	0	O		1.00
2. 00	I STON GENNIG	0.00	027,070	0	1		2. 00
3.00		0.00	O	0	O		3. 00
	TOTALS		327, 670				
	Q - FRINGE GRANT FUNDED						
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	493, 102			1. 00
2.00	CLINIC	90.00	0	230, 853			2. 00
3.00	PSYCH CLINIC	90. 02	0	1, 619, 298	l I		3. 00
4. 00 5. 00	CLINIC THERAPEUTIC SCHOOL	90. 18 90. 08	0	48, 838 94, 250			4. 00 5. 00
6. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	3, 013			6. 00
5. 00	TOTALS		— — <del>ŏ</del>	2, 489, 354			3.00
	S - PROPERTY & AUTO INSURANCE		<u> </u>	-,,			
1.00		0.00	0	0			1.00
	TOTALS		0				_
	T - TEACHING RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	0	1		1.00
2.00	ADULTS & PEDIATRICS	30. 00 40. 00	151, 931	0	0		2.00
3. 00 4. 00	SUBPROVI DER - I PF SUBPROVI DER	40.00	85, 288 0	0	0		3. 00 4. 00
5. 00	CLINIC	90.00	0	0			5. 00
6. 00	PSYCH CLINIC	90.02	17, 120	0			6. 00
		75. 52	, .20	<u> </u>	<u> </u>		3.00

					'	5/30/2024	10: 12 am
		Decreases		<b>'</b>	, i		
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
7.00	PSYCH EMERGENCY	91. 01	23, 828	0	0		7. 00
	TOTALS		278, 167	0			
	V - I&R SALARY RECLASS						
1.00	I&R SERVICES-OTHER PRGM	22. 00	3, 718, 549	0	0		1. 00
	COSTS APPRV						
2.00	CARDIAC CATHETERIZATION	59. 00	78, 279	0			2. 00
3.00	ELECTROCARDI OLOGY	69. 00	76, 315	0			3. 00
4. 00	THERAPEUTIC SCHOOL	90. 08	1, 106	0			4. 00
5.00	PSYCH EMERGENCY	91.01	13 <u>7, 7</u> 63	0			5. 00
	TOTALS		4, 012, 012	0			
	W - ANESTHESIA FEES				_		
1. 00	ADULTS & PEDIATRICS	30.00		<u>3, 013, 220</u>			1. 00
	TOTALS		0	3, 013, 220			
4 00	X - I &R SUPERVI SI ON	20.00	704 444				1 00
1.00	ADULTS & PEDIATRICS	30.00	791, 441	0			1.00
2. 00	PSYCH EMERGENCY	91.01	23, 828	0	0		2. 00
	TOTALS		815, 269	0			
1.00	Y - CONTRACT LABOR  ADMINISTRATIVE & GENERAL	5.00	0	30, 829	0		1. 00
2.00	NURSING ADMINISTRATION	13. 00	0	28, 683			2.00
3.00	SOCIAL SERVICE	17. 00	0	696, 533			3. 00
3.00	TOTALS			756, 045			3.00
	Z - WAGE INDEX		<u> </u>	730, 043			
1.00	ADMINISTRATIVE & GENERAL	5.00	O	4, 705, 080	0		1.00
2. 00	OPERATION OF PLANT	7. 00	104, 191	0			2.00
3.00	NURSI NG ADMI NI STRATI ON	13. 00	128, 687	0			3. 00
4. 00	PHARMACY	15. 00	12, 303	0			4. 00
5. 00	MEDICAL RECORDS & LIBRARY	16.00	20, 514	0			5. 00
6. 00	SOCI AL SERVI CE	17. 00	253, 469	0			6.00
7. 00	NURSING PROGRAM	20.00	58, 500	0			7. 00
8.00	ADULTS & PEDIATRICS	30.00	89, 567	0	0		8. 00
9.00	INTENSIVE CARE UNIT	31.00	107, 224	0	0		9. 00
10.00	SUBPROVI DER	42.00	35, 094	0	0		10. 00
11. 00	NURSERY	43.00	99, 087	0	0		11. 00
12.00	NURSING FACILITY	45.00	81, 580	0			12. 00
13.00	OPERATING ROOM	50.00	176, 346	0	0		13. 00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	306, 860	0	0		14. 00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	80, 127	0	_		15. 00
16.00	RADI OLOGY-THERAPEUTI C	55.00	0	2, 502, 679	0		16. 00
17.00	CARDIAC CATHETERIZATION	59.00	5, 035	0			17. 00
18. 00	RESPIRATORY THERAPY	65.00	50, 080	0			18. 00
19. 00	ELECTROCARDI OLOGY	69. 00	31, 524	0			19. 00
20. 00	RENAL DI ALYSI S	74.00	102, 655	0			20. 00
21. 00	CLINIC	90.00	20, 833	0			21. 00
22. 00	PSYCH CLINIC	90. 02	124, 399	0			22. 00
23. 00	WOUND CENTER	90. 15	25, 384	0			23. 00
24. 00	CLINIC	90. 18	1, 138	0	_		24. 00
25. 00	EMERGENCY	91.00	116, 373	0			25. 00
26. 00	PSYCH EMERGENCY	91.01	55, 950	0	_		26. 00
27. 00	PHYSICIANS PRIVATE OFFICES	192.00	0	<u>1, 699, 440</u>			27. 00
	TOTALS		2, 086, 920	8, 907, 199			_
1 00	ZZ - PHYSI CI AN RECLASS	F 00	400 ((0	000 074			1 00
1.00	ADMINISTRATIVE & GENERAL	5.00	429, 660	833, 374	0		1.00
2. 00	TOTALS — — — —	0.00	429, 660	00 833, 374			2. 00
500 00	Grand Total: Decreases		9, 153, 914	51, 538, 175			500. 00
500.00	prana rotar. Decreases	1	7, 100, 914	51, 530, 175		l	500.00

In Lieu of Form CMS-2552-10
Period: Worksheet A-7
From 01/01/2023 Part I Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS TRINITAS HOSPITAL Provider CCN: 31-0027

				1	o 12/31/2023	Date/Time Prep 5/30/2024 10:	
		Acqui si ti ons					
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	1, 783, 178	0	(	0	0	1. 00
2.00	Land Improvements	1, 124, 183	9, 865	44, 200	54, 065	39, 850	2. 00
3.00	Buildings and Fixtures	95, 490, 277	22, 626, 129	14, 176, 249	36, 802, 378	29, 735, 155	3. 00
4.00	Building Improvements	1, 669, 389	0	(	0	0	4. 00
5.00	Fixed Equipment	258, 803	5, 109	11, 303, 004	11, 308, 113	796, 869	5. 00
6.00	Movable Equipment	27, 297, 957	4, 244, 964	2, 656, 371	6, 901, 335	0	6. 00
7.00	HIT designated Assets	0	0	(	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	127, 623, 787	26, 886, 067	28, 179, 824	55, 065, 891	30, 571, 874	8. 00
9.00	Reconciling Items	0	0	(	0	0	9. 00
10.00	Total (line 8 minus line 9)	127, 623, 787	26, 886, 067	28, 179, 824	55, 065, 891	30, 571, 874	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 783, 178	0				1. 00
2.00	Land Improvements	1, 138, 398	0				2. 00
3.00	Buildings and Fixtures	102, 557, 500	0				3. 00
4.00	Building Improvements	1, 669, 389	0				4. 00
5.00	Fixed Equipment	10, 770, 047	0				5. 00
6.00	Movable Equipment	34, 199, 292	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	152, 117, 804	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	152, 117, 804	0				10. 00

Heal th	Financial Systems	TRINITAS HOSPITAL			In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der CC	CN: 31-0027	Peri od:	Worksheet A-7	
					From 01/01/2023		
					To 12/31/2023		
			CI	IMMADY OF CAR	I TAI	5/30/2024 10:	12 am
			30	JMMARY OF CAP	TTAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	6, 252, 168	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	7, 377, 136	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	13, 629, 304	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	6, 252, 168				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7, 377, 136				2. 00
	1 - 1 (	1	40 (00 00)	1		· ·	

6, 252, 168 7, 377, 136 13, 629, 304

1. 00 2. 00 3. 00

3.00 Total (sum of lines 1-2)

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 31-0027 Period: Worksheet A-7				
From 01/01/2023 Part III To 12/31/2023 Date/Time Pre	ared: 2 am_			
COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL				
Cost Center Description  Gross Assets Leases  Gross Assets Leases  Gross Assets Fatio (see instructions) (col. 1 - col. 2)				
1.00 2.00 3.00 4.00 5.00				
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS				
1. 00 CAP REL COSTS-BLDG & FIXT 100, 325, 829 0 100, 325, 829 0. 786106 0	1.00			
2.00 CAP REL COSTS-MVBLE EQUIP 27, 297, 957 0 27, 297, 957 0. 213894 0	2.00			
3.00 Total (sum of lines 1-2) 127,623,786 0 127,623,786 1.000000 0	3. 00			
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				
Cost Center Description Taxes Other Total (sum of Depreciation Lease				
Capi tal -Rel ate col s. 5				
d Costs through 7)				
6.00 7.00 8.00 9.00 10.00				
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS	1 00			
1. 00 CAP REL COSTS-BLDG & FIXT 0 0 6, 252, 168 0	1. 00			
2. 00 CAP REL COSTS-MVBLE EQUIP 0 0 7, 377, 136 0	2.00			
3.00 Total (sum of lines 1-2) 0 0 13,629,304 0	3. 00			
SUMMARY OF CAPITAL				
Cost Center Description   Interest   Insurance (see   Taxes (see   Other   Total (2) (sum				
instructions   instructions   Capital -Relate   of cols. 9				
d Costs (see   through 14)				
i nstructi ons)				
11.00 12.00 13.00 14.00 15.00				
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS				
1. 00 CAP REL COSTS-BLDG & FIXT 0 0 0 6, 252, 168	1. 00			
2. 00 CAP REL COSTS-MVBLE EQUIP 0 0 0 7, 377, 136	2. 00			
3.00   Total (sum of lines 1-2)   0   0   0   13,629,304	3. 00			

Peri od: Worksheet A-8 From 01/01/2023 Date/Time Prepared: 5/20/2024 10:12 am

				T	o 12/31/2023	Date/Time Prep 5/30/2024 10:	
				Expense Classification on		07 007 202 1 101	
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 0	1. 00
2.00	COSTS-BLDG & FIXT (chapter 2)		201 (20	CAR DEL COCTO MADI E FOLLID	2 00	1.1	2.00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	В	-281,628	CAP REL COSTS-MVBLE EQUIP	2.00	11	2. 00
3.00	Investment income - other		0		0.00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
5. 00	di scounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)		0				
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Tel ephone servi ces (pay	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-22, 749, 811			0	10. 00
11. 00	Sale of scrap, waste, etc.	В	-388	ADMINISTRATIVE & GENERAL	5. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	39, 871, 997			0	12. 00
	transactions (chapter 10)						
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	, в	-829, 845	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee		0		0. 00	0	15. 00
16. 00	and others Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing and allied health	В	-6 410 730	NURSING PROGRAM	20. 00	0	19. 00
19.00	education (tuition, fees,	В	-0, 417, 730	NORST NO TROOKAW	20.00	J	17.00
20. 00	books, etc.) Vending machines	В	0	CAFETERI A	11. 00	0	20. 00
21. 00	Income from imposition of		0	SALETERIA.	0.00	Ö	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
27, 00	(chapter 21)		0	CAD DEL COSTS DIDO 0 FIVE	1 00	0	24 00
26. 00	Depreciation - CAP REL COSTS-BLDG & FIXT		U	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
55.00	therapy costs in excess of	5 5	0	THE STATE OF THE S	07.00		33.00
30. 99	Himitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)	1 402					
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest		_				
33. 00	MI CU/CPR/AHA/I HCE	В	0	AMBULANCE SERVICES	95. 00	0	33. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: Worksheet A-8 From 01/01/2023 Date/Time Prepared: 5/20/2024 10:12 am Provider CCN: 31-0027

						5/30/2024 10:	
				Expense Classification on To/From Which the Amount is t			12 (111
					·		
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
34. 00	HOBOKEN RAD CONTRACT	В	-209, 286	RADI OLOGY-DI AGNOSTI C	54.00	0	
35. 00	GARNI SH	В		ADMINISTRATIVE & GENERAL	5.00	0	
36. 00 37. 00	RENT PARKING GARAGE	B B		WOMENS CLINIC OPERATION OF PLANT	90. 07 7. 00	0	36. 00 37. 00
38. 00	CARDIO DIAG STUDENTS	В		I&R SERVICES-OTHER PRGM	22. 00	0	38. 00
				COSTS APPRV			
39. 00	TOURO COLLEGE	В	0	I&R SERVICES-OTHER PRGM COSTS APPRV	22. 00	0	39. 00
40. 00	SETON HALL PA PROG	В	0	I&R SERVICES-OTHER PRGM	22. 00	0	40. 00
40. 01	MED STUDENTS OTHER	В	_837_2/3	COSTS APPRV I&R SERVICES-OTHER PRGM	22. 00	0	40. 01
40.01	WIED STODENTS OTHER		-037, 243	COSTS APPRV	22.00	O	40.01
40. 02	I&R VERIFICATION FEE	В	-1, 250	I&R SERVICES-OTHER PRGM COSTS APPRV	22. 00	0	40. 02
40. 03	DR. APPLICATION FEE	В	-67, 500	ADMINISTRATIVE & GENERAL	5. 00	0	40. 03
1	GAIN/LOSS SALE OF EQ	В		ADMINISTRATIVE & GENERAL	5. 00	0	40. 04
	PROFESS CONSULTATION	В		SPEECH PATHOLOGY	68. 00	0	41.00
1	MEDICAL RECORDS FEES	В		MEDICAL RECORDS & LIBRARY	16. 00	0	42.00
43. 00 44. 00	OTHER MI SC. PSE&G PROJECT	B B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	43. 00 44. 00
	INSURANCE RECOVERY	B	•	ADMINISTRATIVE & GENERAL	5. 00	0	45. 00
46. 00	UNION CO EDUC SERV C	В		THERAPEUTIC SCHOOL	90. 08	0	46. 00
1	GENERAL CONTRIBUTION	В		ADMINISTRATIVE & GENERAL	5. 00	0	47. 00
48. 00	LOAN FORGIVENESS	В	•	ADMINISTRATIVE & GENERAL	5.00	0	48. 00
49. 00 49. 01	MARILAC OVRHD. REIMBR INTERCOMPANY RENTAL	B B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	49. 00 49. 01
	340B REBATE	B		ADMINISTRATIVE & GENERAL	5. 00	0	49. 02
49. 03	CAPI TATI ON	В		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	49. 03
49. 04	REMEDY PARTNERS	В		ADMINISTRATIVE & GENERAL	5. 00	0	49. 04
	USE OF AUTO TRANSPORT	B B		ADMINISTRATIVE & GENERAL SOCIAL SERVICE	5. 00 17. 00	0	49. 05 49. 06
	TRANSPORT	В		RADI OLOGY-THERAPEUTI C	17. 00 55. 00	0	49.00
	TRANSPORT	В		PHYSI CAL THERAPY	66.00	0	49. 08
49. 09	TRANSPORT	В		CLINIC	90. 00	0	49. 09
1	TRANSPORT	В		PSYCH CLINIC	90.02	0	49. 10
49. 11 49. 12	TRANSPORT TRANSPORT	B B		CLINIC AMBULANCE SERVICES	90. 18 95. 00	0	49. 11 49. 12
	TRANSPORT	B		ADMINISTRATIVE & GENERAL	5. 00	0	49. 13
	LOBBYING DUES	A	-54, 041	ADMINISTRATIVE & GENERAL	5. 00	0	49. 15
1	LINDEN CAB	A		RENAL DIALYSIS	74.00	0	49. 16
1	LINDEN CAB	A A		RADI OLOGY-THERAPEUTI C PHARMACY	55. 00 15. 00	0	49. 17 49. 18
1	LINDEN CAB	A		SUBPROVI DER - I PF	40.00	0	
1	LINDEN CAB	A		PSYCH CLINIC	90. 02	0	49. 20
	LINDEN CAB	A		PSYCH EMERGENCY	91. 01	0	49. 21
1	LINDEN CAB APN	A A	•	SOCIAL SERVICE ADMINISTRATIVE & GENERAL	17. 00 5. 00	0	49. 22 49. 23
	APN	A	•	NURSING ADMINISTRATION	13. 00	0	49. 23
49. 25	APN	A		ADULTS & PEDIATRICS	30. 00	0	49. 25
	APN	A		SUBPROVI DER - I PF	40.00	0	49. 26
49. 27 49. 28	APN APN	A A		SUBPROVI DER	42. 00 46. 00	0	49. 27
	APN APN	A A		OTHER LONG TERM CARE RADIOLOGY-DIAGNOSTIC	46. 00 54. 00	0	49. 28 49. 29
	APN	Ä		RADI OLOGY-THERAPEUTI C	55. 00	0	49. 31
	APN	A	•	RENAL DIALYSIS	74. 00	0	49. 32
	APN	A		CLINIC	90.00	0	49. 33
	APN APN	A A	•	PSYCH CLINIC PEDIATRIC CLINIC	90. 02 90. 06	0	49. 34 49. 35
	APN	A		THERAPEUTI C SCHOOL	90. 08	0	49. 36
	APN	A		PSYCH CLINIC	90. 02	0	49. 37
	APN	A		PSYCH CLINIC	90. 02	0	49. 38
1	APN APN	A A		BAYONNE MENTAL HEALTH CENTER PSYCH EMERGENCY	90. 17 91. 01	0	49. 39 49. 40
	OTHER ADJUSTMENTS (SPECIFY)		20, 094	. O. OIT EMERGENOT	0.00	0	49. 41
	(3)		_			_	
	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	49. 42
49. 43	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0. 00	0	49. 43

				T	o 12/31/2023	Date/Time Prep 5/30/2024 10:	
				Expense Classification on	Worksheet A	07 007 202 1 101	
				To/From Which the Amount is			
				registrom minion the game and	to bo haj dotod		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	, , , , , , , , , , , , , , , , , , ,	1.00	2. 00	3.00	4. 00	5. 00	
49. 44	OTHER ADJUSTMENTS (SPECIFY)		0		0.00		49. 44
	(3)		_				
49. 45	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 45
	(3)						
49. 46	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 46
	(3)						
49. 47	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 47
	(3)						
49. 48	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 48
	(3)						
49. 49	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 49
	(3)						
49. 50	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 50
	(3)						
49. 51	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 51
	(3)						
49. 52	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 52
	(3)						
49. 53	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 53
	(3)						
49. 54	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 54
	(3)						
49. 55	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	49. 55
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		657, 603				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)			0110 D 1 45 4			

<sup>(1)</sup> 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.

<sup>(3)</sup> Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 31-0027

Peri od: Worksheet A-8-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

				10 12/31/2023	5/30/2024 10:	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:		I			
1.00	1		S-COPE	14, 225		1. 00
2.00		ADULTS & PEDIATRICS		21, 542		2. 00
3.00	1	RADI OLOGY-DI AGNOSTI C		3, 105		3. 00
4.00		CARDI AC CATHETERI ZATI ON		2, 924		4. 00
4. 01		PHYSI CAL THERAPY		31, 916	· ·	4. 01
4. 02		OCCUPATIONAL THERAPY		21, 671		4. 02
4.03	1 7 7	RENAL DIALYSIS		6, 210		4. 03
4.04		PSYCH CLINIC		7, 556	· ·	4. 04
4.05		PEDIATRIC CLINIC		21, 548	48, 297	4. 05
4.06		WOMENS CLINIC		63, 466		4. 06
4.07	1	WOUND CENTER		27, 141	61, 541	4. 07
4.08	5. 00	ADMINISTRATIVE & GENERAL		53, 062, 610	12, 997, 979	4. 08
4.09	0.00			0	0	4. 09
5.00	TOTALS (sum of lines 1-4).			53, 283, 914	13, 411, 917	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

\* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6. 00	В	0. 00 RWJBH 100.	00	6. 00
7.00		0.00	00	7. 00
8.00		0.00	00	8. 00
9.00		0.00	00	9. 00
10.00		0.00	00	10. 00
100.00	G. Other (financial or			100.00
	non-financial) specify:			

- (1) Use the following symbols to indicate 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.

4.00

4.01

4 02

4.03

4.04

4.05

4.06

4.07

4.08

4 09

5.00 | 39,871,997 | 5.00

\* The amounts on lines 1-4 (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 has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	FED 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII

	. Comont under the Arrive	
	HOSPI TAL	6. 00
7.00		7.00
8.00		8.00
9.00		9. 00
10.00		10.00
100.00		100.00

- (1) Use the following symbols to indicate 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.

4.00

4.01

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-2, 726

-32,869

-25, 440

-5, 790

-7, 176

-26, 749

-18, 845

-34, 400

40, 064, 631

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O

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 31-0027

Peri od: Worksheet A-8-2 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

5/30/2024 10:12 am Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov Identi fi er ider Component Remuneration Component Component Hours 1. 00 2.00 3.00 4.00 5. 00 6. 00 7. 00 5. 00 ADMI NI STRATI VE & GENERAL 1. 00 1.00 0 2.00 17. 00 SOCIAL SERVICE 321, 259 0 321, 259 211, 500 3, 310 2.00 0.00 3.00 3.00 4.00 30.00 ADULTS & PEDIATRICS 6, 521, 000 5, 923, 895 597, 105 10, 153 4.00 211, 500 31. 00 INTENSIVE CARE UNIT 5.00 675, 608 675, 608 5.00 6.00 40. 00 SUBPROVI DER - I PF 1, 996, 115 1, 969, 245 26, 870 211,500 386 6.00 7.00 0.00 0 0 7.00 8.00 30.00 ADULTS & PEDIATRICS 0 Ω 0 8.00 9.00 30.00 ADULTS & PEDIATRICS 9.00 10.00 53. 00 ANESTHESI OLOGY 5, 106, 558 4, 595, 902 510, 656 271, 900 4, 255 10.00 54. 00 RADI OLOGY-DI AGNOSTI C 1, 209, 333 271, 900 44, 400 11.00 11.00 1, 164, 933 212 55. 00 RADI OLOGY-THERAPEUTI C 12.00 0 12.00 13.00 60. 00 LABORATORY 269, 342 180, 459 88,883 211,500 738 13.00 14.00 65. 00 RESPIRATORY THERAPY 287 287 14.00 69. 00 ELECTROCARDI OLOGY 101, 586 101, 586 15.00 15.00 0 74.00 RENAL DIALYSIS 16.00 231, 029 50,000 181,029 211, 500 1,040 16.00 17.00 90. 00 CLI NI C 200, 470 200, 470 17.00 18.00 90. 02 PSYCH CLINIC 1, 983, 041 1, 697, 108 285, 933 181, 300 1,004 18.00 90. 06 PEDIATRIC CLINIC 19.00 234.870 19.00 234, 870 0 22.00 91. 00 EMERGENCY 1, 133, 540 1, 133, 540 22.00 23.00 91. 01 PSYCH EMERGENCY 1, 110, 390 1, 080, 843 614 23.00 29, 547 211,500 90. 07 WOMENS CLINIC 24.00 56, 229 56, 229 24.00 0 59. 00 CARDI AC CATHETERI ZATI ON 25.00 107, 010 107, 010 0 25.00 52.00 DELIVERY ROOM & LABOR ROOM 26.00 1, 443, 201 1, 443, 201 0 26.00 50. 00 OPERATING ROOM 39 27.00 1, 823, 905 1,811,200 12,705 211,500 27.00 28.00 59. 00 CARDI AC CATHETERI ZATI ON O 28 00 29.00 90. 08 THERAPEUTIC SCHOOL 14,853 14, 853 0 29.00 200.00 24, 539, 626 22, 441, 239 2, 098, 387 21, 751 200. 00

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT TRINITAS HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 31-0027 

						10 12/31/2023	5/30/2024 10:	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		ADMINISTRATIVE & GENERAL	0	0	0	0	0	1. 00
2.00		SOCIAL SERVICE	336, 570	16, 829	0	0	0	2. 00
3.00	0. 00		0	0	0	0	0	3. 00
4.00		ADULTS & PEDIATRICS	1, 032, 384	51, 619	0	0	43, 949	4. 00
5. 00		INTENSIVE CARE UNIT	0	0	0	0	0	5. 00
6.00	•	SUBPROVIDER - IPF	39, 250	1, 963	0	0	23, 596	6. 00
7.00	0.00		0	0	0	0	0	7.00
8.00		ADULTS & PEDIATRICS	0	0	0	0	0	8. 00
9.00		ADULTS & PEDIATRICS	0	07.011	0	0	0	9.00
10.00	•	ANESTHESI OLOGY	556, 218		0	0	0	10.00
11. 00		RADI OLOGY THE PARELLE	27, 713	1, 386	0	0	0	11. 00
12. 00 13. 00		RADI OLOGY-THERAPEUTI C LABORATORY	75.042	2 752	0	0	U	12. 00 13. 00
14. 00		RESPI RATORY THERAPY	75, 042	3, 752	0	0	17	14. 00
15. 00		ELECTROCARDI OLOGY	0	0	0	0	1/	15. 00
16. 00		RENAL DI ALYSI S	105, 750	5, 288	0	0	0	16. 00
17. 00		CLI NI C	105, 750	3, 200	0	0	2, 896	17. 00
18. 00		PSYCH CLINIC	87, 512	4, 376	0	0	30, 483	18. 00
19. 00		PEDIATRIC CLINIC	07, 312	4, 370	0	0	30, 403	19. 00
22. 00		EMERGENCY		١	0	0		22. 00
23. 00		PSYCH EMERGENCY	62, 433	3, 122	0	0	4, 969	23. 00
24. 00		WOMENS CLINIC	02, 100	0, 122	0	0	1, 707	24. 00
25. 00		CARDI AC CATHETERI ZATI ON	0	0	0	0	0	25. 00
26. 00		DELIVERY ROOM & LABOR ROOM	0	0	0	0	٥	26. 00
27. 00		OPERATING ROOM	3, 966	198	0	0	o	27. 00
28. 00		CARDI AC CATHETERI ZATI ON	0,700	0	0	0	ol	28. 00
29. 00		THERAPEUTI C SCHOOL	l o	l ő	l	l ő	373	29. 00
200.00			2, 326, 838	116, 344	0	0	106, 283	

Provider CCN: 31-0027

						10 12/31/2023	5/30/2024 10:	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	, .,	
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	1	ADMINISTRATIVE & GENERAL	0	0	0	0		1. 00
2.00		SOCIAL SERVICE	0	336, 570	0	0		2. 00
3.00	0.00		0	0	0	0		3. 00
4.00		ADULTS & PEDIATRICS	4, 024	1, 036, 408	0	5, 923, 895		4. 00
5.00		INTENSIVE CARE UNIT	0	0	0	675, 608		5. 00
6.00	•	SUBPROVIDER - IPF	318	39, 568	0	1, 969, 245		6. 00
7.00	0.00		0	0	0	0		7. 00
8.00	•	ADULTS & PEDIATRICS	0	0	0	0		8. 00
9.00		ADULTS & PEDIATRICS	0	0	0	0		9. 00
10.00	•	ANESTHESI OLOGY	0	556, 218		4, 595, 902		10. 00
11. 00		RADI OLOGY-DI AGNOSTI C	0	27, 713	16, 687	1, 181, 620		11. 00
12.00	•	RADI OLOGY-THERAPEUTI C	0	0	0	0		12. 00
13.00		LABORATORY	0	75, 042	13, 841	194, 300		13. 00
14. 00	•	RESPI RATORY THERAPY	0	0	0	287		14. 00
15.00		ELECTROCARDI OLOGY	0	0	0	101, 586		15. 00
16. 00		RENAL DIALYSIS	0	105, 750	75, 279			16. 00
17. 00		CLINIC	0	0	0	200, 470		17. 00
18. 00		PSYCH CLINIC	4, 395	91, 907	194, 026			18. 00
19. 00		PEDIATRIC CLINIC	0	0	0	234, 870		19. 00
22. 00		EMERGENCY	0	0	0	1, 133, 540		22. 00
23. 00		PSYCH EMERGENCY	132	62, 565	0	1, 080, 843		23. 00
24. 00	l .	WOMENS CLINIC	0	0	0	56, 229		24. 00
25. 00		CARDIAC CATHETERIZATION	0	0	0	107, 010		25. 00
26.00		DELIVERY ROOM & LABOR ROOM	0	0	0	1, 443, 201		26. 00
27. 00		OPERATING ROOM	0	3, 966	8, 739	1, 819, 939		27. 00
28. 00	1	CARDIAC CATHETERIZATION	0	0	0	0		28. 00
29. 00	90. 08	THERAPEUTIC SCHOOL	0	0	0	14, 853		29. 00
200. 00			8, 869	2, 335, 707	308, 572	22, 749, 811		200. 00

| Period: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS TRINITAS HOSPITAL Provider CCN: 31-0027

					o 12/31/2023		
			CAPI TAL REI	LATED COSTS		5/30/2024 10:	12 am
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost Allocation			BENEFITS DEPARTMENT		
		(from Wkst A			DEI / IKTIMEIVT		
		col . 7)	1.00	2.00	4.00	4.0	
	GENERAL SERVICE COST CENTERS	0	1.00	2. 00	4. 00	4A	
1.00	00100 CAP REL COSTS-BLDG & FIXT	6, 252, 168	6, 252, 168				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	7, 377, 136	l	7, 377, 136	1		2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	36, 718, 128 83, 907, 425				89, 821, 852	4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	2, 777, 370	l			3, 014, 154	6.00
7.00	00700 OPERATION OF PLANT	13, 307, 323	l			18, 703, 197	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 244, 342	l			1, 304, 667	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	5, 633, 517 3, 588, 658	97, 663 83, 376			6, 497, 884 4, 065, 900	9. 00 10. 00
11. 00	01100 CAFETERI A	1, 877, 389	l			2, 243, 117	11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0		1	1	0	12. 00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	5, 401, 985 3, 486, 089				6, 524, 770 3, 826, 572	13. 00 14. 00
15. 00	01500 PHARMACY	3, 521, 660				4, 356, 950	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 345, 042	l			3, 783, 378	1
17.00	01700 SOCIAL SERVICE	2, 046, 871	6, 683		l	2, 301, 751	17. 00
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM	-2, 412, 593	0 53, 648	1	1	0 -1, 641, 774	19. 00 20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	4, 012, 012	32, 479			4, 962, 218	
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	1, 871, 246	60, 070	70, 878	328, 674	2, 330, 868	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	C	0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	16, 440, 521	501, 761	592, 044	4, 183, 288	21, 717, 614	30. 00
31. 00	03100   NTENSI VE CARE UNI T	6, 352, 672	l				•
40. 00	04000 SUBPROVI DER - I PF	11, 167, 277				14, 330, 869	1
41. 00 42. 00	04100   SUBPROVI DER	0 2 974 259	-	1		2 447 722	41. 00 42. 00
43.00	04300 NURSERY	2, 874, 258 1, 301, 100				3, 647, 723 1, 628, 061	43.00
44.00	04400 SKILLED NURSING FACILITY	297, 074				456, 447	44. 00
45.00	04500 NURSING FACILITY	7, 566, 899					45.00
46. 00	O4600 OTHER LONG TERM CARE   ANCILLARY SERVICE COST CENTERS	2, 541, 744	59, 160	69, 805	508, 023	3, 178, 732	46. 00
50. 00	05000 OPERATING ROOM	9, 529, 737	210, 250	248, 080	1, 278, 548	11, 266, 615	50. 00
51. 00	05100 RECOVERY ROOM	1, 323, 283	l				51. 00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	3, 423, 070 535, 925				4, 481, 746 542, 726	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 605, 694	l			5, 520, 817	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	5, 090, 882	l			6, 764, 533	55. 00
56.00	05600 RADI OI SOTOPE	633, 528	l			713, 800	1
57. 00 58. 00	05700   CT   SCAN   05800   MRI	1, 150, 857 440, 869	6, 268 7, 109			1, 330, 325 517, 057	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 615, 394	1		l	1, 904, 048	ł
60.00	06000 LABORATORY	9, 376, 457	1			9, 563, 313	1
62. 00 62. 30	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06250 BLOOD CLOTTING FOR HEMOPHILIACS	5, 423	4, 103 0		1	14, 367 0	62. 00 62. 30
65. 00	06500 RESPIRATORY THERAPY	3, 807, 518			1	4, 467, 518	1
66.00	06600 PHYSI CAL THERAPY	1, 635, 103	45, 578			2, 074, 804	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	185, 296				219, 562	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	163, 928 1, 052, 267	l .			200, 844 1, 253, 620	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 061, 053	1			9, 061, 053	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 949, 662	l	C	o	6, 949, 662	
73.00	07300 DRUGS CHARGED TO PATIENTS	14, 617, 585	l e	105 500	-	14, 617, 585	
74. 00 76. 97	07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON	9, 544, 275	89, 445	105, 539	1, 336, 402	11, 075, 661 0	74. 00 76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	Ö	ď	Ö	Ö	76. 98
76. 99	07699 LI THOTRI PSY	0	0	C	o	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	C		0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	<u> </u>	<u>C</u>	<u>'l</u> U	0	78. 00
90.00	09000 CLI NI C	1, 544, 057	71, 083	83, 874	363, 147	2, 062, 161	90.00
90. 01	09016 CLINIC-NOT USED	0	0	000.010	-	0	90. 01
90. 02 90. 03	09001 PSYCH CLINIC 09002 PSYCH CLINIC FEE BASED	15, 037, 463	197, 309	232, 812	3, 256, 824	18, 724, 408 0	90. 02 90. 03
90. 03	09003 WORKFIRST					0	90.03
90. 05	09004 CANCER CLINIC	0	0	l c	ol ol	0	90. 05
90.06	09005 PEDIATRIC CLINIC	622, 691	0	C			90.06
90. 07	09006 WOMENS CLINIC	1, 936, 336	0	C	416, 923	2, 353, 259	90.07

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2023 Part I Provider CCN: 31-0027

			T-	12/31/2023	Date/Time Pre 5/30/2024 10:	pared:
		CAPI TAL REL	ATED COSTS		3/30/2024 10.	12 alli
		CALL TAL INCL	LATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFI TS		
	Allocation			DEPARTMENT		
	(from Wkst A					
	col . 7)					
	0	1. 00	2. 00	4. 00	4A	
90. 08 09007 THERAPEUTIC SCHOOL	67, 668	0	0	88, 270	155, 938	
90. 09 09008 AFTER SCHOOL PROGRAM	0	0	0	0	0	90. 09
90. 10   09017   CLI NI C-NOT USED	0	0	0	0	0	90. 10
90. 11 09009 PERINATAL ADDICTION	0	0	0	0	0	90. 11
90. 12 09010 THERAPEUTIC NURSERY	0	0	0	0	0	90. 12
90. 13 09011 CHILD DAY TREATMENT	0	0	0	0	0	90. 13
90. 14   09012   DI ABETES CENTER	0	0	0	0	0	90. 14
90. 15   09013   WOUND CENTER	589, 243	6, 308	·	·	699, 999	1
90. 16   09014   MI CA	0	29, 950	35, 338		65, 288	ł
90. 17 09015 BAYONNE MENTAL HEALTH CENTER	936, 208	0	0	212, 381	1, 148, 589	1
90. 18  09018   CLI NI C	214, 541	0	0	45, 931	260, 472	1
91. 00 09100 EMERGENCY	11, 098, 822	142, 565	·	2, 003, 765	13, 413, 369	1
91. 01   09101   PSYCH EMERGENCY	2, 844, 437	30, 256	35, 701	807, 397	3, 717, 791	91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0	0	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS		_	_			
95. 00 09500 AMBULANCE SERVICES	0	0			0	
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						440.00
113. 00 11300 INTEREST EXPENSE	252 427 505	/ 000 000	7 100 505	27 200 072	251 401 757	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	352, 136, 585	6, 088, 082	7, 183, 525	36, 398, 962	351, 401, 756	1118.00
192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES	4, 167, 629	22, 107	26, 085	377, 132	4, 592, 953	102 00
193. 00 19300 NONPALD WORKERS	4, 107, 029	22, 107	20,000	377, 132		193. 00
194.00 07950 NON REIMBURSABLE	491, 514	134, 250	158, 406	0	784, 170	
194. 01 07951 RETAIL PHARMACY	2, 991, 474	7, 729		0	3, 008, 323	
200.00 Cross Foot Adjustments	2, //1, 4/4	1, 127	7, 120	٩		200. 00
201.00 Negative Cost Centers		0	٥ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ ـ	0		201.00
202.00 TOTAL (sum lines 118 through 201)	359, 787, 202	6, 252, 168	7, 377, 136	36, 776, 094	359, 787, 202	
202.00   TOTAL (Sum Times The through 201)	337, 707, 202	0, 202, 100	1, 377, 130	30, 770, 074	337, 101, 202	1202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0027

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/30/2024 10:12 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 89, 821, 852 5 00 6.00 00600 MAINTENANCE & REPAIRS 996, 796 4,010,950 6.00 00700 OPERATION OF PLANT 6, 185, 241 1, 682, 037 26, 570, 475 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 431, 460 14.035 160, 126 1, 910, 288 8.00 9, 592, 263 00900 HOUSEKEEPI NG 2.148.883 815.096 9.00 71, 443 58.957 9 00 10.00 01000 DI ETARY 1, 344, 613 60, 992 695, 855 50, 332 260, 784 10.00 11.00 01100 CAFETERI A 741,810 47, 926 546, 781 39, 549 204, 916 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 0 C 0 0 13.00 01300 NURSING ADMINISTRATION 2, 157, 774 4, 739 54,071 3, 911 20, 264 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 1, 265, 466 25, 222 287, 762 20,814 107, 844 14.00 01500 PHARMACY 15.00 1.440.865 20.487 233, 738 16. 907 87. 597 15.00 01600 MEDICAL RECORDS & LIBRARY 19, 878 102, 991 274.813 16.00 1, 251, 182 24.087 16.00 17.00 01700 SOCIAL SERVICE 761, 201 4, 889 55, 778 4,035 20, 904 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING PROGRAM 32, 386 20.00 39, 245 447, 746 20.00 167, 800 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 1,641,030 23, 759 271,066 19,607 101, 587 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 770,830 43, 943 501, 342 36, 263 187, 887 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 182, 145 367, 054 4, 187, 703 302, 899 1, 569, 412 30.00 31.00 03100 INTENSIVE CARE UNIT 2, 533, 021 66, 908 763.349 55, 214 286, 078 31.00 40.00 04000 SUBPROVIDER - IPF 138, 933 4, 739, 290 1, 585, 086 114, 651 594, 038 40.00 04100 SUBPROVIDER - IRF 41.00 Λ 41.00 42.00 04200 SUBPROVI DER 1, 206, 320 51, 759 590, 512 42, 712 221, 305 42.00 04300 NURSERY 29, 733 43.00 538, 408 339, 224 24, 536 127, 130 43.00 04400 SKILLED NURSING FACILITY 150.949 44.00 31,670 361, 327 26, 135 135, 413 44.00 04500 NURSING FACILITY 45.00 3,008,794 129, 979 1, 482, 920 107, 261 555, 750 45.00 46.00 04600 OTHER LONG TERM CARE 1,051,223 43, 278 493, 753 35, 714 185, 043 46.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 3, 725, 926 153 804 1 754 745 126, 923 657 621 50 00 05100 RECOVERY ROOM 51.00 544,880 12,048 137, 454 9, 942 51, 513 51.00 05200 DELIVERY ROOM & LABOR ROOM 1, 482, 136 35, 233 401, 975 29, 075 150, 647 52.00 52.00 53.00 05300 ANESTHESI OLOGY 179, 482 2, 282 26, 039 1.883 9.759 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 825, 762 62, 875 717, 342 51, 886 268, 836 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 2, 237, 065 148, 807 1, 697, 734 122, 799 636, 255 55.00 56.00 05600 RADI OI SOTOPE 236, 057 1, 696 19, 352 1, 400 7, 252 56.00 57 00 05700 CT SCAN 439, 945 4, 586 52, 316 3, 784 19, 606 57 00 58.00 05800 MRI 170, 993 5, 201 59, 336 4, 292 22, 237 58.00 05900 CARDIAC CATHETERIZATION 629, 678 22, 753 259, 588 18, 776 97, 285 59.00 59.00 60.00 06000 LABORATORY 3, 162, 635 44, 533 508, 077 36, 750 190, 411 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62 00 4, 751 3, 002 34, 245 2, 477 12,834 62.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 65.00 06500 RESPIRATORY THERAPY 1, 477, 431 13, 154 150, 071 10, 855 56, 242 65.00 06600 PHYSI CAL THERAPY 66, 00 686.148 33, 342 380.394 27, 514 142, 559 66, 00 06700 OCCUPATIONAL THERAPY 67.00 72,610 C 0 67.00 68.00 06800 SPEECH PATHOLOGY 66, 420 416 4,743 343 1,778 68.00 06900 ELECTROCARDI OLOGY 69.00 414, 578 10, 348 118,055 8,539 44, 243 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 996, 536 71.00 71.00 C 0 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 298, 288 72 00 0 0 0 72 00 07300 DRUGS CHARGED TO PATIENTS 4, 834, 108 73.00 0 73.00 74 00 07400 RENAL DIALYSIS 3, 662, 776 65, 432 746, 511 53, 996 279, 768 74.00 07697 CARDIAC REHABILITATION 76.97 0 C 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 C 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 76.99 76.99 0 0 07700 ALLOGENEIC HSCT ACQUISITION 0 o 77.00 0 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 681, 967 52, 000 593, 263 42, 911 222, 336 90.00 90.01 09016 CLINIC-NOT USED 90.01 0 90.02 09001 PSYCH CLINIC 6, 192, 255 144, 338 1, 646, 746 119, 111 617, 146 90.02 09002 PSYCH CLINIC FEE BASED 90.03 90.03 90.04 09003 WORKFIRST 0 0 0 90.04 C 0 09004 CANCER CLINIC 0 0 90.05 90.05 0 C 0 0 90.06 09005 PEDIATRIC CLINIC 264, 784 C 0 90.06 09006 WOMENS CLINIC 0 90.07 778, 235 0 0 0 90.07 90.08 09007 THERAPEUTIC SCHOOL 51, 569 0 0 90.08 0 0 09008 AFTER SCHOOL PROGRAM 90.09 90 09 0 C 0 90.10 09017 CLINIC-NOT USED 0 0 0 0 0 90.10 09009 PERINATAL ADDICTION o 90.11 0 0 0 90.11 90. 12 09010 THERAPEUTIC NURSERY 0 0 ol 90.12

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS TRINITAS HOSPITAL Provider CCN: 31-0027

					5/30/2024 10:	<u> 12 am</u>
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
90. 13 09011 CHILD DAY TREATMENT	0	0	0	0	0	90. 13
90. 14   09012 DI ABETES CENTER	0	0	0	0	0	90. 14
90. 15   09013   WOUND CENTER	231, 493	4, 615	52, 648	3, 808	19, 731	90. 15
90. 16   09014 MI CA	21, 591	21, 909	249, 960	18, 080	93, 677	90. 16
90. 17 09015 BAYONNE MENTAL HEALTH CENTER	379, 844	0	0	0	0	90. 17
90. 18   09018   CLI NI C	86, 139	0	0	0	0	90. 18
91. 00 09100 EMERGENCY	4, 435, 868	104, 290	1, 189, 846	86, 063	445, 915	91.00
91. 01 09101 PSYCH EMERGENCY	1, 229, 492	22, 134	252, 521	18, 265	94, 637	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	87, 048, 743	3, 890, 916	25, 201, 009	1, 811, 233	9, 079, 031	118. 00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS PRIVATE OFFICES	1, 518, 913	16, 172	184, 505	13, 345	69, 147	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 NON REIMBURSABLE	259, 329	98, 208	1, 120, 455	81, 044	419, 910	194. 00
194.01 07951 RETAIL PHARMACY	994, 867	5, 654	64, 506	4, 666	24, 175	194. 01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	89, 821, 852	4, 010, 950	26, 570, 475	1, 910, 288	9, 592, 263	202. 00

Provider CCN: 31-0027

				0 12/31/2023	Date/lime Pre 5/30/2024 10:	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	12 (
			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
	10.00	11. 00	12. 00	13.00	SUPPLY 14. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00   00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL 6. 00   00600   MAI NTENANCE & REPAI RS						5. 00 6. 00
7.00   00700   OPERATION OF PLANT						7. 00
8. 00   00800   LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	6, 478, 476					10.00
11. 00   01100   CAFETERI A	0	3, 824, 099				11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	(			12. 00
13. 00 01300 NURSING ADMINISTRATION	0	130, 877	(	8, 896, 406		13. 00
14. 00   01400   CENTRAL SERVI CES & SUPPLY	0	59, 763	(		5, 609, 414	14.00
15. 00   01500   PHARMACY	0	90, 561		-	56, 361	15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY 17. 00   01700   SOCI AL SERVI CE		78, 481 27, 619		-	0	16. 00 17. 00
19. 00   01900   NONPHYSI CLAN ANESTHETI STS		27, 01 <del>9</del>		100, 300	0	17.00
20. 00   02000   NURSI NG   PROGRAM	0	73, 395		2, 852	4, 647	20. 00
21. 00   02100   L&R SERVICES-SALARY & FRINGES APPRV	O	0	d	0	0	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	O	152, 232	(	o o	190	22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	(	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	2, 008, 611	460, 828	(	, , , , , ,	169, 912	30.00
31. 00   03100   NTENSI VE CARE UNI T	189, 639	120, 536			83, 125	31.00
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF	1, 210, 187	308, 222		000, 200	33, 664 0	40. 00 41. 00
42. 00   04200   SUBPROVI DER	362, 932	77, 210	1	1	14, 223	42.00
43. 00   04300   NURSERY	0	22, 551		175, 246	13, 391	43. 00
44. 00 04400 SKILLED NURSING FACILITY	o	12, 977			30	44. 00
45.00 04500 NURSING FACILITY	1, 846, 529	177, 251			44, 015	45. 00
46.00 O4600 OTHER LONG TERM CARE	0	91, 010	(	27, 957	402	46. 00
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	47, 474	161, 525	(		938, 058	50. 00
51. 00   05100   RECOVERY ROOM	0	29, 788		1	3, 388	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	35, 284	85, 344		,	50, 913	52.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C		94, 488		44, 241	60, 229 72, 788	53. 00 54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C		103, 632			22, 661	55. 00
56. 00   05600   RADI OI SOTOPE	l o	7, 087		0	28, 329	56. 00
57. 00   05700 CT SCAN	O	18, 419	ď	o	12, 392	57. 00
58. 00   05800   MRI	o	7, 910	(	ol ol	3, 512	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	25, 225	(	79, 046	95, 226	59. 00
60. 00   06000   LABORATORY	0	6, 788	(	35, 362	1, 968	60. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	(	0	0	62.00
62.30   06250   BLOOD CLOTTING FOR HEMOPHILIACS 65.00   06500   RESPIRATORY THERAPY	0	74, 274	(		0 57, 637	62. 30 65. 00
66. 00   06600 PHYSI CAL THERAPY		74, 274 39, 138		19, 048	4, 932	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY		4, 301		17,040	4, 732	67. 00
68. 00 06800 SPEECH PATHOLOGY	o	4, 974		ol ol	191	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	31, 396		33, 779	5, 783	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	o	1, 944, 869	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0	1, 491, 773	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 00
74. 00   07400   RENAL DI ALYSI S	0	169, 977	(	678, 243	183, 205	74.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	(		0	76. 97
76. 98   07698   HYPERBARI C OXYGEN THERAPY 76. 99   07699   LI THOTRI PSY	0	0	(		0	76. 98
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0			0	76. 99 77. 00
78. 00   07800   CAR T-CELL   IMMUNOTHERAPY		0			0	78.00
OUTPATIENT SERVICE COST CENTERS				91 91		70.00
90. 00 09000 CLINIC	0	63, 653	(	109, 055	3, 462	90. 00
90. 01   09016   CLI NI C-NOT USED	o	0		o	0	90. 01
90. 02 09001 PSYCH CLINIC	254, 334	503, 053	(	232, 137	3, 947	90. 02
90. 03 09002 PSYCH CLINIC FEE BASED	0	0	(	이	0	90. 03
90. 04   09003   WORKFI RST	0	0	(	이	0	90. 04
90. 05   09004   CANCER CLINIC	0	10.017	]	0 410	1 444	90. 05
90. 06   09005   PEDIATRIC CLINIC 90. 07   09006   WOMENS CLINIC		19, 017 67, 598		86, 412 130, 819	1, 466 5, 908	90. 06 90. 07
90. 07   09006   WOMENS CLINIC 90. 08   09007   THERAPEUTI C SCHOOL		11, 238		20, 660	5, 908	90.07
90. 09   09008 AFTER SCHOOL PROGRAM		11, 230 N		) 20, 000	0	90.08
90. 10   09017   CLI NI C-NOT USED		0			0	90. 10
90. 11 09009 PERI NATAL ADDI CTI ON	o	0		ol ol	0	90. 11

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS TRINITAS HOSPITAL Provider CCN: 31-0027

			T	o 12/31/2023	Date/Time Pre 5/30/2024 10:	pared:
Cost Center Description	DIETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	12 alli
oost content beschiptron	DI ETTAKI	ON ETENIA		ADMI NI STRATI ON	SERVICES &	
			. 2.1.00111122	7.5 111 6 110 111 611	SUPPLY	
	10.00	11. 00	12.00	13. 00	14. 00	
90. 12 09010 THERAPEUTIC NURSERY	0	0	0	0	0	90. 12
90. 13 O9011 CHILD DAY TREATMENT	0	0	0	0	0	90. 13
90. 14   09012   DI ABETES CENTER	0	0	0	0	0	90. 14
90. 15   09013   WOUND CENTER	0	13, 389	0	48, 637	29, 190	90. 15
90. 16   09014   MI CA	0	0	0	0	0	90. 16
90. 17   09015 BAYONNE MENTAL HEALTH CENTER	0	34, 407	0	26, 512	153	90. 17
90. 18   09018   CLI NI C	0	2, 001	0	0	0	90. 18
91. 00   09100   EMERGENCY	523, 486	269, 813	0	986, 466	161, 192	91. 00
91. 01   09101   PSYCH EMERGENCY	0	92, 151	0	137, 540	6, 130	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
93. 99 O9399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS						
95. 00   09500   AMBULANCE SERVI CES	0	0	0	0	0	, , , , , ,
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 478, 476	3, 824, 099	0	8, 896, 406	5, 609, 287	118. 00
NONREI MBURSABLE COST CENTERS			T			
192. 00 19200 PHYSI CLANS PRI VATE OFFICES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 NON REI MBURSABLE	0	0	0	0		194. 00
194. 01 07951 RETAIL PHARMACY	0	0	0	0		194. 01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00   TOTAL (sum lines 118 through 201)	6, 478, 476	3, 824, 099	0	8, 896, 406	5, 609, 414	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0027

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/30/2024 10:12 am

			'	0 12/31/2023	5/30/2024 10:	
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSI NG	
		RECORDS &		ANESTHETI STS	PROGRAM	
	15. 00	16. 00	17. 00	19. 00	20. 00	
GENERAL SERVICE COST CENTERS	15.00	16.00	17.00	19.00	20.00	
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00  01000 DI ETARY						10. 00
11. 00  01100   CAFETERI A						11. 00
12.00 01200 MAINTENANCE OF PERSONNEL						12. 00
13.00 O1300 NURSING ADMINISTRATION						13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00   01500   PHARMACY	6, 303, 466	· · · · · ·				15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	5, 534, 810				16. 00
17. 00   01700   SOCI AL SERVI CE	0	0	3, 276, 743			17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0		)	070 700	19.00
20. 00   02000   NURSI NG PROGRAM	0	0			-873, 703	20.00
21. 00   02100   1&R SERVI CES-SALARY & FRI NGES APPRV	0	0				21.00
22. 00   02200   1&R SERVICES-OTHER PRGM COSTS APPRV 23. 00   02300   PARAMED ED PRGM-(SPECIFY)		0	l d			22. 00 23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U U					23.00
30. 00 03000 ADULTS & PEDIATRICS	O	2, 988, 797	3, 276, 743	0	0	30. 00
31. 00   03100   NTENSI VE CARE UNIT		442, 785			0	31. 00
40. 00   04000 SUBPROVI DER - I PF		55, 348			Ö	40. 00
41. 00   04100   SUBPROVI DER -   I RF	0	00, 010	Ö	o o	Ö	41. 00
42. 00   04200   SUBPROVI DER	0	0	Ö	o o	Ö	42. 00
43. 00   04300   NURSERY	o	0		0	Ö	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	i c	0	0	44. 00
45. 00 04500 NURSING FACILITY	4, 599	0		Ö	Ö	45. 00
46.00 04600 OTHER LONG TERM CARE	0	0	l d	0	1	46. 00
ANCILLARY SERVICE COST CENTERS	-1		_			
50. 00 05000 OPERATING ROOM	0	0	C	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	C	0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	O	0	C	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	O	0	C	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	0	0	C	0	0	56. 00
57. 00  05700 CT SCAN	0	0	C	0	0	57. 00
58. 00   05800   MRI	0	0	0	0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00   06000   LABORATORY	0	0	C	0	0	60. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	C	0	0	62. 00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	0	C	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00   06800  SPEECH PATHOLOGY 69. 00   06900  ELECTROCARDI OLOGY		0			0	68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0		0		71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0			0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	5, 742, 271	0		0	Ö	73. 00
74. 00 07400 RENAL DI ALYSI S	556, 596	719, 525		o o	0	74. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	717, 020	Ö	o o	Ö	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	Ö	o o	Ö	76. 98
76. 99   07699   LI THOTRI PSY	o	0		0	Ö	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	o	0		0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	Ö	0	C	o	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	442, 785	C	0	0	90. 00
90. 01   09016   CLI NI C-NOT USED	0	0	[ C	0	0	90. 01
90. 02   09001   PSYCH CLINIC	0	0	0	0	0	90. 02
90. 03 09002 PSYCH CLINIC FEE BASED	0	0	0	0	0	90. 03
90. 04   09003   WORKFI RST	0	0	0	0	0	90. 04
90. 05   09004   CANCER CLINIC	0	0	0	0	0	90. 05
90. 06   09005   PEDI ATRI C   CLI NI C	0	0	C	0	0	90.06
90. 07   09006   WOMENS CLINIC	0	0	C	0	0	90. 07
90. 08   09007   THERAPEUTI C   SCHOOL	0	0	0	0	0	90. 08
90. 09   09008 AFTER SCHOOL PROGRAM	ا و	0	0	0	0	90. 09
90. 10   09017   CLINI C-NOT USED	0	0		0	0	90. 10
90. 11  09009  PERINATAL ADDICTION	<u> </u>	0	1 0	<u>' </u>	<u> </u>	90. 11

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS TRINITAS HOSPITAL Provider CCN: 31-0027

| Period: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared:

			T	12/31/2023	Date/Time Pre 5/30/2024 10:	
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSI NG	12 (1111
5550 5511011 B5551 1 p 11 511		RECORDS &	0001712 021111 02	ANESTHETI STS	PROGRAM	
		LI BRARY				
	15. 00	16. 00	17. 00	19. 00	20.00	
90. 12 09010 THERAPEUTI C NURSERY	0	0	0	0	0	90. 12
90. 13   09011 CHILD DAY TREATMENT	0	0	0	0	0	90. 13
90. 14   09012 DI ABETES CENTER	0	0	0	0	0	90. 14
90. 15   09013   WOUND CENTER	0	0	0	0	0	90. 15
90. 16   09014 MI CA	0	0	0	0	0	90. 16
90. 17   09015 BAYONNE MENTAL HEALTH CENTER	0	0	0	0	0	90. 17
90. 18   09018   CLI NI C	0	0	0	0	0	90. 18
91. 00 09100 EMERGENCY	0	608, 829	0	0	0	91.00
91. 01 09101 PSYCH EMERGENCY	0	276, 741	0	0	0	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 303, 466	5, 534, 810	3, 276, 743	0	0	118. 00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0		192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 NON REIMBURSABLE	0	0	0	0		194. 00
194. 01 07951 RETAIL PHARMACY	0	0	0	0		194. 01
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers	0	0	0	0	-873, 703	
202.00   TOTAL (sum lines 118 through 201)	6, 303, 466	5, 534, 810	3, 276, 743	0	-873, 703	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | From 01/2024 | Peri od: | Peri o Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-0027

					lo	12/31/2023	Date/lime Pre 5/30/2024 10:	
		INTERNS &	RESI DENTS				07 007 2021 10.	12 4111
	Cook Comban Doorani adi an	CEDVI CEC CALAD	CEDVI CEC OTHER	DADAMED ED		C	1 + 0	
	Cost Center Description	Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM		Subtotal	Intern & Residents Cost	
		APPRV	APPRV	PRGW			& Post	
		7	7				Stepdown	
							Adjustments	
	CENEDAL SERVICE COST CENTERS	21. 00	22. 00	23. 00		24. 00	25. 00	
1. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT				$\top$			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP							2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT							4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL							5. 00
6.00	00600 MAINTENANCE & REPAIRS							6.00
7. 00 8. 00	OO7OO  OPERATION OF PLANT   OO8OO  LAUNDRY & LINEN SERVICE							7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG							9. 00
10.00	01000 DI ETARY							10. 00
11. 00	01100 CAFETERI A							11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL							12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY							13. 00 14. 00
15. 00	01500 PHARMACY							15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY							16. 00
17. 00	01700 SOCI AL SERVI CE							17. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS							19.00
20. 00 21. 00	02000   NURSING PROGRAM   02100   I&R SERVICES-SALARY & FRINGES APPRV	7, 019, 267						20. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	7,017,207	4, 023, 555					22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)		1, 122, 111		0			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	5, 053, 872	1		0	54, 389, 653		30.00
31. 00 40. 00	03100   INTENSIVE CARE UNIT   04000   SUBPROVI DER -   I PF	1, 544, 239	0 885, 182	1	0	12, 896, 623 26, 407, 997		31. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	1, 344, 237	003, 102		0	20, 407, 777		41. 00
42.00	04200 SUBPROVI DER	0	0		0	6, 422, 803	0	42. 00
43.00	04300 NURSERY	0	0		0	2, 898, 280		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		0	1, 194, 749		44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0		0	16, 804, 461 5, 107, 112	0	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS					3, 107, 112		40.00
50.00	05000 OPERATING ROOM	0	0		0	19, 550, 965	0	50. 00
51.00	05100 RECOVERY ROOM	0	0		0	2, 631, 778		51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0		0	7, 240, 580		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	822, 400 8, 659, 035		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	Ö	Ö		0	11, 888, 658		55. 00
56.00	05600 RADI OI SOTOPE	0	0		0	1, 014, 973	0	56. 00
57. 00	05700 CT SCAN	0	0		0	1, 881, 373		57. 00
58.00	05800   MRI   05900   CARDI AC   CATHETERI ZATI ON	0	0		0	790, 538 3, 131, 625		58. 00 59. 00
60.00	06000 LABORATORY		0		0	13, 549, 837	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	O		0	71, 676	1	62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	0		0	6, 307, 182		65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0		0	3, 407, 879		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	296, 498 279, 709		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	o o		0	1, 920, 341	Ö	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	14, 002, 458	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	10, 739, 723		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	25, 193, 964		73.00
74. 00 76. 97	07400  RENAL DI ALYSI S   07697  CARDI AC REHABI LI TATI ON	0	0		0	18, 191, 690	0	74. 00 76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0			0	0	0	76. 97 76. 98
76. 99	07699 LI THOTRI PSY	0	0		0	0	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	421, 156	241, 413		0	4, 936, 162	-662, 569	90. 00
90. 00	09016 CLINIC-NOT USED	421, 130	241, 413		0	-, 730, 102 0	-002, 509	90.00
90. 02	09001 PSYCH CLINIC	0	0		0	28, 437, 475		90. 02
90. 03	09002 PSYCH CLINIC FEE BASED	0	0		0	0	0	90. 03
90.04	09003 WORKFI RST	0	0		0	0	0	90.04
90. 05 90. 06	O9004   CANCER CLINIC   O9005   PEDIATRIC CLINIC	0			0	1, 172, 344	0	90. 05 90. 06
	09006 WOMENS CLINIC	0	0		0	3, 335, 819		90. 07
	•	•	. '	-			•	·

| Period: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 31-0027

SERVICES-SALAR SERVICES-OTHER Y & FRINGES APPRV   PARAMED ED PRGM   Subtotal   Intern & Residents Cost & Post Stepdown Adjustments   Parametric School   Parametric
Cost Center Description   SERVICES-SALAR SERVICES-OTHER Y & FRINGES APPRV   PRGM COSTS
Y & FRINGES   PRGM COSTS   PRGM   Residents Cost   & Post   Stepdown   Adjustments
APPRV   APPRV   APPRV   & Post Stepdown Adjustments
Stepdown Adjustments   21.00   22.00   23.00   24.00   25.00
Adjustments   21.00   22.00   23.00   24.00   25.00
90. 08   09007   THERAPEUTI C SCHOOL   0   0   0   239, 405   0   90. 08   09007   09008   AFTER SCHOOL PROGRAM   0   0   0   0   0   0   0   0   0
90. 08         09007         THERAPEUTI C SCHOOL         0         0         239, 405         0         90. 08           90. 09         09008         AFTER SCHOOL PROGRAM         0         0         0         0         0         90. 09           90. 10         09017         CLI NI C-NOT USED         0         0         0         0         0         90. 10           90. 11         09009         PERI NATAL ADDI CTI ON         0         0         0         0         90. 11
90. 09
90. 10   09017   CLINIC-NOT USED   0 0 0 0 90. 10 90. 11   09009   PERINATAL ADDICTION   0 0 0 0 90. 11
90. 11 09009 PERINATAL ADDICTION 0 0 0 90. 11
90. 12   09010  THERAPEUTI C NURSERY   0  0  0  0  0   0   90. 12
90. 13   09011   CHI LD DAY TREATMENT
90. 14   09012 DI ABETES CENTER
90. 15   09013   WOUND CENTER   0   0   1, 103, 510   0   90. 15
90. 16   09014   MI CA
90. 17   09015 BAYONNE MENTAL HEALTH CENTER   0   0   1,589,505   0   90. 17
90. 18   09018   CLI NI C   0   0   348, 612   0   90. 18   91. 00   09100   EMERGENCY   0   91. 00   0   22. 225. 137   0   91. 00
92. 00   09200  0BSERVATI ON BEDS (NON-DI STI NCT PART   0   92. 00   93. 99   09399  PARTI AL HOSPI TALI ZATI ON PROGRAM 0   0   0   0   93. 99
OTHER REIMBURSABLE COST CENTERS
95. 00
102.00 10200 0PI 0I D TREATMENT PROGRAM 0 0 0 0 0102.00
SPECIAL PURPOSE COST CENTERS
113. 00 11300  INTEREST EXPENSE   113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 7,019,267 4,023,555 0 347,400,436 -11,042,822 118.00
NONREI MBURSABLE COST CENTERS
192.00 19200 PHYSI CLANS PRI VATE OFFI CES 0 0 0 6, 395, 162 0 192.00
193. 00   19300   NONPAI D WORKERS   0   0   0   0   193. 00
194. 00 07950 NON REI MBURSABLE 0 0 0 2, 763, 116 0 194. 00
194. 01 07951 RETAIL PHARMACY 0 0 0 4, 102, 191 0 194. 01
200.00   Cross Foot Adjustments   0   0   0   0   200.00
201.00   Negative Cost Centers   0   0   -873,703   0   201.00
202.00   TOTAL (sum lines 118 through 201)   7,019,267   4,023,555   0   359,787,202   -11,042,822   202.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 | 10: 12 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-0027

			5/30/2024 10:	<u>12 am</u>
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FLXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL			5. 00
6.00	00600 MAINTENANCE & REPAIRS			6. 00
7. 00	00700 OPERATION OF PLANT			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00	00900 HOUSEKEEPI NG			9. 00
10. 00	01000 DI ETARY			10.00
	1 1			11.00
11.00	01100 CAFETERI A			1
12.00	01200 MAI NTENANCE OF PERSONNEL			12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00	01500 PHARMACY			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY			16. 00
17. 00	01700 SOCIAL SERVICE			17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS			19. 00
20.00	02000 NURSI NG PROGRAM			20. 00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>		
30. 00	03000 ADULTS & PEDIATRICS	46, 438, 821		30. 00
31. 00	03100 INTENSIVE CARE UNIT	12, 896, 623		31.00
40. 00	04000 SUBPROVI DER – I PF	23, 978, 576		40. 00
41. 00	04100 SUBPROVIDER - I RF	23, 770, 370		41.00
42. 00	04200 SUBPROVI DER	6, 422, 803		42.00
		1 1		1
43. 00	04300 NURSERY	2, 898, 280		43. 00
44. 00	04400 SKILLED NURSING FACILITY	1, 194, 749		44. 00
45. 00	04500 NURSING FACILITY	16, 804, 461		45. 00
46. 00	04600 OTHER LONG TERM CARE	5, 107, 112		46. 00
	ANCILLARY SERVICE COST CENTERS			
50. 00	05000 OPERATING ROOM	19, 550, 965		50. 00
51. 00	05100 RECOVERY ROOM	2, 631, 778		51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 240, 580		52. 00
53.00	05300 ANESTHESI OLOGY	822, 400		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 659, 035		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	11, 888, 658		55. 00
56.00	05600 RADI OI SOTOPE	1, 014, 973		56. 00
57.00	05700 CT SCAN	1, 881, 373		57. 00
58.00	05800 MRI	790, 538		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 131, 625		59. 00
60. 00	06000 LABORATORY	13, 549, 837		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	71, 676		62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	71,070		62. 30
65. 00	06500 RESPIRATORY THERAPY	6, 307, 182		65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 407, 879		66.00
67. 00		1		1
	06700 OCCUPATIONAL THERAPY	296, 498		67. 00
68. 00	06800 SPEECH PATHOLOGY	279, 709		68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 920, 341		69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	14, 002, 458		71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	10, 739, 723		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	25, 193, 964		73. 00
74. 00	07400 RENAL DIALYSIS	18, 191, 690		74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		76. 98
76. 99	07699 LI THOTRI PSY	0		76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0		78. 00
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLI NI C	4, 273, 593		90.00
90. 01	09016 CLINIC-NOT USED	0		90. 01
90. 02	09001 PSYCH CLINIC	28, 437, 475		90. 02
90. 03	09002 PSYCH CLINIC FEE BASED	0		90. 03
90. 04	09003 WORKFI RST			90. 04
90. 05	09004 CANCER CLINIC			90.05
90.06	09005 PEDIATRI C CLI NI C	1, 172, 344		90.06
90.06				90.06
	09006 WOMENS CLINIC	3, 335, 819		1
90. 08	09007 THERAPEUTI C SCHOOL	239, 405		90. 08
90. 09	09008 AFTER SCHOOL PROGRAM	0		90.09
90. 10	09017 CLINI C-NOT USED	0		90. 10
90. 11	09009 PERINATAL ADDICTION	0		90. 11
90. 12	09010 THERAPEUTI C NURSERY	0		90. 12
90. 13	09011 CHI LD DAY TREATMENT	0		90. 13

	TOLAU TAC LIO	CDLTAI		C. F. ONC 0550 40
Health Financial Systems	TRINITAS HOS			u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 31-0027	Peri od: From 01/01/2023	Worksheet B Part I
			To 12/31/2023	Date/Time Prepared:
			10 12/31/2023	5/30/2024 10: 12 am
Cost Center Description	Total			
	26. 00			
90. 14   09012 DI ABETES CENTER	0	·		90. 14
90. 15   09013   WOUND CENTER	1, 103, 510			90. 15
90. 16   09014 MI CA	470, 505			90. 16
90.17 09015 BAYONNE MENTAL HEALTH CENTER	1, 589, 505			90. 17
90. 18   09018 CLI NI C	348, 612			90. 18
91. 00 09100 EMERGENCY	22, 225, 137			91. 00
91. 01   09101 PSYCH EMERGENCY	5, 847, 402			91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
93.99 09399 PARTIAL HOSPITALIZATION PROGRAM	o			93. 99
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0			95. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0			102. 00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	336, 357, 614			118. 00
NONREI MBURSABLE COST CENTERS				
192.00 19200 PHYSICIANS PRIVATE OFFICES	6, 395, 162			192. 00
193.00 19300 NONPALD WORKERS	0			193. 00
194.00 07950 NON REIMBURSABLE	2, 763, 116			194. 00
194.01 07951 RETAIL PHARMACY	4, 102, 191			194. 01
200.00 Cross Foot Adjustments	0			200. 00
201.00 Negative Cost Centers	-873, 703			201. 00
202.00 TOTAL (sum lines 118 through 201)	348, 744, 380			202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0027

					То	12/31/2023	Date/Time Prep 5/30/2024 10:	
				CAPI TAL REI	LATED COSTS		0,00,2021 101	
		Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		oost content beschiptron	Assigned New	DEDG G TTAT	MVDEE EQUIT	Jubrotai	BENEFITS	
			Capi tal				DEPARTMENT	
			Related Costs 0	1. 00	2.00	2A	4. 00	
		AL SERVICE COST CENTERS						
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0	26, 591	31, 375	57, 966	57, 966	4. 00
5.00		ADMINISTRATIVE & GENERAL	0	668, 905		1, 458, 167	7, 097	5. 00
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	0	73, 720 2, 299, 339		160, 705 5, 012, 406	120 604	6. 00 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE	0	2, 299, 339 19, 186		41, 824	29	8. 00
9.00	00900	HOUSEKEEPI NG	0	97, 663		212, 899	1, 025	9. 00
10.00		DIETARY	0	83, 376		181, 754	465	10.00
11. 00 12. 00	1	CAFETERIA MAINTENANCE OF PERSONNEL	0	65, 514 0		142, 816 0	351 0	11. 00 12. 00
13. 00	1	NURSING ADMINISTRATION	0	6, 479		14, 123	1, 745	13. 00
14.00		CENTRAL SERVICES & SUPPLY	0	34, 479		75, 162	418	14.00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	0	28, 006 32, 928		61, 051 71, 780	1, 219 577	15. 00 16. 00
17. 00		SOCIAL SERVICE	0	6, 683		14, 569	378	17. 00
19. 00		NONPHYSICIAN ANESTHETISTS	0	0	_	0	0	19. 00
20. 00 21. 00		NURSING PROGRAM I&R SERVICES-SALARY & FRINGES APPRV	0	53, 648 32, 479		116, 949 70, 801	1, 029	20. 00 21. 00
21.00	1	I &R SERVICES-SALARY & FRINGES APPRV	0	60, 070	·	130, 948	1, 384 517	
23. 00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		0	0	
20.00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0	FO1 7/1	E02 044	1 002 005	/ E04	20.00
30. 00 31. 00	1	INTENSIVE CARE UNIT	0	501, 761 91, 463		1, 093, 805 199, 383	6, 584 1, 743	1
40.00	04000	SUBPROVI DER - I PF	0	189, 921		414, 015	4, 328	40. 00
41. 00		SUBPROVIDER - IRF	0	70.754		154 220	0	41.00
42. 00 43. 00	1	SUBPROVI DER NURSERY	0	70, 754 40, 645		154, 239 88, 603	975 375	
44. 00		SKILLED NURSING FACILITY	0	43, 293		94, 376	102	
45.00		NURSING FACILITY	0	177, 680		387, 330	1, 800	
46. 00		OTHER LONG TERM CARE  LARY SERVICE COST CENTERS	0	59, 160	69, 805	128, 965	800	46. 00
50.00	05000	OPERATING ROOM	0	210, 250		458, 330	2, 012	50. 00
51. 00 52. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	0	16, 469 48, 164		35, 902 104, 994	454 1, 501	51. 00 52. 00
53. 00		ANESTHESI OLOGY	0	3, 120		6, 801	1, 501	53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	85, 950	101, 415	187, 365	1, 145	54.00
55.00		RADI OLOGY-THERAPEUTI C	0	203, 419		443, 439	1, 936	
56. 00 57. 00		RADI OI SOTOPE CT SCAN	0	2, 319 6, 268		5, 055 13, 664	118 261	
58. 00	05800	MRI	0	7, 109		15, 498	96	
59.00		CARDI AC CATHETERI ZATI ON	0	31, 103		67, 803	348	
60. 00 62. 00		LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELL	0	60, 877 4, 103		132, 707 8, 944	85	60. 00 62. 00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0, 711	0	
65. 00		RESPI RATORY THERAPY	0	17, 981		39, 198	977	
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	45, 578 0		99, 357 0	536 54	
68. 00	1	SPEECH PATHOLOGY		568		1, 239	56	1
69. 00	1	ELECTROCARDI OLOGY	0	14, 145		30, 835	268	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT  IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73. 00	1	DRUGS CHARGED TO PATIENTS	0	0	o	o	0	
74.00		RENAL DIALYSIS	0	89, 445	105, 539	194, 984	2, 103	
		CARDIAC REHABILITATION HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	
	1	LI THOTRI PSY	0	0		0	0	
77. 00	1	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00		CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
90. 00		TIENT SERVICE COST CENTERS CLINIC	0	71, 083	83, 874	154, 957	572	90. 00
90. 01	09016	CLINIC-NOT USED	0	0	О	0	0	90. 01
90. 02		PSYCH CLINIC	0	197, 309	232, 812	430, 121	5, 126	
90. 03 90. 04	1	PSYCH CLINIC FEE BASED WORKFIRST		0		0  nl	0	
90. 05		CANCER CLINIC	0	Ö	Ö	ő	0	1
90.06		PEDIATRIC CLINIC	0	0	0	O	280	
		WOMENS CLINIC THERAPEUTIC SCHOOL	0	0	0	0	656 139	90. 07 90. 08
-3.00	10,007	1	. 0		<u>,                                    </u>	<u> </u>	137	, , 5. 55

| Period: | Worksheet B | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time Prepared:

			To	12/31/2023	Date/Time Pre 5/30/2024 10:	
		CAPI TAL REL	ATED COSTS		07 007 202 1 101	12 (3
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs 0	1. 00	2.00	24	4.00	
90. 09 09008 AFTER SCHOOL PROGRAM	0	1.00	2.00	2A	4. 00	90. 09
90. 10   09008 AFTER SCHOOL PROGRAM 90. 10   09017   CLINI C-NOT USED	0	0	0	U O	0	
90. 10   09007   CETNIC-NOT GSED 90. 11   09009   PERINATAL ADDICTION	0	0	0	0	0	90. 10
90. 12   09010 THERAPEUTI C NURSERY	0	0	0	0	0	90.11
90. 13   09011 CHI LD DAY TREATMENT		0	0	0	0	90. 12
90. 14   09012 DI ABETES CENTER		0	0	0	0	90. 13
90. 15   09013   WOUND CENTER		6, 308	7, 443	13, 751	153	90. 15
90. 16   09014 MI CA		29, 950		65, 288	0	90. 16
90. 17 09015 BAYONNE MENTAL HEALTH CENTER		27, 700	00,000	00, 200	334	90. 17
90. 18   09018   CLINI C		0	0	Ö	72	90. 18
91. 00 09100 EMERGENCY		142, 565	168, 217	310, 782	3, 154	91.00
91. 01   09101   PSYCH EMERGENCY	l ol	30, 256	· ·	65, 957	1, 271	91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	]			0	.,	92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	o	0	0	o	0	93. 99
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
102.00 10200 OPIOID TREATMENT PROGRAM	o	0	0	o	0	102. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	6, 088, 082	7, 183, 525	13, 271, 607	57, 372	118. 00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	22, 107	26, 085	48, 192		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 NON REI MBURSABLE	0	134, 250	· ·	292, 656		194. 00
194. 01 07951 RETAIL PHARMACY	0	7, 729	9, 120	16, 849	0	194. 01
200.00 Cross Foot Adjustments		_	_	0	_	200. 00
201. 00 Negative Cost Centers	_	0	0	0		201. 00
202.00   TOTAL (sum lines 118 through 201)	[ O	6, 252, 168	7, 377, 136	13, 629, 304	57, 966	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0027

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/30/2024 10:12 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 1, 465, 264 5 00 5 00 6.00 00600 MAINTENANCE & REPAIRS 16, 261 177, 086 6.00 00700 OPERATION OF PLANT 100, 904 7.00 74, 259 5, 188, 173 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 7,039 620 31, 266 80.778 8.00 00900 HOUSEKEEPI NG 3, 154 159, 156 413, 783 9.00 35.056 2.493 9 00 10.00 01000 DI ETARY 21, 936 2, 693 135, 873 2, 128 11, 249 10.00 11.00 01100 CAFETERI A 12, 102 2, 116 106, 765 1,672 8,839 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12 00 Ω C 0 0 13.00 01300 NURSING ADMINISTRATION 35, 201 209 10, 558 165 874 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 20,644 1, 114 56, 189 880 4,652 14.00 01500 PHARMACY 23, 506 15.00 905 45, 640 715 3.779 15.00 01600 MEDICAL RECORDS & LIBRARY 53.660 16.00 20, 411 1.063 841 4.443 16.00 17.00 01700 SOCIAL SERVICE 12, 418 216 10, 891 171 902 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING PROGRAM 20.00 1,733 87. 427 1, 369 7, 238 20.00 0 02100 | &R SERVICES-SALARY & FRINGES APPRV 21.00 26.771 1.049 52, 929 829 4.382 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 12,575 1,940 97, 893 1,533 8, 105 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 117, 111 16, 206 817, 696 12, 810 67, 700 30.00 149, 052 31.00 03100 INTENSIVE CARE UNIT 41.323 2, 954 2, 335 12, 341 31.00 04000 SUBPROVI DER - I PF 40.00 6, 134 309, 505 40.00 77.315 4.848 25.625 04100 SUBPROVIDER - IRF 41.00  $\cap$ Ω 41.00 42.00 04200 SUBPROVI DER 19,679 2, 285 115, 304 1,806 9,546 42.00 04300 NURSERY 8, 783 5, 484 43.00 1, 313 66, 237 1,038 43.00 04400 SKILLED NURSING FACILITY 1, 105 5.841 44.00 44.00 2.463 1, 398 70.553 04500 NURSING FACILITY 45.00 49.084 5, 739 289, 556 4,536 23, 973 45.00 96, 411 46.00 04600 OTHER LONG TERM CARE 17, 149 1,911 1,510 7, 982 46.00 ANCILLARY SERVICE COST CENTERS 6, 791 50 00 05000 OPERATING ROOM 60, 783 342 633 5, 367 28 368 50 00 05100 RECOVERY ROOM 51.00 8,889 532 26,839 420 2, 222 51.00 05200 DELIVERY ROOM & LABOR ROOM 24, 179 1, 556 78, 490 1, 229 6, 498 52.00 52.00 53.00 05300 ANESTHESI OLOGY 2.928 101 5.084 80 421 53.00 29, 785 05400 RADI OLOGY-DI AGNOSTI C 2,776 140, 069 54.00 2, 194 11, 597 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 36, 495 6,570 331, 501 5, 193 27, 446 55.00 56.00 05600 RADI OI SOTOPE 3,851 75 3, 779 59 313 56.00 57 00 05700 CT SCAN 7, 177 202 10, 215 57 00 160 846 05800 MRI 58.00 2,790 230 11,586 181 959 58.00 05900 CARDIAC CATHETERIZATION 10, 272 1,005 794 4, 197 59.00 59.00 50, 687 60.00 06000 LABORATORY 51, 594 99, 208 1,554 8, 214 60.00 1,966 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 78 105 62 00 133 6, 687 554 62.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 65.00 06500 RESPIRATORY THERAPY 24, 102 581 29, 303 459 2, 426 65.00 06600 PHYSI CAL THERAPY 66, 00 11.194 74, 276 6, 150 66, 00 1.472 1, 163 06700 OCCUPATIONAL THERAPY 1, 185 67.00 C 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 1,084 18 926 15 77 68.00 06900 ELECTROCARDI OLOGY 69.00 6,763 457 23, 052 361 1,909 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 48, 884 71.00 71.00 0 0 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 37 493 C 0 0 0 72 00 07300 DRUGS CHARGED TO PATIENTS 78,862 73.00 0 73.00 74 00 07400 RENAL DIALYSIS 59, 753 2, 889 145, 764 2, 283 12,068 74.00 07697 CARDIAC REHABILITATION 76. 97 0 C 0 0 76.97 07698 HYPERBARIC OXYGEN THERAPY 76.98 0 C 0 0 0 76.98 07699 LI THOTRI PSY 0 0 0 76.99 76.99 0 0 07700 ALLOGENEIC HSCT ACQUISITION 0 o 77.00 0 77.00 Ω 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 11, 125 2, 296 115, 841 1, 815 9, 591 90.00 90.01 09016 CLINIC-NOT USED 90.01 09001 PSYCH CLINIC 90.02 101, 018 6, 373 321, 545 5.037 26, 622 90.02 09002 PSYCH CLINIC FEE BASED 90.03 90.03 90.04 09003 WORKFIRST 0 0 0 0 90.04 0 09004 CANCER CLINIC 0 0 90.05 90.05 0 C 0 0 0 90.06 09005 PEDIATRIC CLINIC 4, 320 C 0 90.06 09006 WOMENS CLINIC 0 90.07 12,696 0 0 0 90.07 90.08 09007 THERAPEUTIC SCHOOL 841 0 0 90.08 0 0 09008 AFTER SCHOOL PROGRAM 0 90.09 90 09 0 0 90.10 09017 CLINIC-NOT USED 0 0 0 0 0 90.10 09009 PERINATAL ADDICTION o 90.11 0 0 0 90.11 90. 12 09010 THERAPEUTIC NURSERY 0 ol 90.12

Health Financial Systems TRINITAS HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0027 Period: Worksheet B From 01/01/2023 Part II

12/31/2023 Date/Time Prepared: 5/30/2024 10:12 am ADMINISTRATIVE MAINTENANCE & Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS PLANT LINEN SERVICE 5.00 6.00 7.00 8.00 9.00 90. 13 | 09011 CHI LD DAY TREATMENT 90. 13 0 0 0 90. 14 | 09012 | DI ABETES CENTER 0 0 0 90.14 90. 15 09013 WOUND CENTER 3,776 204 10, 280 161 851 90.15 09014 MI CA 90.16 352 967 48, 807 765 4, 041 90.16 09015 BAYONNE MENTAL HEALTH CENTER 90 17 6, 197 90 17 C 0 0 0 90.18 09018 CLI NI C 1, 405 C 0 0 0 90.18 91. 00 09100 EMERGENCY 72, 365 4,604 232, 330 3, 639 19, 236 91.00 91. 01 09101 PSYCH EMERGENCY 20, 057 977 49, 307 772 4, 082 91.01 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0 93. 99 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 0 0 0 0 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 1, 420, 024 171, 786 4, 920, 770 76, 590 391, 643 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS PRIVATE OFFICES 24, 779 2, 983 192. 00 714 36, 027 564 0 193.00 193. 00 19300 NONPALD WORKERS 194.00 07950 NON REIMBURSABLE 218, 781 18, 114 194. 00 4.231 4, 336 3, 427 194. 01 07951 RETAIL PHARMACY 16, 230 250 12, 595 197 1, 043 194. 01 200.00 Cross Foot Adjustments 200.00 0 201.00 201.00 Negative Cost Centers

1, 465, 264

177, 086

5, 188, 173

80, 778

413, 783 202. 00

202.00

TOTAL (sum lines 118 through 201)

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0027

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/30/2024 10:12 am Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL ADMI NI STRATI ON SERVICES & **PERSONNEL SUPPLY** 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 356, 098 10 00 01100 CAFETERI A 11.00 274, 661 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 72, 275 13.00 01300 NURSING ADMINISTRATION 0 9, 400 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 4, 292 130 163, 481 14.00 01500 PHARMACY 0 6, 504 0 1,643 15.00 15.00 0 01600 MEDICAL RECORDS & LIBRARY 0 16.00 5, 637 0 0 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 1,984 817 0 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 O 19.00 19.00 0 0 02000 NURSING PROGRAM 20 00 5, 272 23 135 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 10, 934 0 6 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 110, 407 33, 098 0 17, 932 4, 952 30.00 03100 INTENSIVE CARE UNIT 31.00 10, 424 8, 657 0 5, 659 2, 423 31.00 04000 SUBPROVIDER - IPF 40 00 66, 519 0 7, 054 981 40 00 22, 138 04100 SUBPROVIDER - IRF 0 41.00 Λ 41.00 42.00 04200 SUBPROVI DER 19, 949 5, 545 0 1, 691 415 42.00 0 43.00 04300 NURSERY 1,620 1, 424 390 43.00 0 04400 SKILLED NURSING FACILITY 0 44.00 932 161 44.00 45.00 04500 NURSING FACILITY 101, 497 12, 731 0 2,837 1, 283 45.00 04600 OTHER LONG TERM CARE 46.00 6,537 0 12 46.00 227 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2,609 11,601 0 5,835 27, 339 50.00 05100 RECOVERY ROOM 2, 139 0 1,585 99 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 1,939 6, 130 0 3, 966 1,484 52.00 1, 755 05300 ANESTHESI OLOGY 0 53 00 0 53 00 r 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 6,786 359 2, 121 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 7, 443 1, 261 660 55.00 56.00 05600 RADI OI SOTOPE 509 0 826 56, 00 0 0 0 0 05700 CT SCAN 57 00 1, 323 0 361 57 00 0 58.00 05800 MRI 568 0 102 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 1,812 0 642 2,775 59.00 06000 LABORATORY 0 60.00 60.00 488 287 57 οl 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL C 0 0 62.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0 62.30 65 00 06500 RESPIRATORY THERAPY 5, 335 0 1,680 65.00 06600 PHYSI CAL THERAPY 0 2, 811 144 66,00 66,00 155 0 06700 OCCUPATIONAL THERAPY 67.00 309 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 357 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 2, 255 0 274 169 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 56, 678 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 43, 477 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 07400 RENAL DIALYSIS 0 74.00 12, 208 5, 510 5, 339 74.00 76.97 07697 CARDIAC REHABILITATION 0 0 76.97 0 07698 HYPERBARIC OXYGEN THERAPY 0 0 76.98 0 0 76.98 0 76. 99 07699 LI THOTRI PSY 0 76. 99 Ω 0 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION C 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 101 90.00 4.572 886 09016 CLINIC-NOT USED 0 90.01 0 Λ 90.01 0 90.02 09001 PSYCH CLINIC 13, 980 36, 131 1,886 115 90.02 09002 PSYCH CLINIC FEE BASED 0 90.03 0 0 90.03 0 90.04 09003 WORKFIRST 0 0 0 0 90.04 0 0 09004 CANCER CLINIC 90.05 0 0 90.05 90.06 09005 PEDIATRIC CLINIC 0 1, 366 0 702 43 90.06 90.07 09006 WOMENS CLINIC 0 0 4, 855 0 1,063 172 90.07 09007 THERAPEUTIC SCHOOL 0 90. 08 90.08 807 168 0 0 90.09 09008 AFTER SCHOOL PROGRAM 0 0 90.09 C 09017 CLINIC-NOT USED 0 0 90.10 90.10 90. 11 09009 PERINATAL ADDICTION 0 0 0 0 90.11

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS TRINITAS HOSPITAL Provider CCN: 31-0027

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time | Prepared:

			1	0 12/31/2023	Date/lime Prep   5/30/2024 10:	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	12 (1111
300 t 30.1.tol. 3000 1 pt. 611	5.2.7	07.11 2.1 2.11.71		ADMI NI STRATI ON	SERVICES &	
					SUPPLY	
	10.00	11. 00	12.00	13.00	14.00	
90. 12 09010 THERAPEUTI C NURSERY	0	0	0	0	0	90. 12
90. 13 09011 CHILD DAY TREATMENT	0	0	0	0	0	90. 13
90. 14   09012 DI ABETES CENTER	0	0	0	0	0	90. 14
90. 15   09013   WOUND CENTER	0	962	0	395	851	90. 15
90. 16   09014 MI CA	0	0	0	0	0	90. 16
90. 17 09015 BAYONNE MENTAL HEALTH CENTER	0	2, 471	0	215	4	90. 17
90. 18   09018   CLI NI C	0	144	0	0	0	90. 18
91. 00 09100 EMERGENCY	28, 774	19, 379	0	8, 014	4, 698	91.00
91. 01   09101   PSYCH EMERGENCY	0	6, 619	0	1, 117	179	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	356, 098	274, 661	0	72, 275	163, 477	118. 00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS PRIVATE OFFICES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	-	193. 00
194.00 07950 NON REIMBURSABLE	0	0	0	0		194. 00
194. 01 07951 RETAIL PHARMACY	0	0	0	0		194. 01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	-	201. 00
202.00   TOTAL (sum lines 118 through 201)	356, 098	274, 661	0	72, 275	163, 481	202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0027

				T	o 12/31/2023	Date/Time Prep 5/30/2024 10:	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	NURSI NG PROGRAM	12 (111
		15.00	16. 00	17. 00	19. 00	20.00	
	GENERAL SERVICE COST CENTERS	13.00	10.00	17.00	19.00	20.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAI RS						6. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL						12.00
	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVI CES & SUPPLY						14. 00
	01500 PHARMACY	144, 962	450 440				15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	158, 412	42, 346			16. 00 17. 00
	01900 NONPHYSICIAN ANESTHETISTS	0	0	42, 340 0	0		17.00
	02000 NURSI NG PROGRAM	0	0	0	0	221, 175	20. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV	o	0	Ö		,	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	0	85, 542				30.00
	03100   I NTENSI VE CARE UNI T   04000   SUBPROVI DER - I PF	0	12, 673	0			31.00
40. 00 41. 00	04100 SUBPROVIDER - TPF	0	1, 584	0			40. 00 41. 00
42. 00	04200 SUBPROVI DER	0	0	0			42. 00
43. 00	04300 NURSERY	0	0	0			43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0			44.00
45. 00	04500 NURSING FACILITY	106	0	0			45.00
46. 00	04600 OTHER LONG TERM CARE	0	0	0			46.00
F0 00	ANCI LLARY SERVI CE COST CENTERS						F0 00
	05000 OPERATING ROOM 05100 RECOVERY ROOM	0 0	0	0			50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0	0			52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0			53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	o	0	Ö			54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0			55.00
	05600 RADI OI SOTOPE	0	0	0			56.00
57. 00	05700 CT SCAN	0	0	0			57. 00
	05800 MRI	0	0	0			58. 00
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	0	0	0			59. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	J 0			62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62. 30
	06500 RESPI RATORY THERAPY	0	0	0			65.00
	06600 PHYSI CAL THERAPY	0	0	0			66.00
	06700 OCCUPATI ONAL THERAPY	0	0	0			67. 00
	06800 SPEECH PATHOLOGY	0	0	0			68. 00
	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			69. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0			71.00
	07300 DRUGS CHARGED TO PATIENTS	132, 056	0	0			73. 00
	07400 RENAL DIALYSIS	12, 800	20, 594	0			74. 00
	07697 CARDIAC REHABILITATION	0	0	0			76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0			76. 98
	07699 LI THOTRI PSY	0	0	0			76. 99
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0			77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0			78. 00
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	O	12, 673	0			90. 00
	09016 CLINIC-NOT USED		12, 0/3	0			90. 00
	09001 PSYCH CLINIC	l ol	Ö	0			90. 02
90. 03	09002 PSYCH CLINIC FEE BASED	0	0	0			90. 03
	09003 WORKFI RST	0	0	0			90. 04
	09004 CANCER CLINIC	0	0	0			90.05
90.06	09005 PEDIATRIC CLINIC	0	0	]			90.06
	09006 WOMENS CLINIC 09007 THERAPEUTIC SCHOOL		0				90. 07 90. 08
	09008 AFTER SCHOOL PROGRAM		0	0			90.08
	09017 CLINI C-NOT USED		0	0			90. 10
	09009 PERINATAL ADDICTION	O	0	0			90. 11

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS TRINITAS HOSPITAL Provider CCN: 31-0027

| Period: | Worksheet B | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time Prepared:

			T	o 12/31/2023	Date/Time Pro 5/30/2024 10	
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSI NG	. 12 (1111
5551 551151 F11511		RECORDS &	0001712 021111 02	ANESTHETI STS	PROGRAM	
		LI BRARY				
	15. 00	16. 00	17. 00	19. 00	20.00	
90. 12 09010 THERAPEUTI C NURSERY	0	0	0			90. 12
90. 13   09011 CHILD DAY TREATMENT	0	0	0			90. 13
90. 14   09012   DI ABETES CENTER	0	0	0			90. 14
90. 15   09013   WOUND CENTER	0	0	0			90. 15
90. 16   09014   MI CA	0	0	0			90. 16
90. 17   09015 BAYONNE MENTAL HEALTH CENTER	0	0	0			90. 17
90. 18   09018   CLI NI C	0	0	0			90. 18
91. 00   09100   EMERGENCY	0	17, 425	0			91.00
91.01 09101 PSYCH EMERGENCY	0	7, 921	0			91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0			93. 99
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	0			95. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0			102. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	144, 962	158, 412	42, 346	0	(	0 118. 00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0	0			192. 00
193. 00 19300 NONPALD WORKERS	0	0	0			193. 00
194. 00 07950 NON REI MBURSABLE	0	0	0			194. 00
194. 01 07951 RETAIL PHARMACY	0	0	0			194. 01
200.00 Cross Foot Adjustments				0		0 200. 00
201.00 Negative Cost Centers	0	0	0	0		5 201. 00
202.00   TOTAL (sum lines 118 through 201)	144, 962	158, 412	42, 346	이	221, 17!	5 202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0027

Cost Center Description					T	0 12/31/2023		
PROM			INTERNS &	RESI DENTS			5/30/2024 10:	12 alli
PROM		Cost Cantar Description	SEDVI CES_SALAD	SEDVI CES_OTHED	DADAMEN EN	Subtotal	Intern &	
BENEFINE SERVICE COST CENTERS		cost denter bescription				Subtotal		
CEMERAL SERVICE COST CENTERS			APPRV	APPRV				
REPRINT SERVICE PROST CREATE PROTEST   100   1								
1.00   200100 CAP REL COSTS-HUBG & LIXT			21.00	22. 00	23. 00	24. 00		
2.00   DOORD CAP SEL COSTS-MANUE EQUIP	1 00							1 00
DOCSO   DOCSO   AMM INSTRAINE & REPAIRS								
0.00   0.000		00400 EMPLOYEE BENEFITS DEPARTMENT						
7.00 00700   ORDEN TO TO 6F PLANT		1 1						
B.00   00800  AJMOREY & LINEN SERVICE		1 1						
10.00   01000   DETARY		1 1						
11.00   10.00   CAFETERIA     11.00   12.00		1 1						
12.00   10200   MAINTERNATIC OF PERSONNEL   13.00		1 1						
14. 00   1400 CENTRAL SERVICES & SUPPLY   16. 00   1500 MEDICAL RECORDS & LIBRARY   1.0 0   1700 MEDICAL RECORDS & LIBRARY   1.0 0		1 1						
15.00   01500   PHARMANCY		1 1						
10.00   10.000   MEDICAL RECORDS & LIBRARY     11.00   17.00		1 1						
19.00   1900   MONINYSI CI AN ARESTHETISTS   2.00   20.00   20.00   20.00   18.7 SEPRI (CES-SALARY & FRI NICES APPRY   158, 145   22.4, 451   22.00   22.00   22.00   18.7 SEPRI (CES-SALARY & FRI NICES APPRY   254, 451   22.00   23.00   23.00   PARAMED ED PRICH. (SPECI PTY)   2.20   23.00   23.00   PARAMED ED PRICH. (SPECI PTY)   2.20   23.00   23.00   PARAMED ED PRICH. (SPECI PTY)   2.20   23.00   23.00   PARAMED ED PRICH. (SPECI PTY)   2.24   26, 189   0.30		1						
20. 00		1 1						
21.00		1 1						
22.00		1 1	158, 145					
INPATI ENT ROUTINE SERVICE COST CENTERS   2,426,189   0, 30, 00   31, 30   31, 30		1		264, 451				
30. 00	23. 00	. ,			0			23. 00
31.00   03100   INTERSIVE CARE UNIT	30. 00					2, 426, 189	0	30. 00
11. 00   04100   SUBPROVI DER - I RF		03100 INTENSIVE CARE UNIT						
A2 00   04200   SUBPROVI DER   331, 434   0   42 00     A3 00   04400   04400   SKI LLED NURSI NG FACILITY   880, 472   0   45 00     A5 00   04600   NURSI NG FACILITY   880, 472   0   45 00     A6 00   04600   NURSI NG FACILITY   880, 472   0   45 00     A6 00   04600   OHIER LONG TERM CARE   261, 504   0   46 00     A6 00   04600   OHIER LONG TERM CARE   261, 504   0   45 00     A6 00   04600   OHIER LONG TERM CARE   261, 504   0   45 00     A6 00   04600   OHIER LONG TERM CARE   261, 504   0   45 00     A6 00   05000   OFFATI NG ROOM   951, 668   0   50 00     A7 00   05000   PECOVERY ROOM   951, 668   0   50 00     A8 00   05000   PECOVERY ROOM   231, 966   0   52 00     A5 00   05000   DELUKERY ROOM & LABOR ROOM   231, 966   0   52 00     A5 00   05000   PECOVERY ROOM & 17, 170   0   53 00     A5 00   05000   PADIOLOCY-DI AGNOSTI C   384, 197   0   54 00     A5 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 55 00     A5 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 55 00     A6 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 55 00     A6 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 55 00     A6 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 55 00     A6 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 55 00     A6 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 55 00     A6 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 55 00     A6 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 55 00     A6 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 55 00     A6 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 50 00     A6 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 50 00     A6 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 50 00     A6 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 50 00     A6 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 50 00     A6 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 50 00     A6 00   0500   PADIOLOCY-DI AGNOSTI C   881, 944   0   6 50 00     A6 00   0500   PADIOLOCY-DI A		1 1						
44. 00   04400   SKI LED NURSI NG FACILITY   880. 472						_		
45. 00   04500   NURSI NG FACILITY   880, 472   0   45. 00							-	
Accord   Oxford   Carbon   C								
SOLO		1 1						
51.00   05100   RECOVERY ROOM						051 //0		
S2.00   05.200   05		1						
54.00   05400   RADI OLOGY-DI AGNOSTI C   384, 197   0   54.00   05500   RADI OLOGY-THERAPEUTI C   861, 944   0   55.00   05500   RADI OLOGY-THERAPEUTI C   861, 944   0   55.00   05500   RADIO I SOTOPE   14, 585   0   56.00   05600   RADIO I SOTOPE   34, 209   0   57.00   34, 209   0   57.00   34, 209   0   57.00   34, 209   0   57.00   34, 209   0   57.00   34, 209   0   57.00   34, 209   0   57.00   34, 209   0   57.00   34, 209   0   57.00   34, 209   0   57.00   34, 209   0   57.00   34, 209   0   58.00   MRI CARDIAC CATHETERI ZATI ON   140, 335   0   59.00   06.00   06000   LABORATORY   296, 160   0   60.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   16, 501   0   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   10, 501   0   62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   10, 501   0   62.00   06500   RSPER RATORY THERAPY   16, 501   0   62.00   06.00   06600   PHYSI CAL THERAPY   197, 258   0   66.00   06600   PHYSI CAL THERAPY   1, 549   0   67.00   06700   0CCUPATI ONAL THERAPY   1, 549   0   67.00   06800   SPECER PATHOLOGY   3, 778   0   68.00   070   070   070   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   80, 970   0   72.00   73.00   07000   IMPL. DEV. CHARGED TO PATI ENTS   80, 970   0   72.00   73.00   07000   SPECER PATHOLOGY   70.00							0	
55. 00   05500   RADI OLOGY-THERAPEUTI C   861, 944   0   55. 00		1 1						
56. 00   05600   RADI OI SOTOPE     14, 585   0   56. 00   057. 00   05700   CT SCAN   34, 209   0   57. 00   05800   MRI   32, 010   0   58. 00   05800   MRI   32, 010   0   58. 00   05800   MRI   32, 010   0   58. 00   05900   CARDI AC CATHETERI ZATI ON   140, 335   0   59. 00   05900   CARDI AC CATHETERI ZATI ON   140, 335   0   59. 00   05900   CARDI AC CATHETERI ZATI ON   140, 335   0   59. 00   06. 00   06. 000   LABORATORY   296, 160   0   06. 00		1 1						
58. 00   05800   NRI   32. 010   0   58. 00							0	
59,00   05900   CARDIAC CATHETERIZATION   140, 335   0   59,00								
60.00   06000   LABORATORY   296, 160   0 60.00								
62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS   0   0   62. 30		06000 LABORATORY						60.00
65. 00   06500   RESPIRATORY THERAPY   104, 061   0   65. 00		1				16, 501	1	
66. 00   06600   PHYSI CAL THERAPY   197, 258   0   66. 00		1 1				104 061		
68. 00   06800   SPEECH PATHOLOGY   3,778   0   68. 00		1 1						
69.00   06900   ELECTROCARDI OLOGY   66, 343   0   69.00     71.00   7100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   105, 562   0   71.00     72.00   70200   IMPL. DEV. CHARGED TO PATI ENTS   80, 970   0   72.00     73.00   07300   DRUGS CHARGED TO PATI ENTS   210, 918   0   73.00     74.00   07400   RENAL DI ALYSI S   476, 295   0   74.00     76.97   07697   CARDI AC REHABI LI TATI ON   0   0   76.97     76.98   07698   HYPERBARI C OXYGEN THERAPY   0   0   0   76.98     76.99   07699   LI THOTRI PSY   0   0   0   76.99     77.00   07700   ALLOGENEI C HSCT ACQUI SI TI ON   0   0   77.00     78.00   07800   CAR T-CELL I MMUNOTHERAPY   0   0   0   78.00     90.01   09000   CLI NI C   0   0   0   0     90.01   09000   CLI NI C   0   0   0   0     90.01   09000   PSYCH CLI NI C   947, 954   0   90.02     90.02   09001   PSYCH CLI NI C FEE BASED   0   0   0   90.03     90.04   09003   WORKFI RST   0   0   0   90.05     90.06   09005   PEDI ATRI C CLI NI C   0   0   90.06     90.06   09005   PEDI ATRI C CLI NI C   0   0   90.06     90.06   09005   PEDI ATRI C CLI NI C   0   0   90.06     90.07   07200   07200   0   0   0   0   0   0     90.08   09006   09006   09006   09006   09006   09006   09006     90.09   09006   09006   09006   09006   09006   09006   09006     90.09   09006   09006   09006   09006   09006   09006   09006   09006     90.09   09006   0		1 1						
71.00		1 1						
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSIS 76. 97 07697 CARDI AC REHABI LI TATI ON 76. 98 07698 HYPERBARI C OXYGEN THERAPY 77. 90 07699 LI THOTRI PSY 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 90. 00 09000 CLI NI C 90. 01 09016 CLI NI C STORY CONTROL STORY 90. 02 09001 PSYCH CLI NI C 90. 03 09002 PSYCH CLI NI C FEE BASED 90. 04 09003 WORKFI RST 90. 06 09005 PEDI ATRI C CLI NI C 90. 05 09004 CANCER CLI NI C 90. 06 09005 PEDI ATRI C CLI NI C 90. 06 09005 PEDI ATRI C CLI NI C 90. 06 09005 PEDI ATRI C CLI NI C 90. 06 09005 PEDI ATRI C CLI NI C 90. 06 09005 PEDI ATRI C CLI NI C		1 1						
74. 00 07400 RENAL DI ALYSI S 76. 97 07697 CARDI AC REHABI LI TATI ON 76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 99 07699 LI THOTRI PSY 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 78. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 90. 00 09000 CLI NI C 90. 01 09016 CLI NI C-NOT USED 90. 02 09001 PSYCH CLI NI C 90. 03 09002 PSYCH CLI NI C FEE BASED 90. 04 09003 WORKFI RST 90. 05 09004 CANCER CLI NI C 90. 05 09004 CANCER CLI NI C 90. 06 09005 PEDI ATRI C CLI NI C 90. 06 09005 PEDI ATRI C CLI NI C 90. 06 09005 PEDI ATRI C CLI NI C 90. 06 09005 PEDI ATRI C CLI NI C 90. 074. 00 90. 74. 00 90. 74. 00 90. 76. 97 90. 00 90. 76. 99 90. 00 90. 76. 99 90. 00 90. 77. 00 90. 77. 00 90. 00								
76. 97		1 1					1	
76. 99   07699   LI THOTRI PSY   0   0   76. 99   77. 00   07700   ALLOGENEI C HSCT ACQUI SI TI ON   0   0   77. 00   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   0   78. 00    OUTPATI ENT SERVI CE COST CENTERS   314, 429   0   90. 00   90. 01   09016   CLI NI C   0   0   90. 01   90. 02   09001   PSYCH CLI NI C   947, 954   0   90. 02   90. 03   09002   PSYCH CLI NI C FEE BASED   0   0   0   90. 03   90. 04   09003   WORKFI RST   0   0   0   90. 04   90. 05   09004   CANCER CLI NI C   0   0   90. 05   90. 06   09005   PEDI ATRI C CLI NI C   0   90. 06		1 1				470, 273		
77. 00   07700   ALLOGENEI C HSCT ACQUI SITION   0   0   77. 00   78. 00   0   78. 00   0   0   78. 00   0   0   0   0   0   0   0   0   0	76. 98	07698 HYPERBARI C OXYGEN THERAPY				0		76. 98
78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0   0   78. 00		1 1				0		
OUTPATIENT SERVICE COST CENTERS		1 1				0		
90. 01   09016   CLI NI C-NOT USED   0   90. 01   90. 02   90. 02   90. 03   09002   PSYCH CLI NI C   90. 03   09002   PSYCH CLI NI C FEE BASED   0   90. 03   90. 04   90. 05   09004   CANCER CLI NI C   0   90. 05   90. 06   09005   PEDI ATRI C CLI NI C   0   90. 06   090. 06   09005   PEDI ATRI C CLI NI C   0   90. 06   090		OUTPATIENT SERVICE COST CENTERS				-		
90. 02   09001   PSYCH CLINIC   947, 954   0   90. 02   90. 03   09002   PSYCH CLINIC FEE BASED   0   90. 03   90. 04   09003   WORKFIRST   0   090. 04   09004   CANCER CLINIC   0   90. 05   09004   CANCER CLINIC   0   90. 05   09005   PEDIATRIC CLINIC   0   90. 06   09005   PEDIATRIC CLINIC   0   90. 06   09005   09						314, 429		
90. 03   09002   PSYCH CLINIC FEE BASED   0   90. 03   90. 04   90. 05   90. 05   90. 06   90. 05   90. 06   90. 05   90. 06   90		1 1				947, 954		
90. 05   09004   CANCER CLINIC   0   90. 05   90. 06   09005   PEDIATRIC CLINIC   0   90. 06   90. 06	90. 03	09002 PSYCH CLINIC FEE BASED				0		90. 03
90. 06   09005   PEDI ATRI C CLI NI C   6, 711   0   90. 06						0		
90. 07  09006 WOMENS CLINIC   19,442 0 90. 07						6, 711		
	90. 07	09006 WOMENS CLINIC				19, 442	0	90. 07

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared:

				10 12/31/2023	Date/lime Pre 5/30/2024 10:	pared:
	INTERNS & RESIDENTS				3/30/2024 10.	12 alli
	TIVILING &	KESI DENTS				
Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	Intern &	
oost content boson per on	Y & FRINGES	PRGM COSTS	PRGM		Residents Cost	
	APPRV	APPRV			& Post	
	7	7.11.11.1			Stepdown	
					Adjustments	
	21.00	22. 00	23. 00	24.00	25. 00	
90. 08   09007 THERAPEUTI C SCHOOL				1, 955	0	90. 08
90. 09 09008 AFTER SCHOOL PROGRAM				0	0	90. 09
90. 10   09017 CLI NI C-NOT USED				0	0	90. 10
90. 11 09009 PERINATAL ADDICTION				0	0	90. 11
90. 12 09010 THERAPEUTIC NURSERY				0	0	90. 12
90. 13   09011   CHI LD DAY TREATMENT				0	0	90. 13
90. 14   09012 DI ABETES CENTER				0	0	90. 14
90. 15   09013   WOUND CENTER				31, 384	0	90. 15
90. 16 09014 MI CA				120, 220	0	90. 16
90. 17 09015 BAYONNE MENTAL HEALTH CENTER				9, 221	0	90. 17
90. 18 09018 CLI NI C				1, 621	0	90. 18
91. 00 09100 EMERGENCY				724, 400	0	91. 00
91. 01 09101 PSYCH EMERGENCY				158, 259		91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
93. 99 09399 PARTIAL HOSPITALIŽATION PROGRAM				0	0	93. 99
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES				0	0	95. 00
102.00 10200 OPIOID TREATMENT PROGRAM				0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0		0 12, 282, 967	0	118. 00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS PRIVATE OFFICES				113, 857		192. 00
193.00 19300 NONPALD WORKERS				0	0	193. 00
194. 00 07950 NON REIMBURSABLE				541, 545	0	194. 00
194. 01 07951 RETAIL PHARMACY				47, 164		194. 01
200.00 Cross Foot Adjustments	158, 145	264, 451		0 422, 596	0	200. 00
201.00 Negative Cost Centers	0	0		0 221, 175	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	158, 145	264, 451		0 13, 629, 304	0	202. 00
	·					

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2023 Part II | To 12/31/2023 Date/Time Prepared: 5/30/2024 10: 12 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0027

			10 12/31/2023	5/30/2024 10: 12 am
	Cost Center Description	Total		07 007 2021 101 12 4
		26. 00		
	GENERAL SERVICE COST CENTERS			
1. 00	00100 CAP REL COSTS-BLDG & FIXT			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL			5. 00
6. 00	00600 MAI NTENANCE & REPAI RS			6. 00
7. 00	00700 OPERATION OF PLANT			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00	00900 HOUSEKEEPI NG			9.00
10. 00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11.00
12. 00	01200 MAI NTENANCE OF PERSONNEL			12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY			14.00
15. 00	01500 PHARMACY			15.00
	01600 MEDI CAL RECORDS & LI BRARY			16. 00
17. 00	01700 SOCI AL SERVI CE			17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS			19. 00
20. 00	02000 NURSI NG PROGRAM			20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV			21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)			23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00	03000 ADULTS & PEDI ATRI CS	2, 426, 189		30. 00
31. 00	03100 I NTENSI VE CARE UNI T	448, 967		31. 00
40. 00	04000 SUBPROVI DER - I PF	940, 046		40. 00
41. 00	04100 SUBPROVI DER - I RF	0		41. 00
42.00	04200 SUBPROVI DER	331, 434		42. 00
43.00	04300 NURSERY	175, 267		43. 00
44.00	04400 SKILLED NURSING FACILITY	176, 932		44. 00
45.00	04500 NURSING FACILITY	880, 472		45. 00
46.00	04600 OTHER LONG TERM CARE	261, 504		46. 00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	951, 668		50.00
51.00	05100 RECOVERY ROOM	79, 081		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	231, 966		52. 00
53.00	05300 ANESTHESI OLOGY	17, 170		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	384, 197		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	861, 944		55. 00
56. 00	05600 RADI OI SOTOPE	14, 585		56. 00
57. 00	05700 CT SCAN	34, 209		57. 00
58. 00	05800 MRI	32, 010		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	140, 335		59.00
60. 00	06000 LABORATORY	296, 160		60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	16, 501		62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		62. 30
65. 00	06500 RESPIRATORY THERAPY	104, 061		65. 00
66. 00	06600 PHYSI CAL THERAPY	197, 258		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 549		67. 00
	06800 SPEECH PATHOLOGY	3, 778		68. 00
69. 00	06900 ELECTROCARDI OLOGY	66, 343		69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	105, 562		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS			<b>I</b>
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS	80, 970 210, 918		72. 00 73. 00
74.00	07400 RENAL DIALYSIS	1		74. 00
74. 00 76. 97	07697 CARDI AC REHABI LI TATI ON	476, 295 0		74.00
76. 97 76. 98	1 1			76. 97
	07698 HYPERBARI C OXYGEN THERAPY			
76. 99	07699 LI THOTRI PSY	0		76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	1		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		78. 00
00.00	OUTPATIENT SERVICE COST CENTERS	214 420		00.00
90.00	09000 CLINIC	314, 429		90.00
90. 01	09016 CLINIC-NOT USED	047.05		90. 01
90. 02	09001 PSYCH CLINIC	947, 954		90. 02
90. 03	09002 PSYCH CLINIC FEE BASED	0		90. 03
90. 04	09003 WORKFI RST	0		90. 04
90. 05	09004 CANCER CLINIC	0		90. 05
90. 06	09005 PEDIATRIC CLINIC	6, 711		90. 06
90. 07	09006 WOMENS CLINIC	19, 442		90. 07
90. 08	09007 THERAPEUTI C SCHOOL	1, 955		90. 08
90. 09	09008 AFTER SCHOOL PROGRAM	0		90. 09
90. 10	09017 CLI NI C-NOT USED	0		90. 10
90. 11	09009 PERINATAL ADDICTION	0		90. 11
90. 12	09010 THERAPEUTIC NURSERY	0		90. 12
90. 13	09011 CHILD DAY TREATMENT	0		90. 13
	,			

Health Financial Systems	TRINITAS HO	SPITAL	In Lieu of Form CMS-2552-1			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 31-0027	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/30/2024 10:12 am		
Cost Center Description	Total					
	26. 00					
90. 14   09012 DI ABETES CENTER	0			90. 14		
90. 15   09013   WOUND CENTER	31, 384			90. 15		
90. 16 09014 MI CA	120, 220			90. 16		
90. 17 09015 BAYONNE MENTAL HEALTH CENTER	9, 221			90. 17		
90. 18   09018   CLI NI C	1, 621			90. 18		
91. 00   09100   EMERGENCY	724, 400			91.00		
91. 01   09101   PSYCH EMERGENCY	158, 259			91. 01		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00		
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0			93. 99		
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0			95. 00		
102.00 10200 OPIOLD TREATMENT PROGRAM	0			102. 00		
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE				113. 00		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	12, 282, 967			118. 00		
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSICIANS PRIVATE OFFICES	113, 857			192. 00		
193. 00 19300 NONPALD WORKERS	0			193. 00		
194. 00 07950 NON REIMBURSABLE	541, 545			194. 00		
194. 01 07951 RETAIL PHARMACY	47, 164			194. 01		
200.00 Cross Foot Adjustments	422, 596			200. 00		
201.00 Negative Cost Centers	221, 175			201. 00		
202 00 TOTAL (sum Lines 118 through 201)	13 629 304			202 00		

13, 629, 304

Cross Foot Adjustments Negative Cost Centers TOTAL (sum lines 118 through 201)

202.00

202. 00

| Period: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 31-0027

						o 12/31/2023		
			CAPITAL REI	LATED COSTS			5/30/2024 10:	12 am
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Peconciliation	ADMI NI STRATI VE	
		cost center bescription	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	Reconciliation	& GENERAL	
					DEPARTMENT		(ACCUM. COST)	
					(GROSS SALARI ES)			
	OENED	AL CERVILOR COCT OFFITERS	1.00	2. 00	4. 00	5A	5. 00	
1. 00		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT	1, 100, 146					1. 00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		1, 100, 146				2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	4, 679				271 407 124	4.00
5. 00 6. 00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	117, 702 12, 972				271, 607, 124 3, 014, 154	5. 00 6. 00
7.00	00700	OPERATION OF PLANT	404, 597	404, 597	1, 749, 455	0	18, 703, 197	7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	3, 376 17, 185				1, 304, 667 6, 497, 884	8. 00 9. 00
10.00		DIETARY	14, 671	14, 671			4, 065, 900	
11. 00	01100	CAFETERI A	11, 528	11, 528	1, 016, 967	0	2, 243, 117	11. 00
12. 00 13. 00		MAI NTENANCE OF PERSONNEL NURSI NG ADMINISTRATION	0 1, 140	0 1, 140	_	_	0 6, 524, 770	12. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	6, 067	6, 067	1, 210, 445		3, 826, 572	14. 00
15. 00	1	PHARMACY	4, 928				4, 356, 950	
16. 00 17. 00		MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	5, 794 1, 176		1, 672, 297 1, 096, 345		3, 783, 378 2, 301, 751	16. 00 17. 00
19. 00	1	NONPHYSI CI AN ANESTHETI STS	0	0		Ö	0	19. 00
20.00		NURSI NG PROGRAM	9, 440		,		0	20.00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV	5, 715 10, 570				4, 962, 218 2, 330, 868	21. 00 22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)	0				0	23. 00
20.00		ENT ROUTINE SERVICE COST CENTERS	00 201	00.201	19, 084, 953		21 717 /14	20.00
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	88, 291 16, 094	88, 291 16, 094			21, 717, 614 7, 659, 458	30. 00 31. 00
40.00	04000	SUBPROVI DER - I PF	33, 419			0	14, 330, 869	40. 00
41. 00	1	SUBPROVIDER - IRF	0	-	-	_	0	41. 00
42. 00 43. 00	1	SUBPROVI DER NURSERY	12, 450 7, 152				3, 647, 723 1, 628, 061	42. 00 43. 00
44. 00	04400	SKILLED NURSING FACILITY	7, 618				456, 447	44. 00
45. 00 46. 00		NURSING FACILITY OTHER LONG TERM CARE	31, 265				9, 098, 122	45. 00
46.00		LARY SERVICE COST CENTERS	10, 410	10, 410	2, 317, 697	0	3, 178, 732	46. 00
50.00		OPERATI NG ROOM	36, 996				11, 266, 615	50. 00
51. 00 52. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	2, 898 8, 475				1, 647, 631 4, 481, 746	
53. 00	1	ANESTHESI OLOGY	549				542, 726	
54.00	1	RADI OLOGY - DI AGNOSTI C	15, 124				5, 520, 817	54.00
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	35, 794 408				6, 764, 533 713, 800	55. 00 56. 00
57. 00	05700	CT SCAN	1, 103	1, 103	756, 430	0	1, 330, 325	57. 00
58.00	05800		1, 251				517, 057	
59. 00 60. 00	1	CARDI AC CATHETERI ZATI ON LABORATORY	5, 473 10, 712				1, 904, 048 9, 563, 313	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	722	722	C	0	14, 367	62. 00
62. 30 65. 00		BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY	3, 164		_	0	0 4, 467, 518	62. 30 65. 00
66. 00		PHYSI CAL THERAPY	8, 020				2, 074, 804	66. 00
67. 00		OCCUPATI ONAL THERAPY	0	0			219, 562	
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	100 2, 489		· ·		200, 844 1, 253, 620	68. 00 69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 407	777,730	0	9, 061, 053	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	6, 949, 662	
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	15, 739	0 15, 739	6, 096, 920	0	14, 617, 585 11, 075, 661	
76. 97		CARDI AC REHABI LI TATI ON	0	0	0,070,720	0	0	76. 97
76. 98		HYPERBARI C OXYGEN THERAPY	0	0	C	0	0	76. 98
76. 99 77. 00	1	LITHOTRIPSY ALLOGENEIC HSCT ACQUISITION	0	0		0	0	76. 99 77. 00
78. 00	07800	CAR T-CELL IMMUNOTHERAPY	0	o o	C	0	0	78. 00
00 00		TIENT SERVICE COST CENTERS CLINIC	12 500	12 500	1 454 744	0	2 042 141	00 00
90. 00 90. 01	1	CLINIC CLINIC-NOT USED	12, 508 0	12, 508 0	1, 656, 744 C	0	2, 062, 161 0	90. 00 90. 01
90. 02	09001	PSYCH CLINIC	34, 719	34, 719	14, 858, 249	0	18, 724, 408	90. 02
90. 03 90. 04		PSYCH CLINIC FEE BASED WORKFIRST	0	0	0	0	0	90. 03 90. 04
90. 04		CANCER CLINIC	0	0		0	0	90. 04
90.06	09005	PEDIATRIC CLINIC	0	O	811, 949		800, 665	90.06
90. 07	104006	WOMENS CLINIC	0	0	1, 902, 080	0	2, 353, 259	90. 07

			T	o 12/31/2023	Date/Time Prep 5/30/2024 10:	
	CAPITAL REL	ATED COSTS			37 307 2024 10.	12 (111)
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS			
			SALARI ES)			
	1.00	2. 00	4. 00	5A	5. 00	
90. 08   09007   THERAPEUTI C   SCHOOL	0	-	402, 706	0	155, 938	
90. 09 09008 AFTER SCHOOL PROGRAM	0	0	0	0	0	90. 09
90. 10   09017   CLI NI C-NOT USED	0	0	0	0	0	90. 10
90. 11 09009 PERINATAL ADDICTION	0	0	0	0	0	90. 11
90. 12 09010 THERAPEUTI C NURSERY	0	0	0	0	0	90. 12
90. 13 09011 CHILD DAY TREATMENT	0	0	0	0	0	90. 13
90. 14   09012   DI ABETES CENTER	0	0	0	0	0	90. 14
90. 15   09013   WOUND CENTER	1, 110		442, 554	0	699, 999	
90. 16   09014   MI CA	5, 270		0	0	65, 288	
90. 17 09015 BAYONNE MENTAL HEALTH CENTER	0	0	968, 923	0	1, 148, 589	
90. 18   09018   CLI NI C	0	0	209, 544	0	260, 472	
91. 00   09100   EMERGENCY	25, 086		9, 141, 556	0	13, 413, 369	
91. 01   09101   PSYCH EMERGENCY	5, 324	5, 324	3, 683, 498	0	3, 717, 791	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	_	_	_	_	_	92. 00
93. 99 O9399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVI CES	0	1	0		0	
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						440.00
113. 00 11300 I NTEREST EXPENSE	1 071 070	1 071 070	1// 050 170	00 100 070	2/2 221 /70	113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 071, 273	1, 071, 273	166, 059, 178	-88, 180, 078	263, 221, 678	118.00
NONREI MBURSABLE COST CENTERS  192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES	2 000	2 000	1 700 F44		4 502 052	102 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES  193. 00 19300 NONPALD WORKERS	3, 890		1, 720, 546	0	4, 592, 953	192.00
193. 00 19300 NONPALD WORKERS 194. 00 07950 NON REIMBURSABLE		Ĭ	0	0	784, 170	
194. 01 07951 RETAIL PHARMACY	23, 623 1, 360		0	0	3, 008, 323	
200.00 Cross Foot Adjustments	1, 360	1, 300	U	0	3, 008, 323	200. 00
201.00 Regative Cost Centers						200.00
	( 252 1/0	7 277 127	27 777 004			
202.00 Cost to be allocated (per Wkst. B, Part I)	6, 252, 168	7, 377, 136	36, 776, 094		89, 821, 852	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	5. 683035	6. 705597	0. 219193		0. 330705	202 00
204.00 Cost to be allocated (per Wkst. B,	3. 003033	0.703347	57, 966		1, 465, 264	
Part II)			37,900		1, 400, 204	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0. 000345		0. 005395	205 00
203.00   Gill Cost martipirer (wkst. B, Fart			0.000343		0.003373	200.00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						
			•	•		

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0027

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:

5/30/2024 10:12 am Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY LINEN SERVICE REPAI RS PLANT (SQUARE FEET) (MEALS SERVED) (SQUARE FEET) (SQUARE FEET) (SQUARE FEET) 9. 00 10.00 7.00 8.00 6.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 964, 793 6.00 6.00 7.00 00700 OPERATION OF PLANT 404, 597 560, 196 7.00 00800 LAUNDRY & LINEN SERVICE 556, 820 8.00 3.376 3.376 8 00 9.00 00900 HOUSEKEEPI NG 17, 185 17, 185 17, 185 539, 635 9.00 10.00 01000 DI ETARY 14,671 14,671 14,671 14, 671 377, 321 10.00 01100 CAFETERI A 11, 528 11.00 11, 528 11, 528 11.00 11, 528 0 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 1, 140 1, 140 1, 140 1, 140 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 6,067 6, 067 6,067 6,067 0 14.00 4, 928 4, 928 01500 PHARMACY 4, 928 4, 928 15.00 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 5, 794 5, 794 5, 794 5, 794 0 16.00 17.00 01700 SOCIAL SERVICE 1, 176 1, 176 1, 176 1, 176 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 19.00 C 02000 NURSING PROGRAM 9.440 9 440 9 440 9 440 20 00 Λ 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 5, 715 5, 715 5, 715 5, 715 0 21.00 02200 | &R SERVICES-OTHER PRGM COSTS APPRV 22.00 10,570 10, 570 10,570 10,570 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 88, 291 88, 291 88, 291 88, 291 116, 986 30.00 03100 INTENSIVE CARE UNIT 31.00 16,094 16, 094 16,094 16,094 11,045 31.00 04000 SUBPROVIDER - IPF 33, 419 33, 419 40 00 33, 419 33, 419 70, 484 40 00 04100 SUBPROVIDER - IRF 41.00 C Λ 41.00 42.00 04200 SUBPROVI DER 12, 450 12, 450 12, 450 12, 450 21, 138 42.00 43.00 04300 NURSERY 7, 152 7, 152 7, 152 7, 152 0 43.00 04400 SKILLED NURSING FACILITY 44.00 7,618 7, 618 7, 618 7,618 Λ 44.00 45.00 04500 NURSING FACILITY 31, 265 31, 265 31, 265 31, 265 107, 546 45.00 04600 OTHER LONG TERM CARE 46.00 10, 410 10, 410 10, 410 10, 410 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 36, 996 36, 996 36, 996 36, 996 2, 765 50.00 05100 RECOVERY ROOM 2,898 2, 898 2, 898 2,898 0 51.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 8, 475 8, 475 52.00 8, 475 8, 475 2,055 52.00 05300 ANESTHESI OLOGY 549 53 00 549 549 549 53 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 15, 124 15, 124 15, 124 15, 124 0 54.00 35, 794 35, 794 05500 RADI OLOGY-THERAPEUTI C 35, 794 35, 794 55.00 55.00 0 56.00 05600 RADI OI SOTOPE 408 408 408 408 0 56, 00 05700 CT SCAN 57 00 1.103 1, 103 1.103 1.103 0 57 00 58.00 05800 MRI 1, 251 1, 251 1, 251 1, 251 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 5, 473 5, 473 5, 473 5, 473 0 59.00 06000 LABORATORY 10, 712 10, 712 10, 712 60.00 10.712 60.00 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 722 722 722 722 0 62.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 65 00 06500 RESPIRATORY THERAPY 3, 164 3, 164 3, 164 3, 164 0 65.00 06600 PHYSI CAL THERAPY 8,020 8,020 66,00 8,020 8,020 0 66,00 06700 OCCUPATIONAL THERAPY 67.00  $\Gamma$ 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 100 100 100 100 0 69.00 06900 ELECTROCARDI OLOGY 2, 489 2, 489 2, 489 2, 489 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 C 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 C 0 0 73.00 07400 RENAL DIALYSIS 74.00 15, 739 15, 739 15, 739 15, 739 0 74.00 76.97 07697 CARDIAC REHABILITATION r C 0 0 76.97 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 76.98 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 0 0 76. 99 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 0 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 12, 508 12, 508 12, 508 0 90.00 12,508 09016 CLINIC-NOT USED 90.01 Λ 90.01 90.02 09001 PSYCH CLINIC 34, 719 34, 719 34, 719 34, 719 14,813 90.02 09002 PSYCH CLINIC FEE BASED 90.03 0 0 0 90.03 0 90.04 09003 WORKFIRST 0 0 0 90.04 0 0 0 09004 CANCER CLINIC 0 0 90.05 C 0 90.05 90.06 09005 PEDIATRIC CLINIC 0 0 0 0 0 90.06 0 90.07 09006 WOMENS CLINIC 0 0 0 0 0 90.07 09007 THERAPEUTIC SCHOOL Ω 0 90 08 90.08 0 0 90.09 09008 AFTER SCHOOL PROGRAM C 0 0 90.09 09017 CLINIC-NOT USED 0 90.10 90.10 90. 11 09009 PERINATAL ADDICTION 0 0 90.11

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0027

From 01/01/2023 12/31/2023

Date/Time Prepared: 5/30/2024 10:12 am Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY REPAI RS PLANT LINEN SERVICE (SQUARE FEET) (MEALS SERVED) (SQUARE FEET) (SQUARE FEET) (SQUARE FEET) 9. 00 10.00 6.00 7.00 8.00 90. 12 09010 THERAPEUTIC NURSERY 90. 12 0 0 0 90.13 09011 CHILD DAY TREATMENT 0 0 0 0 0 90.13 09012 DI ABETES CENTER 0 0 90.14 90 14 90. 15 09013 WOUND CENTER 1, 110 1, 110 1, 110 90. 15 1, 110 0 90.16 09014 MI CA 5, 270 5, 270 5, 270 5, 270 0 90.16 90. 17 09015 BAYONNE MENTAL HEALTH CENTER 90.17 90.18 09018 CLI NI C 0 90. 18 0 0 91.00 09100 EMERGENCY 25, 086 25,086 25, 086 25,086 30, 489 91.00 91.01 09101 PSYCH EMERGENCY 5, 324 5, 324 5, 324 5, 324 0 91.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 09399 PARTIAL HOSPITALIZATION PROGRAM 0 93. 99 93.99 0 0 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 0 95.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 935, 920 531, 323 527, 947 510, 762 377, 321 118. 00 118.00 NONREI MBURSABLE COST CENTERS 0 192. 00 192, 00 19200 PHYSICIANS PRIVATE OFFICES 3,890 3, 890 3, 890 3, 890 193. 00 19300 NONPALD WORKERS 0 193. 00 194.00 07950 NON REIMBURSABLE 0 194.00 23, 623 23, 623 23, 623 23, 623 194. 01 07951 RETAIL PHARMACY 0 194. 01 1.360 1.360 1, 360 1.360 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 4, 010, 950 26, 570, 475 1, 910, 288 9, 592, 263 6, 478, 476 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 4. 157317 47. 430676 3 430710 17. 775465 17. 169667 203. 00 204.00 Cost to be allocated (per Wkst. B, 177, 086 5, 188, 173 80, 778 413, 783 356, 098 204. 00 Part II) Unit cost multiplier (Wkst. B, Part 0.145070 0. 943753 205. 00 205.00 0. 183548 9. 261353 0.766783 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems TRINITAS HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 31-0027 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 10:12 am Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** PERSONNEL (MEALS SERVED) ADMI NI STRATI ON SERVICES & (COSTED (NUMBER **SUPPLY** REQUIS.) (DIRECT NRSING HOUSED) (COSTED HRS) REQUIS.) 15.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 204, 504 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 6, 999 910, 729 13.00 01400 CENTRAL SERVICES & SUPPLY 3 196 26, 132, 327 14 00 1, 635 14 00 15.00 01500 PHARMACY 4,843 C 262, 567 16, 046, 167 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 4, 197 C 16.00 0 01700 SOCIAL SERVICE 10, 295 17 00 1,477 17 00 0 0 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 02000 NURSING PROGRAM 3, 925 292 21, 650 20.00 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 0 21.00 0 C 02200 & SERVICES-OTHER PRGM COSTS APPRV C O 22 00 8.141 886 0 22 00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 C 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 24.644 0 225, 942 791, 561 0 30.00 03100 INTENSIVE CARE UNIT 71, 302 31.00 6, 446 0 387, 249 0 31 00 04000 SUBPROVIDER - IPF 40.00 16, 483 0 88, 887 156, 830 0 40.00 04100 SUBPROVIDER - IRF 41.00 0 0 41.00 04200 SUBPROVI DER 66, 259 42.00 4.129 0 21.304 0 42.00 04300 NURSERY 17, 940 0 43.00 1.206 62, 386 0 43.00 44.00 04400 SKILLED NURSING FACILITY 694 0 2,027 138 0 44.00 04500 NURSING FACILITY 45 00 9 479 35, 752 205 051 11, 706 45.00 04600 OTHER LONG TERM CARE 46.00 4,867 0 1, 874 0 46.00 2,862 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 370, 092 50.00 8,638 73, 530 0 05100 RECOVERY ROOM 51.00 1,593 0 19, 976 15, 783 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 237, 186 52.00 49, 980 52.00 4, 564 0 0 53.00 05300 ANESTHESI OLOGY 0 280, 585 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 5.053 0 4.529 339, 093 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 105, 568 55.00 5.542 15, 885 55.00 05600 RADI OI SOTOPE 0 131, 975 56.00 56.00 379  $\cap$ Λ 57.00 05700 CT SCAN 985 0 C 57, 729 0 57.00 58.00 05800 MRI 423 16, 359 58.00 05900 CARDIAC CATHETERIZATION 0 443, 624 59.00 1,349 8.092 0 59.00 60.00 06000 LABORATORY 363 C 3,620 9, 167 Ω 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 62.30 06500 RESPIRATORY THERAPY 3.972 268, 513 65.00 C  $\cap$ 0 65.00 66.00 06600 PHYSI CAL THERAPY 2,093 1,950 22, 976 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 230 118 0 67.00 C 06800 SPEECH PATHOLOGY 68.00 889 68.00 266 69.00 06900 ELECTROCARDI OLOGY 1, 679 0 3, 458 26, 942 Λ 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 C 9,060,466 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 6, 949, 662 72.00 C 0 14, 617, 585 73 00 07300 DRUGS CHARGED TO PATIENTS Ω 73 00 0 07400 RENAL DIALYSIS 74.00 9,090 0 69, 432 853, 490 1, 416, 876 74.00 07697 CARDIAC REHABILITATION 76. 97 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.98 0 76 99 07699 LITHOTRI PSY 0 Ω 0 0 76.99 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 3.404 11, 164 16, 130 0 90.01 09016 CLINIC-NOT USED 0 0 90.01 09001 PSYCH CLINIC 90.02 26, 902 23, 764 18.387 90.02 90.03 09002 PSYCH CLINIC FEE BASED 0 90.03 0 0 C 0 90.04 09003 WORKFIRST 0 0 0 0 0 90.04

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90.07

0 90.06

0

0 90.08

0 90.09

90.05

90.06

90 07

90.08

90.09

09004 CANCER CLINIC

09006 WOMENS CLINIC

09005 PEDIATRIC CLINIC

09007 THERAPEUTIC SCHOOL

09008 AFTER SCHOOL PROGRAM

Peri od: Worksheet B-1
From 01/01/2023
To 12/31/2023 Provider CCN: 31-0027

				To	12/31/2023	Date/Time Pre 5/30/2024 10:	
Cost Center Description	CAFETERI A	MAI NTENANCE	0F	NURSI NG	CENTRAL	PHARMACY	
	(MEALS SERVED)	PERSONNEL	-	ADMI NI STRATI ON	SERVICES &	(COSTED	
	()	(NUMBER			SUPPLY	REQUIS.)	
		HOUSED)	10	(DIRECT NRSING	(COSTED	,	
		,	l`	HRS)	REQUIS.)		
	11.00	12.00		13. 00	14. 00	15. 00	
90. 10   09017 CLI NI C-NOT USED	0		0	0	0	0	90. 10
90. 11 09009 PERINATAL ADDICTION	o		0	0	0	0	90. 11
90. 12 09010 THERAPEUTIC NURSERY	o		0	0	0	0	90. 12
90. 13 09011 CHILD DAY TREATMENT	0		o	0	0	0	90. 13
90. 14 09012 DI ABETES CENTER	0		0	0	o	0	90. 14
90. 15 09013 WOUND CENTER	716		0	4, 979	135, 986	0	90. 15
90. 16 09014 MI CA	0		0	0	0	0	90. 16
90. 17 09015 BAYONNE MENTAL HEALTH CENTER	1, 840		0	2, 714	713	0	90. 17
90. 18 09018 CLI NI C	107		o	, 0	0	0	1
91. 00 09100 EMERGENCY	14, 429		o	100, 985	750, 939	0	91.00
91. 01   09101   PSYCH EMERGENCY	4, 928		o	14, 080	28, 557	0	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	.,			.,	,		92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	o		o	0	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS	-			- 1	- 1		
95. 00 09500 AMBULANCE SERVI CES	0		0	0	0	0	95. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0		0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS	·						1
113. 00 11300   NTEREST EXPENSE							113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	204, 504		0	910, 729	26, 131, 734	16, 046, 167	118. 00
NONREI MBURSABLE COST CENTERS							
192.00 19200 PHYSICIANS PRIVATE OFFICES	0		0	0	593	0	192. 00
193.00 19300 NONPALD WORKERS	0		0	0	0	0	193. 00
194. 00 07950 NON REIMBURSABLE	0		0	0	0	0	194. 00
194.01 07951 RETAIL PHARMACY	0		0	0	0	0	194. 01
200.00 Cross Foot Adjustments			İ				200. 00
201.00 Negative Cost Centers			İ				201. 00
202.00 Cost to be allocated (per Wkst. B,	3, 824, 099		0	8, 896, 406	5, 609, 414	6, 303, 466	202. 00
Part I)							
203.00 Unit cost multiplier (Wkst. B, Part I)	18. 699385	0. 0000	000	9. 768445	0. 214654	0. 392833	1
204.00 Cost to be allocated (per Wkst. B,	274, 661		0	72, 275	163, 481	144, 962	204. 00
Part II)							
205.00 Unit cost multiplier (Wkst. B, Part	1. 343059	0. 0000	000	0. 079360	0. 006256	0. 009034	205. 00
206.00 NAHE adjustment amount to be allocated							206. 00
(per Wkst. B-2)							207.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)							207. 00
rai ts iii anu iv)	1		- 1		l		I

Health Financial Systems TRINITAS HOSPITAL In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0027 Period:
From 01/01/2023 To 12/31/2023 Date/Time Prepared:
5/30/2024 10: 12 am

					7 12/31/2023	5/30/2024 10: INTERNS &	12 am
	Cost Center Description	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	NURSI NG PROGRAM (ASSI GNED TI ME)	RESI DENTS SERVI CES-SALAR Y & FRI NGES APPRV (ASSI GNED	
			17.00	,		TIME)	
	GENERAL SERVICE COST CENTERS	16.00	17. 00	19. 00	20. 00	21. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	OO200   CAP REL COSTS-MVBLE EQUIP   OO400   EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG						9.00
11. 00	01000  DI ETARY  01100  CAFETERI A						10. 00 11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 14. 00	01300   NURSI NG ADMI NI STRATI ON   01400   CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY						15. 00
16. 00 17. 00	01600   MEDICAL RECORDS & LIBRARY   01700   SOCIAL SERVICE	100	100				16. 00 17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	Ö	0				19. 00
20. 00 21. 00	02000 NURSI NG PROGRAM	0	0		0	100	20.00
21.00	O2100   I &R SERVICES-SALARY & FRINGES APPRV   O2200   I &R SERVICES-OTHER PRGM COSTS APPRV					100	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0				23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	54	100	ol	O	72	30. 00
31. 00	03100 INTENSIVE CARE UNIT	8		0	0	0	31. 00
40. 00 41. 00	04000   SUBPROVI DER -   PF   04100   SUBPROVI DER -   RF	1	0	0	0	22	40. 00 41. 00
42. 00	04200 SUBPROVI DER	0	Ö	Ö	0	0	42. 00
43.00	04300 NURSERY	0	0	0	0	0	43.00
44. 00 45. 00	04400  SKILLED NURSING FACILITY   04500  NURSING FACILITY			0	0	0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM	0	0	O	0	0	50. 00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51. 00
52. 00 53. 00	05200   DELI VERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY	0	0	0	0	0	52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	Ö	Ö	ő	Ö	0	54. 00
55. 00 56. 00	05500   RADI OLOGY-THERAPEUTI C   05600   RADI OI SOTOPE	0	0	0	0	0	55. 00 56. 00
57. 00	05700 CT SCAN	Ö	Ö	ő	0	0	57. 00
58.00	05800 MRI	0	0	0	0	0	58.00
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY			0	0	0	59. 00 60. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62. 00
62. 30 65. 00	06250   BLOOD CLOTTING FOR HEMOPHILIACS   06500   RESPIRATORY THERAPY	0	0	0	0	0	62. 30 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	Ö	0	0	66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	Ö	Ö	ő	Ö	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS			0	0	0	72. 00 73. 00
74.00	07400 RENAL DI ALYSI S	13	0	0	0	0	74. 00
76. 97 76. 98	O7697   CARDI AC REHABI LI TATI ON   O7698   HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 97 76. 98
76. 99	07699 LI THOTRI PSY	0	O	Ö	O	0	76. 99
77. 00 78. 00	07700   ALLOGENEIC HSCT ACQUISITION   07800   CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	77. 00 78. 00
70.00	OUTPATIENT SERVICE COST CENTERS			0		0	70.00
	09000 CLINIC	8	0		0	6	90.00
90. 01 90. 02	09016   CLI NI C-NOT USED   09001   PSYCH CLI NI C	0	0	0	0	0	90. 01 90. 02
90. 03	09002 PSYCH CLINIC FEE BASED	0	0	0	o	0	90. 03
90. 04 90. 05	09003   WORKFIRST   09004   CANCER CLINIC	0	0	0	O  0	0	90. 04 90. 05
90. 06	09005 PEDIATRIC CLINIC	0	0	Ō	0	0	90. 06
90. 07	09006 WOMENS CLINIC	0	0	0	0	0	90. 07

			1	0 12/31/2023	5/30/2024 10:	
					INTERNS &	12 (1111
					RESI DENTS	
Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSICIAN	NURSI NG	SERVI CES-SALAR	
	RECORDS &		ANESTHETI STS	PROGRAM	Y & FRINGES	
	LI BRARY	(TIME SPENT)	(ASSI GNED	(ASSI GNED	APPRV	
	(TIME SPENT)	(	TIME)	TIME)	(ASSI GNED	
			,	,	TIME)	
	16.00	17. 00	19. 00	20.00	21. 00	
90. 08   09007   THERAPEUTI C   SCHOOL	0	0	0	0	0	90. 08
90.09   09008 AFTER SCHOOL PROGRAM	0	0	0	0	0	90. 09
90. 10   09017   CLI NI C-NOT USED	0	0	0	0	0	90. 10
90. 11 09009 PERINATAL ADDICTION	0	0	0	0	0	90. 11
90. 12 09010 THERAPEUTI C NURSERY	0	0	0	0	0	90. 12
90. 13 09011 CHILD DAY TREATMENT	0	0	0	0	0	90. 13
90. 14 09012 DI ABETES CENTER	0	0	l o	0	o	90. 14
90. 15 09013 WOUND CENTER	0	0	l o	0	o	90. 15
90. 16 09014 MI CA	0	0	0	0	0	90. 16
90. 17 09015 BAYONNE MENTAL HEALTH CENTER	0	0	0	0	0	90. 17
90. 18   09018   CLI NI C	0	0	0	0	0	90. 18
91. 00 09100 EMERGENCY	11	0	0	0	0	91. 00
91. 01 09101 PSYCH EMERGENCY	5	0	0	0	0	91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		Ĭ	Ĭ	J	Ŭ	92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS				<u> </u>	U	70. 77
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	l e				102. 00
SPECIAL PURPOSE COST CENTERS	_		-		_	
113. 00 11300 I NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	100	100	0	0		118. 00
NONREI MBURSABLE COST CENTERS						
192. 00 19200 PHYSI CLANS PRI VATE OFFI CES	0	0	0	0	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	l o	0	0	193. 00
194.00 07950 NON REIMBURSABLE	0	0	l o	0	0	194. 00
194. 01 07951 RETAIL PHARMACY	0	0	0	0	0	194. 01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	5, 534, 810	3, 276, 743	0	-873, 703		
Part I)	0,001,010	0,2,0,710		0,0,700	7,0.7,207	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	55, 348. 100000	32, 767, 430000	0. 000000	0.000000	70, 192. 670000	203. 00
204.00 Cost to be allocated (per Wkst. B,	158, 412					
Part II)	1007112	12,010		22.17.70	1007 110	20 00
205.00 Unit cost multiplier (Wkst. B, Part	1, 584. 120000	423, 460000	0. 000000	0. 000000	1, 581. 450000	205 00
	,			1.223000	,	
206.00 NAHE adjustment amount to be allocated				0		206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,				0. 000000		207. 00
Parts III and IV)						
	•	•	•	•	. '	•

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 TRINITAS HOSPITAL

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 10:12 am Provider CCN: 31-0027

				5/30/202	4 10: 12 am
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS APPRV (ASSI GNED TI ME)	PARAMED ED PRGM (ASSIGNED TIME)		
	OFFICE ASSESSMENT OF ASSESSMEN	22.00	23. 00		
	GENERAL SERVICE COST CENTERS	1			4 00
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL				5. 00
6.00	00600 MAINTENANCE & REPAIRS				6. 00
7.00	00700 OPERATION OF PLANT				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00	00900 HOUSEKEEPI NG				9. 00
10.00	01000 DI ETARY				10.00
11. 00	01100 CAFETERI A				11.00
12. 00	01200 MAINTENANCE OF PERSONNEL				12. 00
	01300 NURSI NG ADMI NI STRATI ON				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY				14. 00
	01500 PHARMACY				15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY				16. 00
	01700 SOCIAL SERVICE				17. 00
	01900 NONPHYSI CI AN ANESTHETI STS				19. 00
	02000 NURSI NG PROGRAM				20.00
	02100 I &R SERVICES-SALARY & FRINGES APPRV				21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	100			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	100	0		23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS		0	/	25.00
30. 00	03000 ADULTS & PEDIATRICS	72	0		30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	0		31.00
	1 1	22	0	l e e e e e e e e e e e e e e e e e e e	40.00
41. 00	04100 SUBPROVI DER - I RF	0	0		41. 00
42. 00	04200 SUBPROVI DER	0	0		42.00
43. 00	04300 NURSERY	0	0		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	l control of the cont	44. 00
45. 00	04500 NURSING FACILITY	0	0	l control of the cont	45. 00
46. 00	04600 OTHER LONG TERM CARE		0	•	46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	<u> </u>	<u>/ </u>	+0.00
50.00	05000 OPERATI NG ROOM	0	0		50.00
51. 00	05100 RECOVERY ROOM	o	0		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0		52.00
53. 00	05300 ANESTHESI OLOGY		0	l control of the cont	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0	•	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C		0	l control of the cont	55. 00
56. 00	05600 RADI OI SOTOPE		0	l .	56. 00
57. 00	05700 CT SCAN		0	l control of the cont	57. 00
58. 00	05800 MRI		0	l control of the cont	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0		59.00
60. 00	06000 LABORATORY	o	0		60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	o	0	l control of the cont	62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0	•	62. 30
65. 00	06500 RESPI RATORY THERAPY	o	0		65. 00
66. 00	06600 PHYSI CAL THERAPY		0		66.00
67. 00	06700 OCCUPATI ONAL THERAPY		n		67. 00
68. 00	06800 SPEECH PATHOLOGY		0		68. 00
	06900 ELECTROCARDI OLOGY		O		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0		71.00
	1 1	0	0	1	72. 00
	07300 DRUGS CHARGED TO PATIENTS	l o	0		73. 00
	07400 RENAL DI ALYSI S		0	•	74. 00
76. 97	07697 CARDI AC REHABI LI TATI ON		0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY		0		76. 98
	07699 LI THOTRI PSY		n		76. 99
	07700 ALLOGENEIC HSCT ACQUISITION	l o	0		77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	l control of the cont	78. 00
	OUTPATIENT SERVICE COST CENTERS	<u>,                                     </u>		•	
90.00		6	0		90. 00
90. 01	09016 CLINIC-NOT USED	O	0	•	90. 01
	09001 PSYCH CLINIC		o		90. 02
90. 03	09002 PSYCH CLINIC FEE BASED		o		90. 03
90. 04	09003 WORKFIRST		0		90. 04
90. 05	09004 CANCER CLINIC	o	0		90. 05
90.06	09005 PEDIATRIC CLINIC	0	0		90.06
90. 07	09006 WOMENS CLINIC	o	O		90. 07
		<u>'</u>			<u> </u>

				To	12/31/2023	Date/Time 5/30/2024	
		INTERNS &				10,00,202.	10. 12 4
		RESI DENTS					
	Cost Center Description	SERVI CES-OTHER	PARAMED ED				
		PRGM COSTS	PRGM				
		APPRV	(ASSI GNED				
		(ASSI GNED	TIME)				
		TI ME) 22. 00	23. 00				
90. 08 0900	7 THERAPEUTI C SCHOOL	22.00	23.00				90, 08
	8 AFTER SCHOOL PROGRAM	0	0				90. 09
	7 CLINIC-NOT USED	0	0				90. 10
	9 PERINATAL ADDICTION	0	0				90. 11
	O THERAPEUTI C NURSERY	0	0				90. 12
	1 CHILD DAY TREATMENT		0				90. 13
	2 DI ABETES CENTER		0				90. 14
	3 WOUND CENTER	o	0				90. 15
	4 MI CA	O	0				90. 16
90. 17 0901	5 BAYONNE MENTAL HEALTH CENTER	0	o				90. 17
90. 18   0901	8 CLI NI C	o	0				90. 18
91. 00 0910	O EMERGENCY	0	0				91.00
91. 01   0910	1 PSYCH EMERGENCY	0	0				91. 01
92. 00 0920	O OBSERVATION BEDS (NON-DISTINCT PART						92. 00
93. 99 0939	9 PARTIAL HOSPITALIZATION PROGRAM	0	0				93. 99
	R REIMBURSABLE COST CENTERS						
	O AMBULANCE SERVICES	0	0				95. 00
	O OPIOID TREATMENT PROGRAM	0	0				102. 00
	I AL PURPOSE COST CENTERS	1					
	O INTEREST EXPENSE		_				113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	100	0				118. 00
	EIMBURSABLE COST CENTERS						100.00
	O PHYSICIANS PRIVATE OFFICES	0	0				192. 00
	O NONPALD WORKERS	0	ŭ,				193. 00
	O NON REIMBURSABLE 1 RETAIL PHARMACY	0	0				194. 00 194. 01
200. 00	Cross Foot Adjustments	٩	U				200. 00
200.00	Negative Cost Centers	1					200.00
201.00	Cost to be allocated (per Wkst. B,	4 022 555	0				201.00
202.00	Part 1)	4, 023, 555	U				202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	40, 235. 550000	0. 000000				203. 00
204.00	Cost to be allocated (per Wkst. B,	264, 451	0. 000000				204. 00
201.00	Part II)	201, 401					201.00
205.00	Unit cost multiplier (Wkst. B, Part	2, 644. 510000	0. 000000				205. 00
		,	2. 222000				
206. 00	NAHE adjustment amount to be allocated	1	O				206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,		0. 000000				207. 00
	Parts III and IV)	1					
							•

	n Financial Systems TATION OF RATIO OF COSTS TO CHARGES	TRI NI TAS	HOSPITAL Provider C		In Lie Period: From 01/01/2023	u of Form CMS-2 Worksheet C Part I	2552-10
					o 12/31/2023	Date/Time Pre	
			Ti tl e	e XVIII	Hospi tal	5/30/2024 10: PPS	12 am_
		T		T 1 1 0 1	Costs	T 1 1 0 1	
	Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		Part I, col. 26)					
		1.00	2.00	3.00	4. 00	5. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	47 420 021		1/ /20 021		47 420 021	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	46, 438, 821 12, 896, 623	l .	46, 438, 821 12, 896, 623		46, 438, 821 12, 896, 623	
40. 00	04000 SUBPROVI DER - I PF	23, 978, 576	l .	23, 978, 576	0	23, 978, 576	40. 00
41. 00 42. 00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	6, 422, 803		6, 422, 803	1	0 6, 422, 803	
43. 00	1	2, 898, 280		2, 898, 280		2, 898, 280	
44. 00	04400 SKILLED NURSING FACILITY	1, 194, 749		1, 194, 749	o	1, 194, 749	44. 00
45. 00 46. 00		16, 804, 461 5, 107, 112		16, 804, 461 5, 107, 112		16, 804, 461 5, 107, 112	
40.00	ANCILLARY SERVICE COST CENTERS	5, 107, 112		5, 107, 112	<u>-                                    </u>	5, 107, 112	40.00
50.00	05000 OPERATING ROOM	19, 550, 965	l .	19, 550, 965		19, 559, 704	
51. 00 52. 00	05100 RECOVERY ROOM   05200 DELIVERY ROOM & LABOR ROOM	2, 631, 778 7, 240, 580	l .	2, 631, 778 7, 240, 580		2, 631, 778 7, 240, 580	
53. 00	05300 ANESTHESI OLOGY	822, 400	l .	822, 400		822, 400	
54. 00		8, 659, 035		8, 659, 035		8, 675, 722	
55. 00 56. 00	05500  RADI OLOGY-THERAPEUTI C   05600  RADI OI SOTOPE	11, 888, 658 1, 014, 973		11, 888, 658 1, 014, 973		11, 888, 658 1, 014, 973	
57. 00	05700 CT SCAN	1, 881, 373		1, 881, 373		1, 881, 373	
58. 00		790, 538		790, 538		790, 538	1
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	3, 131, 625 13, 549, 837	l .	3, 131, 625 13, 549, 837		3, 131, 625 13, 563, 678	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	71, 676		71, 676		71, 676	1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		( 007 106	1	0	
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	6, 307, 182 3, 407, 879	l .			6, 307, 182 3, 407, 879	
67. 00	06700 OCCUPATIONAL THERAPY	296, 498	_			296, 498	
68. 00	06800 SPEECH PATHOLOGY	279, 709	l .	279, 709		279, 709	
69. 00 71. 00	1	1, 920, 341 14, 002, 458	l .	1, 920, 341 14, 002, 458		1, 920, 341 14, 002, 458	
72. 00		10, 739, 723	l .	10, 739, 723		10, 739, 723	
73.00		25, 193, 964		25, 193, 964		25, 193, 964	
74. 00 76. 97	07400 RENAL DIALYSIS 07697 CARDIAC REHABILITATION	18, 191, 690		18, 191, 690	75, 279	18, 266, 969 0	74. 00 76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0			0	0	76. 98
76. 99 77. 00	· · · · · · · · · · · · · · · · · · ·	0				0	
78.00	1 1					0	
	OUTPATIENT SERVICE COST CENTERS						
	09000	4, 273, 593		4, 273, 593		4, 273, 593 0	
90. 02		28, 437, 475		28, 437, 475	1	28, 631, 501	90. 02
90. 03		0			0	0	90. 03
90. 04 90. 05		0				0	
90. 06	1 I	1, 172, 344		1, 172, 344	i o	1, 172, 344	1
90. 07	1	3, 335, 819		3, 335, 819		3, 335, 819	
90. 08 90. 09	l l	239, 405	ľ	239, 405		239, 405 0	1
90. 10	09017 CLINIC-NOT USED	0			0	0	90. 10
90. 11	09009 PERINATAL ADDICTION 09010 THERAPEUTIC NURSERY	0				0	90. 11 90. 12
90. 12						0	90. 12
	09012 DI ABETES CENTER	0		(	0	0	90. 14
90. 15	09013   WOUND CENTER	1, 103, 510 470, 505	l .	1, 103, 510 470, 505		1, 103, 510 470, 505	1
90. 10		1, 589, 505	l .	1, 589, 505		1, 589, 505	
90. 18		348, 612		348, 612	2 0	348, 612	90. 18
91. 00 91. 01	09100 EMERGENCY 09101 PSYCH EMERGENCY	22, 225, 137 5, 847, 402		22, 225, 137 5, 847, 402		22, 225, 137 5, 847, 402	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 548, 384	l .	5, 548, 384		5, 548, 384	
	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0				0	1
95 NN	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	0			ol ol	0	95. 00
	0 10200 OPIOID TREATMENT PROGRAM	Ö	l .				102. 00
112 0	SPECIAL PURPOSE COST CENTERS						112 00
200.00	0 11300 INTEREST EXPENSE   Subtotal (see instructions)	341, 905, 998	C	341, 905, 998	308, 572	342, 214, 570	113. 00 200. 00
201.00	Less Observation Beds	5, 548, 384		5, 548, 384		5, 548, 384	201. 00
202.00	0   Total (see instructions)	336, 357, 614	-  C	336, 357, 614	308, 572	336, 666, 186	1202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 | 10: 12 am Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 31-0027

							5/30/2024 10:	12 am
					XVIII	Hospi tal	PPS	
		Cost Center Description	Inpatient	Charges Outpatient	Total (col. 4	Cost or Other	TEFRA	
		cost center bescription	пранен	outpatrent	+ col . 7)	Ratio	Inpatient	
					1 (01. 7)	Ratio	Ratio	
			6.00	7. 00	8. 00	9. 00	10.00	
	I NPAT	IENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000	ADULTS & PEDIATRICS	186, 974, 568		186, 974, 568			30. 00
31. 00		INTENSIVE CARE UNIT	73, 857, 962		73, 857, 962			31. 00
40. 00		SUBPROVIDER - IPF	100, 767, 772		100, 767, 772			40. 00
41.00		SUBPROVIDER - IRF	0		0			41. 00
42.00		SUBPROVI DER	11, 098, 076		11, 098, 076			42.00
43. 00 44. 00		NURSERY SKILLED NURSING FACILITY	23, 694, 120 1, 122, 409		23, 694, 120 1, 122, 409			43. 00 44. 00
45. 00		NURSING FACILITY	7, 135, 927		7, 135, 927			45. 00
46. 00		OTHER LONG TERM CARE	4, 285, 995		4, 285, 995			46. 00
		LARY SERVICE COST CENTERS	., ====,		., .,			1
50.00	05000	OPERATING ROOM	23, 833, 277	85, 087, 425	108, 920, 702	0. 179497	0. 000000	50.00
51. 00		RECOVERY ROOM	2, 621, 235	6, 965, 415	9, 586, 650	0. 274525	0. 000000	51.00
52. 00		DELIVERY ROOM & LABOR ROOM	9, 760, 217	1, 342, 336			0. 000000	1
53. 00		ANESTHESI OLOGY	2, 926, 973	3, 853, 391			0.000000	
54.00		RADI OLOGY THE PARELLE C	10, 701, 307	35, 497, 953			0.000000	
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	584, 577 2, 792, 004	14, 353, 277 16, 320, 452			0. 000000 0. 000000	
57. 00		CT SCAN	22, 935, 668	48, 617, 334			0. 000000	
58. 00	05800		5, 953, 817	6, 698, 182			0. 000000	
59. 00		CARDI AC CATHETERI ZATI ON	9, 269, 226	8, 237, 528			0. 000000	1
60.00		LABORATORY	47, 377, 798	73, 680, 633			0. 000000	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7, 612, 466	6, 853, 363	14, 465, 829	0. 004955	0. 000000	62. 00
62. 30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	C	0.000000	0. 000000	62. 30
65. 00		RESPI RATORY THERAPY	9, 975, 983	7, 501, 336			0. 000000	
66. 00		PHYSI CAL THERAPY	3, 048, 077	5, 522, 991			0. 000000	
67. 00		OCCUPATIONAL THERAPY	1, 345, 949	840, 463			0.000000	1
68. 00	06800	SPEECH PATHOLOGY	1, 136, 933	111, 941			0.000000	
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	25, 270, 743 10, 223, 625	17, 236, 535 18, 415, 418			0. 000000 0. 000000	1
71.00		IMPL. DEV. CHARGED TO PATIENTS	5, 958, 023	9, 749, 541			0. 000000	1
73. 00		DRUGS CHARGED TO PATIENTS	42, 513, 329	103, 489, 218			0. 000000	1
74. 00		RENAL DIALYSIS	2, 123, 118	56, 597, 545			0. 000000	
76. 97		CARDI AC REHABI LI TATI ON	0	0			0. 000000	1
76. 98	07698	HYPERBARI C OXYGEN THERAPY	o	0	C	0. 000000	0. 000000	76. 98
76. 99		LI THOTRI PSY	0	0	C		0. 000000	
77. 00		ALLOGENEIC HSCT ACQUISITION	0	0			0. 000000	
78. 00		CAR T-CELL IMMUNOTHERAPY	0	0	C	0.000000	0. 000000	78. 00
90. 00		TIENT SERVICE COST CENTERS	O	027 122	027 122	E 10E041	0.000000	90.00
90.00	1	CLINIC-NOT USED	0	837, 132 0	1		0. 000000 0. 000000	
90. 01		PSYCH CLINIC		26, 356, 648			0. 000000	
90. 03		PSYCH CLINIC FEE BASED	l ől	20, 000, 010		0. 000000	0. 000000	
90. 04		WORKFIRST	o	0	C		0.000000	
90.05	09004	CANCER CLINIC	o	0	C	0. 000000	0. 000000	90. 05
90. 06	1	PEDIATRIC CLINIC	0	746, 405			0. 000000	1
90. 07		WOMENS CLINIC	0	18, 558, 723			0. 000000	1
90. 08		THERAPEUTI C SCHOOL	0	916, 100			0.000000	
90. 09 90. 10		AFTER SCHOOL PROGRAM	0	0		0. 000000 0. 000000	0.000000	
90. 10		CLINIC-NOT USED PERINATAL ADDICTION	0	0		0.00000	0. 000000 0. 000000	1
90. 11		THERAPEUTIC NURSERY		0		0.00000	0. 000000	
90. 13		CHILD DAY TREATMENT	٥	0		0. 000000	0. 000000	1
90. 14		DI ABETES CENTER	l ol	0		0. 000000	0. 000000	
90. 15	1	WOUND CENTER	o	7, 629, 736	7, 629, 736		0.000000	1
90. 16	09014	MI CA	o	0	C	0. 000000	0. 000000	90. 16
90. 17	09015	BAYONNE MENTAL HEALTH CENTER	0	2, 369, 779	2, 369, 779	0. 670740	0. 000000	
90. 18		CLINIC	0	0	C	0. 000000	0. 000000	
91.00	1	EMERGENCY	26, 345, 025	133, 282, 234			0.000000	
91. 01		PSYCH EMERGENCY	309, 197	947, 146			0.000000	1
92. 00 93. 99		OBSERVATION BEDS (NON-DISTINCT PART PARTIAL HOSPITALIZATION PROGRAM	501, 450 0	29, 235, 394 0			0. 000000 0. 000000	1
73.77		REIMBURSABLE COST CENTERS	<u> </u>	0	1	J. 000000	0.000000	73.77
95. 00		AMBULANCE SERVICES	0	0	С	0.000000	0. 000000	95. 00
		OPIOID TREATMENT PROGRAM	0	0				102. 00
		AL PURPOSE COST CENTERS						
		INTEREST EXPENSE						113. 00
200.00	1	Subtotal (see instructions)	684, 056, 846	747, 851, 574	1, 431, 908, 420			200.00
201. 00 202. 00		Less Observation Beds	684 054 944	7/7 051 574	1, 431, 908, 420			201. 00 202. 00
202. UL	<b>'</b>	Total (see instructions)	684, 056, 846	141, 831, 3/4	1,431,908,420	ן י	I	12U2. UU

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 | 10: 12 am Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES TRINITAS HOSPITAL Provider CCN: 31-0027

		Title XVIII	Hospi tal	5/30/2024 10: 12 PPS	am_
Cost Center Description	PPS Inpatient				
	Ratio				
INDATIENT DOUTINE CEDVICE COST CENTEDS	11.00				
30.00 O3000 ADULTS & PEDIATRICS				2	30. 00
31. 00   03100   NTENSI VE CARE UNI T				l	31. 00
40. 00   04000   SUBPROVI DER -   PF					40. 00
41. 00   04100   SUBPROVI DER -   I RF					41. 00
42. 00   04200   SUBPROVI DER				4	42. 00
43. 00   04300   NURSERY				4	43. 00
44.00 04400 SKILLED NURSING FACILITY					44. 00
45. 00   04500   NURSI NG FACILITY				l	45. 00
46. 00 O4600 OTHER LONG TERM CARE				4	46. 00
ANCILLARY SERVICE COST CENTERS  50.00 OFERATING ROOM	0. 179577				EO 00
51. 00   05100   RECOVERY   ROOM	0. 179577				50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 652155				52. 00
53. 00   05300   ANESTHESI OLOGY	0. 121291			I	53. 00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0. 187789			<b>I</b>	54. 00
55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 795875			5	55. 00
56. 00   05600   RADI OI SOTOPE	0. 053105			5	56. 00
57.00  05700   CT   SCAN	0. 026293			5	57. 00
58. 00   05800   MRI	0. 062483			•	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 178881			•	59. 00
60. 00   06000   LABORATORY	0. 112042			· ·	60.00
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	0. 004955			1	62.00
62. 30   06250 BLOOD CLOTTING FOR HEMOPHILIACS 65. 00   06500 RESPIRATORY THERAPY	0.000000				62. 30
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	0. 360878 0. 397603			· ·	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 347603			l	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 133007			l	57. 00 58. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 045177				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 488929				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 683729				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 172558			7	73. 00
74. 00   07400   RENAL DIALYSIS	0. 311082			7	74. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			7	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			·	76. 98
76. 99   07699   LI THOTRI PSY	0. 000000			I	76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			/	78. 00
OUTPATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC	5. 105041			0	90. 00
90. 01 09016 CLI NI C-NOT USED	0. 000000			<b>I</b>	90. 01
90. 02   09001   PSYCH CLINIC	1. 086310				90. 02
90. 03 09002 PSYCH CLINIC FEE BASED	0. 000000			•	90. 03
90. 04   09003   WORKFI RST	0. 000000				90. 04
90. 05   09004 CANCER CLINIC	0. 000000			9	90. 05
90. 06   09005   PEDIATRIC CLINIC	1. 570654			9	90. 06
90. 07   09006   WOMENS CLINIC	0. 179744			•	90. 07
90. 08 09007 THERAPEUTIC SCHOOL	0. 261331				90. 08
90. 09 09008 AFTER SCHOOL PROGRAM	0. 000000			· ·	90. 09
90. 10   09017   CLI NI C-NOT USED	0. 000000				90. 10
90. 11   09009   PERI NATAL   ADDI CTI ON	0.000000				90. 11
90. 12   09010   THERAPEUTI C NURSERY 90. 13   09011   CHI LD DAY TREATMENT	0. 000000 0. 000000			l	90. 12
90. 13   09011   CHI LD DAY TREATMENT 90. 14   09012   DI ABETES CENTER	0. 000000				90. 13 90. 14
90. 15   09013   WOUND CENTER	0. 144633				90. 1 <del>4</del> 90. 15
90. 16   09014 MI CA	0. 000000				90. 16
90. 17 09015 BAYONNE MENTAL HEALTH CENTER	0. 670740			I	90. 17
90. 18   09018   CLI NI C	0. 000000				90. 18
91. 00 09100 EMERGENCY	0. 139231				91. 00
91. 01 09101 PSYCH EMERGENCY	4. 654304				91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 186583			9	92. 00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000			9	93. 99
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 000000			I	95.00
102. 00 10200 OPI OI D TREATMENT PROGRAM				10	02. 00
SPECIAL PURPOSE COST CENTERS				4.4	12 00
113.00 11300 INTEREST EXPENSE 200.00  Subtotal (see instructions)					13. 00 00. 00
201.00 Less Observation Beds					30.00
202.00 Total (see instructions)					02.00
, , , , , , , , , , , , , , , , , , ,				120	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 | 10: 12 am Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 31-0027

-			Title XIX		Hospi tal	5/30/2024 10: TEFRA	12 am_
			11 (1	CAIA	Costs	TEHRA	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26) 1.00	2.00	3.00	4. 00	5. 00	
I NPAT	TIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
	ADULTS & PEDIATRICS	46, 438, 821		46, 438, 821	0	46, 438, 821	30. 00
	INTENSIVE CARE UNIT	12, 896, 623	l .	12, 896, 623		12, 896, 623	31. 00
	SUBPROVIDER - I PF	23, 978, 576		23, 978, 576	0	23, 978, 576	
	SUBPROVI DER - I RF SUBPROVI DER	6, 422, 803		6, 422, 803	0	0 6, 422, 803	41. 00 42. 00
	NURSERY	2, 898, 280		2, 898, 280	0	2, 898, 280	43.00
	SKILLED NURSING FACILITY	1, 194, 749		1, 194, 749	0	1, 194, 749	44. 00
	NURSING FACILITY	16, 804, 461	l .	16, 804, 461		16, 804, 461	45. 00
	OTHER LONG TERM CARE	5, 107, 112		5, 107, 112	0	5, 107, 112	46. 00
	LARY SERVICE COST CENTERS	10.550.075	T	10.550.045	0 700	40.550.704	
	OPERATING ROOM RECOVERY ROOM	19, 550, 965 2, 631, 778		19, 550, 965 2, 631, 778		19, 559, 704 2, 631, 778	50. 00 51. 00
	DELIVERY ROOM & LABOR ROOM	7, 240, 580		7, 240, 580		7, 240, 580	52.00
	ANESTHESI OLOGY	822, 400		822, 400		822, 400	53.00
	RADI OLOGY-DI AGNOSTI C	8, 659, 035		8, 659, 035		8, 675, 722	54.00
55. 00 05500	RADI OLOGY-THERAPEUTI C	11, 888, 658		11, 888, 658	0	11, 888, 658	55. 00
	RADI OI SOTOPE	1, 014, 973		1, 014, 973		1, 014, 973	56. 00
	CT SCAN	1, 881, 373		1, 881, 373		1, 881, 373	57. 00
58. 00   05800	1	790, 538		790, 538		790, 538	58. 00
	CARDI AC CATHETERI ZATI ON	3, 131, 625		3, 131, 625		3, 131, 625	
	LABORATORY WHOLE BLOOD & PACKED RED BLOOD CELL	13, 549, 837 71, 676		13, 549, 837 71, 676		13, 563, 678 71, 676	60. 00 62. 00
	BLOOD CLOTTING FOR HEMOPHILIACS	71,070		71,070	0	71,070	62. 30
	RESPIRATORY THERAPY	6, 307, 182	О	6, 307, 182	0	6, 307, 182	65. 00
	PHYSI CAL THERAPY	3, 407, 879		3, 407, 879		3, 407, 879	66.00
	OCCUPATIONAL THERAPY	296, 498		296, 498		296, 498	67.00
	SPEECH PATHOLOGY	279, 709	0	279, 709	0	279, 709	68. 00
	ELECTROCARDI OLOGY	1, 920, 341		1, 920, 341		1, 920, 341	69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENT	14, 002, 458		14, 002, 458		14, 002, 458	71. 00
	IMPL. DEV. CHARGED TO PATIENTS	10, 739, 723		10, 739, 723		10, 739, 723	72.00
	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	25, 193, 964	l .	25, 193, 964 18, 191, 690		25, 193, 964	73. 00 74. 00
	CARDI AC REHABILITATION	18, 191, 690		10, 191, 090	75, 279	18, 266, 969 0	76. 97
	HYPERBARI C OXYGEN THERAPY			0	0	Ö	76. 98
	LI THOTRI PSY	0		Ö	0	Ö	76. 99
77. 00 07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78. 00
	ATIENT SERVICE COST CENTERS	4 272 502	I	4 272 502	0	4 272 502	00.00
	CLINIC CLINIC-NOT USED	4, 273, 593		4, 273, 593	0	4, 273, 593 0	90. 00 90. 01
	PSYCH CLINIC	28, 437, 475		28, 437, 475	194, 026		
	PSYCH CLINIC FEE BASED	20, 437, 473		20, 437, 479	0 174,020	20, 031, 301	90. 03
90. 04 09003	WORKFI RST	0		Ö	0	0	90. 04
90. 05 09004	CANCER CLINIC	0		0	0	0	90. 05
	PEDIATRIC CLINIC	1, 172, 344		1, 172, 344	0	1, 172, 344	90. 06
	WOMENS CLINIC	3, 335, 819		3, 335, 819		3, 335, 819	90. 07
	THERAPEUTI C SCHOOL	239, 405		239, 405	0	239, 405	90. 08
	AFTER SCHOOL PROGRAM	0		0	0	0	90.09
	CLINIC-NOT USED PERINATAL ADDICTION	0		0	0	0	90. 10 90. 11
	THERAPEUTIC NURSERY			0	0	0	90. 11
	CHILD DAY TREATMENT			0	0	ő	90. 13
	DI ABETES CENTER	0		Ö	0	0	90. 14
90. 15 09013	WOUND CENTER	1, 103, 510		1, 103, 510	0	1, 103, 510	90. 15
	MI CA	470, 505		470, 505	0	470, 505	90. 16
	BAYONNE MENTAL HEALTH CENTER	1, 589, 505	l .	1, 589, 505		1, 589, 505	90. 17
	B CLINIC	348, 612		348, 612		348, 612	90. 18
	EMERGENCY   PSYCH EMERGENCY	22, 225, 137	l .	22, 225, 137 5, 847, 402		22, 225, 137 5, 847, 402	91. 00 91. 01
	OBSERVATION BEDS (NON-DISTINCT PART	5, 847, 402 5, 548, 384		5, 548, 384		5, 847, 402	1
	PARTIAL HOSPITALIZATION PROGRAM	3, 340, 364	l	J, J40, 304	n	0, 546, 364	93. 99
	R REIMBURSABLE COST CENTERS						, , , , ,
	AMBULANCE SERVICES	0		0	0	0	95. 00
	OPIOID TREATMENT PROGRAM	0		0		0	102. 00
	AL PURPOSE COST CENTERS						
	INTEREST EXPENSE	244 005 000	_	244 005 000	200 572	242 244 572	113.00
200. 00 201. 00	Subtotal (see instructions) Less Observation Beds	341, 905, 998 5, 548, 384		341, 905, 998 5, 548, 384		342, 214, 570 5, 548, 384	
201.00	Total (see instructions)	336, 357, 614					
	(222 :::22 22 23 31 31 31 31 31 31 31 31 31 31 31 31 31	1, 55, 7511		1 222,007,011	000,072	1 222, 000, 100	1

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COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 31-0027

				Ti tl	e XIX	Hospi tal	5/30/2024 10: TEFRA	<u>12 am</u>
				Charges		·		
		Cost Center Description	Inpati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient	
					+ COI. /)	Ratio	Ratio	
			6. 00	7. 00	8.00	9. 00	10.00	
20.00		IENT ROUTINE SERVICE COST CENTERS	10/ 07/ 5/0		10/ 07/ 5/0	1		00.00
30. 00 31. 00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	186, 974, 568 73, 857, 962		186, 974, 568 73, 857, 962			30. 00 31. 00
40. 00		SUBPROVI DER - I PF	100, 767, 772		100, 767, 772			40.00
41. 00		SUBPROVI DER - I RF	0		0			41. 00
42. 00		SUBPROVI DER	11, 098, 076		11, 098, 076			42. 00
43.00		NURSERY	23, 694, 120		23, 694, 120			43. 00
44. 00 45. 00		SKILLED NURSING FACILITY NURSING FACILITY	1, 122, 409 7, 135, 927		1, 122, 409 7, 135, 927			44. 00 45. 00
46. 00		OTHER LONG TERM CARE	4, 285, 995		4, 285, 995			46.00
.0.00	ANCI L	LARY SERVICE COST CENTERS	1, 200, 7,0		1,200,770			.0.00
50.00	05000	OPERATING ROOM	23, 833, 277	85, 087, 425			0. 179497	
51.00		RECOVERY ROOM	2, 621, 235	6, 965, 415			0. 274525	
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	9, 760, 217 2, 926, 973	1, 342, 336 3, 853, 391			0. 652155 0. 121291	
54. 00		RADI OLOGY-DI AGNOSTI C	10, 701, 307	35, 497, 953			0. 121291	
55. 00	05500	RADI OLOGY-THERAPEUTI C	584, 577	14, 353, 277			0. 795875	
56. 00		RADI OI SOTOPE	2, 792, 004	16, 320, 452			0. 053105	
57. 00		CT SCAN	22, 935, 668	48, 617, 334			0. 026293	
58. 00 59. 00	05800	CARDI AC CATHETERI ZATI ON	5, 953, 817 9, 269, 226	6, 698, 182 8, 237, 528			0. 062483 0. 178881	58. 00 59. 00
60.00		LABORATORY	47, 377, 798	73, 680, 633			0. 111928	
62.00		WHOLE BLOOD & PACKED RED BLOOD CELL	7, 612, 466	6, 853, 363			0. 004955	62. 00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0. 000000	0. 000000	
65. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	9, 975, 983	7, 501, 336 5, 522, 991			0. 360878 0. 397603	
66. 00 67. 00		OCCUPATIONAL THERAPY	3, 048, 077 1, 345, 949	5, 522, 991 840, 463			0. 397603	1
68. 00	1	SPEECH PATHOLOGY	1, 136, 933	111, 941			0. 223969	1
69. 00		ELECTROCARDI OLOGY	25, 270, 743	17, 236, 535			0. 045177	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	10, 223, 625	18, 415, 418			0. 488929	
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS   DRUGS CHARGED TO PATIENTS	5, 958, 023	9, 749, 541			0. 683729	
74.00		RENAL DIALYSIS	42, 513, 329 2, 123, 118	103, 489, 218 56, 597, 545			0. 172558 0. 309800	
76. 97		CARDI AC REHABI LI TATI ON	2, 123, 110	00, 377, 343		0. 000000	0. 000000	
76. 98		HYPERBARI C OXYGEN THERAPY	o	0	0	0. 000000	0. 000000	76. 98
76. 99	1	LI THOTRI PSY	0	0	· -	0. 000000	0. 000000	
77. 00 78. 00		ALLOGENEIC HSCT ACQUISITION CAR T-CELL IMMUNOTHERAPY	0	0			0. 000000 0. 000000	
76.00		TIENT SERVICE COST CENTERS	<u> </u>	0	<u> </u>	0.000000	0.000000	78. 00
90.00		CLINIC	0	837, 132	837, 132	5. 105041	5. 105041	90.00
90. 01		CLINIC-NOT USED	0	0	0		0. 000000	
90. 02		PSYCH CLINIC	0	26, 356, 648	26, 356, 648		1. 078949	
90. 03 90. 04		PSYCH CLINIC FEE BASED WORKFIRST	0	0		0. 000000 0. 000000	0. 000000 0. 000000	
90. 05		CANCER CLINIC	l ő	0			0. 000000	
		PEDIATRIC CLINIC	0	746, 405	746, 405			
90. 07	1	WOMENS CLINIC	0	18, 558, 723			0. 179744	
90. 08 90. 09		THERAPEUTIC SCHOOL AFTER SCHOOL PROGRAM	0	916, 100	916, 100	0. 261331 0. 000000	0. 261331 0. 000000	90. 08 90. 09
90. 09		CLINIC-NOT USED	0	0		0. 000000	0. 000000	1
90. 11	1	PERINATAL ADDICTION	O	0	Ö	0. 000000	0. 000000	
90. 12	09010	THERAPEUTIC NURSERY	0	0	0	0. 000000	0. 000000	90. 12
90. 13		CHILD DAY TREATMENT	0	0	0	0. 000000	0. 000000	
90. 14 90. 15		DIABETES CENTER WOUND CENTER	0	7 420 724	7, 629, 736	0. 000000 0. 144633	0. 000000 0. 144633	1
90. 15	09013		0	7, 629, 736 0	7,029,730	0. 000000	0. 000000	
90. 17	1	BAYONNE MENTAL HEALTH CENTER	O	2, 369, 779	2, 369, 779		0. 670740	
90. 18		CLINIC	0	0	0	0. 000000	0. 000000	1
91.00	1	EMERGENCY EMERGENCY	26, 345, 025	133, 282, 234			0. 139231	91.00
91. 01 92. 00	1	PSYCH EMERGENCY   OBSERVATION BEDS (NON-DISTINCT PART	309, 197 501, 450	947, 146 29, 235, 394			4. 654304 0. 186583	
93. 99		PARTIAL HOSPITALIZATION PROGRAM	0	29, 233, 394			0. 000000	
	OTHER	REIMBURSABLE COST CENTERS	·					]
95. 00		AMBULANCE SERVI CES	0	0			0. 000000	
102.00		OPIOID TREATMENT PROGRAM	0	0	0			102. 00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE						113. 00
200.00		Subtotal (see instructions)	684, 056, 846	747, 851, 574	1, 431, 908, 420			200.00
201.00	)	Less Observation Beds						201. 00
202.00	)	Total (see instructions)	684, 056, 846	747, 851, 574	1, 431, 908, 420			202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES TRINITAS HOSPITAL Provider CCN: 31-0027

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 | 10: 12 am

			Title XIX	Hospi tal	5/30/2024 10: 12 TEFRA	<u>am</u>
	Cost Center Description	PPS Inpatient	ITTIE XIX	Hospi tal	IEFRA	
	oost conten beschiptron	Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDI ATRI CS					30. 00
31. 00	03100 I NTENSI VE CARE UNI T					31. 00
40. 00	04000 SUBPROVI DER - I PF					10.00
41. 00	04100 SUBPROVIDER - I RF					11.00
42. 00	04200 SUBPROVI DER					12.00
43. 00	04300 NURSERY					13.00
44. 00	04400 SKILLED NURSING FACILITY					14.00
45. 00	04500 NURSING FACILITY					15.00
46. 00	04600 OTHER LONG TERM CARE				40	16. 00
50. 00	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM	0. 000000			5.0	50. 00
51. 00	05100 RECOVERY ROOM	0. 000000				51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
56. 00	05600 RADI OI SOTOPE	0. 000000				6. 00
57. 00	05700 CT SCAN	0. 000000				57. 00
58. 00	05800 MRI	0. 000000				8. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				9. 00
60.00	06000 LABORATORY	0. 000000				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62	52. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62	52. 30
65.00	06500 RESPIRATORY THERAPY	0. 000000			65	55.00
66.00	06600 PHYSI CAL THERAPY	0. 000000			66	6. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000			67	57. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000			68	8. 00
	06900 ELECTROCARDI OLOGY	0. 000000				9. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	07400 RENAL DIALYSIS	0.000000				74.00
	07697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000				76. 98
76. 99 77. 00	07699 LI THOTRI PSY	0.000000				76. 99
78. 00	07700   ALLOGENEIC HSCT ACQUISITION   07800   CAR T-CELL IMMUNOTHERAPY	0. 000000 0. 000000				77. 00 78. 00
70.00	OUTPATIENT SERVICE COST CENTERS	0. 000000				0.00
90. 00	09000 CLINIC	0. 000000			90	90.00
	09016 CLINIC-NOT USED	0. 000000				90. 01
	09001 PSYCH CLINIC	0. 000000				90. 02
90. 03	09002 PSYCH CLINIC FEE BASED	0. 000000				90. 03
90.04	09003 WORKFI RST	0. 000000			90	90. 04
90.05	09004 CANCER CLINIC	0. 000000			90	90. 05
90.06	09005 PEDIATRIC CLINIC	0. 000000			90	90.06
90. 07	09006 WOMENS CLINIC	0. 000000			90	90. 07
90. 08	09007 THERAPEUTIC SCHOOL	0. 000000			90	90.08
	09008 AFTER SCHOOL PROGRAM	0. 000000				90. 09
	09017 CLINI C-NOT USED	0. 000000				90. 10
90. 11	09009 PERI NATAL ADDI CTI ON	0. 000000				90. 11
	09010 THERAPEUTI C NURSERY	0. 000000				90. 12
90. 13	09011 CHILD DAY TREATMENT	0.000000				90. 13
	09012 DI ABETES CENTER	0.000000				90. 14
	09013 WOUND CENTER	0.000000				90. 15
	09014 MICA	0.000000				90. 16
	09015 BAYONNE MENTAL HEALTH CENTER   09018 CLINIC	0.000000				90. 17 90. 18
	09100 EMERGENCY	0. 000000 0. 000000				91. 00
	09101 PSYCH EMERGENCY	0. 000000				91. 00
91.01	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
	09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000				93. 99
, 5. 77	OTHER REIMBURSABLE COST CENTERS	0.00000			73	5. 77
95. 00	09500 AMBULANCE SERVICES	0. 000000			9.5	95. 00
	10200 OPI OI D TREATMENT PROGRAM	3. 330000				2. 00
50	SPECIAL PURPOSE COST CENTERS				1.02	
113.00	11300   INTEREST EXPENSE				113	13. 00
200.00						00.00
201.00	Less Observation Beds					01.00
202.00	Total (see instructions)				202	2. 00

Heal th Financial Systems TRINITA
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 31-0027

KEDOOT	10110 1				То	12/31/2023	Date/Time Prep 5/30/2024 10:	pared:
				Ti tl	e XIX	Hospi tal	TEFRA	12 4111
		Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
				(Wkst. B, Part	Net of Capital	Reduction	Reduction	
			I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
			1.00	2. 00	col . 2) 3.00	4. 00	5. 00	
	ANCI L	LARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50.00		OPERATI NG ROOM	19, 550, 965	951, 668	18, 599, 297	95, 167	1, 078, 759	50. 00
51. 00		RECOVERY ROOM	2, 631, 778	79, 081		7, 908	148, 056	51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	7, 240, 580	231, 966		23, 197	406, 500	52. 00
53.00		ANESTHESI OLOGY	822, 400	17, 170	1	1, 717	46, 703	53. 00
54.00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	8, 659, 035	384, 197		38, 420	479, 941	54.00
55. 00 56. 00	1	RADI OLOGI - THERAPEUTI C	11, 888, 658 1, 014, 973	861, 944 14, 585		86, 194 1, 459	639, 549 58, 023	55. 00 56. 00
57. 00		CT SCAN	1, 881, 373	34, 209		3, 421	107, 136	57. 00
58. 00	05800		790, 538	32, 010		3, 201	43, 995	58. 00
59.00	05900	CARDI AC CATHETERI ZATI ON	3, 131, 625	140, 335	2, 991, 290	14, 034	173, 495	59. 00
60.00	1	LABORATORY	13, 549, 837	296, 160		29, 616	768, 713	60.00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELL	71, 676	16, 501		1, 650	3, 200	62. 00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY	( 207 102	104.041		10 404	0	62. 30 65. 00
65. 00 66. 00		PHYSI CAL THERAPY	6, 307, 182 3, 407, 879	104, 061 197, 258		10, 406 19, 726	359, 781 186, 216	66. 00
67. 00		OCCUPATIONAL THERAPY	296, 498	1, 549		155	17, 107	67. 00
68. 00	1	SPEECH PATHOLOGY	279, 709	3, 778		378	16, 004	68. 00
69. 00	06900	ELECTROCARDI OLOGY	1, 920, 341	66, 343	1, 853, 998	6, 634	107, 532	69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	14, 002, 458	105, 562		10, 556	806, 020	71. 00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	10, 739, 723	80, 970		8, 097	618, 208	72. 00
73. 00 74. 00	1	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	25, 193, 964 18, 191, 690	210, 918 476, 295		21, 092 47, 630	1, 449, 017 1, 027, 493	73. 00 74. 00
76. 97		CARDIAC REHABILITATION	18, 191, 090	470, 293	17, 713, 373	47, 030 0	1,027,493	76. 97
76. 98	1	HYPERBARI C OXYGEN THERAPY	l o	0	Ö	0	Ö	76. 98
76. 99		LI THOTRI PSY	0	0	O	0	0	76. 99
77. 00	1	ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77. 00
78. 00		CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
90. 00		TIENT SERVICE COST CENTERS CLINIC	4, 273, 593	314, 429	3, 959, 164	31, 443	229, 632	90. 00
90. 01	1	CLINIC-NOT USED	0	0	3, 737, 104	0	0	90. 01
90. 02		PSYCH CLINIC	28, 437, 475	947, 954	27, 489, 521	94, 795	1, 594, 392	90. 02
90. 03		PSYCH CLINIC FEE BASED	0	0	0	0	0	90. 03
90. 04	1	WORKFI RST	0	0	0	0	0	90. 04
90. 05 90. 06		CANCER CLINIC PEDIATRIC CLINIC	1, 172, 344	6, 711	1, 165, 633	0 671	0 67, 607	90. 05 90. 06
90. 00		WOMENS CLINIC	3, 335, 819	19, 442		1, 944	192, 350	90.00
90. 08		THERAPEUTIC SCHOOL	239, 405	1, 955		196	13, 772	90. 08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90. 09
90. 10		CLINIC-NOT USED	0	0	0	0	0	90. 10
90. 11		PERI NATAL ADDI CTI ON	0	0	0	0	0	90. 11
90. 12 90. 13	1	THERAPEUTIC NURSERY CHILD DAY TREATMENT	0	0		0	0	90. 12 90. 13
90. 13		DI ABETES CENTER	0	0		0	0	90. 13
		WOUND CENTER	1, 103, 510	31, 384	1, 072, 126	3, 138	62, 183	
90. 16	09014		470, 505	120, 220		12, 022	20, 317	90. 16
90. 17		BAYONNE MENTAL HEALTH CENTER	1, 589, 505	9, 221		922	91, 656	90. 17
90. 18		CLINIC	348, 612	1, 621	1	162	20, 125	90. 18
91.00	1	EMERGENCY	22, 225, 137	724, 400		72, 440	1, 247, 043	
91. 01 92. 00		PSYCH EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	5, 847, 402 5, 548, 384	158, 259 289, 875	1	15, 826 28, 988	329, 970 304, 994	91. 01 92. 00
93. 99		PARTIAL HOSPITALIZATION PROGRAM	0, 540, 504	207, 073		20, 700	0	
		REIMBURSABLE COST CENTERS						
	1	AMBULANCE SERVICES	0	0		0	-	95. 00
102.00		OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
112 00	+	AL PURPOSE COST CENTERS						113. 00
200.00		INTEREST EXPENSE Subtotal (sum of lines 50 thru 199)	226, 164, 573	6, 932, 031	219, 232, 542	693, 205		
201.00	1	Less Observation Beds	5, 548, 384	289, 875		28, 988		
202.00	1	Total (line 200 minus line 201)	220, 616, 189	6, 642, 156		664, 217		

REDUCTIONS FOR MEDICALD ONLY

Peri od: Worksheet C From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared: 5/30/2024 10:12 am

					5/30/2024 10:	12 am
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Cost Net of	Total Charges	Outpati ent	·		
	Capital and		Cost to Charge			
	Operating Cost					
	Reducti on	8)	/ col . 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	18, 377, 039	108, 920, 702	0. 168719			50. 00
51. 00   05100   RECOVERY ROOM	2, 475, 814	9, 586, 650	0. 258256			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 810, 883					52. 00
53. 00   05300   ANESTHESI OLOGY	773, 980		1			53.00
						•
54. 00   05400   RADI OLOGY-DI AGNOSTI C	8, 140, 674		1			54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	11, 162, 915					55. 00
56. 00   05600   RADI 01 SOTOPE	955, 491	19, 112, 456	0. 049993			56. 00
57.00 05700 CT SCAN	1, 770, 816	71, 553, 002	0. 024748			57.00
58. 00   05800   MRI	743, 342		1			58. 00
	1		1			1
	2, 944, 096	1	1			59. 00
60. 00   06000   LABORATORY	12, 751, 508					60.00
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	66, 826	14, 465, 829	0. 004620			62. 00
62.30  06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	5, 936, 995	17, 477, 319	0. 339697			65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 201, 937					66. 00
						1
	279, 236					67. 00
68. 00 06800 SPEECH PATHOLOGY	263, 327					68. 00
69. 00  06900 ELECTROCARDI OLOGY	1, 806, 175	42, 507, 278	0. 042491			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	13, 185, 882	28, 639, 043	0. 460416			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 113, 418					72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	23, 723, 855					73. 00
	1					•
74. 00   07400   RENAL DI ALYSI S	17, 116, 567	58, 720, 663				74. 00
76. 97   07697   CARDIAC REHABILITATION	0	0	0.000000			76. 97
76. 98   07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 000000			76. 98
76. 99   07699 LI THOTRI PSY	0	0	0.000000			76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 000000			77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0					78. 00
OUTPATIENT SERVICE COST CENTERS			0.00000			1 /0.00
90. 00 09000 CLINIC	4, 012, 518	837, 132	4. 793172			90.00
90. 01 09016 CLINIC-NOT USED	4,012,310	037, 132	0.000000			90. 01
l l	0 740 000	0, 05, ,,0				
90. 02   09001   PSYCH CLINIC	26, 748, 288	26, 356, 648				90. 02
90. 03  09002 PSYCH CLINIC FEE BASED	0	0	0.000000			90. 03
90. 04   09003   WORKFI RST	0	0	0. 000000			90. 04
90. 05   09004 CANCER CLINIC	0	0	0.000000			90. 05
90. 06 09005 PEDIATRIC CLINIC	1, 104, 066	746, 405	1. 479178			90.06
90. 07   09006   WOMENS CLINIC	3, 141, 525		1			90. 07
	1					1
	225, 437	916, 100				90. 08
90.09 09008 AFTER SCHOOL PROGRAM	0	1	0.000000			90. 09
90. 10  09017  CLINI C-NOT USED	0	0	0. 000000			90. 10
90. 11  09009 PERINATAL ADDICTION	0	0	0.000000			90. 11
90. 12 09010 THERAPEUTIC NURSERY	0	0	0. 000000			90. 12
90. 13 09011 CHILD DAY TREATMENT	0		0. 000000			90. 13
						1
	1 000 400	7 (00 70)	0.000000			90. 14
90. 15   09013   WOUND CENTER	1, 038, 189	7, 629, 736				90. 15
90. 16   09014   MI CA	438, 166	0	0.000000			90. 16
90. 17   09015 BAYONNE MENTAL HEALTH CENTER	1, 496, 927	2, 369, 779	0. 631674			90. 17
90. 18 09018 CLI NI C	328, 325		0. 000000			90. 18
91. 00 09100 EMERGENCY	20, 905, 654		1			91.00
	5, 501, 606					91.00
						•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 214, 402	1				92. 00
93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0	0.000000			93. 99
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	0	0. 000000			95. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0		•			102.00
SPECIAL PURPOSE COST CENTERS						1
113. 00 11300   NTEREST EXPENSE		1				113. 00
	212 755 070	1 022 071 501				1
200.00 Subtotal (sum of lines 50 thru 199)		1, 022, 971, 591	J			200. 00
201.00 Less Observation Beds	5, 214, 402		ή			201. 00
202.00   Total (line 200 minus line 201)	207, 541, 477	1, 022, 971, 591	I			202. 00

Health Financial Systems	TRI NI TAS I	LAT IOSOL		ln Lie	eu of Form CMS-	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I	pared:
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)	Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	·		•	<del>'</del>	•	
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199)  Cost Center Description	2, 426, 189 448, 967 940, 046 0 331, 434 175, 267 176, 932 880, 472 5, 379, 307 Inpatient Program days	0 0 0	448, 96 940, 04	7 5,602 6 19,391 0 0 4 6,808 7 3,332 2 4,311 2 27,408	80. 14 48. 48 0. 00 48. 68 52. 60 41. 04 32. 12	31. 00 40. 00 41. 00 42. 00 43. 00 44. 00
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 42.00 SUBPROVIDER 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199)	7, 028 1, 409 2, 238 0 0 0 2, 325 0 13, 000	112, 917 108, 498 0 0 0 95, 418				30. 00 31. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 200. 00

Health Financial Systems	TRI NI TAS I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der CO	CN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet D	pared.
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)		, in the second of the second	
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		2.00	0.00		0.00	
50. 00 05000 OPERATI NG ROOM	951, 668	108, 920, 702	0. 00873	7 11, 218, 355	98, 015	50.00
51. 00   05100   RECOVERY ROOM	79, 081				9, 822	
						1
	231, 966				655	1
53. 00   05300   ANESTHESI OLOGY	17, 170				1, 520	1
54. 00   05400   RADI OLOGY-DI AGNOSTI C	384, 197				42, 286	1
55. 00   05500   RADI OLOGY-THERAPEUTI C	861, 944				5, 643	
56. 00   05600   RADI 0I SOTOPE	14, 585				664	
57.00  05700   CT   SCAN	34, 209	71, 553, 002	0. 00047	8 10, 760, 600	5, 144	57. 00
58. 00   05800   MRI	32, 010	12, 651, 999	0. 00253	0 2, 608, 982	6, 601	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	140, 335	17, 506, 754	0. 00801	6 3, 516, 803	28, 191	59. 00
60. 00 06000 LABORATORY	296, 160				49, 593	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	16, 501	14, 465, 829			1, 259	1
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0. 00000		0	62. 30
						1
65. 00 06500 RESPI RATORY THERAPY	104, 061	17, 477, 319			33, 288	1
66. 00   06600   PHYSI CAL THERAPY	197, 258				29, 941	1
67. 00 06700 OCCUPATI ONAL THERAPY	1, 549				108	
68. 00   06800   SPEECH PATHOLOGY	3, 778	1, 248, 874	0. 00302		1, 640	68. 00
69. 00   06900   ELECTROCARDI OLOGY	66, 343	42, 507, 278	0. 00156	13, 585, 698	21, 207	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	105, 562	28, 639, 043	0. 00368	4, 373, 413	16, 120	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	80, 970	15, 707, 564	0. 00515	5 2, 533, 006	13, 058	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	210, 918		0. 00144		24, 629	
74. 00 07400 RENAL DIALYSIS	476, 295				11, 297	
76. 97 07697 CARDI AC REHABI LI TATI ON	0		0.00000		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0. 00000		0	76. 98
76. 99 07699 LI THOTRI PSY			0. 00000		0	76. 99
+ I	0					1
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0		0.00000		0	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	T	1	<b>-</b>			
90. 00   09000   CLI NI C	314, 429	837, 132			0	
90. 01  09016  CLINI C-NOT USED	0	0	0. 00000	0 0	0	90. 01
90. 02   09001   PSYCH CLINIC	947, 954	26, 356, 648	0. 03596	6 0	0	90. 02
90. 03 09002 PSYCH CLINIC FEE BASED	0	0	0. 00000	0	0	90. 03
90. 04   09003   WORKFI RST	0	0	0. 00000	0	0	90. 04
90. 05   09004 CANCER CLINIC	0	0	0. 00000		0	90. 05
90. 06   09005   PEDI ATRI C   CLI NI C	6, 711	746, 405			0	90.06
90. 07 09006 WOMENS CLINIC	19, 442				0	90. 07
90. 08   09007   THERAPEUTI C SCHOOL	1, 955	916, 100			0	90.08
					0	
90. 09 09008 AFTER SCHOOL PROGRAM	0		0.00000			90.09
90. 10   09017   CLI NI C-NOT USED	0				0	90. 10
90. 11 O9009 PERINATAL ADDICTION	0	0	0.0000		0	
90. 12   09010   THERAPEUTI C NURSERY	0	0	0.00000	0 0	0	90. 12
90. 13 O9011 CHILD DAY TREATMENT	0	0	0.00000	0	0	90. 13
90. 14   09012 DI ABETES CENTER	0	0	0. 00000	0	0	90. 14
90. 15 09013 WOUND CENTER	31, 384	7, 629, 736	0. 00411	3 0	0	90. 15
90. 16   09014 MI CA	120, 220		0.00000		0	90. 16
90. 17 09015 BAYONNE MENTAL HEALTH CENTER	9, 221	l .			0	90. 17
90. 18   09018   CLI NI C	1, 621		0.00000		0	90. 17
91. 00   09100   EMERGENCY	724, 400				42, 568	
91. 01   09101   PSYCH EMERGENCY	158, 259				0	91. 01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	289, 875		0. 00974		0	92. 00
93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0	0. 00000	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	6, 932, 031	1, 022, 971, 591		113, 255, 341	443, 249	200. 00

APPORTIONMENT OF INPATTENT ROUTINE SERVICE OTHER PA	SS THROUGH COST		<u> </u>	From 01/01/2023 To 12/31/2023	Part III Date/Time Pre 5/30/2024 10:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	(	0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31. 00
40. 00   04000   SUBPROVI DER - 1 PF	0	0		0	0	40.00
41. 00   04100   SUBPROVI DER -   RF	0	0		0	0	41. 00
42. 00   04200   SUBPROVI DER	0	0		0	0	42. 00
43. 00   04300   NURSERY		0			0	43. 00
	0	0	)		U	
	0	0				44. 00
45. 00 04500 NURSING FACILITY	0	0		0		45. 00
200.00 Total (lines 30 through 199)	0	0	(	0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4.00	5.00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	38, 702	0.00	7, 028	30. 00
31.00 03100 INTENSIVE CARE UNIT	1	0	5, 602	0.00	1, 409	31. 00
40. 00   04000   SUBPROVI DER - I PF	o	0	19, 39			40.00
41. 00   04100   SUBPROVI DER -   I RF	0	0				41.00
42. 00   04200   SUBPROVI DER	0	0	6, 808		0	42. 00
43. 00   04300   NURSERY	Ĭ	0	3, 332			43. 00
44. 00 04400 SKILLED NURSING FACILITY	1	0	4, 31			44. 00
	1	0				
	1	0	,			45. 00
200.00 Total (lines 30 through 199)		0	105, 55	1	13, 000	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30. 00
31.00   03100   INTENSIVE CARE UNIT	0					31. 00
40. 00   04000   SUBPROVI DER - I PF	0					40.00
41. 00   04100   SUBPROVI DER -   RF	0					41. 00
42. 00   04200   SUBPROVI DER	o					42.00
43. 00   04300   NURSERY	0					43. 00
44.00 04400 SKILLED NURSING FACILITY	0					44. 00
45. 00   04500   NURSI NG   FACILITY						45. 00
200.00 Total (lines 30 through 199)						200. 00
200.00   Total (Titles 30 till ough 199)	١					1200.00

In Lieu of Form CMS-2552-10

Period: Worksheet D
From 01/01/2023 Part IV
To 12/31/2023 Date/Time Prepared: 5/30/2024 10: 12 am Provider CCN: 31-0027 THROUGH COSTS

				10 12/31/2023	5/30/2024 10:	
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
· ·	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	)	0 0	0	50.00
51.00   05100   RECOVERY ROOM	0	0	)	0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	)	0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	1	0 0	0	53.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	1	0 0	0	55. 00
56. 00   05600   RADI 0I SOTOPE	0	0	1	0 0	0	56. 00
57. 00   05700   CT   SCAN	0	0	1	0 0	0	57. 00
58. 00   05800   MRI	0	0	1	0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	1	0 0	0	59. 00
60. 00   06000   LABORATORY	0	0	1	0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	)	0 0	0	62. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	)	0 0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	0	)	0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	1	0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	)	0 0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	)	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	)	0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	,	0 0	o	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	,	0 0	o	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	Ō	73. 00
74. 00   07400   RENAL DI ALYSI S	0	0	1	0 0	o o	74. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	,	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	1	0 0	o o	76. 98
76. 99   07699   LI THOTRI PSY	0	0		0 0	o o	76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	Ö	1	0 0	o o	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0		1	0 0	_	78. 00
OUTPATIENT SERVICE COST CENTERS			1	<u> </u>	<u> </u>	70.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01   09016   CLINI C-NOT USED	0	Ö	1	0 0		90. 01
90. 02   09001   PSYCH CLINIC	0	0	1	0 0	,	90. 02
90. 03 09002 PSYCH CLINIC FEE BASED	0	0	,	0 0	Ō	90. 03
90. 04   09003   WORKFI RST	0	0	1	0 0	Ō	90. 04
90. 05   09004   CANCER   CLINIC	0	0	1	0 0	Ō	90. 05
90. 06   09005   PEDIATRIC CLINIC	0	0	,	0 0	o o	90.06
90. 07   09006   WOMENS CLINIC	0	0	1	0 0	Ō	90. 07
90. 08 09007 THERAPEUTIC SCHOOL	0	0	,	0 0	o o	90. 08
90. 09 09008 AFTER SCHOOL PROGRAM	0	0	1	0 0	o o	90. 09
90. 10   09017 CLI NI C-NOT USED	0	0	,	0 0	o o	90. 10
90. 11 09009 PERINATAL ADDICTION	0	0	1	0 0	Ō	90. 11
90. 12 09010 THERAPEUTI C NURSERY	0	0		0 0	Ō	90. 12
90. 13 09011 CHILD DAY TREATMENT	0	0		0 0	,	90. 13
90. 14   09012   DI ABETES CENTER	0	0		0 0	o o	90. 14
90. 15   09013   WOUND CENTER	0	0	1	0 0	_	1
90. 16 09014 MI CA	0	1		0 0		1
90. 17 09015 BAYONNE MENTAL HEALTH CENTER	0	0	1	0 0		1
90. 18   09018   CLI NI C				0 0	0	90. 17
91. 00   09100   EMERGENCY				0 0	0	91. 00
91. 00   09101   EMERGENCY			1	0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0	0	1
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM		0	1	0 0		1
OTHER REIMBURSABLE COST CENTERS			1	<u> </u>	1 0	73.77
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	0	0		0 0	n	200. 00
255. 55 <sub>1</sub>   15tal (11165 55 thi bugh 177)	1	1	1	J <sub>1</sub>	1	1200.00

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time Prepared: 
 Heal th Financial
 Systems
 TRINITAS HOST

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
 OTHER PASS
 Provider CCN: 31-0027 THROUGH COSTS

11111000	Timodal 30010			-	Го 12/31/2023	Date/Time Pre 5/30/2024 10:	pared: 12 am
			Title	· XVIII	Hospi tal	PPS	12 (
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	'	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS			1			
50. 00	05000 OPERATI NG ROOM	0	0	1	108, 920, 702		1
51. 00	05100 RECOVERY ROOM	0	0		9, 586, 650		1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		11, 102, 553		1
53. 00	05300 ANESTHESI OLOGY	0	0		6, 780, 364	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		46, 199, 260		1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		14, 937, 854		1
56. 00	05600 RADI OI SOTOPE	0	0		19, 112, 456		1
57. 00	05700 CT SCAN	0	0	•	71, 553, 002	0. 000000	1
58. 00	05800 MRI	0	0		12, 651, 999		1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		17, 506, 754	0. 000000	1
60. 00	06000 LABORATORY	0	0		121, 058, 431	0. 000000	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		14, 465, 829		1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	0	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0	1	17, 477, 319		1
66. 00	06600 PHYSI CAL THERAPY	0	0		8, 571, 068		1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		2, 186, 412	0. 000000	
68. 00	06800 SPEECH PATHOLOGY	0	0	1	1, 248, 874	0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	0	0		42, 507, 278		1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	i	28, 639, 043		1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		15, 707, 564	0. 000000	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	i	146, 002, 547	0. 000000	1
74. 00	07400 RENAL DI ALYSI S	0	0	1	58, 720, 663		1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0. 000000	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(	0	0. 000000	1
76. 99	07699 LI THOTRI PSY	0	0	9	0	0. 000000	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0.000000	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(	0 0	0. 000000	78. 00
00 00	OUTPATIENT SERVICE COST CENTERS		0	1 /	027 122	0.000000	00 00
90.00	09000 CLINIC	0	0		837, 132		1
90. 01	09016 CLINI C-NOT USED	0	0		0	0.000000	1
90. 02	09001 PSYCH CLINIC	0	0		26, 356, 648		1
90. 03	09002 PSYCH CLINIC FEE BASED	0	0		0	0.000000	1
90. 04	09003 WORKFIRST	0	0		0	0.000000	1
90. 05	09004 CANCER CLINIC	0	0		0	0. 000000 0. 000000	
90. 06 90. 07	09005 PEDIATRIC CLINIC 09006 WOMENS CLINIC	0	0		746, 405		1
90.07	09007 THERAPEUTI C SCHOOL	0	0	1	18, 558, 723 916, 100		1
90.08	09007 THERAPEUTTC SCHOOL	0	0		916, 100 0 0	0.000000	1
90. 10	09017 CLINIC-NOT USED	0	0	)	) 0	0. 000000	1
90. 10	09009 PERINATAL ADDICTION	0	0	)	) 0	0. 000000	1
90. 11	09010 THERAPEUTI C NURSERY	0	0	)		0.000000	
	09011 CHILD DAY TREATMENT		0	)		0. 000000	
	09011 CHIED DAY TREATMENT		0	)			
	09013 WOUND CENTER		0	i	7, 629, 736		
	09014 MI CA		0	1	0 7, 629, 736	0.000000	
	09015 BAYONNE MENTAL HEALTH CENTER		0	i	2, 369, 779		
	09018 CLINIC		0	i	0 2, 304, 774	0. 000000	
	09100 EMERGENCY		0	•	159, 627, 259		
	09101 PSYCH EMERGENCY		0	1	1, 256, 343		
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0		29, 736, 844		
	09399 PARTIAL HOSPITALIZATION PROGRAM		0	1	0 27, 730, 044		1
, 5. , ,	OTHER REIMBURSABLE COST CENTERS	<u> </u>		'	<u> </u>	0.000000	1 /3. //
95, 00	09500 AMBULANCE SERVI CES						95. 00
200.00		0	0		1, 022, 971, 591		200. 00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	, ,		'	1	1	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: 5/30/2024 10: 12 am 
 Heal th Financial APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 31-0027 THROUGH COSTS

						5/30/2024 10:	12 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000  OPERATI NG ROOM	0. 000000	11, 218, 355	0	7, 858, 550	0	50.00
51.00	05100  RECOVERY ROOM	0. 000000	1, 190, 712	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	31, 330	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	600, 422	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	5, 084, 841	0	2, 230, 711	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	97, 797	0	2, 677, 787	0	55.00
56.00	05600 RADI OI SOTOPE	0. 000000	870, 673	0	936, 398	0	56.00
57.00	05700 CT SCAN	0. 000000	10, 760, 600	0	3, 990, 797	0	57.00
58.00	05800 MRI	0. 000000	2, 608, 982	0	566, 165	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	3, 516, 803	0	1, 840, 299	0	59.00
60.00	06000 LABORATORY	0. 000000	20, 275, 152	0	3, 494, 749	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	1, 103, 312	0	135, 744	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62.30
65.00	06500 RESPI RATORY THERAPY	0. 000000	5, 590, 823	0	321, 826	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 300, 980	0	52, 606	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	153, 139	0	200	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	542, 234	0	450	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	13, 585, 698	0	894, 780	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	4, 373, 413	0	1, 548, 980	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 533, 006	0	1, 310, 233	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	17, 044, 041	0	8, 966, 776	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	1, 392, 763	0	2, 555	0	74.00
76. 97	07697 CARDIAC REHABILITATION	0. 000000	0		0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	0	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0	0	545, 394	0	90.00
90. 01	09016 CLI NI C-NOT USED	0. 000000	0	0	0	0	90. 01
90. 02	09001 PSYCH CLINIC	0. 000000	0		1, 105, 014	0	90. 02
90. 03	09002 PSYCH CLINIC FEE BASED	0. 000000	0		0	0	90. 03
90. 04	09003 WORKFI RST	0. 000000	0		0	0	90. 04
90. 05	09004 CANCER CLINIC	0. 000000	0		0	0	90. 05
90. 06	09005 PEDIATRIC CLINIC	0. 000000	0		0	0	90. 06
90. 07	09006 WOMENS CLINIC	0. 000000	0		262	0	90. 07
90. 08	09007 THERAPEUTI C SCHOOL	0. 000000	0		0	0	90. 08
90. 09	09008 AFTER SCHOOL PROGRAM	0. 000000	0		0	0	90. 09
90. 10	09017 CLINIC-NOT USED	0. 000000	0		0	0	90. 10
90. 11	09009 PERI NATAL ADDI CTI ON	0. 000000	0		0	0	90. 11
90. 12	09010 THERAPEUTI C NURSERY	0. 000000	0		0	0	90. 12
90. 13	09011 CHILD DAY TREATMENT	0. 000000	0		0	0	90. 13
90. 14	09012 DI ABETES CENTER	0.000000	0	1	1 570 007	0	90. 14
90. 15	09013 WOUND CENTER	0. 000000	0	0	1, 579, 996	0	
90. 16	09014 MI CA	0.000000	0		0	0	90. 16
90. 17	09015 BAYONNE MENTAL HEALTH CENTER 09018 CLINIC	0.000000	0	· -	0	0	90. 17
90. 18 91. 00		0.000000	9, 380, 265		7 021 E00	0	90. 18 91. 00
91.00	O9100   EMERGENCY   O9101   PSYCH   EMERGENCY	0. 000000 0. 000000	9, 380, 265		7, 031, 590	0	91. 00 91. 01
91.01	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	91.01
92.00	09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000	0		0	0	92. 00 93. 99
73. 77	OTHER REIMBURSABLE COST CENTERS	0.000000	0	U U	U	U	73.77
95. 00	09500 AMBULANCE SERVICES			T			95. 00
200.00	i i		113, 255, 341	0	47, 091, 862	Ω	200. 00
_55.50	1.5ta. (1.1.55 55 till odgil 177)	1		,	, 571, 502	٥١	_55.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 31-0027 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/30/2024 10:12 am Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1.00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 179497 7, 858, 550 0 1, 410, 586 50.00 51.00 05100 RECOVERY ROOM 0. 274525 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52 00 52 00 0.652155 C 0 0 0 53.00 05300 ANESTHESI OLOGY 0.121291 Ω 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 187428 2, 230, 711 0 418, 098 54.00 2, 677, 787 0 2, 131, 184 05500 RADI OLOGY-THERAPEUTI C 0.795875 0 55 00 55 00 05600 RADI OI SOTOPE 0 56.00 0.053105 936, 398 49, 727 56.00 57.00 05700 CT SCAN 0.026293 3, 990, 797 0 104, 930 57.00 58.00 05800 MRI 0.062483 566, 165 0 0 35, 376 58.00 05900 CARDIAC CATHETERIZATION 0 1, 840, 299 329, 195 59 00 0 178881 59 00 60.00 06000 LABORATORY 0.111928 3, 494, 749 0 391, 160 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.004955 0 62.00 135, 744 673 62.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 62.30 62.30 0 0 65 00 06500 RESPIRATORY THERAPY 0.360878 321.826 116, 140 65 00 66.00 06600 PHYSI CAL THERAPY 0.397603 52, 606 0 0 20, 916 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.135609 200 27 67.00 06800 SPEECH PATHOLOGY 0. 223969 0 68.00 450 0 101 68.00 06900 ELECTROCARDI OLOGY 894, 780 0 40, 423 69 00 0.045177 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 488929 1, 548, 980 757, 341 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.683729 1, 310, 233 146, 771 0 895, 844 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.172558 8, 966, 776 0 1, 547, 289 73.00 07400 RENAL DIALYSIS 0 792 74.00 0.309800 2, 555 74 00 07697 CARDIAC REHABILITATION 0.000000 0 76.97 76.97 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 76. 98 0 07699 LI THOTRI PSY 0 76.99 76.99 0.000000 0 0 07700 ALLOGENEIC HSCT ACQUISITION 77 00 0.000000 C 0 0 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 5. 105041 2, 784, 259 90.00 545, 394 14.806 0 90.01 09016 CLINIC-NOT USED 0.000000 0 90.01 0 90.02 09001 PSYCH CLINIC 1.078949 1, 105, 014 0 0 0 1, 192, 254 90.02 09002 PSYCH CLINIC FEE BASED 90.03 0.000000 0 90.03 0 0 90.04 09003 WORKFIRST 0.000000 C 0 90.04 90.05 09004 CANCER CLINIC 0.000000 0 0 0 0 0 0 0 0 0 0 90.05 09005 PEDIATRIC CLINIC 1.570654 0 90.06 90.06 0 09006 WOMENS CLINIC 0 47 90 07 90 07 0.179744 262 90.08 09007 THERAPEUTIC SCHOOL 0. 261331 C 0 0 90.08 90.09 09008 AFTER SCHOOL PROGRAM 0.000000 0 90.09 09017 CLINIC-NOT USED 0 0 90.10 90.10 0.000000 0 09009 PERINATAL ADDICTION 0 90.11 0.000000 C 0 90.11 90. 12 09010 THERAPEUTIC NURSERY 0.000000 C 0 90.12 90.13 09011 CHILD DAY TREATMENT 0.000000 0 0 0 90.13 90 14 09012 DI ABETES CENTER 0.000000 0 90 14 0 90.15 09013 WOUND CENTER 0.144633 1, 579, 996 0 228, 520 90.15 09014 MI CA 0.000000 0 90.16 90.16 0 0 90.17 09015 BAYONNE MENTAL HEALTH CENTER 0.670740 90.17 0 09018 CLINIC O 90 18 90 18 0.000000 0 0 91.00 09100 EMERGENCY 0.139231 7, 031, 590 0 979, 015 91.00 09101 PSYCH EMERGENCY 0 91.01 91.01 4.654304 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.186583 0 0 0 92.00 09399 PARTIAL HOSPITALIZATION PROGRAM 0.000000 O 93.99 0 93.99 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 Subtotal (see instructions) 13, 433, 897 200.00 47, 091, 862 161, 577 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 0 201. 00

47, 091, 862

161, 577

0

13, 433, 897 202. 00

202.00

Only Charges

Net Charges (line 200 - line 201)

Health Financial Systems TRINITAS HOSPITAL In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 31-0027 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/30/2024 10:12 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 51.00 05100 RECOVERY ROOM 0000000000000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 52 00 05300 ANESTHESI OLOGY 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 05600 RADI OI SOTOPE 0 56.00 56.00 57.00 05700 CT SCAN 0 57.00 05800 MRI 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 0 59 00 59 00 60.00 06000 LABORATORY 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62.00 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 62.30 06500 RESPIRATORY THERAPY 0 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 0 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 100, 352 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 73.00 07400 RENAL DIALYSIS 0 74.00 74 00 76. 97 07697 CARDIAC REHABILITATION 0 76.97 0 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 76. 98 76. 99 07699 LI THOTRI PSY 0 76.99 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 75, 585 90.00 0 90. 01 09016 CLINIC-NOT USED 0 90.01 09001 PSYCH CLINIC 0 0 90. 02 90.02 09002 PSYCH CLINIC FEE BASED 0000000000000000000 90.03 0 90.03 0 90.04 09003 WORKFIRST 90.04 90.05 09004 CANCER CLINIC 0 90.05 90.06 09005 PEDIATRIC CLINIC 0 90.06 90 07 09006 WOMENS CLINIC 0 90 07 90.08 09007 THERAPEUTIC SCHOOL 0 90.08 90.09 09008 AFTER SCHOOL PROGRAM 90.09 90. 10 09017 CLINIC-NOT USED 0 90.10 09009 PERINATAL ADDICTION 0 90.11 90 11 90.12 09010 THERAPEUTIC NURSERY 0 90.12 09011 CHILD DAY TREATMENT 90. 13 0 90.13 90 14 09012 DI ABETES CENTER 0 90 14 90.15 09013 WOUND CENTER 0 90.15 90. 16 09014 MI CA 0 90.16 09015 BAYONNE MENTAL HEALTH CENTER 90. 17 0 90.17 90 18 09018 CLINIC 0 90 18 09100 EMERGENCY 91.00 0 91.00 09101 PSYCH EMERGENCY 91.01 91.01 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 93.99 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 Subtotal (see instructions) 0 200.00 175.937 200.00 Less PBP Clinic Lab. Services-Program 201.00 201. 00

175.937

0

202.00

202.00

Only Charges

Net Charges (line 200 - line 201)

PP0R	ı Financial Systems FIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der C	CN: 31-0027	Peri od:	Worksheet D	
			Component	CCN: 31-S027	From 01/01/2023 To 12/31/2023	Part II Date/Time Pre 5/30/2024 10:	pare
			Ti tl e	: XVIII	Subprovi der - I PF	PPS	
	Cost Center Description		Total Charges		t Inpatient	Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B, Part II, col.	Part I, col. 8)	(col . 1 ÷ col 2)	. Charges	column 4)	
		26)	0)	2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
00	ANCILLARY SERVICE COST CENTERS	054 //0	400 000 700	0.00070	27	0	
. 00	05000 OPERATING ROOM	951, 668				0	
. 00	05100 RECOVERY ROOM   05200 DELIVERY ROOM & LABOR ROOM	79, 081 231, 966				0	
. 00	05300 ANESTHESI OLOGY	17, 170				0	1
. 00	05400 RADI OLOGY-DI AGNOSTI C	384, 197				182	
00	05500 RADI OLOGY-THERAPEUTI C	861, 944				0	
00	05600 RADI OI SOTOPE	14, 585				0	
00	05700 CT SCAN	34, 209				23	
00	05800 MRI	32, 010			3, 000	8	58
00	05900 CARDI AC CATHETERI ZATI ON	140, 335			16 0	0	59
00	06000 LABORATORY	296, 160				1, 074	
00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	16, 501	1			0	
30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0.0000		0	
00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	104, 061				0	
00	06700 OCCUPATI ONAL THERAPY	197, 258 1, 549				442 27	6
00	06800 SPEECH PATHOLOGY	3, 778				0	
00	06900 ELECTROCARDI OLOGY	66, 343				39	
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	105, 562				1	7
00	07200 IMPL. DEV. CHARGED TO PATIENTS	80, 970				0	
00	07300 DRUGS CHARGED TO PATIENTS	210, 918	146, 002, 547	0. 00144	470, 641	680	7:
00	07400 RENAL DIALYSIS	476, 295	58, 720, 663	0. 00811	11 0	0	74
97	07697 CARDI AC REHABI LI TATI ON	0	0			0	
98	07698 HYPERBARI C OXYGEN THERAPY	0	0			0	
99	07699 LI THOTRI PSY	0	0			0	
. 00	07700 ALLOGENEI C HSCT ACQUISITION	0	0			0	
00	07800 CAR T-CELL IMMUNOTHERAPY  OUTPATIENT SERVICE COST CENTERS	0	0	0.00000	00 0	0	78
00	09000 CLINIC	314, 429	837, 132	0. 37560	03	0	90
01	09016 CLINI C-NOT USED	0 0 0	1	1		Ö	
02	09001 PSYCH CLINIC	947, 954	1			0	
03	09002 PSYCH CLINIC FEE BASED	0	0	0. 00000		0	90
04	09003 WORKFI RST	0	0			0	
05	09004 CANCER CLINIC	0	0	0.00000		0	
06	09005 PEDIATRIC CLINIC	6, 711				0	
07	09006 WOMENS CLINIC	19, 442		1		_	
08 09	09007 THERAPEUTIC SCHOOL 09008 AFTER SCHOOL PROGRAM	1, 955	l _	1		0	
10	09017 CLINIC-NOT USED	0	0	0.00000		0	
11	1	0		0. 00000		0	
12	09010 THERAPEUTI C NURSERY	0	0	0. 00000		0	
13		0	0	0.00000		0	
14		0	0	0. 00000		0	90
15	1	31, 384				0	
16	09014 MI CA	120, 220		0. 00000		0	
17	09015 BAYONNE MENTAL HEALTH CENTER	9, 221				0	
18		1, 621		0.00000		0	
. 00	09100 EMERGENCY	724, 400				2, 069	
00	09101 PSYCH EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	158, 259 0				0	
	09399 PARTIAL HOSPITALIZATION PROGRAM		29, 736, 844			0	

6, 642, 156 1, 022, 971, 591

0.000000

1, 522, 197

4, 545 200. 00

93. 99

95.00

09399 PARTIAL HOSPITALIZATION PROGRAM

95. 00 OP500 AMBULANCE SERVICES
200. 00 Total (lines 50 through 199)

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 | 10: 12 am | THROUGH COSTS Component CCN: 31-S027 Title XVIII Subprovi der -PPS

			li tl e	e XVIII	Subprovi der I PF	- PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		th Allied Health	1
	F	Anesthetist	Program	Program	Post-Stepdo		
		Cost	Post-Stepdown		Adj ustment	:s	
		1.00	Adjustments	0.00	0.4	2.00	
	ANCILLARY SERVICE COST CENTERS	1.00	2A	2.00	3A	3. 00	
50. 00	05000 OPERATING ROOM	0		)	0	0	50.00
51. 00	05100 RECOVERY ROOM	0	ĺ	•	0		0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	O		0	0	0 52.00
53.00	05300 ANESTHESI OLOGY	0	C		0	0	0 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0		0 54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0	-	0 55.00
56.00	05600	0	0	1	0		0 56.00 0 57.00
57. 00 58. 00	05800 MRI	0		1	0		0 58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	l o	1	0	۳	0 59.00
60.00	06000 LABORATORY	0	Ö		O		0 60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	o		0	0	0 62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0	0 62. 30
65. 00	06500 RESPI RATORY THERAPY	0	0	1	0		0 65.00
66.00	06600 PHYSI CAL THERAPY	0	0	1	0		0 66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	1	0		0 67.00 0 68.00
69. 00	06900 ELECTROCARDI OLOGY	0		1	0		0 69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	ĺ	1	0	•	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	O		0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0 73.00
74.00	07400 RENAL DIALYSIS	0	0	)	0	-	0 74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	2	0		0 76. 97
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0			0	-	0 76. 98 0 76. 99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0		•	0	-	0 77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	Ö		o		77.00
	OUTPATIENT SERVICE COST CENTERS			•			
90.00	09000 CLI NI C	0	O		0		90.00
90. 01	09016 CLI NI C-NOT USED	0	0		0		0 90. 01
90. 02	09001 PSYCH CLINIC	0	0	1	0	-	0 90.02
90. 03 90. 04	09002 PSYCH CLINIC FEE BASED 09003 WORKFIRST	0	0	1	0		0 90. 03 0 90. 04
90.04	09004 CANCER CLINIC	0		1	0		0 90.05
90.06	09005 PEDI ATRI C CLI NI C	0		1	Ö	•	90.06
90. 07	09006 WOMENS CLINIC	0	O		0	0	0 90.07
90. 08	09007 THERAPEUTIC SCHOOL	0	0		0	0	90. 08
90.09	09008 AFTER SCHOOL PROGRAM	0	0	)	0	-	0 90.09
90. 10	O9017   CLI NI C-NOT USED   O9009   PERI NATAL ADDI CTI ON	0	0		0		0 90. 10 0 90. 11
90. 11 90. 12	09010 THERAPEUTIC NURSERY	0			0	-	0 90.11
90. 12	09011 CHILD DAY TREATMENT	0			0		0 90. 12
90. 14	09012 DI ABETES CENTER	0	Ö		O	-	0 90.14
90. 15	09013 WOUND CENTER	0	0		0	0	0 90. 15
90. 16		0	0	)	0	-	0 90. 16
		0	0	2	0	•	0 90. 17
	09018 CLI NI C 09100 EMERGENCY	0			U	-	0 90. 18 0 91. 00
91.00		0	1		0		0 91.00
				1	Ö	-	0 92.00
		0	O	o l	O	•	0 93. 99
	OTHER REIMBURSABLE COST CENTERS						
95.00		_	_				95. 00
200.00	Total (lines 50 through 199)	0	0	וי	0	0	0 200. 00

Hool +h	Financial Systems	TRI NI TAS I	LICOL TAI		In Lie	of Form CMS	2552 10
	<u>Financial Systems</u> TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CN: 31-0027	Peri od:	u of Form CMS-2552-10 Worksheet D	
	SH COSTS			CCN: 31-S027	From 01/01/2023 To 12/31/2023		pared:
			Title	: XVIII	Subprovider - IPF	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical Education Cost	(sum of cols. 1, 2, 3, and	Outpatient Cost (sum o		to Charges (col. 5 ÷ col.	
			4)	col s. 2, 3,		7)	
				and 4)		(see	
		4.00	5.00	6. 00	7. 00	instructions) 8.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	l e	•	0 108, 920, 702		
51. 00 52. 00	O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM	0	0	1	0 9, 586, 650 0 11, 102, 553		
53. 00	05300 ANESTHESI OLOGY	Ö	Ö		0 6, 780, 364		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 46, 199, 260		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 14, 937, 854		1
56. 00 57. 00	05600	0			0 19, 112, 456 0 71, 553, 002		
58. 00	05800 MRI	Ö	Ö		0 12, 651, 999		1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 17, 506, 754		
60. 00 62. 00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 121, 058, 431 0 14, 465, 829	0.000000	1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 14, 465, 829	0. 000000 0. 000000	
65. 00	06500 RESPIRATORY THERAPY	Ö	Ö		0 17, 477, 319		
66. 00	06600 PHYSI CAL THERAPY	0	0		0 8, 571, 068		
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0 2, 186, 412 0 1, 248, 874		
69.00	06900 ELECTROCARDI OLOGY	0			0 1, 248, 874 0 42, 507, 278		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	Ö	Ö		0 28, 639, 043		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0 15, 707, 564		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 146, 002, 547	0.000000	
74. 00 76. 97	07400 RENAL DI ALYSI S 07697 CARDI AC REHABI LI TATI ON	0			0 58, 720, 663	0. 000000 0. 000000	
	07698 HYPERBARI C OXYGEN THERAPY	0	Ö		0 0	0. 000000	
76. 99	07699 LI THOTRI PSY	0	0		0 0		
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0 0	0		0 0		
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0			0 0	0.000000	78. 00
90.00	09000 CLI NI C	0	0		0 837, 132	0. 000000	90.00
90. 01	09016 CLINIC-NOT USED	0	0		0 0	0. 000000	
90. 02 90. 03	09001 PSYCH CLINIC 09002 PSYCH CLINIC FEE BASED	0	0		0 26, 356, 648	0. 000000 0. 000000	
90. 04	09003 WORKFIRST	0			0 0	0. 000000	
90. 05	09004 CANCER CLINIC	0	0		0 0	0. 000000	
90.06	09005 PEDIATRIC CLINIC	0	0		0 746, 405		
90. 07 90. 08	O9006   WOMENS CLINIC   O9007   THERAPEUTIC SCHOOL	0	1	1	0 18, 558, 723 0 916, 100		
90. 09	09008 AFTER SCHOOL PROGRAM	0	Ö		0 0	0. 000000	
90. 10	09017 CLINIC-NOT USED	0	0		0 0	0. 000000	
	09009 PERI NATAL ADDI CTI ON	0	0		0 0	0.000000	
90. 12 90. 13	09010 THERAPEUTI C NURSERY 09011 CHI LD DAY TREATMENT	0	0			0. 000000 0. 000000	
90. 14	09012 DI ABETES CENTER	0	Ö		0 0	0. 000000	
90. 15	09013 WOUND CENTER	0	0		0 7, 629, 736	0. 000000	90. 15
90. 16	09014 MI CA	0	0		0 0	0.000000	
90. 17 90. 18	09015 BAYONNE MENTAL HEALTH CENTER 09018 CLI NI C	0			0 2, 369, 779	0. 000000 0. 000000	
91. 00	09100 EMERGENCY	0			0 159, 627, 259		
91. 01	09101 PSYCH EMERGENCY	0	0		0 1, 256, 343	0. 000000	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	•	0 29, 736, 844		
93. 99	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM OTHER REI MBURSABLE COST CENTERS	0	0		0 0	0. 000000	93. 99
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0		0 1, 022, 971, 591		200. 00

	Financial Systems	TRINITAS HO		ON 04 0007		n Lie	u of Form CMS-2552-10	
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS	RVICE OTHER PASS	Provider Component (	CCN: 31-0027 CCN: 31-S027	Period: From 01/01, To 12/31,	/2023 /2023	Worksheet D Part IV Date/Time Pre 5/30/2024 10:	pared:
			Title	XVIII	Subprovi de I PF	er -	PPS	12 GIII
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col.	Outpati Progra Charge	ım	Outpatient Program Pass-Through Costs (col. 9	
		7)	10. 00	x col . 10) 11.00	12.00	)	x col . 12) 13.00	
	ANCILLARY SERVICE COST CENTERS				_		_	
50. 00	O5000   OPERATING ROOM   O5100   RECOVERY ROOM	0. 000000 0. 000000	0		0	0	0	50.00 51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0		o	0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	21, 876		0	0	0	54.00
5.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	0	55.00
6. 00	05600 RADI OI SOTOPE	0. 000000	0		0	0	0	56.00
7.00	05700 CT SCAN	0. 000000	48, 367		0	0	0	57.00
58. 00 59. 00	05800   MRI   05900   CARDI AC   CATHETERI ZATI ON	0. 000000 0. 000000	3, 000		0	0	0	58.00
50.00	06000 LABORATORY	0. 000000	439, 159		0	0	0	60.00
52. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	437, 137	ı	0	0	0	62.0
52. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		o	Ö	0	62. 3
5.00	06500 RESPI RATORY THERAPY	0. 000000	0		0	0	0	65. 0
6. 00	06600 PHYSI CAL THERAPY	0. 000000	19, 225		0	0	0	66. 0
57. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	38, 616		0	0	0	67. 0
8. 00	06800 SPEECH PATHOLOGY	0.000000	0		0	0	0	68. 0
59. 00 71. 00	06900   ELECTROCARDI OLOGY   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 000000 0. 000000	25, 169 288		0	0	0	69.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	200		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	470, 641		o	Ö	0	73.00
74. 00	07400 RENAL DIALYSIS	0. 000000	0		0	0	0	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	0	76. 9
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0.000000	0		0	0	0	76. 9
77. 00 78. 00	07700   ALLOGENEIC HSCT ACQUISITION   07800   CAR T-CELL IMMUNOTHERAPY	0. 000000 0. 000000	0		0	0	0	77. 0
0.00	OUTPATIENT SERVICE COST CENTERS	0.00000					0	70.0
90.00	09000 CLI NI C	0. 000000	0		0	0	0	90.0
90. 01	09016 CLI NI C-NOT USED	0. 000000	0		0	0	0	90.0
90. 02	09001 PSYCH CLINIC	0. 000000	0		0	0	0	90. 0
0.03	09002 PSYCH CLINIC FEE BASED	0.000000	0		0	0	0	90.0
90. 04 90. 05	O9003   WORKFI RST   O9004   CANCER CLINIC	0. 000000 0. 000000	0		0	0	0	90.0
90.06	09005 PEDIATRIC CLINIC	0. 000000	0		0	0	0	
0. 07	09006 WOMENS CLINIC	0. 000000	0		o	Ö	0	
90.08	09007 THERAPEUTI C SCHOOL	0. 000000	0		0	0	0	90.08
90. 09	09008 AFTER SCHOOL PROGRAM	0. 000000	0		0	0	0	
90. 10	09017 CLI NI C-NOT USED	0. 000000	0		0	0	0	
90. 11	09009 PERI NATAL ADDI CTI ON	0. 000000	0		U	0	0	90.1
90. 12	09010   THERAPEUTI C NURSERY   09011   CHI LD DAY TREATMENT	0. 000000 0. 000000	0		0	0	0	90. 12
90. 13	09011 CHIED DAY TREATMENT	0. 000000	0		ŏ	0	0	90. 1.
90. 15	09013 WOUND CENTER	0. 000000	0		ō	0	0	90. 15
90. 16	09014 MI CA	0. 000000	0		0	Ó	0	90. 16
90. 17	09015 BAYONNE MENTAL HEALTH CENTER	0. 000000	0		0	0	0	90. 1 <sup>-</sup>
90. 18	09018 CLI NI C	0. 000000	0		0	0	0	90. 18
91.00	09100 EMERGENCY	0. 000000	455, 856		0	0	0	91.0
91. 01	09101 PSYCH EMERGENCY	0. 000000	0		0	0	0	91.0
92.00 93.99	09200 OBSERVATION BEDS (NON-DISTINCT PART 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000 0. 000000	0		0	0	0	
, J. 77	OTHER REIMBURSABLE COST CENTERS	0.000000	0		<u> </u>	J	0	73. 7
95. 00	09500 AMBULANCE SERVICES							95.00
0.00								

THROUGH COSTS Component CCN: 31-5442 Title XVIII Skilled Nursing

			Titl∈	e XVIII		led Nursing	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		acility ied Health	Allied Health	
	oost denter bescription	Anesthetist	Program	Program		st-Stepdown	Airred fiedi tii	
		Cost	Post-Stepdown			djustments		
			Adjustments					
	ANOLLI ADV. CEDVI OF COCT. CENTEDO	1.00	2A	2. 00		3A	3. 00	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		0	<u>,                                      </u>	0	0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	0	•	0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	Ö	•	0	0	Ö	52. 00
53. 00	05300 ANESTHESI OLOGY	0	O		0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0		0	0	0	56. 00
57. 00	05700 CT SCAN	0	0	2	0	0	0	57. 00
58. 00 59. 00	05800   MRI   05900   CARDI AC   CATHETERI ZATI ON	0	0		0	0	0	58. 00 59. 00
60.00	06000 LABORATORY	0	0		0	0	0	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	1	0	0	Ö	62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	O		0	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	O		0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	O		0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	)	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	)	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	1	0	0	0	69.00
71. 00 72. 00	O7100   MEDICAL SUPPLIES CHARGED TO PATIENT   O7200   MPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	0 0	71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	l o	Ö	1	o	0	ő	74.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	O		0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	O		0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0		0	0	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	•	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	)	0	0	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	О		0	0	0	90. 00
90. 01	09016 CLINIC-NOT USED	o o	Ö	•	o	0	Ö	90. 01
90. 02	09001 PSYCH CLINIC	0	O	•	0	0	0	90. 02
90. 03	09002 PSYCH CLINIC FEE BASED	0	0		0	0	0	90. 03
90. 04	09003 WORKFI RST	0	O		0	0	0	90. 04
90. 05	09004 CANCER CLINIC	0	0		0	0	0	90. 05
90.06	09005 PEDIATRIC CLINIC	0	0	2	0	0	0	90.06
90. 07 90. 08	09006   WOMENS CLINIC   09007   THERAPEUTIC SCHOOL	0	0	1	0	0	0	90. 07 90. 08
90.08	09008 AFTER SCHOOL PROGRAM	0	0	1	0	0	0	90.08
90. 10	09017 CLINIC-NOT USED	l o	Ö	1	o	0	Ö	90. 10
90. 11	09009 PERINATAL ADDICTION	0	O		0	0	0	90. 11
90. 12	09010 THERAPEUTIC NURSERY	0	0		0	0	0	90. 12
90. 13	09011 CHI LD DAY TREATMENT	0	0		0	0	0	90. 13
90. 14	09012 DI ABETES CENTER	0	0		0	0	0	90. 14
90. 15	09013 WOUND CENTER	0	0	)	0	0	0	90. 15
	O9014  MLCA   O9015  BAYONNE MENTAL HEALTH CENTER				0	0	0	
90. 17	09018 CLINIC		0	1	0	0	0	90. 17
91. 00	09100 EMERGENCY		0	1	Ö	0	0	91.00
91. 01	09101 PSYCH EMERGENCY		O		0	0	Ö	91. 01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o			0		0	92. 00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	)	0	0	0	93. 99
05.00	OTHER REIMBURSABLE COST CENTERS	1						05.00
	09500 AMBULANCE SERVICES			J	0	0	_	95. 00
200.00	Total (lines 50 through 199)	0	0	Ί	0	0	0	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS		Component	CCN: 31-5442	Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 10:	pared:
		Title	· XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C,	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see	
	4.00	5. 00	6. 00	7. 00	instructions) 8.00	
ANCILLARY SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
50. 00   05000   OPERATING ROOM 51. 00   05100   RECOVERY ROOM 52. 00   05200   DELIVERY ROOM & LABOR ROOM	0 0	0		0 108, 920, 702 0 9, 586, 650 0 11, 102, 553	0. 000000 0. 000000	51. 00 52. 00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C 56. 00   05600   RADI OI SOTOPE	0 0 0		1	0 6, 780, 364 0 46, 199, 260 0 14, 937, 854 0 19, 112, 456	0. 000000 0. 000000	54. 00 55. 00
50. 00   05700   CT SCAN   05700   CT SCAN   05800   MRI   05900   CARDI AC CATHETERI ZATI ON	0	0		0 71, 553, 002 0 12, 651, 999 0 17, 506, 754	0. 000000 0. 000000	57. 00 58. 00
50. 00   06000   LABORATORY 52. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL 52. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS	0 0	0		0 121, 058, 431 0 14, 465, 829 0 0	0. 000000	60. 00 62. 00
55. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY 57. 00   06700   OCCUPATI ONAL THERAPY	0			0 17, 477, 319 0 8, 571, 068 0 2, 186, 412	0. 000000 0. 000000	66. 00 67. 00
68. 00   06800   SPEECH PATHOLOGY 59. 00   06900   ELECTROCARDI OLOGY 71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT	0 0	0		0 1, 248, 874 0 42, 507, 278 0 28, 639, 043	0. 000000 0. 000000	69. 00 71. 00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS 74.00   07400   RENAL DIALYSIS 76.97   07697   CARDIAC REHABILITATION	0 0 0	0		0 15, 707, 564 0 146, 002, 547 0 58, 720, 663 0 0	l	73. 00 74. 00
76. 98   07697 CARDIAC REPARTED TATTON 76. 98   07698   HYPERBARI C OXYGEN THERAPY 76. 99   07699   LI THOTRI PSY 77. 00   07700  ALLOGENEI C HSCT ACQUISITION	0	0		0 0 0	0. 000000 0. 000000	76. 98 76. 99
78. 00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0		l .	0 0	<b>l</b>	1
90. 00   09000  CLI NI C 90. 01   09016  CLI NI C-NOT USED 90. 02   09001  PSYCH CLI NI C	0 0	0	l .	0 837, 132 0 0 0 26, 356, 648	0. 000000	90. 01
90. 03   09002   PSYCH   CLINI C   FEE   BASED   90. 04   09003   WORKFIRST   90. 05   09004   CANCER   CLINI C	0	0		0 0 0	0. 000000 0. 000000 0. 000000	90. 03 90. 04
90. 06	0 0	0		0 746, 405 0 18, 558, 723 0 916, 100	0. 000000 0. 000000	90. 06 90. 07
PO. 09   09008 AFTER SCHOOL PROGRAM PO. 10   09017 CLINIC-NOT USED PO. 11   09009 PERINATAL ADDICTION	0 0	0 0 0		0 0 0 0	0. 000000 0. 000000 0. 000000	90. 10
PO. 12   09010   THERAPEUTI C NURSERY PO. 13   09011   CHI LD DAY TREATMENT PO. 14   09012   DI ABETES CENTER	0 0	0 0 0		0 0 0 0	0. 000000 0. 000000 0. 000000	90. 13
PO. 15   09013   WOUND CENTER PO. 16   09014   MICA PO. 17   09015   BAYONNE MENTAL HEALTH CENTER	0 0	0 0 0		0 7, 629, 736 0 0 0 2, 369, 779	0. 000000 0. 000000	90. 16 90. 17
PO. 18   09018   CLINIC P1. 00   09100   EMERGENCY P1. 01   09101   PSYCH EMERGENCY P2. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART	0 0 0	0 0 0 0		0 0 159, 627, 259 0 1, 256, 343 0 29, 736, 844	0. 000000 0. 000000 0. 000000 0. 000000	91. 00 91. 01
23. 99 O9399 PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS	0			0 27, 730, 844	0.00000	1

			XVIII SI	killed Nursing	PPS	12 (111
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Facility Outpatient	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	_	Costs (col. 8	-	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS	0.000000			al		
50. 00   05000   OPERATING ROOM	0. 000000	0	0	0	0	50.00
51. 00   05100   RECOVERY ROOM	0. 000000	0		0	0	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54. 00 05400 RADI OLOGY -DI AGNOSTI C	0. 000000	0	0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.000000	0	0	0	0	55. 00
56. 00   05600   RADI 0 I SOTOPE 57. 00   05700   CT   SCAN	0.000000	0	0	0	0	56.00
	0.000000	0	0	0	0	57.00
58. 00   05800   MRI 59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 000000 0. 000000	0	0	0	0	58. 00 59. 00
60. 00   06000   LABORATORY	0. 000000	81, 712	0	0	0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	01,712	0	0	0	62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 000000	0	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	550, 370	١	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	184, 820		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	14, 720		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	14, 720	Ö	0	0	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0	Ö	0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	Ö	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	580		0	0	73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000	0	o o	0	0	74. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	Ö	Ö	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	Ö	Ō	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	o	0	0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90. 00
90. 01   09016   CLI NI C-NOT USED	0. 000000	0	0	0	0	90. 01
90. 02   09001   PSYCH CLI NI C	0. 000000	0	0	0	0	90. 02
90.03 09002 PSYCH CLINIC FEE BASED	0. 000000	0	0	0	0	90. 03
90. 04   09003   WORKFI RST	0. 000000	0	0	0	0	90. 04
90. 05   09004   CANCER CLINIC	0. 000000	0	0	0	0	90. 05
90. 06   09005   PEDI ATRI C CLI NI C	0. 000000	0	0	0	0	90. 06
90. 07   09006   WOMENS CLINIC	0. 000000	0		0	0	90. 07
90. 08   09007   THERAPEUTI C SCHOOL	0. 000000	0		0	0	90. 08
90. 09 09008 AFTER SCHOOL PROGRAM	0. 000000	0	0	0	0	90. 09
90. 10   09017   CLINI C-NOT USED	0. 000000	0	0	0	0	90. 10
90. 11 09009 PERINATAL ADDICTION	0. 000000	0	0	0	0	90. 11
90. 12 09010 THERAPEUTI C NURSERY	0.000000	0	0	0	0	90. 12
90. 13   09011   CHI LD DAY TREATMENT 90. 14   09012   DI ABETES CENTER	0. 000000	0	0	0	0	90. 13 90. 14
, , , , , , , , , , , , , , , , , , ,	0.000000	-		0	0	
90. 15   09013   WOUND CENTER 90. 16   09014   MI CA	0. 000000 0. 000000	0	-	0	0	90. 15 90. 16
90. 17   09015   BAYONNE MENTAL HEALTH CENTER	0. 000000	0	0	0	0	90. 18
90. 17   09015 BAYONNE MENTAL HEALTH CENTER  90. 18   09018   CLINIC	0. 000000	0		0	0	90. 17
91. 00   09100   EMERGENCY	0. 000000	0	0	0	0	91.00
91. 01   09101   PSYCH EMERGENCY	0. 000000	0	0	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	l ĭ	0	0	92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	0. 000000	0		0	0	93. 99
OTHER REI MBURSABLE COST CENTERS	3. 000000		·	<u> </u>		1 , ,
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)		832, 202	0	0	0	200. 00
	,			- 1		•

Health Financial Systems	TRINITAS H				u of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CA	NMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS Provider CCN		F	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Pre 5/30/2024 10:	
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	,					
30. 00 ADULTS & PEDI ATRI CS	2, 426, 189	C	2, 426, 189			
31.00 INTENSIVE CARE UNIT	448, 967		448, 967		80. 14	
40. 00 SUBPROVI DER - I PF	940, 046	0	940, 046	19, 391	48. 48	
41. 00 SUBPROVI DER - I RF	0	0	)	1 1	0.00	
42. 00 SUBPROVI DER	331, 434	0	331, 434		48. 68	
43. 00 NURSERY	175, 267		175, 267			
44.00 SKILLED NURSING FACILITY	176, 932		176, 932		41. 04	
45.00 NURSING FACILITY	880, 472		880, 472			
200.00 Total (lines 30 through 199)	5, 379, 307		5, 379, 307	105, 554		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col. 6)				
	6. 00	7. 00	+			
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00				
30. 00 ADULTS & PEDIATRICS	3, 921	245, 807	,			30.00
31. 00 INTENSIVE CARE UNIT	530	42, 474	•			31.00
40. 00   SUBPROVI DER - I PF	1, 593	77, 229	•			40.00
41 00 SUPPROVIDED I DE	1,0,0	77,227	•			11 00

6, 065

1, 849

1, 096

15, 054

295, 244

97, 257

35, 204 793, 215

41.00

42.00

43.00

44.00

45.00

200. 00

SUBPROVIDER - I PF SUBPROVIDER - I RF

44.00 SKILLED NURSING FACILITY

45.00 NURSING FACILITY 200.00 Total (lines 30 through 199)

SUBPROVI DER

41.00

42.00

43. 00 NURSERY

Heal th	Financial Systems	TRINITAS I	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI		L COSTS	Provi der Co	CN: 31-0027	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D	
					10 12/31/2023	Date/Time Pre 5/30/2024 10:	pared: 12 am
			Ti tl	e XIX	Hospi tal	TEFRA	12 (111
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	0.00	0.00	4.00	F 00	
	ANCHI LADV CEDVI CE COCT CENTEDO	1.00	2.00	3. 00	4. 00	5. 00	
50. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	951, 668	108, 920, 702	0. 00873	1, 666, 737	14, 562	50.00
51.00	05100 RECOVERY ROOM	79, 081		0. 00824		· ·	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	231, 966					
53. 00	05300 ANESTHESI OLOGY	17, 170					1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	384, 197					1
55.00	05500 RADI OLOGY-THERAPEUTI C	861, 944				1	1
56.00	05600 RADI 0I SOTOPE	14, 585	19, 112, 456	0. 00076	102, 051	78	56. 00
57. 00	05700 CT SCAN	34, 209	71, 553, 002	0. 00047	1, 673, 800	800	57. 00
58.00	05800 MRI	32, 010	12, 651, 999	0. 00253	450, 993	1, 141	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	140, 335					
60.00	06000 LABORATORY	296, 160		0. 00244			1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	16, 501		0. 00114		357	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	1	0.00000		· -	
65.00	06500 RESPI RATORY THERAPY	104, 061	17, 477, 319	0. 00595			1
66.00	06600 PHYSI CAL THERAPY	197, 258		0. 02301		1	1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 549 3, 778		0. 00070 0. 00302		66 749	1
69. 00	06900 ELECTROCARDI OLOGY	66, 343		1		l e	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	105, 562					1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	80, 970		0. 00505			1
73. 00	07300 DRUGS CHARGED TO PATIENTS	210, 918		0. 00144			1
74. 00	07400 RENAL DIALYSIS	476, 295		0. 00811			1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0.00000		0	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000		0	1
76. 99	07699 LI THOTRI PSY	0	0	0. 00000	00	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000	00	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000	00	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLINIC	314, 429		0. 37560		•	
90. 01	09016 CLINI C-NOT USED	0	-	0.00000		•	
90. 02	09001 PSYCH CLINIC	947, 954	26, 356, 648				
90. 03 90. 04	09002 PSYCH CLINIC FEE BASED 09003 WORKFIRST	0	0	0. 00000 0. 00000		l	
90.04	09004 CANCER CLINIC	0		0. 00000		0	1
90. 06	09005 PEDIATRIC CLINIC	6, 711	746, 405	0. 00899		0	1
90. 07	09006 WOMENS CLINIC	19, 442		0. 00104		0	1
90. 08	09007 THERAPEUTI C SCHOOL	1, 955		0. 00213		0	1
90. 09	09008 AFTER SCHOOL PROGRAM	0		0. 00000		0	1
90. 10	09017 CLI NI C-NOT USED	0	0	0. 00000		0	90. 10
	09009 PERINATAL ADDICTION	0	0	0. 00000		0	90. 11
90. 12	09010 THERAPEUTIC NURSERY	0	0	0. 00000	00	0	90. 12
90. 13	09011 CHI LD DAY TREATMENT	0	0	0. 00000	00	0	90. 13
90. 14	09012 DI ABETES CENTER	0	0	0. 00000	00	0	90. 14
90. 15	09013 WOUND CENTER	31, 384		0. 00411		0	90. 15
90. 16	09014 MI CA	120, 220		0. 00000		0	
90. 17	09015 BAYONNE MENTAL HEALTH CENTER	9, 221		0. 00389		0	
90. 18	09018 CLINIC	1, 621		0.00000		0	
91.00	09100 EMERGENCY	724, 400		0. 00453		l	1
91. 01	09101 PSYCH EMERGENCY	158, 259		0. 12596		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART 09399 PARTIAL HOSPITALIZATION PROGRAM	289, 875 0	29, 736, 844	0. 00974 0. 00000			
73. 77	OTHER REIMBURSABLE COST CENTERS		1 0	0.00000	0	10	73.77
95 00	09500 AMBULANCE SERVICES						95. 00
200.00		6, 932, 031	1, 022, 971, 591		27, 142, 798	161, 175	
	, ( c oug)	2, 702, 301	, ,, ,, ,, ,, ,,	1			, 55

APPORTIONMENT OF INPATTENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST		<u> </u>	From 01/01/2023 Fo 12/31/2023	Part III Date/Time Pre 5/30/2024 10:	
		Titl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown	Ŭ	Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1				2.22	
30. 00 03000 ADULTS & PEDIATRICS		0		0	0	30.00
31. 00   03100   NTENSI VE CARE UNI T	0	0			_	31.00
40. 00   04000   SUBPROVI DER -   1 PF	0	0			0	40.00
	0	0				
41. 00   04100   SUBPROVI DER -   RF	0	0	1	0	0	41. 00
42. 00   04200   SUBPROVI DER	0	0	1	0	0	42. 00
43. 00   04300   NURSERY	0	0		0	0	43. 00
44.00  04400   SKILLED NURSING FACILITY	0	0		0		44.00
45.00 04500 NURSING FACILITY	0	0		0		45. 00
200.00 Total (lines 30 through 199)	o	0		0	0	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	,-			
		minus col. 4)				
	4. 00	5.00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	38, 70	0.00	3, 921	30.00
	U	-				
31. 00 03100 I NTENSI VE CARE UNI T		0	-,			1
40. 00   04000   SUBPROVI DER - I PF	0	0	19, 39			
41. 00   04100   SUBPROVI DER - I RF	0	0		0.00		41. 00
42. 00   04200   SUBPROVI DER	0	0	6, 80			
43. 00   04300 NURSERY		0	3, 33:	0.00	1, 849	43.00
44.00   04400   SKILLED NURSING FACILITY		0	4, 31	0.00	0	44.00
45.00 04500 NURSING FACILITY		0	27, 40	0.00	1, 096	45. 00
200.00 Total (lines 30 through 199)		0			15, 054	
Cost Center Description	Inpatient		100700	•	.0,00.	200.00
oost denter beson per on	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
						20.00
+ I	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31. 00
40. 00   04000   SUBPROVI DER - 1 PF	0					40. 00
41. 00   04100   SUBPROVI DER - I RF	0					41. 00
42. 00   04200   SUBPROVI DER	0					42.00
43. 00   04300   NURSERY	O					43. 00
44.00 04400 SKILLED NURSING FACILITY	o					44. 00
45. 00 04500 NURSING FACILITY						45. 00
200.00 Total (Lines 30 through 199)						200. 00
	١					1-30.00

In Lieu of Form CMS-2552-10

Period: Worksheet D
From 01/01/2023 Part IV
To 12/31/2023 Date/Time Prepared: 5/30/2024 10: 12 am Provider CCN: 31-0027 THROUGH COSTS

					10 127	3172023	5/30/2024 10:	
			Ti tI	e XIX	Hospi	i tal	TEFRA	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied	Heal th	Allied Health	
	<b>'</b>	Anestheti st	Program	Program		tepdown		
		Cost	Post-Stepdown			tments		
			Adjustments					
		1.00	2A	2.00	3	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS			•	<u> </u>			
50.00	05000 OPERATING ROOM	0	O	1	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	)	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		)	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	l o	)	0	o	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		,	0	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		,	O	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0		,	0	0	0	56.00
57. 00	05700 CT SCAN	0		,	0	0	0	57. 00
58. 00	05800 MRI	0			0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			Ö	0	Ö	59. 00
60.00	06000 LABORATORY	0		1	0	0	ő	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0			0	0	ő	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		1	0	0	Ö	62. 30
65. 00	06500 RESPIRATORY THERAPY	0			0	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY				0	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY				0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY				0	0	0	68.00
	06900 ELECTROCARDI OLOGY	0			0	0	0	69.00
69.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ĭ		0	0		•
71. 00		0	0		0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	1		-	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	'	0	U	0	74.00
76. 97	O7697   CARDI AC REHABI LI TATI ON	0			0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0			0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0			0	0	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	1	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	1	0	U	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0	ı	0	O	0	90.00
90.00	09016 CLINIC-NOT USED	0		1	0	0	0	90.00
90.01	09001 PSYCH CLINIC	0		1	0	0	0	90.01
90. 02	09002 PSYCH CLINIC FEE BASED				0	0	0	90.02
90. 03	09003 WORKFIRST				0	0	0	90.03
90.04	09004 CANCER CLINIC				0	0	0	90.04
90.06	09005 PEDIATRIC CLINIC				0	0	0	90.05
90.00	09006 WOMENS CLINIC			1	0	0	0	90.00
90.07	09007 THERAPEUTI C SCHOOL				0	0	0	90.07
90.09	09008 AFTER SCHOOL PROGRAM			1	0	0	0	90.09
90. 10	09017 CLINIC-NOT USED	0			0	0	0	90. 10
90. 10	09009 PERINATAL ADDICTION	0			0	0	0	90. 10
90. 11	09010 THERAPEUTI C NURSERY	0			0	0	0	90. 12
90. 12	09011 CHILD DAY TREATMENT	0			0	0	0	90. 12
90. 13	09012 DI ABETES CENTER	0			0	0	0	90. 13
	09013 WOUND CENTER	0			0	0	0	•
	09014 MI CA	0	1		0	0	0	1
90. 10	09015 BAYONNE MENTAL HEALTH CENTER			1	0	0	0	•
90. 17	09018 CLINIC			1	0	0	0	90. 17
91.00	09100 EMERGENCY			1	0	0	0	91.00
91.00	09101 PSYCH EMERGENCY				0	0	0	91.00
91.01	09200 OBSERVATION BEDS (NON-DISTINCT PART			1	0	۷	0	•
	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM		0	J	0	0	0	•
73. 77	OTHER REIMBURSABLE COST CENTERS			1	J	<u> </u>	0	73.77
95. 00	09500 AMBULANCE SERVICES			1				95. 00
200.00		0	o	J	0	0	n	200.00
200.00	1. Trail (Trails 55 thi bugh 177)	1	1	T	٦,	٩	٥	1-00.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | T 
 Heal th Financial
 Systems
 TRINITAS HOST

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
 OTHER PASS
 Provider CCN: 31-0027 THROUGH COSTS

				'	0 12/31/2023	5/30/2024 10:		
				Titl	e XIX	Hospi tal	TEFRA	
	(	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
			Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
				4)	col s. 2, 3,	8)	7)	
					and 4)		(see	
							instructions)	
			4. 00	5. 00	6. 00	7. 00	8. 00	
F0 00		ARY SERVICE COST CENTERS		^	1	400 000 700	0.00000	F0 00
50.00		OPERATING ROOM	0	0			l	
51.00		RECOVERY ROOM	0	0		1	l e	
52.00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	0		1	l	
53. 00 54. 00		RADI OLOGY-DI AGNOSTI C	0		"	.,	0. 000000 0. 000000	
55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	0	0			l .	
56. 00		RADI OI SOTOPE	0	0	0		0. 000000	56. 00
57. 00	1 1	CT SCAN	0	0	0		0.000000	57.00
58. 00	05800 N		0	0	٥		l e	
59. 00	1 1	CARDI AC CATHETERI ZATI ON	0	0			0. 000000	
60. 00	1 1	LABORATORY	0	0	٥		0. 000000	
62. 00		NHOLE BLOOD & PACKED RED BLOOD CELL	0	Ö			0. 000000	
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	Ö		1	0. 000000	
65.00		RESPI RATORY THERAPY	0	0	0	17, 477, 319	0. 000000	
66.00		PHYSI CAL THERAPY	0	0	0		0.000000	66. 00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2, 186, 412	0.000000	67. 00
68.00	06800	SPEECH PATHOLOGY	0	0	0		0.000000	68. 00
69.00	06900 E	ELECTROCARDI OLOGY	0	0	0	42, 507, 278	0.000000	69. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	28, 639, 043	0.000000	71. 00
72.00	07200 I	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15, 707, 564	0.000000	72. 00
73.00		DRUGS CHARGED TO PATIENTS	0	0	0	146, 002, 547	0.000000	73. 00
74.00		RENAL DIALYSIS	0	0	0	58, 720, 663	0.000000	
76. 97		CARDIAC REHABILITATION	0	0	0	0	0. 000000	
76. 98		HYPERBARI C OXYGEN THERAPY	0	0	0	0	0. 000000	76. 98
76. 99	1 1	LI THOTRI PSY	0	0	0	0	0.000000	
77. 00	1 1	ALLOGENEIC HSCT ACQUISITION	0	0			0.000000	
78. 00		CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78. 00
90. 00	09000 (	LENT SERVICE COST CENTERS	0	0	0	837, 132	0. 000000	90. 00
90. 00		CLINIC-NOT USED	0	0			0.000000	90.00
90. 01		PSYCH CLINIC	0	0			0.000000	90.01
90. 03		PSYCH CLINIC FEE BASED	0	0		20, 330, 040	0. 000000	90. 03
90. 04		NORKFIRST	0	0		0	0. 000000	90. 04
90. 05	1 1	CANCER CLINIC	0	0		0	0. 000000	90. 05
90. 06	1 1	PEDIATRIC CLINIC	0	Ö	Ö	746, 405	0. 000000	90.06
90. 07	1 1	NOMENS CLINIC	0	0	0			
90. 08		THERAPEUTIC SCHOOL	0	0	0	916, 100	0.000000	
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0.000000	90. 09
90. 10	09017	CLINIC-NOT USED	0	0	0	0	0.000000	90. 10
90. 11	09009 F	PERINATAL ADDICTION	0	0	0	0	0. 000000	90. 11
		THERAPEUTIC NURSERY	0	0	0	0	0.000000	90. 12
		CHILD DAY TREATMENT	0	0	0	0	0.000000	90. 13
	1 1	DI ABETES CENTER	0	0	•		0.000000	
90. 15		NOUND CENTER	0	0	0	7, 629, 736		
90. 16	1 1		0	0	· -	0	0. 000000	
90. 17	1 1	BAYONNE MENTAL HEALTH CENTER	0	0		2, 369, 779		
90. 18			0	0	· -	0	0.000000	
91.00		EMERGENCY	0	0	1			
91. 01		PSYCH EMERGENCY	0	0				91. 01
92. 00 93. 99	1 1	OBSERVATION BEDS (NON-DISTINCT PART PARTIAL HOSPITALIZATION PROGRAM		0			l	
73. 77		REIMBURSABLE COST CENTERS	0	0	1 0	·1 0	0. 000000	93. 99
95. 00		AMBULANCE SERVICES						95. 00
200.00	1 1	Total (lines 50 through 199)	0	0	0	1, 022, 971, 591		200. 00
_55.50	-1 1	. 111. (11.100 00 till bugit 177)	1	•	1	., 522, 7, 1, 571	ı	

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2023	Part IV
To 12/31/2023	Date/Time Prepared:
5/30/2024	10: 12 am
 Heal th Financial APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 TRINITAS HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 31-0027
 THROUGH COSTS

					12/31/2023	5/30/2024 10:	
			Ti tl	e XIX	Hospi tal	TEFRA	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000  OPERATI NG ROOM	0. 000000	1, 666, 737	0	0	0	50.00
51. 00	05100 RECOVERY ROOM	0. 000000	132, 512		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	3, 739, 086	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	711, 542		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 353, 551	0	0	0	54.00
55. 00	05500  RADI OLOGY-THERAPEUTI C	0. 000000	0	0	0	0	55. 00
56.00	05600  RADI 0I SOTOPE	0. 000000	102, 051	0	0	0	56. 00
57.00	05700 CT SCAN	0. 000000	1, 673, 800	0	0	0	57. 00
58. 00	05800  MRI	0. 000000	450, 993	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	713, 130	0	0	0	59. 00
60.00	06000 LABORATORY	0. 000000	5, 879, 840	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	313, 201	0	0	0	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62. 30
65.00	06500 RESPIRATORY THERAPY	0. 000000	769, 582	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	159, 117	0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	93, 221	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	247, 473	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	1, 569, 371	0	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	802, 537	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	160, 084	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	4, 488, 627	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	135, 690	0	0	0	74.00
76. 97	07697 CARDIAC REHABILITATION	0. 000000	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000  CLI NI C	0. 000000	0		0	0	90.00
90. 01	09016 CLINIC-NOT USED	0. 000000	0	- 1	0	0	90. 01
90. 02	09001 PSYCH CLINIC	0. 000000	0	1	0	0	90. 02
90. 03	09002 PSYCH CLINIC FEE BASED	0. 000000	0		0	0	90. 03
90. 04	09003 WORKFI RST	0. 000000	0	_	0	0	90. 04
90. 05	09004 CANCER CLINIC	0. 000000	0	-	0	0	
90. 06	09005 PEDIATRIC CLINIC	0. 000000	0	-	0	0	90. 06
90. 07	09006 WOMENS CLINIC	0. 000000	0		0	0	90. 07
90. 08	09007 THERAPEUTI C SCHOOL	0. 000000	0		0	0	90. 08
90. 09	09008 AFTER SCHOOL PROGRAM	0. 000000	0		0	0	90. 09
90. 10	09017 CLINIC-NOT USED	0. 000000	0		0	0	90. 10
90. 11	09009 PERINATAL ADDICTION	0. 000000	0	_	0	0	90. 11
90. 12	09010 THERAPEUTI C NURSERY	0. 000000	0		0	0	90. 12
90. 13	09011 CHI LD DAY TREATMENT	0. 000000	0		0	0	90. 13
90. 14	09012 DI ABETES CENTER	0. 000000	0	1	0	0	
90. 15	09013 WOUND CENTER	0. 000000	0		0	0	
90. 16	09014 MI CA	0. 000000	0		0	0	
90. 17	09015 BAYONNE MENTAL HEALTH CENTER	0. 000000	0		0	0	90. 17
90. 18	09018 CLI NI C	0. 000000	0	_	0	0	90. 18
91.00	09100 EMERGENCY	0. 000000	1, 980, 653		0	0	91.00
91. 01	09101 PSYCH EMERGENCY	0. 000000	0	- 1	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	
93. 99	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0. 000000	0	0	0	0	93. 99
05 00	OTHER REIMBURSABLE COST CENTERS						05.00
95.00	09500 AMBULANCE SERVICES		27 442 722		0	_	95. 00
200.00	Total (lines 50 through 199)	1	27, 142, 798	0	0	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 31-0027 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/30/2024 10:12 am Title XIX Hospi tal TEFRA Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Subject To Part I, col. Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 168719 706, 540 0 50.00 51.00 05100 RECOVERY ROOM 0. 258256 1, 465 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 613452 0 562, 589 52 00 0 53.00 05300 ANESTHESI OLOGY 0.114150 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 176208 1, 197, 036 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0.747290 0 183.834 55 00 0 55 00 05600 RADI OI SOTOPE 56.00 0.049993 0 137, 045 0 56.00 57.00 05700 CT SCAN 0.024748 711, 676 0 57.00 58.00 05800 MRI 0.058753 142, 618 0 58.00 05900 CARDIAC CATHETERIZATION 59 00 59 00 0 168169 55 526 0 60.00 06000 LABORATORY 0.105333 0 90, 091 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.004620 0 62.00 25, 659 62.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 0 62.30 06500 RESPIRATORY THERAPY 65 00 0.339697 0 13,626 0 65 00 66.00 06600 PHYSI CAL THERAPY 0.373575 0 61,038 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.127714 3, 927 67.00 06800 SPEECH PATHOLOGY 0. 210852 0 2, 638 68.00 0 68.00 06900 ELECTROCARDI OLOGY 69 00 0.042491 0 541, 200 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.460416 149, 456 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.643857 64, 236 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.162489 0 1,605,461 0 73.00 07400 RENAL DIALYSIS 0 74.00 0.291491 1, 696 0 74 00 07697 CARDIAC REHABILITATION 0.000000 0 76.97 76.97 C 0 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0.000000 0 0 0 76. 98 07699 LI THOTRI PSY 0 0 76. 99 76.99 0.000000 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0.000000 0 0 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 0 09000 CLI NI C 4. 793172 90.00 28, 515 0 90. 01 09016 CLINIC-NOT USED 0.000000 C 0 90.01 09001 PSYCH CLINIC 90.02 1.014859 0 470, 189 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 90.02 09002 PSYCH CLINIC FEE BASED 0.000000 90.03 0 90.03 C 0 90.04 09003 WORKFIRST 0.000000 0 0 0 90.04 90.05 09004 CANCER CLINIC 0.000000 0 90.05 09005 PEDIATRIC CLINIC 1. 479178 90.06 90.06 56, 889 90 07 09006 WOMENS CLINIC 5, 370, 539 90 07 0.169275 Λ 90.08 09007 THERAPEUTIC SCHOOL 0.246083 0 0 90.08 90.09 09008 AFTER SCHOOL PROGRAM 0.000000 0 0 90.09 09017 CLINIC-NOT USED 0.000000 0 90.10 90.10 0 09009 PERINATAL ADDICTION 0 90.11 0.000000 0 90.11 90.12 09010 THERAPEUTIC NURSERY 0.000000 0 0 90.12 09011 CHILD DAY TREATMENT 90.13 0.000000 0 0 90.13 90 14 09012 DI ABETES CENTER 0.000000 90 14 0 0 90.15 09013 WOUND CENTER 0.136071 16, 396 0 90.15 90.16 09014 MI CA 0.000000 0 90.16 C 90.17 09015 BAYONNE MENTAL HEALTH CENTER 90.17 0.631674 0 0 90 18 09018 CLINIC 90 18 0.000000 Ω 0 0 91.00 09100 EMERGENCY 0.130965 0 6, 795, 995 0 91.00 09101 PSYCH EMERGENCY 4. 379064 0 91.01 91.01 106, 758 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.175352 0 C 0 92.00 09399 PARTIAL HOSPITALIŽATION PROGRAM 93.99 93.99 0.000000 0 0 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 Subtotal (see instructions) 200.00 0 19, 102, 638 0 0 200, 00 Less PBP Clinic Lab. Services-Program 0 201.00 201. 00 Only Charges

19, 102, 638

0

0 202.00

Net Charges (line 200 - line 201)

202.00

Health Financial Systems TRINITAS HOSPITAL In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 31-0027 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/30/2024 10:12 am Title XIX Hospi tal TEFRA Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 119, 207 0 50.00 51.00 05100 RECOVERY ROOM 378 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 52 00 345, 121 05300 ANESTHESI OLOGY 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 210, 927 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 137 377 05600 RADI OI SOTOPE 0 56.00 6, 851 56.00 57.00 05700 CT SCAN 17,613 0 57.00 05800 MRI 58.00 8, 379 0 58.00 05900 CARDIAC CATHETERIZATION 0 59 00 59 00 9 338 60.00 06000 LABORATORY 9,490 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 62.00 119 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 06500 RESPIRATORY THERAPY 4.629 0 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 22,802 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 502 67.00 68.00 06800 SPEECH PATHOLOGY 556 0 68.00 06900 ELECTROCARDI OLOGY 22, 996 0 69 00 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 68, 812 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 41, 359 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 260.870 0 73.00 07400 RENAL DIALYSIS 0 74.00 494 74 00 76. 97 07697 CARDIAC REHABILITATION 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 76. 99 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 0 77 00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 136, 677 0 90. 01 09016 CLINIC-NOT USED 0 90.01 09001 PSYCH CLINIC 0 90. 02 477, 176 90.02 09002 PSYCH CLINIC FEE BASED 0 90.03 90.03 0 0 90.04 09003 WORKFIRST 0 90.04 90.05 09004 CANCER CLINIC 0 0 90.05 90.06 09005 PEDIATRIC CLINIC 0 90.06 84.149 90 07 09006 WOMENS CLINIC 909.098 0 90 07 90.08 09007 THERAPEUTIC SCHOOL 0 0 90.08 90.09 09008 AFTER SCHOOL PROGRAM 0 90.09 0 90. 10 09017 CLINIC-NOT USED 0 90.10 09009 PERINATAL ADDICTION 0 0 90.11 90 11 90.12 09010 THERAPEUTIC NURSERY 0 0 90.12 09011 CHILD DAY TREATMENT 0 90. 13 0 90.13 90 14 09012 DI ABETES CENTER 0 90 14 90.15 09013 WOUND CENTER 2, 231 0 90.15 90. 16 09014 MI CA 0 90.16 0 09015 BAYONNE MENTAL HEALTH CENTER 90. 17 0 0 90.17 90 18 09018 CLINIC 0 90 18 0 09100 EMERGENCY 91.00 890, 037 0 91.00 09101 PSYCH EMERGENCY 91.01 91.01 467, 500 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 93.99 0 0 OTHER REIMBURSABLE COST CENTERS

4, 254, 688

4, 254, 688

0

0

95.00

200.00

201. 00

202.00

95.00

200.00

201.00

202.00

09500 AMBULANCE SERVICES

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

	Financial Systems	TRINITAS				u of Form CMS-	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS		CN: 31-0027	Peri od: From 01/01/2023	Worksheet D Part II	
			Component	CCN: 31-S027	To 12/31/2023	Date/Time Pre 5/30/2024 10:	pared: 12 am
			Ti tl	e XIX	Subprovi der  - I PF	TEFRA	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. B,	(from Wkst. C, Part I, col.			(column 3 x column 4)	
		Part II, col.	8)	2)		ĺ	
		26) 1. 00	2.00	3.00	4. 00	5. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS	051 //0	100 000 700	0.0007	27		F0 00
50. 00 51. 00	05000   OPERATING ROOM   05100   RECOVERY ROOM	951, 668 79, 081		l		1	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	231, 966		1		l	1
53. 00	05300 ANESTHESI OLOGY	17, 170				Ō	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	384, 197	46, 199, 260	0. 0083	16 0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	861, 944				1	55. 00
56.00	05600 RADI OI SOTOPE	14, 585				0	56.00
57. 00 58. 00	05700   CT   SCAN   05800   MRI	34, 209 32, 010		•		0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	140, 335		1			59.00
60.00	06000 LABORATORY	296, 160		1		0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	16, 501	14, 465, 829			0	62. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	_	0.0000			62. 30
65.00	06500 RESPIRATORY THERAPY	104, 061 197, 258	17, 477, 319	1		0	65.00
66. 00 67. 00	06600  PHYSI CAL THERAPY   06700  OCCUPATI ONAL THERAPY	1, 549		1		0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	3, 778				Ö	68.00
69. 00	06900 ELECTROCARDI OLOGY	66, 343		1		Ō	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	105, 562					71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	80, 970					72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	210, 918 476, 295				0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	470, 293	38, 720, 003			0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		0.0000		Ö	76. 98
76. 99	07699 LI THOTRI PSY	0	C	0.0000		0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	C			l	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	<u> </u>	0.0000	00 0	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC	314, 429	837, 132	0. 37560	03	0	90.00
90.00	09016 CLI NI C-NOT USED	314, 429	037, 132	1			
90. 02	09001 PSYCH CLINIC	947, 954	_	1		l	90. 02
90. 03	09002 PSYCH CLINIC FEE BASED	0	C	0.0000	00	0	90. 03
90. 04	09003 WORKFI RST	0	C	0.0000		0	90. 04
90.05	O9004   CANCER CLINIC   O9005   PEDIATRIC CLINIC	0	744 405	0.0000		0	90.05
90. 06 90. 07	09006 WOMENS CLINIC	6, 711 19, 442	746, 405 18, 558, 723				90. 06 90. 07
	09007 THERAPEUTI C SCHOOL	1, 955				ľ	
	09008 AFTER SCHOOL PROGRAM	0	C	0.0000		0	90.09
	09017 CLINIC-NOT USED	0	C	0.0000		0	
90. 11	09009 PERI NATAL ADDI CTI ON	0	( C	0.0000		0	90. 11
90. 12 90. 13	09010 THERAPEUTI C NURSERY			0.0000		0	90. 12 90. 13
90. 13	09011   CHI LD DAY TREATMENT   09012   DI ABETES CENTER			0.0000		0	90. 13
90. 15	09013 WOUND CENTER	31, 384	7, 629, 736			o o	90. 15
90. 16	09014 MI CA	120, 220		0.0000		0	90. 16
90. 17	09015 BAYONNE MENTAL HEALTH CENTER	9, 221	2, 369, 779	1		0	
90. 18	09018 CLI NI C	1, 621	150 (07 05)	0.0000		0	90. 18
91. 00 91. 01	O9100   EMERGENCY   O9101   PSYCH   EMERGENCY	724, 400 158, 259				0	91. 00 91. 01
91.01	09200 OBSERVATION BEDS (NON-DISTINCT PART	156, 259				0	1
	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0					1
	OTHER REIMBURSABLE COST CENTERS	•		•	•	•	1

6, 642, 156 1, 022, 971, 591

95.00

0 200. 00

95. 00 OP500 AMBULANCE SERVICES
200. 00 Total (lines 50 through 199)

THROUGH COSTS Component CCN: 31-S027 Title XIX Subprovi der -TEFRA

			litl	e XIX	Subprovi der -	TEFRA	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		h Allied Health	
	F	Anesthetist	Program	Program	Post-Stepdow		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments	0.00	0.4	2.00	
	ANCILLARY SERVICE COST CENTERS	1.00	2A	2.00	3A	3. 00	
50. 00	05000 OPERATING ROOM	0		)	0	0 0	50.00
51. 00	05100 RECOVERY ROOM	0	ĺ	•	Ö		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	O		0	0 0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0	0 0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0	0 0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0	0	
56.00	05600 RADI OI SOTOPE	0	0	1	0	0	1
57. 00 58. 00	05700   CT   SCAN     05800   MRI	0		1	0	0 0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0		1	0		59.00
60.00	06000 LABORATORY	0	ĺ		0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	O		0	0 0	62.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	0 0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0	1	0	0 0	
66. 00	06600 PHYSI CAL THERAPY	0	0	1	0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	1
68. 00 69. 00	06800  SPEECH PATHOLOGY 06900  ELECTROCARDI OLOGY	0	0	1	0	0 0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		1	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0		1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ö		0	ol o	1
74.00	07400 RENAL DIALYSIS	0	0		0	0 0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	O		0	0 0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0	
76. 99	07699 LI THOTRI PSY	0	0	•	0	0	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		l .	0	0 0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY  OUTPATIENT SERVICE COST CENTERS	0		'	U	0 0	78. 00
90. 00	09000 CLINIC	0	О		0	0 0	90.00
90. 01	09016 CLINIC-NOT USED	0	O	•	0	0 0	1
90. 02	09001 PSYCH CLINIC	0	0		0	0 0	90. 02
90. 03	09002 PSYCH CLINIC FEE BASED	0	0		0	0 0	1
90. 04	09003 WORKFI RST	0	0	1	0	0	
90. 05	09004 CANCER CLINIC	0	0	1	0	0 0	1
90. 06 90. 07	09005   PEDIATRIC CLINIC   09006   WOMENS CLINIC	0	0		0	0 0	90. 06 90. 07
90.07	09007 THERAPEUTI C SCHOOL	0			0		90.07
90. 09	09008 AFTER SCHOOL PROGRAM	0			0	ol o	90. 09
90. 10	09017 CLINIC-NOT USED	0	O		0	0 0	90. 10
90. 11	09009 PERINATAL ADDICTION	0	O		0	0 0	90. 11
90. 12	09010 THERAPEUTIC NURSERY	0	0		0	0	1
90. 13	09011 CHI LD DAY TREATMENT	0	0	)	0	0	90. 13
90. 14	09012 DI ABETES CENTER	0	0	)	0	0 0	90. 14
90. 15 90. 16	09013 WOUND CENTER 09014 MI CA	0	0		0	0 0	
		0			0		
		0	0		Ö		
	09100 EMERGENCY	0		o l	0	0 0	1
91. 01	09101 PSYCH EMERGENCY	0	0		0	0 0	91. 01
		0			0	0	
93. 99		] 0	0	)	0	0 0	93. 99
95. 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES						05 00
95. 00 200. 00		0	o	J	0	0 0	95. 00 200. 00
200.00	1 Total (Trilos 50 till bugli 177)	1		71	Ŭ	ο <sub>1</sub> 0	1200.00

<b>PPORT</b>	Financial Systems  IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	TRINITAS F RVICE OTHER PASS	Provider Co	CN: 31-0027	Peri od:	Worksheet D	2552-10
	H COSTS				From 01/01/2023 To 12/31/2023		pared:
			Ti tl	e XIX	Subprovider -	TEFRA	12 uiii
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medical Education Cost	(sum of cols. 1, 2, 3, and	Outpatient Cost (sum of	(from Wkst. C, Part I, col.	to Charges (col. 5 ÷ col.	
		Ludouti on oost	4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	5. 00	6. 00	7. 00	instructions) 8.00	
	ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
0. 00	05000 OPERATING ROOM	0	0		0 108, 920, 702		1
1. 00	05100 RECOVERY ROOM	0	0		0 9, 586, 650		1
2.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 11, 102, 553		1
3. 00 4. 00	05300  ANESTHESI OLOGY   05400  RADI OLOGY-DI AGNOSTI C	0	0		0 6, 780, 364 0 46, 199, 260		1
5. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 14, 937, 854		1
6. 00	05600 RADI OI SOTOPE	l o	0		0 19, 112, 456		
7. 00	05700 CT SCAN	0	0		0 71, 553, 002	0. 000000	
8. 00	05800 MRI	0	0		0 12, 651, 999	l .	1
9. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 17, 506, 754		1
0. 00 2. 00	06000   LABORATORY   06200   WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 121, 058, 431 0 14, 465, 829		1
2. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 14, 403, 829	0.000000	1
5. 00	06500 RESPIRATORY THERAPY	Ö	0		0 17, 477, 319		
6. 00	06600 PHYSI CAL THERAPY	0	0		0 8, 571, 068		66.00
7. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 2, 186, 412		
8. 00	06800 SPEECH PATHOLOGY	0	0		0 1, 248, 874		1
	06900  ELECTROCARDI OLOGY   07100  MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0 42, 507, 278 0 28, 639, 043		
1. 00 2. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 28, 639, 043 0 15, 707, 564		
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 146, 002, 547		1
	07400 RENAL DIALYSIS	0	0	•	0 58, 720, 663		1
	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0. 000000	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0. 000000	1
	07699 LITHOTRI PSY	0	0		0	0.000000	1
	07700  ALLOGENEIC HSCT ACQUISITION   07800  CAR T-CELL IMMUNOTHERAPY	0	0		0 0		1
0. 00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>	0.00000	70.00
0. 00	09000 CLI NI C	0	0		0 837, 132	0. 000000	90.00
0. 01	09016 CLINIC-NOT USED	0	0		0 0		1
0. 02	09001 PSYCH CLINIC	0	0		0 26, 356, 648		
0. 03 0. 04	09002 PSYCH CLINIC FEE BASED 09003 WORKFIRST	0	0			0. 000000 0. 000000	1
0. 05	09004 CANCER CLINIC	0	0		0 0	0.000000	1
	09005 PEDIATRIC CLINIC	0	0		0 746, 405		
	09006 WOMENS CLINIC	0	0		0 18, 558, 723		90.07
	09007 THERAPEUTIC SCHOOL	0	0		0 916, 100		1
0. 09	09008 AFTER SCHOOL PROGRAM	0	0		0	0.000000	
0. 10 0. 11	09017 CLINIC-NOT USED	0	0		0	0. 000000 0. 000000	1
	09009   PERI NATAL   ADDI CTI ON   09010   THERAPEUTI C   NURSERY	0	0		0 0	0.00000	
0. 12	09011 CHILD DAY TREATMENT	Ö	0		o o	0. 000000	1
0. 14	09012 DI ABETES CENTER	0	0		0 0	0. 000000	
0. 15	09013 WOUND CENTER	0	0		0 7, 629, 736	0. 000000	90. 15
0. 16	09014 MI CA	0	0		0	0.000000	
0. 17	09015 BAYONNE MENTAL HEALTH CENTER	0	0		0 2, 369, 779		1
0. 18 1. 00	09018   CLI NI C   09100   EMERGENCY		0		0 0 159, 627, 259	0. 000000 0. 000000	
1. 00	09101 PSYCH EMERGENCY		0	•	0 159, 627, 259		
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	ł	0 29, 736, 844		1
	09399 PARTIAL HOSPITALIZATION PROGRAM	Ö	0		0 0	0. 000000	1
	OTHER REIMBURSABLE COST CENTERS						1
	09500 AMBULANCE SERVICES	1					95.00

51.00   05100   RECOVERY ROOM   0.000000   0   0   0   0   0   5   5   5	52-10
Component CCX: 31-SO27   To 12/31/2023   Date/Time Prepara System   Date of Cox 1   Date of	<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>
Cost Center Description	red:
Cost Center Description	
NAICLLARY SERVICE COST CENTERS   Col. 6 + col. 7   Pass-Through Costs (col. 8 x col. 10)   Tol. 00   Tol	
COL 6   COL   COL   COSTS (COL 8   COSTS (COL 9   7)   COSTS (COL 8   X COL 10)   COSTS (COL 9   7)   CO	
77	
ANCILLARY SERVICE COST CENTERS	
50.00   05000   05000   05000   0   0   0	
51.00   05100   RECOVERY ROOM   0.000000   0   0   0   0   5   5   5   2   0   05200   DELI VERY ROOM & LABOR ROOM   0.000000   0   0   0   0   0   5   5   5	
52.00   05.200   DELIVERY ROOM & LABOR ROOM   0.0000000   0   0   0   0   5   5   3.00   05.300   ANESTHESI OLOGY   0.0000000   0   0   0   0   5   5   5   5	50. 00 51. 00
53.00   05300   AMESTHESI OLOGY   0.000000   0   0   0   0   54.00   544.00   05400   RADI OLOGY-DI ACNOSTI C   0.000000   0   0   0   0   0   555.00   05500   RADI OLOGY-THERAPEUTI C   0.000000   0   0   0   0   556.00   05500   RADI OLOGY-THERAPEUTI C   0.000000   0   0   0   0   556.00   05500   RADI OLOGY-THERAPEUTI C   0.000000   0   0   0   0   557.00   055700   CT SCAN   0.000000   0   0   0   0   58.00   05800   MRI   0.000000   0   0   0   0   0   58.00   05800   MRI   0.000000   0   0   0   0   59.00   059900   CARDIA C. CATHETERI ZATI ON   0.000000   0   0   0   0   0   60.00   06000   LABORATORY   0.000000   0   0   0   0   0   62.00   062500   LABORATORY   0.000000   0   0   0   0   0   62.00   062500   BLODO LOUTTI INS FOR HEMOPHI LI ACS   0.000000   0   0   0   0   65.00   065500   RESPI RATORY THERAPY   0.000000   0   0   0   0   66.00   06600   PHYSI CAL THERAPY   0.000000   0   0   0   0   66.00   06600   PHYSI CAL THERAPY   0.000000   0   0   0   0   67.00   06700   OCCUPATI ONAL THERAPY   0.000000   0   0   0   0   68.00   06900   SPEECH PATHOLOGY   0.000000   0   0   0   0   68.00   06900   ELECTROCARDI OLOGY   0.000000   0   0   0   0   69.00   06990   ELECTROCARDI OLOGY   0.000000   0   0   0   0   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0.000000   0   0   0   0   72.00   07200   IMPLE DEV. CHARGED TO PATI ENTS   0.000000   0   0   0   0   74.00   07400   RENAL DI ALYSI S   0.000000   0   0   0   0   75.99   07697   CARDIA C REHABI LITATI ON   0.000000   0   0   0   0   76.99   07699   LTHOTRIP BYY   0.000000   0   0   0   0   77.00   07700   ALLOGENEI C HISCT ACQUI SITION   0.000000   0   0   0   0   77.00   07700   ALLOGENEI C HISCT ACQUI SITION   0.000000   0   0   0   0   77.00   0700   0700   CALOGENEI C HISCT ACQUI SITION   0.000000   0   0   0   77.00   0700   0700   0700   0700   0   0	52. 00
54.00   05400   RADI OLOGY-THERAPEUTI C   0.000000   0   0   0   0   55.00   05500   RADI OLOGY-THERAPEUTI C   0.000000   0   0   0   0   0   55.00   05500   RADI OLOGY-THERAPEUTI C   0.000000   0   0   0   0   0   55.00   05500   RADI OLOGY-THERAPEUTI C   0.000000   0   0   0   0   0   55.00   05500   RADI OLOGY-THERAPEUTI C   0.000000   0   0   0   0   0   55.00   05500   CRDI ROTOR CARDI ROTOR CARDINA C CATHETER ZATI ON   0.000000   0   0   0   0   0   55.00   05800   MRI C CATHETER ZATI ON   0.000000   0   0   0   0   0   0   0	3. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C   0.000000   0   0   0   5   5   5   5   0   0	4. 00
57. 00   05700   CT SCAN   0.000000   0   0   0   0   58. 00   05800   MRI   0.000000   0   0   0   0   0   59. 00   05900   CARDI AC CATHETERI ZATI ON   0.000000   0   0   0   0   0   0   0	5.00
58.00   05800   MRI   0.000000   0   0   0   0   55.00   05900   0.000000   0   0   0   0   0   0	6. 00
59. 00 05900 CARDI AC CATHETERI ZATION	7. 00
60. 00   66000   LABORATORY   0.000000   0   0   0   0   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL   0.000000   0   0   0   0   0   0   66. 230   06250   BLOOD CLOTTING FOR HEMOPHILIACS   0.000000   0   0   0   0   0   0   66. 00   06500   RESPIRATORY THERAPY   0.000000   0   0   0   0   0   0   0	8. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 0 0 0 0 0 0 6 6 6 2 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9. 00
62. 30   06250   BLOOD CLOTTING FOR HEMOPHILIACS   0.000000   0   0   0   0   0   6   6   5   0   0   0   0   0   0   0   0   0	0. 00 2. 00
65. 00	2. 30
66. 00 06600 PHYSICAL THERAPY	5. 00
67. 00 06700 OCCUPATIONAL THERAPY	6. 00
69. 00	7. 00
71. 00	8. 00
72. 00	9. 00
73. 00	1.00
74. 00	2.00
76. 97	'3. 00 '4. 00
76. 98	4. 00 76. 97
76. 99	6. 98
78. 00	6. 99
OUTPATIENT SERVICE COST CENTERS   O. 000000   O   O   O   O   O   O   O   O	7.00
90. 00   09000   CLI NI C   0.000000   0   0   0   9   9   9   0.01   09016   CLI NI C   NOT USED   0.000000   0   0   0   0   9   9   9   0.02   09001   PSYCH CLI NI C   0.000000   0   0   0   0   0   0   9   9	8. 00
90. 01   09016   CLINI C-NOT USED   0.000000   0   0   9   9   9   0   0   9   9	90. 00
90. 02   09001   PSYCH CLINIC   0.000000   0   0   0   9   9   9   9   0   0	0. 00
90. 03   09002   PSYCH CLINIC FEE BASED   0.000000   0   0   9   9   9   9   9   0   0	0. 02
90. 05   09004   CANCER CLINIC   0. 000000   0   0   0   9   9   9   9   9	0. 03
90. 06   09005   PEDIATRIC CLINIC   0. 000000   0   0   0   9	0. 04
	0. 05
90 07 1090061W0MENS CLINIC 1 0 00000001 01 01 01 01 01	0.06
	0. 07
	90. 08 90. 09
	0. 09
	0. 10
	0. 12
	0. 13
	0. 14
	0. 15
	0. 16
	0. 17
	90. 18 91. 00
	91. 00
	2. 00
93. 99   09399   PARTI AL HOSPI TALI ZATI ON PROGRAM   0. 000000   0   0   0   9   9	3. 99

93. 99 95.00 0 200. 00

Health Financial Systems	TRINITAS HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-0027	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre	pared:
		10 12,01,2020	5/30/2024 10:	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

-		Title XVIII	Hospi tal	5/30/2024 10: PPS	12 am_
	Cost Center Description	THE AVIII	nospi tai	113	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		38. 702	1. 00
2. 00	Inpatient days (including private room days and swing bed days)			38, 702	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day		vate room days,	0	3. 00
	do not complete this line.	, , , , , , , , , , , , , , , , , , ,	3		
4.00	Semi-private room days (excluding swing-bed and observation be			34, 078	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private rooms	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) at tel becember :	of the cost	U	0.00
7.00	Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	a the Drogram (eveluding	cwing had and	7, 028	9. 00
9.00	newborn days) (see instructions)	of the Program (excruding	Swifig-bed and	7,020	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days)	0	10. 00
	through December 31 of the cost reporting period (see instruc-		,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12.00	December 31 of the cost reporting period (if calendar year, el		a maam daysa)	0	12 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	t only (flictually private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period	a through Dagambar 21 of	the cost	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through becember 31 of	the cost	0.00	19. 00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0.00	20. 00
	reporting period	_			
21. 00	Total general inpatient routine service cost (see instructions		ing ported (Line	46, 438, 821	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost report	ing period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	X Time 19)  Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	neriod (line 8	0	25. 00
20.00	x line 20)	or the cost reporting	perred (Trie 6	o o	20.00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		46, 438, 821	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had sh	arace)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	d and observation bed ch	ai ges)	0	
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mi)		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 35)	ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fforential (line	0 46, 438, 821	36. 00 37. 00
37.00	27 minus line 36)	and private room cost ur	Transmittal (TITIE	70, 430, 021	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see	,		1, 199. 91	
39.00	Program general inpatient routine service cost (line 9 x line	,		8, 432, 967	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0 8, 432, 967	40. 00 41. 00
	1.042. Trogram general impatreme routine service cost (Title 37			5, 752, 707	

COMPLIT	Financial Systems ATION OF INPATIENT OPERATING COST	TRINITAS HO	Provider CO	N. 31_0027	Peri od:	eu of Form CMS-2 Worksheet D-1	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider Co	JN: 31-0027	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
			Title	XVIII	Hospi tal	5/30/2024 10: PPS	12 am
	Cost Center Description	Total Inpatient Costl	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00				42. 00
	Intensive Care Type Inpatient Hospital Units		E 400			0.040.700	
43. 00 44. 00	INTENSIVE CARE UNIT	12, 896, 623	5, 602	2, 302.	15 1, 409	3, 243, 729	43.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					18, 707, 217	
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				, column 1)	0 30, 383, 913	
49.00	PASS THROUGH COST ADJUSTMENTS	41 till ough 46.01	) (see Thistruc	ti ons)		30, 363, 913	49.00
50.00	Pass through costs applicable to Program inp	atient routine s	services (from	Wkst. D, su	m of Parts I and	553, 502	50. 00
51. 00	<pre>       Pass through costs applicable to Program inp</pre>	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	443, 249	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				996, 751	52. 00
53. 00	Total Program inpatient operating cost exclu		ated, non-phy	sician anest	hetist, and	29, 387, 162	1
	medical education costs (line 49 minus line		. ,				
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge						55. 00
55. 01	Permanent adjustment amount per discharge					0.00	
55. 02 56. 00	Adjustment amount per discharge (contractor					0.00	55. 02 56. 00
57. 00							57.00
58.00	0 Bonus payment (see instructions)						58. 00
59. 00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)						59. 00
60.00	00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the						60.00
61. 00	market basket) Continuous improvement bonus payment (if lin	e 53 ÷ line 54 i	s less than t	he lowest of	lines 55 plus	0	61. 00
	55.01, or line 59, or line 60, enter the les		,				
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	60), or 1 % of	the target am	ount (line 5	6), otherwise		
62.00	Relief payment (see instructions)					0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instruc	ctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost report	ina period (See	0	64. 00
	instructions)(title XVIII only)	Ü		·			
65. 00	<pre>Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after Decembe	er 31 of the c	ost reportin	g period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	5)(title XVI	II only); for	0	66. 00
<b>.</b>	CAH, see instructions		D 1 04	6.11			(7.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	December 31 o	T the cost r	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N						1
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c				)		70.00
72.00	Program routine service cost (line 9 x line		110 70 1 11110				72. 00
73. 00	Medically necessary private room cost applic			ne 35)			73. 00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		orkshoot R	Part II column		74. 00 75. 00
73.00	26, line 45)	Toutine service	COSTS (TIOII W	orksneet b,	rait II, corumii		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		ovi der record	s)			79.00
80.00	Total Program routine service costs for comp	arison to the co		•	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi						81. 00 82. 00
83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (						83.00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85.00	Utilization review - physician compensation						85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)				86. 00
07.00	Total observation bed days (see instructions					4, 624	87. 00
87. 00 88. 00	Adjusted general inpatient routine cost per					1, 199. 91	88.00

Health Financial Systems	TRINITAS H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 10:	pared: 12 am_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 426, 189	46, 438, 821	0. 05224	5, 548, 384	289, 875	90.00
91.00 Nursing Program cost	0	46, 438, 821	0.00000	5, 548, 384	0	91.00
92.00 Allied health cost	0	46, 438, 821	0.00000	0 5, 548, 384	0	92.00
93.00 All other Medical Education	0	46, 438, 821	0.00000	5, 548, 384	0	93. 00

Health Financial Systems	TRINITAS HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-0027	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 31-S027		Date/Time Prepared: 5/30/2024 10:12 am
	Title XVIII	Subprovi der -	PPS
		IDE	

		litle XVIII	Supprovider -	PPS	
	Cost Center Description				
	DADT I ALL DROW DED COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		19, 391	1. 00
2.00	Inpatient days (including private room days, excluding swing-			19, 391	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3. 00
4 00	do not complete this line.	ad daya)		10 201	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	19, 391 0	4. 00 5. 00
0.00	reporting period	om dayo, em oagn becombe	. 0. 0	Ü	0.00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		24 6 11		7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	n davs) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	3 7			
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 238	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	alv (including private r	oom dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruc-	tions)	oom days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days) after	0	11. 00
10.00	December 31 of the cost reporting period (if calendar year, e				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	confy (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
10.00	reporting period	<del></del>	46	0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after becember 31 of	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	0.00	19. 00		
	reporting period	6. 6. 6.			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		23, 978, 576	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportin	a ported (line 4	0	23. 00
23.00	x line 18)	31 of the cost reportin	g perrou (i'ille o	U	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25 00	7 x line 19)	)1 -£			25 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	or the cost reporting	period (iine 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		23, 978, 576	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had ch	argos)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed en	ai ges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 mi)	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x li	, ,	- /	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	23, 978, 576	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 236. 58	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			2, 767, 466 0	
	Total Program general inpatient routine service cost (line 39	•		2, 767, 466	
	, , , , , , , , , , , , , , , , , , , ,	•	'		

	Financial Systems ATION OF INPATIENT OPERATING COST	TRINITAS HO	Provider CCN: 31-0027	Peri od:	u of Form CMS-2 Worksheet D-1	
			Component CCN: 31-S027	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 10:	
			Title XVIII	Subprovi der - I PF	PPS	12 (111)
	Cost Center Description	Total npatient Costlr	Total Average Per patient Days Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00 3.00 0 0.	4. 00 00 0	5. 00	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	0 0.	00 0	0	43. 00
44. 00 45. 00 46. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT		0.	00 0	0	44. 00 45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description					47. 00
48. 00	Program inpatient ancillary service cost (Wkst	D-3 col 3	line 200)		1. 00 213, 612	48. 00
48. 01 49. 00	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines 41 PASS THROUGH COST ADJUSTMENTS	cost (Workshee	et D-6, Part III, line 10	, column 1)	2, 981, 078	48. 01
50. 00	Pass through costs applicable to Program inpat	ient routine se	ervices (from Wkst. D, su	m of Parts I and	108, 498	50. 00
51.00	Pass through costs applicable to Program inpat and IV)	,	services (from Wkst. D,	sum of Parts II	4, 545	
52. 00 53. 00	Total Program excludable cost (sum of lines 50 Total Program inpatient operating cost excluding medical education costs (line 49 minus line 52 TARGET AMOUNT AND LIMIT COMPUTATION	ng capital rela	ited, non-physician anest	hetist, and	113, 043 2, 868, 035	
54. 00	Program di scharges				0	
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge				0. 00 0. 00	
	Adjustment amount per discharge (contractor use				0.00	
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55.0 Difference between adjusted inpatient operation		not amount (line E4 minus	lino E2)	0	
58. 00	Bonus payment (see instructions)	y cost and tare	get amount (Time 50 minus	111le 53)	0	1
59. 00	Trended costs (lesser of line 53 ÷ line 54, or	line 55 from 1	the cost reporting period	endi ng 1996,	0. 00	59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 $\div$ line 54, o market basket)				0.00	
61. 00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the lesse 53) are less than expected costs (lines 54 x 60 enter zero. (see instructions)	r of 50% of the	e amount by which operati	ng costs (line	0	61. 00
62. 00	Relief payment (see instructions)				0	
63. 00	Allowable Inpatient cost plus incentive paymen PROGRAM INPATIENT ROUTINE SWING BED COST	t (see instruct	i ons)		0	63.00
64. 00	Medicare swing-bed SNF inpatient routine costs instructions)(title XVIII only)	through Decemb	per 31 of the cost report	ing period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine costs	after December	31 of the cost reportin	g period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine</pre>	costs (line 64	l plus line 65)(title XVI	ll only); for	0	66. 00
	CAH, see instructions	·		3,7		
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	costs through t	December 31 of the cost r	eporting period	0	67. 00
68. 00 69. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient ro		•	orting period	0	
	PART III - SKILLED NURSING FACILITY, OTHER NURS	SING FACILITY,	AND ICF/IID ONLY			
70. 00 71. 00	Skilled nursing facility/other nursing facility Adjusted general inpatient routine service cos			)		70.00
72. 00	Program routine service cost (line 9 x line 71)	)	·			72. 00
73.00	Medically necessary private room cost applicab					73.00
74. 00 75. 00	Total Program general inpatient routine service Capital-related cost allocated to inpatient rou 26, line 45)	utine service o		Part II, column		74. 00 75. 00
76.00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line 76	. *				76. 00 77. 00
	Inpatient routine service cost (line 74 minus	line 77)				78. 00
79.00	Aggregate charges to beneficiaries for excess			nuc line 70)		79.00
80. 00 81. 00	Total Program routine service costs for compar Inpatient routine service cost per diem limita		st ithiitation (line 78 Mi	ius iiile /9)		80.00
82. 00	Inpatient routine service cost limitation (line					82. 00
83.00	Reasonable inpatient routine service costs (se					83.00
84. 00 85. 00	Program inpatient ancillary services (see inst Utilization review - physician compensation (se		5)			84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum o	flines 83 thro				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST			^	07 00
	Total observation bed days (see instructions)				0	87.00

Health Financial Systems	TRI NI TAS I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 10:	
		Title	XVIII	Subprovi der -	PPS	
				I PF		
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)		-		0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	940, 046	23, 978, 576	0. 03920	0	0	90.00
91.00 Nursing Program cost	0	23, 978, 576	0.00000	0 0	0	91.00
92.00 Allied health cost	0	23, 978, 576	0.00000	0	0	92.00
93.00 All other Medical Education	0	23, 978, 576	0. 00000	0	0	93. 00

Health Financial Systems	TRINITAS HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-0027	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 31-5442	To 12/31/2023	Date/Time Prepared: 5/30/2024 10:12 am
	Title XVIII	Skilled Nursing	PPS
		Facility	

		litle XVIII	Facility	PPS	
	Cost Center Description			1	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		4, 311	1. 00
2.00	Inpatient days (including private room days, excluding swing-			4, 311	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	ivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed davs)		4, 311	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5. 00
	reporting period	d) - <del>-</del>	24 - 5 + 1 +	0	/ 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December	31 OF the COST	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	m days) after December 3	1 of the cost	0	8. 00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	2, 325	9. 00
	newborn days) (see instructions)		-		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instructions)		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including privat	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye			· ·	10.00
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
10.00	reporting period	<del></del> D 21 - <del>-</del>	+1	0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es arter becember 31 01	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		1, 194, 749	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	n period (line 6	0	23. 00
23.00	x line 18)	31 of the cost reportin	g perrou (Triic o	O	25.00
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December :	31 of the cost reporting	period (line 8	0	25. 00
23.00	x line 20)	or the cost reporting	perrou (Trile o	O	25.00
	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		1, 194, 749	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00			, ,	0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0. 000000 0. 00	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 mi)	nus line 33)(see instruc	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	•
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 1, 194, 749	36. 00 37. 00
37.00	27 minus line 36)	and private room cost dr	Troncincial (Title	1, 174, 149	37.00
	PART II - HOSPITÁL AND SUBPROVIDERS ONLY				
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line				38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Progra				40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)			41. 00

	Financial Systems ATION OF INPATIENT OPERATING COST	TRINITAS		CCN: 31-0027	In Lie	worksheet D-1	
UMPU I	ATTON OF INPATTENT OPERATING COST			CCN: 31-0027 CCN: 31-5442	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 10:	pared
			Ti tl	e XVIII	Skilled Nursing Facility	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day	Average Per sDiem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2.00	3.00	4. 00	5.00	
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	5					42. 0
3. 00	INTENSIVE CARE UNIT	5		1			43. 0
	CORONARY CARE UNIT						44. 0
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 0
	OTHER SPECIAL CARE (SPECIFY)						47. (
	Cost Center Description			•			
8. 00	Program inpatient ancillary service cost (W	lkst D_3 col '	3 line 200)			1.00	48. 0
	Program inpatient cellular therapy acquisit			: III, line 10	, column 1)		48. 0
9. 00	Total Program inpatient costs (sum of lines	41 through 48.0	01)(see instru	ıcti ons)	,		49. (
0. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program in	nationt routing	convices (fra	m Wkst D su	m of Dorte L and		50. (
0. 00	[11]	ipatrent routine	services (iic	oni wkst. D, Sui	iii Oi Faits i aliu		30.
1. 00	Pass through costs applicable to Program in	patient ancilla	ry services (f	rom Wkst. D,	sum of Parts II		51. (
2. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)					52. (
3. 00	•		elated, non-ph	ysician anestl	hetist, and		53. (
	medical education costs (line 49 minus line	52)					-
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						54.
	Target amount per discharge						55.
	Permanent adjustment amount per discharge						55.
5. 02 6. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 5						55. 56.
	Difference between adjusted inpatient opera			line 56 minus	line 53)		57.
8. 00	Bonus payment (see instructions)	Ü			,		58.
9. 00	Trended costs (lesser of line 53 ÷ line 54,		n the cost rep	orting period	endi ng 1996,		59.
0. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					60.	
1. 00	Continuous improvement bonus payment (if li 55.01, or line 59, or line 60, enter the le 53) are less than expected costs (lines 54 enter zero. (see instructions)	esser of 50% of	the amount by	which operation	ng costs (line		61.
2. 00	Relief payment (see instructions)						62.
3. 00	Allowable Inpatient cost plus incentive pay	ment (see instru	uctions)				63.
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of th	ne cost report	ing period (See		64.
	instructions)(title XVIII only)	· ·		•			
5. 00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts after Decemb	per 31 of the	cost reporting	g period (See		65.
6. 00	Total Medicare swing-bed SNF inpatient rout CAH, see instructions		•		•		66.
7. 00	Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	_					67.
8. 00 9. 00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20) Total title V or XIX swing-bed NF inpatient			·	orting period		68.
	PART III - SKILLED NURSING FACILITY, OTHER	NURSING FACILITY	, AND ICF/IID	ONLY			
	Skilled nursing facility/other nursing faci				)	1, 194, 749	1
	Adjusted general inpatient routine service Program routine service cost (line 9 x line		ine /U ÷ line	: 2)		277. 14 644, 351	1
3. 00	Medically necessary private room cost appli	cable to Program	•	,		0	73.
4. 00 5. 00	Total Program general inpatient routine ser	•		•	Dart II column	644, 351	
	Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ l		e costs (trom	worksneet B,	Part II, column	0.00	
	Program capital -related costs (line 9 x lin					0.00	1
8. 00	Inpatient routine service cost (line 74 min	.*		!->		0	
9. 00 0. 00	Aggregate charges to beneficiaries for exce Total Program routine service costs for com				nus line 79)	0	
1. 00	Inpatient routine service costs for com	•	Jose Timi tati U	(11110 /0 11111	11110 17)	0.00	1
2. 00	Inpatient routine service cost limitation (	line 9 x line 8	•			0	1
	Reasonable inpatient routine service costs Program inpatient ancillary services (see i		ns)			644, 351 256, 444	1
	Utilization review - physician compensation		ons)			256, 444	
6. 00	Total Program inpatient operating costs (su	m of lines 83 th				900, 795	1
	PART IV - COMPUTATION OF OBSERVATION BED PA Total observation bed days (see instruction					Ιο	   87.
7. 00						i U	/ .

Health Financial Systems	TRI NI TAS	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (	CCN: 31-5442	From 01/01/2023 To 12/31/2023		
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	0	0	0.00000	00	0	90. 00
91.00 Nursing Program cost	0	0	0.00000	0 0	0	91.00
92.00 Allied health cost	0	0	0. 00000	00	0	92.00
93.00 All other Medical Education	0	0	0. 00000	00 0	0	93. 00

Health Financial Systems	TRINITAS HOSPITAL	In Lie	u of Form CMS-2552	-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-0027	Peri od: From 01/01/2023	Worksheet D-1	
		To 12/31/2023	Date/Time Prepare 5/30/2024 10:12 a	
	Title XIX	Hospi tal	TEFRA	
Cost Center Description				

		Title XIX	Hospi tal	5/30/2024 10: TEFRA	12 am		
	Cost Center Description	TI LIE XIX	nospi tai	TETIVA			
	PART I - ALL PROVIDER COMPONENTS			1. 00			
	INPATIENT DAYS						
1.00	Inpatient days (including private room days and swing-bed days			38, 702	1. 00		
2.00	Inpatient days (including private room days, excluding swing-	<i>3</i> ,		38, 702 0	2. 00 3. 00		
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.						
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		34, 078	4. 00		
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost						
	reporting period	om daya) after Dacambar (	21 of the cost	0	4 00		
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) arter becember .	si oi the cost	0	6. 00		
7.00	Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7. 00		
0.00	reporting period		1 -6	0	0.00		
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after becember 3	or the cost	0	8. 00		
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	3, 921	9. 00		
40.00	newborn days) (see instructions)				40.00		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc-		oom days)	0	10. 00		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00		
	December 31 of the cost reporting period (if calendar year, er			_			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	Conly (including private	e room days)	0	12. 00		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	13. 00		
	after December 31 of the cost reporting period (if calendar ye						
14.00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed o	days)	2 222	14.00		
15. 00 16. 00	Nursery days (title V or XIX only)			3, 332 1, 849			
	SWING BED ADJUSTMENT			.,, 0.,,	10.00		
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00		
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	as after December 31 of	the cost	0.00	18. 00		
10.00	reporting period	a trei becember 31 01	the cost	0.00	10.00		
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00		
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00		
20.00	reporting period	s arter becember 31 or tr	ie cost	0.00	20.00		
21. 00	Total general inpatient routine service cost (see instructions			46, 438, 821	1		
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	er 31 of the cost reporti	ng period (line	0	22. 00		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00		
	x line 18)	•					
24. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ ine 19)	1 31 of the cost reportion	ng period (line	0	24. 00		
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00		
	x line 20)						
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(Line 21 minus Line 24)		0 46, 438, 821	26. 00 27. 00		
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIE 21 IIITIUS TITIE 20)		40, 430, 621	27.00		
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00		
29. 00	Private room charges (excluding swing-bed charges)			0	1		
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	30. 00 31. 00		
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11110 20)		0.00	1		
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1		
34.00	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x line		tions)	0.00	1		
35. 00 36. 00	Private room cost differential adjustment (line 3 x line 35)	IC 31)		0.00	35. 00 36. 00		
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	46, 438, 821	37. 00		
	27 minus line 36)						
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS					
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 199. 91	38. 00		
39. 00	Program general inpatient routine service cost (line 9 x line	-		4, 704, 847	39. 00		
40.00	Medically necessary private room cost applicable to the Program	,		4 704 947	40.00		
41.00	Total Program general inpatient routine service cost (line 39	+ ITHE 40)	l	4, 704, 847	41.00		

Hoal +h	Financial Systems	TRINITAS HOS	SPI TAI		In Lie	u of Form CMS-2	2552.1A
	Financial Systems ATION OF INPATIENT OPERATING COST	INTINITAS HUS	Provider CCN: 31	-0027 Pe	IN LIE eri od:	Worksheet D-1	2002-10
					om 01/01/2023	Date/Time Prep 5/30/2024 10:	
			Title XIX		Hospi tal	TEFRA	
	Cost Center Description	Total atient Cost In	patient Days Diem		Program Days	Program Cost (col. 3 x col.	
		1. 00		ol . 2) 3. 00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	2, 898, 280	3, 332	869. 83	1, 849	1, 608, 316	42. 00
40.00	Intensive Care Type Inpatient Hospital Units	10.00/ (00	F (00	0 000 45	F00	4 000 440	40.00
43. 00 44. 00	INTENSIVE CARE UNIT	12, 896, 623	5, 602	2, 302. 15	530	1, 220, 140	43. 00 44. 00
45.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						45.00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1 00	
48. 00	Program inpatient ancillary service cost (Wkst.	D-3 col 3	line 200)			1. 00 6, 053, 004	48. 00
48. 01	Program inpatient cellular therapy acquisition of			line 10, o	column 1)	0, 033, 004	48. 01
49. 00	Total Program inpatient costs (sum of lines 41 t				,	13, 586, 307	49. 00
F0 00	PASS THROUGH COST ADJUSTMENTS				6.5. 1. 1. 1	205 520	
50. 00	Pass through costs applicable to Program inpatie	ent routine se	ervices (Trom WKST	. D, SUM (	or Parts I and	385, 538	50.00
51.00	Pass through costs applicable to Program inpatie and IV)	ent ancillary	services (from Wk	st. D, sur	n of Parts II	161, 175	51.00
52.00	Total Program excludable cost (sum of lines 50 a					546, 713	
53. 00	Total Program inpatient operating cost excluding medical education costs (line 49 minus line 52)	g capital rela	nted, non-physicia	n anesthe	ist, and	13, 039, 594	53. 00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION					4 750	F4 00
54. 00 55. 00	Program discharges Target amount per discharge					1, 750 5, 438. 16	54.00
55. 01	Permanent adjustment amount per discharge					0.00	•
55. 02	Adjustment amount per discharge (contractor use	onl y)				0. 00	•
56.00	Target amount (line 54 x sum of lines 55, 55.01,					9, 516, 780	56.00
57. 00	Difference between adjusted inpatient operating	cost and targ	get amount (line 5	6 minus li	ne 53)	-3, 522, 814	1
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54, or l	ino 55 from t	ho cost roporting	ported or	nding 1006	0 00	58. 00 59. 00
37.00	updated and compounded by the market basket)			•			
60. 00	Expected costs (lesser of line 53 ÷ line 54, or market basket)	line 55 from	prior year cost r	eport, upo	dated by the	0. 00	60.00
61. 00	Continuous improvement bonus payment (if line 53 55.01, or line 59, or line 60, enter the lesser 53) are less than expected costs (lines 54 x 60) enter zero. (see instructions)	of 50% of the	amount by which	operati ng	costs (line	0	61.00
62. 00	Relief payment (see instructions)					951, 678	62. 00
63. 00	Allowable Inpatient cost plus incentive payment	(see instruct	i ons)			11, 015, 171	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs 1	hrough Decemb	per 31 of the cost	reportino	n period (See	0	64. 00
01.00	instructions)(title XVIII only)	in odgir beceme	or or the cost	ropor trig	g perrou (occ	G	01.00
65. 00	Medicare swing-bed SNF inpatient routine costs a instructions)(title XVIII only)	ifter December	31 of the cost r	eporting p	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routine of CAH, see instructions	costs (line 64	l plus line 65)(ti	tle XVIII	only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine co (line 12 x line 19)	sts through [	December 31 of the	cost repo	orting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine co (line 13 x line 20)	sts after Dec	cember 31 of the c	ost repor	ing period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient rout					0	69. 00
70 00	PART III - SKILLED NURSING FACILITY, OTHER NURSI			line 27)			70.00
70. 00 71. 00	Skilled nursing facility/other nursing facility/ Adjusted general inpatient routine service cost			1111e 3/)			70. 00 71. 00
72. 00	Program routine service cost (line 9 x line 71)	, 3. 5 (111					72.00
73. 00	Medically necessary private room cost applicable			)			73. 00
74.00	Total Program general inpatient routine service		•	+			74.00
75. 00	Capital-related cost allocated to inpatient rout 26, line 45)	ine service o	JUSTS (Trom Worksh	eet B, Pai	ι ΙΙ, COIUMN		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line 2	2)					76. 00
77. 00	Program capital-related costs (line 9 x line 76)						77. 00
78.00	Inpatient routine service cost (line 74 minus li	•	vi dor rocarda)				78.00
79. 00 80. 00	Aggregate charges to beneficiaries for excess control of the contr			e 78 minus	s line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limitati						81.00
82.00	Inpatient routine service cost limitation (line	9 x line 81)					82. 00
83.00	Reasonable inpatient routine service costs (see						83.00
84.00	Program inpatient ancillary services (see instru		.)				84.00
85. 00 86. 00	Utilization review - physician compensation (see Total Program inpatient operating costs (sum of						85. 00 86. 00
55. 50	PART IV - COMPUTATION OF OBSERVATION BED PASS TH		,ugii 00)				35.00
87. 00	Total observation bed days (see instructions)					4, 624	•
	Indicated general inputions routing each per dien	. (1: 07 1				1 100 01	88. 00
88. 00 89. 00	Adjusted general inpatient routine cost per dien Observation bed cost (line 87 x line 88) (see in		ine 2)			1, 199. 91 5, 548, 384	

Health Financial Systems	TRINITAS H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023		
				To 12/31/2023	Date/Time Prep 5/30/2024 10:	
		T: +1	o VIV	Hooni tol		12 alli
			e XIX	Hospi tal	TEFRA	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capi tal -related cost	2, 426, 189	46, 438, 821	0. 05224	5, 548, 384	289, 875	90.00
91.00 Nursing Program cost	0	46, 438, 821	0.00000	5, 548, 384	0	91.00
92.00 Allied health cost	0	46, 438, 821	0.00000	5, 548, 384	0	92.00
93.00 All other Medical Education	o	46, 438, 821	0.00000	0 5, 548, 384	0	93. 00

Health Financial Systems	TRI NI TAS HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-0027	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 31-S027		Date/Time Prepared: 5/30/2024 10:12 am
	Title XIX	Subprovi der -	TEFRA
		IDE	

		litle XIX	Subprovider -   IPF	TEFRA	
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			19, 391	1. 00
2.00	Inpatient days (including private room days, excluding swing-			19, 391	2.00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		19, 391	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) arter becember	or or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	m days) after December 2	1 of the cost	0	8. 00
6.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceilbei s	i or the cost	U	8.00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	1, 593	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv. (i naludi na privata r	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		Juli days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
12 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		a room days)	0	12. 00
12. 00	through December 31 of the cost reporting period	t only (flictually private	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14.00	after December 31 of the cost reporting period (if calendar ye			0	14 00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	all (excluding swing-bed	uays)	3, 332	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)				16. 00
47.00	SWING BED ADJUSTMENT			0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
40.00	reporting period			0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	5)		23, 978, 576	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
22.00	5 x line 17)	24 -6 -1		0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December   x line 18)	31 of the cost reporting	g period (iine 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	R1 of the cost reporting	neriod (line 8	0	25. 00
23.00	x line 20)	or the cost reporting	perrou (Trie o	O	23.00
	Total swing-bed cost (see instructions)	(11 04 1 11 04)		0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		23, 978, 576	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges)   General inpatient routine service cost/charge ratio (line 27 -	· Lino 20)		0. 000000	30. 00 31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	- IIIle 20)		0.00000	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 min		tions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	23, 978, 576	37. 00
	27 minus line 36)	·	•		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 236. 58	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		1, 969, 872	39. 00
40.00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 1, 969, 872	
41.00	Trotal Trogram general impatrent routine service cost (ITHE 39	+ 11116 40)	I	1, 707, 0/2	41.00

	Financial Systems TRINI ATION OF INPATIENT OPERATING COST	Provider CCN: 31-0027	Period: From 01/01/2023	worksheet D-1	
		Component CCN: 31-S027	To 12/31/2023	Date/Time Pre 5/30/2024 10:	
		Title XIX	Subprovi der - I PF	TEFRA	12 (
	Cost Center Description Total Inpatient	Total Average Per Cost Inpatient Days Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)		4. 00 00 0	5. 00	42. 0
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT		00 0	0	
44. 00 45. 00 46. 00	CORONARY CARE UNIT  BURN INTENSIVE CARE UNIT  SURGICAL INTENSIVE CARE UNIT  OTHER SPECIAL CARE (SPECIFY)  Cost Center Description	0 0.	00	0	44. 0 45. 0 46. 0 47. 0
	·			1. 00	
48. 00 48. 01 49. 00	Program inpatient ancillary service cost (Wkst. D-3, c Program inpatient cellular therapy acquisition cost (W Total Program inpatient costs (sum of lines 41 through PASS THROUGH COST ADJUSTMENTS	lorksheet D-6, Part III, line 10	, column 1)	0 0 1, 969, 872	48. 0
50. 00	Pass through costs applicable to Program inpatient rou	itine services (from Wkst. D, su	m of Parts I and	77, 229	50. 0
51. 00	<pre>III) Pass through costs applicable to Program inpatient anc and IV)</pre>		sum of Parts II	0	51.0
52. 00 53. 00	Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capit medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION		hetist, and	77, 229 1, 892, 643	
54. 00 55. 00	Program discharges Target amount per discharge			176 0. 00	
55. 01	Permanent adjustment amount per discharge			0. 00	55. 0
56. 00	,			0. 00 0	56. 0
57. 00 58. 00	Difference between adjusted inpatient operating cost a Bonus payment (see instructions)	and target amount (line 56 minus	line 53)	-1, 892, 643 0	
59. 00	Trended costs (lesser of line 53 ÷ line 54, or line 55	from the cost reporting period	endi ng 1996,	0. 00	
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 5 market basket)	5 from prior year cost report,	updated by the	0.00	60. 0
61. 00	Continuous improvement bonus payment (if line 53 ÷ lin 55.01, or line 59, or line 60, enter the lesser of 50% 53) are less than expected costs (lines 54 x 60), or 1 enter zero. (see instructions)	of the amount by which operati	ng costs (line	0	61.0
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see i PROGRAM INPATIENT ROUTINE SWING BED COST	nstructions)		0 77, 229	1
64. 00	Medicare swing-bed SNF inpatient routine costs through	December 31 of the cost report	ing period (See	0	64. 0
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after D</pre>	December 31 of the cost reportin	g period (See	0	65. 0
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (</pre>	line 64 plus line 65)(title XVI	ll only); for	0	66. 0
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routine costs th	irough December 31 of the cost r	eporting period	0	67. 0
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine costs af	-		0	68. 0
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine co PART III - SKILLED NURSING FACILITY, OTHER NURSING FAC	ests (line 67 + line 68)	3 1 2	0	
70. 00	Skilled nursing facility/other nursing facility/ICF/II	D routine service cost (line 37	)		70.0
71. 00 72. 00	Adjusted general inpatient routine service cost per di Program routine service cost (line 9 x line 71)	em (line 70 ÷ line 2)			71. 0
73.00	Medically necessary private room cost applicable to Pr				73. 0
74. 00 75. 00	Total Program general inpatient routine service costs Capital-related cost allocated to inpatient routine se 26, line 45)		Part II, column		74. 0 75. 0
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line 2) Program capital-related costs (line 9 x line 76)				76. 0 77. 0
78. 00	Inpatient routine service cost (line 74 minus line 77)				78. 0
79. 00 80. 00	Aggregate charges to beneficiaries for excess costs (f Total Program routine service costs for comparison to		nus line 79)		79. 0 80. 0
81. 00	Inpatient routine service cost per diem limitation		- ',		81. 0
82. 00 83. 00	Inpatient routine service cost limitation (line 9 x li Reasonable inpatient routine service costs (see instru				82. 0
84. 00	Program inpatient ancillary services (see instructions	5)			84. 0
85. 00 86. 00	Utilization review - physician compensation (see instr Total Program inpatient operating costs (sum of lines				85. 0 86. 0
30.00	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH (				
87. 00	Total observation bed days (see instructions)			0	87.0

Heal th Financial	Systems	TRINITAS I	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF I	NPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
			Component (		From 01/01/2023 To 12/31/2023		
			Ti tl	e XIX	Subprovi der -	TEFRA	
					I PF		
Cos	t Center Description						
						1. 00	
89.00 Observati	on bed cost (line 87 x line 88) (se	e instructions)				0	89. 00
Cos	t Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
			(from line 21)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
		1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATI	ON OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capi tal -r	elated cost	940, 046	23, 978, 576	0. 03920	0	0	90.00
91.00 Nursing P	rogram cost	0	23, 978, 576	0. 00000	0 0	0	91.00
92.00 Allied he	alth cost	0	23, 978, 576	0. 00000	0 0	0	92.00
93.00 All other	Medical Education	0	23, 978, 576	0. 00000	0 0	0	93. 00

near tri Fritaliciai Systems IRINITAS no.		1-		u oi roilli (1/13-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN:	31-0027   F	Peri od:	Worksheet D-3	
			rom 01/01/2023	D 1 /T' D	
			To 12/31/2023	Date/Time Pre	pared:
				5/30/2024 10:	12 am_
	Title X	VIII	Hospi tal	PPS	
Cost Center Description	Ra	atio of Cost	Inpati ent	Inpati ent	
·		To Charges	Program	Program Costs	
		ro onar ges		(col . 1 x col .	
			Chai ges		
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			87, 429, 628		30.00
31. 00   03100   NTENSI VE CARE UNI T					31.00
			37, 895, 841		1
40. 00   04000   SUBPROVI DER - I PF			0		40. 00
41. 00   04100   SUBPROVI DER - I RF			0		41. 00
42. 00  04200  SUBPROVI DER			0		42.00
43. 00   04300   NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					10.00
		0 17057	1 11 010 055	0.011.550	
50. 00   05000   OPERATI NG ROOM		0. 179577		2, 014, 559	50. 00
51.00  05100 RECOVERY ROOM		0. 274525	1, 190, 712	326, 880	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 652155	31, 330	20, 432	52.00
53. 00   05300   ANESTHESI OLOGY		0. 121291		72, 826	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 187789		954, 877	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C		0. 795875	97, 797	77, 834	55. 00
56. 00  05600  RADI 0I SOTOPE		0. 053105	870, 673	46, 237	56. 00
57. 00  05700 CT SCAN		0. 026293	10, 760, 600	282, 928	57.00
58. 00   05800   MRI		0. 062483		163, 017	58.00
					1
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 178881		629, 089	59. 00
60. 00  06000 LAB0RATORY		0. 112042	2 20, 275, 152	2, 271, 669	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0.004955	1, 103, 312	5, 467	62.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0. 000000		0	62. 30
65. 00   06500   RESPI RATORY THERAPY		0. 360878	5, 590, 823	2, 017, 605	65. 00
66. 00   06600   PHYSI CAL THERAPY		0. 397603	1, 300, 980	517, 274	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 135609	153, 139	20, 767	67.00
68. 00   06800   SPEECH PATHOLOGY		0. 223969		121, 444	68. 00
					•
69. 00   06900   ELECTROCARDI OLOGY		0. 045177		613, 761	•
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT		0. 488929	4, 373, 413	2, 138, 288	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 683729	2, 533, 006	1, 731, 890	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 172558		2, 941, 086	73. 00
					1
	ŀ	0. 311082		433, 263	74. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON		0.000000		0	76. 97
76. 98   O7698   HYPERBARI C OXYGEN THERAPY		0.000000	0	0	76. 98
76. 99 07699 LI THOTRI PSY		0.000000	ol ol	0	76. 99
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON		0. 000000		0	77. 00
					1
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY		0. 000000	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00   09000   CLI NI C		5. 105041	0	0	90.00
90. 01   09016   CLI NI C-NOT USED		0.000000	ol ol	0	90. 01
90. 02   09001   PSYCH CLINIC		1. 086310		0	90. 02
90. 03 O9002 PSYCH CLINIC FEE BASED		0.000000		0	90. 03
90. 04   09003   WORKFI RST		0.000000	0	0	90. 04
90. 05   09004   CANCER CLINIC		0.000000	ol ol	0	90. 05
90. 06   09005   PEDI ATRI C CLI NI C		1. 570654		0	1
				0	90.07
		0. 179744			
90. 08   09007   THERAPEUTI C SCHOOL		0. 261331		0	90. 08
90. 09   09008 AFTER SCHOOL PROGRAM		0.000000	0	0	90. 09
90. 10   09017   CLI NI C-NOT USED		0.000000		0	90. 10
90. 11   09009   PERI NATAL   ADDI CTI ON		0. 000000		0	90. 11
					1
90. 12   09010   THERAPEUTI C NURSERY		0.000000		0	90. 12
90. 13 O9011 CHILD DAY TREATMENT		0.000000	0	0	90. 13
90. 14   09012 DI ABETES CENTER		0.000000	ol ol	0	90. 14
90. 15   09013   WOUND CENTER		0. 144633		0	90. 15
90. 16   09014   MI CA		0.000000		0	90. 16
90. 17   09015 BAYONNE MENTAL HEALTH CENTER		0. 670740		0	90. 17
90. 18  09018  CLI NI C		0.000000	)  o	0	90. 18
91. 00   09100   EMERGENCY		0. 139231		1, 306, 024	91.00
91. 01   09101   PSYCH EMERGENCY		4. 654304		1, 300, 024	91. 01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 186583		0	92. 00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM		0. 000000	0	0	93. 99
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95. 00
			110 000 044	10 707 217	1
Total (sum of lines 50 through 94 and 96 through 98)	(1)		113, 255, 341	18, 707, 217	
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (Line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			113, 255, 341		202. 00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT  Cost Center Description	Component	CCN: 31-S027	Peri od: From 01/01/2023 To 12/31/2023 Subprovi der -	Worksheet D-3 Date/Time Pre 5/30/2024 10:
Cost Center Description	Title		Subprovi der -	1 0/ 00/ 2024 10
Cost Center Description		ID-+:E C4	I PF	PPS
		Ratio of Cost		Inpati ent
		To Charges	Program	Program Costs
			Charges	(col. 1 x col.
		1.00	2. 00	2) 3. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
D. 00   03000   ADULTS & PEDI ATRI CS			ļ	
I. 00  03100 INTENSIVE CARE UNIT D. 00  04000 SUBPROVIDER - IPF			10, 394, 766	
1. 00   04100   SUBPROVI DER - 1 PF			10, 394, 700	
2. 00   04200   SUBPROVI DER			ļ ļ	
3. 00   04300   NURSERY			ļ ļ	
ANCILLARY SERVICE COST CENTERS				
0. 00   05000   OPERATI NG ROOM		0. 17957		-
1.00  05100 RECOVERY ROOM 2.00  05200 DELIVERY ROOM & LABOR ROOM		0. 27452		-
2.00   05200   DELIVERY ROOM & LABOR ROOM 3.00   05300   ANESTHESI OLOGY		0. 65215 0. 12129		1
4. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 12127		1
5. 00   05500   RADI OLOGY-THERAPEUTI C		0. 79587		0
6. 00   05600   RADI 0I SOTOPE		0. 05310		0
7. 00   05700   CT   SCAN		0. 02629		1, 272
8. 00   05800   MRI		0.06248		
9. 00   05900   CARDI AC CATHETERI ZATI ON D. 00   06000   LABORATORY		0. 17888 0. 11204		0 49, 204
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 00495		
2.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		
5. 00 06500 RESPI RATORY THERAPY		0. 36087	8 0	0
6. 00 06600 PHYSI CAL THERAPY		0. 39760		
7. 00   06700   OCCUPATI ONAL THERAPY		0. 13560		
8. 00   06800   SPEECH PATHOLOGY 9. 00   06900   ELECTROCARDI OLOGY		0. 22396 0. 04517		0 1, 137
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 48892		
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 68372		0
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 17255		81, 213
4. 00   07400   RENAL DI ALYSI S		0. 31108		0
6.97   07697   CARDIAC REHABILITATION 6.98   07698   HYPERBARIC OXYGEN THERAPY		0.00000		
6. 99   07699   LI THOTRI PSY		0. 00000 0. 00000		1
7. 00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000		
B. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000	0	0
OUTPATIENT SERVICE COST CENTERS				
0. 00   09000   CLI NI C		5. 10504	_	
0. 01   09016   CLI NI C-NOT USED 0. 02   09001   PSYCH CLI NI C		0.00000		
0.03 09002 PSYCH CLINIC FEE BASED		0. 00000		
0. 04   09003   WORKFI RST		0.00000		
D. 05   09004   CANCER CLINIC		0.00000		
0. 06   09005   PEDI ATRI C CLI NI C		1. 57065		-
0. 07   09006 WOMENS CLINIC		0. 17974		1
0.08   09007   THERAPEUTIC SCHOOL 0.09   09008   AFTER SCHOOL PROGRAM		0. 26133 0. 00000		
0. 09   09008  AFTER SCHOOL PROGRAM 0. 10   09017  CLI NI C-NOT USED		0.00000		-
D. 11 09009 PERINATAL ADDICTION		0. 00000		
D. 12 09010 THERAPEUTIC NURSERY		0.00000	0 0	
0. 13   09011   CHI LD DAY TREATMENT		0. 00000		
D. 14   09012 DI ABETES CENTER		0.00000		
0. 15   09013   WOUND CENTER 0. 16   09014   MI CA		0. 14463 0. 00000		
0.17   09015 BAYONNE MENTAL HEALTH CENTER		0. 67074		
D. 18 09018 CLINIC		0.00000		1
1. 00 09100 EMERGENCY		0. 13923		_
1.01 09101 PSYCH EMERGENCY		4. 65430	4 0	0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 18658		
3. 99 09399 PARTIAL HOSPITALIZATION PROGRAM		0.00000	0 0	0
OTHER REIMBURSABLE COST CENTERS  5. 00   O9500   AMBULANCE SERVI CES				
00.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 522, 197	213, 612

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

202. 00

213, 612 200. 00 201. 00

1, 522, 197

201.00 202.00

ealth Financial Systems	TRINITAS HOSPITAL In Lieu of Form CMS	
NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 31-0027   Period:   Worksheet D- From 01/01/2023	
	Component CCN: 31-5442   To   12/31/2023   Date/Time Pr   5/30/2024 10	
	Title XVIII Skilled Nursing PPS	
Cost Center Description	Facility	
	To Charges Program Program Costs Charges (col. 1 x col	
	2)	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00 2.00 3.00	
0. 00 03000 ADULTS & PEDIATRICS		30
1. 00   03100   INTENSIVE CARE UNIT		31
0. 00   04000   SUBPROVI DER - I PF 1. 00   04100   SUBPROVI DER - I RF		40
2. 00   04200   SUBPROVI DER		42
3. 00 04300 NURSERY		43
ANCI LLARY SERVI CE COST CENTERS  0.00 05000 OPERATI NG ROOM	0. 179577 0	0 50
1.00   05100   RECOVERY ROOM		0 51
2.00 05200 DELIVERY ROOM & LABOR ROOM		0 52
3. 00   05300   ANESTHESI OLOGY		0 53
4. 00   05400   RADI OLOGY-DI AGNOSTI C 5. 00   05500   RADI OLOGY-THERAPEUTI C		0 54
6. 00   05600   RADI 0I SOTOPE		0 56
7. 00 05700 CT SCAN		0 57
8. 00   05800   MRI 9. 00   05900   CARDIAC CATHETERIZATION		0 58
9. 00   05900   CARDI AC CATHETERI ZATI ON 0. 00   06000   LABORATORY	0. 178881 0 0. 112042 81, 712 9, 15	0   59 55   60
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0 62
22. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0 62
55. 00   06500  RESPI RATORY THERAPY 66. 00   06600  PHYSI CAL THERAPY	0. 360878 0 0. 397603 550, 370 218, 82	0   65 29   6 <i>6</i>
17. 00   06700   OCCUPATI ONAL THERAPY	0. 135609 184, 820 25, 06	
8. 00 06800 SPEECH PATHOLOGY	0. 223969 14, 720 3, 29	
99. 00   06900   ELECTROCARDI OLOGY		0 69
'1.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT '2.00   07200   IMPL. DEV. CHARGED TO PATIENTS		0 71
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 172558 580 10	- 1
4.00 07400 RENAL DIALYSIS		0 74
(6.97   07697   CARDIAC REHABILITATION (6.98   07698   HYPERBARIC OXYGEN THERAPY		0 76
6. 99 07699 LITHOTRIPSY		0 76
7.00 07700 ALLOGENEIC HSCT ACQUISITION		0 77
8. 00 07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0 78
OUTPATIENT SERVICE COST CENTERS  0. 00   09000   CLINIC	5.105041 0	0 90
0. 01   09016   CLI NI C-NOT USED		0 90
0. 02 09001 PSYCH CLINIC		0 90
0.03   09002   PSYCH CLINIC FEE BASED 0.04   09003   WORKFIRST		0 90
0. 05   09004   CANCER CLINIC		0 90
0. 06   09005   PEDIATRIC CLINIC		0 90
0. 07   09006   WOMENS CLINIC		0 90
0.08   09007   THERAPEUTIC SCHOOL 0.09   09008   AFTER SCHOOL PROGRAM		0 90
0. 10   09017   CLI NI C-NOT USED		0 90
0. 11 09009 PERINATAL ADDICTION		0 90
O. 12   09010  THERAPEUTI C NURSERY O. 13   09011  CHILD DAY TREATMENT		0 90
U. 13 TUZUTTURILU DAT TREATMENT		0 90
	, 0.00000, 0,	0 90
O. 14 09012 DI ABETES CENTER	0. 144633 0	0 /
0. 14   09012 DI ABETES CENTER 0. 15   09013 WOUND CENTER 0. 16   09014 MI CA	0. 000000 0	0 90
00. 14   09012 DI ABETES CENTER 00. 15   09013 WOUND CENTER 00. 16   09014 MI CA 00. 17   09015 BAYONNE MENTAL HEALTH CENTER	0. 000000 0. 670740 0	0 90
00. 14	0.000000 0 0.670740 0 0.000000 0	0 90 0 90 0 90
00. 14   09012 DI ABETES CENTER 00. 15   09013 WOUND CENTER 00. 16   09014 MI CA 00. 17   09015 BAYONNE MENTAL HEALTH CENTER	0. 000000 0 0. 670740 0 0. 000000 0 0. 139231 0	0 90

0.000000

832, 202

832, 202

0 93. 99

256, 444 200. 00 201. 00

95. 00

202. 00

93. 99

200.00

201.00

202.00

OTHER REIMBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVICES

09399 PARTIAL HOSPITALIZATION PROGRAM

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

Health Financial Systems IRINITAS F	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 31-0027	Peri od:	Worksheet D-3	
		From 01/01/2023 To 12/31/2023	Date/Time Pre	nared:
		10 12/01/2020	5/30/2024 10:	12 am
	Title XIX	Hospi tal	TEFRA	
Cost Center Description	Ratio of Cos	t Inpatient	I npati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
	1.00	0.00	2)	
INDATIONT POUTING CERVICE COCT CENTERS	1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		10 477 200		20.00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT		19, 477, 289 5, 232, 623		30. 00 31. 00
40. 00   04000   SUBPROVI DER -   PF		8, 994, 391		40.00
41. 00   04100   SUBPROVI DER -   I RF		0, 7,4, 3,1		41. 00
42. 00   04200   SUBPROVI DER		0		42. 00
43. 00   04300   NURSERY		13, 437, 652		43. 00
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 17949	1, 666, 737	299, 174	50.00
51.00 05100 RECOVERY ROOM	0. 27452	25 132, 512	36, 378	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 65215	3, 739, 086	2, 438, 464	52.00
53. 00   05300   ANESTHESI OLOGY	0. 12129	711, 542	86, 304	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 18742	28 1, 353, 551	253, 693	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 79587		0	55. 00
56. 00   05600   RADI OI SOTOPE	0. 05310		5, 419	56. 00
57. 00   05700   CT   SCAN	0. 02629		44, 009	57. 00
58. 00   05800   MRI	0.06248		28, 179	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 17888		127, 565	59. 00
60. 00   06000   LABORATORY	0. 11192		658, 119	60.00
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELL 62.30   06250   BLOOD CLOTTING FOR HEMOPHILIACS	0.00495		1, 552 0	62. 00 62. 30
65. 00 06500 RESPI RATORY THERAPY	0.00000			65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 36087 0. 39760		277, 725 63, 265	66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	0. 13560		12, 642	67. 00
68. 00   06800   SPEECH PATHOLOGY	0. 22396		55, 426	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0.04517		70, 899	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 48892		392, 384	71. 00
72. 00 O7200 I MPL. DEV. CHARGED TO PATIENTS	0. 68372		109, 454	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0. 17255		774, 548	73. 00
74. 00   07400   RENAL DI ALYSI S	0. 30980		42, 037	74.00
76. 97 07697 CARDIAC REHABILITATION	0.00000	00	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0.00000	00	0	76. 98
76. 99   07699   LI THOTRI PSY	0.00000	00	0	76. 99
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.00000	00	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 00000	00 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS		1		
90. 00   09000   CLI NI C	5. 10504		0	90.00
90. 01   09016   CLI NI C-NOT USED	0.00000		0	90. 01
90. 02   09001   PSYCH CLINI C	1. 07894		0	90. 02
90. 03   09002   PSYCH CLINIC FEE BASED 90. 04   09003   WORKFIRST	0.00000		0	90. 03 90. 04
90. 05   09004   CANCER CLINIC	0.00000 0.00000			90.04
90. 06   09005   PEDI ATRI C   CLI NI C	1. 57065		0	90.05
90. 07   09006   WOMENS CLINIC	0. 17974		0	90.00
90. 08   09007   THERAPEUTI C   SCHOOL	0. 26133		0	90. 08
90. 09 09008 AFTER SCHOOL PROGRAM	0.00000		0	90. 09
90. 10   09017   CLI NI C-NOT USED	0.00000		0	90. 10
90. 11   09009   PERINATAL   ADDICTION	0.00000		0	90. 11
90. 12   09010   THERAPEUTI C NURSERY	0.00000		0	90. 12
90. 13   09011   CHI LD DAY TREATMENT	0. 00000		0	90. 13
90. 14   09012 DI ABETES CENTER	0.00000		0	90. 14
90. 15   09013   WOUND CENTER	0. 14463		0	90. 15
90. 16   09014   MI CA	0.00000	00	0	90. 16
90.17 09015 BAYONNE MENTAL HEALTH CENTER	0. 67074	10 0	0	90. 17
90. 18  09018  CLI NI C	0.00000	00	0	90. 18
91. 00   09100   EMERGENCY	0. 13923		275, 768	91. 00
91. 01   09101   PSYCH EMERGENCY	4. 65430		0	91. 01
92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART	0. 18658		0	92.00
93. 99 O9399 PARTIAL HOSPITALIZATION PROGRAM	0.00000	00 0	0	93. 99
OTHER REI MBURSABLE COST CENTERS				05.00
95. 00 09500 AMBULANCE SERVICES		27 142 700	6 OE2 OC4	95. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98) 201.00 Less PBP Clinic Laboratory Services-Program only charge	res (line 61)	27, 142, 798	6, 053, 004	200.00
202.00 Net charges (line 200 minus line 201)	,00 (IIIIC 01)	27, 142, 798		201.00
	ı	27, 172, 770	l	_52.00

	Title XVIII Hospital	PPS	
	DADT A LINDATIENT MOSDITAL SEDVICES INDED LDDS	1. 00	
1. 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS  DRG Amounts Other than Outlier Payments	0	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see linstructions)	10, 339, 220	1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see linstructions)	3, 906, 148	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1. 04
2.00	Outlier payments for discharges. (see instructions)		2. 00
2.01	Outlier reconciliation amount	0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)	02 503	2. 02
2. 03 2. 04	Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)	93, 583 17, 748	2. 03 2. 04
3. 00	Managed Care Simulated Payments	18, 796, 382	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	169. 33	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on	32. 92	5. 00
	or before 12/31/1996. (see instructions)		
5. 01 6. 00	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for	0. 00 0. 00	5. 01 6. 00
6. 26	new programs in accordance with 42 CFR 413.79(e) Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of	0. 00	6. 26
0. 20	the CAA 2021 (see instructions)	0.00	0.20
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the	0. 81 0. 00	7. 00 7. 01
7 00	cost report straddles July 1, 2011 then see instructions.	0.00	7 00
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)	0.00	7. 02
8. 00	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,	7. 50	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002).  The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost	0. 00	8. 01
8. 02	report straddles July 1, 2011, see instructions.  The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital	1. 23	8. 02
8. 21	under § 5506 of ACA. (see instructions)  The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see	0.00	8. 21
9. 00	instructions) Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or	40. 84	9. 00
10. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records	49. 78	
11. 00	FTE count for residents in dental and podiatric programs.	5. 71	11. 00
12.00	Current year allowable FTE (see instructions)	46. 55	ı
13. 00 14. 00	Total allowable FTE count for the prior year.	46. 84	ı
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	46. 34	14. 00
15. 00			15.00
16. 00			16. 00
17. 00	Adjustment for residents displaced by program or hospital closure		17. 00
18. 00 19. 00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).	46. 58 0. 275084	1
20. 00	Prior year resident to bed ratio (see instructions)	0. 261544	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)	0. 261544	ł
22. 00	IME payment adjustment (see instructions)	1, 897, 455	
22. 01	IME payment adjustment - Managed Care (see instructions)	2, 503, 640	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0.00	23. 00
24. 00	(f)(1)(iv)(C).  IME FTE Resident Count Over Cap (see instructions)	8. 94	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	1
26. 00	Resident to bed ratio (divide line 25 by line 4)	0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)	0. 000000	27. 00
28. 00 28. 01	IME add-on adjustment amount (see instructions) IME add-on adjustment amount - Managed Care (see instructions)	0	28. 00 28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)	1, 897, 455	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	2, 503, 640	1
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	15. 88	30.00
31.00	Percentage of Medicaid patient days (see instructions)	35. 13	
32. 00	Sum of lines 30 and 31	51. 01	1
33. 00	Allowable disproportionate share percentage (see instructions)		33. 00
34. 00	Disproportionate share adjustment (see instructions)	1, 114, 700	34. 00

		20174		6.5	
	Financial Systems TRINITAS HOS ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	u of Form CMS-: Worksheet E Part A Date/Time Pre 5/30/2024 10:	pared:
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Payment Adjustment				
35. 00	Total uncompensated care amount (see instructions)			5, 938, 006, 757	1
35. 01	Factor 3 (see instructions)		0. 000933984	0. 000901147	•
35. 02	Hospital UCP, including supplemental UCP (see instructions)	10.	6, 420, 583	5, 351, 017	1
	Pro rata share of the hospital UCP, including supplemental UC	P (see instructions)	4, 802, 243	1, 345, 064	1
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03) Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 through	6, 147, 307		36. 00
40. 00	Total Medicare discharges (see instructions)	scharges (Triles 40 till oug	2, 740		40. 00
41. 00	Total ESRD Medicare discharges (see instructions)		298		41.00
41. 01	Total ESRD Medicare covered and paid discharges (see instruct	ions)	298		41. 01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not quali		10. 88		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	,	2, 507		43.00
44.00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	1. 201822		44. 00
	days)				
45. 00	Average weekly cost for dialysis treatments (see instructions		796. 71		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 41	. 01)	285, 335		46.00
47. 00	Subtotal (see instructions)	mall rural bassitals	23, 801, 496		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, s only. (see instructions)	maii rurai nospitais	0		48. 00
	John y. (See Thisti de trons)			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instructions	5)		26, 305, 136	49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I an	d Pt. II, as applicable)		1, 333, 089	50. 00
51. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.00
52. 00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		1, 239, 419	
53. 00	Nursing and Allied Health Managed Care payment			0	53. 00
54.00	Special add-on payments for new technologies			0	54.00
54. 01 55. 00	Islet isolation add-on payment	0)		0	54. 01 55. 00
55. 00 55. 01	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cellular therapy acquisition cost (see instructions)	19)		0	55. 00
56. 00	Cost of physicians' services in a teaching hospital (see intr	ructions)		0	56.00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. I		rough 35).	Ö	57. 00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.		3,	0	58. 00
59.00	Total (sum of amounts on lines 49 through 58)	•		28, 877, 644	59. 00
60.00	Primary payer payments			0	60.00
61. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		28, 877, 644	1
62. 00	Deductibles billed to program beneficiaries			1, 190, 944	1
63.00	Coinsurance billed to program beneficiaries			92, 800	
64.00	Allowable bad debts (see instructions)			332, 906	ł
65. 00 66. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		216, 389 313, 653	1
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	ructions)		27, 810, 289	ł
68. 00	Credits received from manufacturers for replaced devices for	applicable to MS-DRGs (se	e instructions)	27, 010, 207	1
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	ł
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		,	0	ł
70. 50	Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see i	nstructions)	0	70. 50
70. 75	N95 respirator payment adjustment amount (see instructions)			0	70. 75
70. 87	Demonstration payment adjustment amount before sequestration			0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)		_	70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70. 90
70. 91 70. 92	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91 70. 92
70. 92 70. 93	Bundled Model 1 discount amount (see instructions)  HVBP payment adjustment amount (see instructions)			0 -32, 711	70. 92 70. 93
70. 93 70. 94	HRR adjustment amount (see instructions)			-32, 711 -43, 380	1
	Recovery of accelerated depreciation			· ·	70. 95
	· · · · · · ·				

Health Financial Systems TRINITAS	HOSPI TAL		In Lie	u of Form CMS-2	2552-1
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider C		Peri od:	Worksheet E	
			From 01/01/2023 Fo 12/31/2023	Part A Date/Time Pre	pared.
				5/30/2024 10:	12 am
	Title	XVIII	Hospi tal	PPS	
			(уууу)	Amount	
0.96 Low volume adjustment for federal fiscal year (yyyy) (Enter	s in column O		0	1. 00	70. 9
the corresponding federal year for the period prior to 10/			0	U	70.9
D. 97 Low volume adjustment for federal fiscal year (yyyy) (Enter			0	0	70. 9
the corresponding federal year for the period ending on or					
0.98 Low Volume Payment-3			0	0	70. 9
0.99 HAC adjustment amount (see instructions)				0	70. 9
1.00 Amount due provider (line 67 minus lines 68 plus/minus line	es 69 & 70)			27, 734, 198	1
1.01 Sequestration adjustment (see instructions)				554, 684	
1.02 Demonstration payment adjustment amount after sequestration	1			0	1
1.03 Sequestration adjustment-PARHM pass-throughs				27 042 040	71. C
2.00  Interim payments 2.01  Interim payments-PARHM				27, 042, 069	72.0
3.00 Tentative settlement (for contractor use only)				0	
3.01 Tentative settlement-PARHM (for contractor use only)				o .	73.0
4.00 Balance due provider/program (line 71 minus lines 71.01, 7	1.02, 72, and			137, 445	
73)					
4.01 Balance due provider/program-PARHM (see instructions)					74.0
5.00 Protested amounts (nonallowable cost report items) in accor	dance with			1, 823, 834	75. 0
CMS Pub. 15-2, chapter 1, §115.2  TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)					
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or su	m of 2 03	T		0	90.0
plus 2.04 (see instructions)	uiii 01 2.03			O	70.0
1.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.0
2.00 Operating outlier reconciliation adjustment amount (see ins	structions)			0	1
3.00 Capital outlier reconciliation adjustment amount (see instr				0	93.0
4.00 The rate used to calculate the time value of money (see ins				0.00	
5.00 Time value of money for operating expenses (see instruction	•			0	
6.00 Time value of money for capital related expenses (see instr	ructions)		D: 1 10/1	0 (4.6) 40 (4	96.0
			Prior to 10/1 1.00	2. 00	_
HSP Bonus Payment Amount			1.00	2.00	
00.00 HSP bonus amount (see instructions)			0	0	100. C
HVBP Adjustment for HSP Bonus Payment			-1	-	
01.00 HVBP adjustment factor (see instructions)			0.0000000000	0.000000000	101. C
02.00 HVBP adjustment amount for HSP bonus payment (see instructi	ons)		0	0	102. C
HRR Adjustment for HSP Bonus Payment					4
03.00 HRR adjustment factor (see instructions)	_		0.0000	0. 0000	
04.00 HRR adjustment amount for HSP bonus payment (see instruction			0	0	104. C
Rural Community Hospital Demonstration Project (§410A Demon					200
00.00 Is this the first year of the current 5-year demonstration Century Cures Act? Enter "Y" for yes or "N" for no.	perioa unaer 1	ine ZIST			200. 0
Cost Reimbursement					1
01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, I	ine 49)				201. (
02.00 Medicare discharges (see instructions)	/				202. (

Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration

203. 00

204. 00

205. 00 206. 00

207. 00

peri od)

204.00 Medicare target amount

203.00 Case-mix adjustment factor (see instructions)

205.00 Case-mix adjusted target amount (line 203 times line 204)

206.00 Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement

207.00 Program reimbursement under the §410A Demonstration (see instructions)

 
 Heal th Financial
 Systems
 TRINITAS HEADSPITAL

 HOSPITAL
 ACQUIRED
 CONDITION (HAC)
 REDUCTION CALCULATION EXHIBIT 5
 Provider CCN: 31-0027 Peri od: Worksheet E From 01/01/2023 Part A Exhibit 5 To 12/31/2023 Date/Time Prepared:

				To	12/31/2023	Date/Time Prep 5/30/2024 10:	
			Title	XVIII	Hospi tal	PPS	
		Wkst. E, Pt.	Amt. from	Period to	Period on	Total (cols. 2	
		A, line	Wkst. E, Pt.	10/01	after 10/01	and 3)	
			A)	0.00	2.00	4.00	
1 00	DDC	0	1.00	2. 00	3. 00	4. 00	1 00
1.00	DRG amounts other than outlier payments	1.00	10 220 220	10 220 220		10 220 220	1.00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 01	10, 339, 220	10, 339, 220		10, 339, 220	1. 01
1. 02	DRG amounts other than outlier payments for	1. 02	3, 906, 148		3, 906, 148	3, 906, 148	1. 02
1.02	di scharges occurring on or after October 1	1.02	0, 700, 110		0, 700, 110	0, 700, 110	1.02
1.03	DRG for Federal specific operating payment	1. 03	o	0		0	1. 03
	for Model 4 BPCI occurring prior to October						
	1				_	_	
1. 04	DRG for Federal specific operating payment	1. 04	U		Ü	0	1. 04
	for Model 4 BPCI occurring on or after October 1						
2.00	Outlier payments for discharges (see	2. 00					2. 00
	instructions)						
2. 01	Outlier payments for discharges for Model 4	2. 02	0	0	0	0	2. 01
	BPCI						
2. 02	Outlier payments for discharges occurring	2. 03	93, 583	93, 583		93, 583	2. 02
2. 03	prior to October 1 (see instructions) Outlier payments for discharges occurring on	2. 04	17, 748		17, 748	17, 748	2. 03
2.03	or after October 1 (see instructions)	2.04	17,740		17, 740	17, 740	2.03
3.00	Operating outlier reconciliation	2. 01	o	0	0	0	3. 00
4.00	Managed care simulated payments	3. 00	18, 796, 382	14, 097, 286	4, 699, 096	18, 796, 382	4.00
	Indirect Medical Education Adjustment						
5. 00	Amount from Worksheet E, Part A, line 21	21. 00	0. 261544	0. 261544	0. 261544		5. 00
6. 00	(see instructions)	22. 00	1, 897, 455	1 277 144	520, 291	1, 897, 455	6. 00
6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00	2, 503, 640	1, 377, 164 1, 877, 730	625, 910		6. 01
0.01	instructions)	22.01	2, 303, 040	1,077,730	023, 710	2, 303, 040	0.01
	Indirect Medical Education Adjustment for the	Add-on for Se	ection 422 of th	he MMA			
7.00	IME payment adjustment factor (see	27. 00	0. 000000	0. 000000	0. 000000		7. 00
	instructions)		_		_	_	
8.00	IME adjustment (see instructions)	28. 00	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	١	U	U	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	1, 897, 455	1, 377, 164	520, 291	1, 897, 455	9. 00
9. 01	Total IME payment for managed care (sum of	29. 01	2, 503, 640	1, 877, 730	625, 910		9. 01
	lines 6.01 and 8.01)						
	Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage	33. 00	0. 3130	0. 3130	0. 3130		10. 00
11 00	(see instructions)	24.00	1, 114, 700	000 044	205 (5)	1 114 700	11 00
11. 00	Disproportionate share adjustment (see instructions)	34.00	1, 114, 700	809, 044	305, 656	1, 114, 700	11. 00
11. 01	Uncompensated care payments	36. 00	6, 147, 307	4, 802, 243	1, 345, 064	6, 147, 307	11. 01
	Additional payment for high percentage of ESF	RD beneficiary					
12. 00	Total ESRD additional payment (see	46.00	285, 335	213, 415	71, 920	285, 335	12. 00
	instructions)						
13.00	Subtotal (see instructions)	47. 00	23, 801, 496	17, 634, 669	6, 166, 827	23, 801, 496	
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48. 00	١	U	U	0	14. 00
	instructions)						
15.00	Total payment for inpatient operating costs	49. 00	26, 305, 136	19, 512, 399	6, 792, 737	26, 305, 136	15. 00
	(see instructions)						
16. 00	Payment for inpatient program capital (from	50. 00	1, 333, 089	997, 077	336, 012	1, 333, 089	16. 00
17 00	Wkst. L, Pt. I, if applicable)	E4.00		0	0		17 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	۷	U	U	0	17. 00 17. 01
17. 01	Credits received from manufacturers for	68. 00		n	n	0	17. 01
17.02	replaced devices for applicable MS-DRGs	00.00	J 4	J	0	l	17.02
18. 00	Capital outlier reconciliation adjustment	93. 00	l o	0	0	0	18. 00
	amount (see instructions)						
19. 00	SUBTOTAL			20, 509, 476	7, 128, 749	27, 638, 225	19. 00

					o 12/31/2023	Date/Time Pre 5/30/2024 10:	pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1.00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1.00	1, 078, 359	806, 553	271, 806	1, 078, 359	
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	C	0	0	20. 01
21. 00	Capital DRG outlier payments	2. 00	1, 532	1, 146	386	1, 532	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	C	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 1260	0. 1260	0. 1260		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	135, 873	101, 625	34, 248	135, 873	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 1088	0. 1088	0. 1088		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	117, 325	87, 753	29, 572	117, 325	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 333, 089	997, 077	336, 012	1, 333, 089	26. 00
	Thisti detrons)	Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
		A, TITIC	A)				
		0	1.00	2.00	3. 00	4. 00	
27. 00		-				,, ,,	27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0	l c		0	28. 00
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	-32, 711	-24, 466	-8, 245	-32, 711	30.00
30. 01	HVBP payment adjustment for HSP bonus	70. 90	0	C	0	0	30. 01
	payment (see instructions)						
31.00	HRR adjustment (see instructions)	70. 94	-43, 380	-32, 052	-11, 328	-43, 380	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0	C	0	0	31. 01
	Thisti detrons)					(Amt. to Wkst.	
						E, Pt. A)	
		0	1.00	2.00	3. 00	4.00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99		С	0	0	32. 00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

Health Financial Systems	TRINITAS HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: Worksheet E From 01/01/2023 Part B To 12/31/2023 Date/Ti me Prepared: 5/30/2024 10:12 am

			10 12/31/2023	5/30/2024 10:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			175, 937	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		13, 433, 897	2.00
3. 00 4. 00	OPPS or REH payments	6, 882, 904	3. 00 4. 00		
4. 00	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			85, 982 0	1
5. 00	Enter the hospital specific payment to cost ratio (see instruct	tions)		0. 000	1
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7. 00
8. 00	Transitional corridor payment (see instructions)			0	8. 00
9. 00	Ancillary service other pass through costs including REH direct	t graduate medical educa	ition costs from	0	9. 00
10. 00	Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions			0	10.00
	Total cost (sum of lines 1 and 10) (see instructions)			175, 937	•
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12. 00	Ancillary service charges			161, 577	•
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Iir	ne 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			161, 577	14.00
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	avment for services on a	charge hasis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	
	had such payment been made in accordance with 42 CFR §413.13(e)				
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			161, 577	1
19. 00	Excess of customary charges over reasonable cost (complete only	y if line 18 exceeds lir	ne 11) (see	0	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete only</pre>	uifling 11 avegads lin	0 10) (600	14, 360	20.00
20.00	instructions)	y II IIIle II exceeds III	ie 10) (See	14, 300	20.00
21. 00	Lesser of cost or charges (see instructions)			161, 577	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			6, 968, 886	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 25 00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line		ictions)	0 1, 348, 056	25. 00 26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			5, 782, 407	27.00
27.00	instructions)	Tub the built of TTHES 22	unu 20] (300	0,702,107	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lir	ne 50)		475, 243	28. 00
	REH facility payment amount (see instructions)				28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00 31. 00	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments			6, 257, 650	1
	Subtotal (line 30 minus line 31)			282 6, 257, 368	•
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)		0, 207, 000	02.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	•		22, 556	33. 00
	Allowable bad debts (see instructions)			210, 912	1
	Adjusted reimbursable bad debts (see instructions)			137, 093	1
	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		197, 922	1
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			6, 417, 017 0	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)	)			39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replace	ed devices (see instruct	i ons)	0	39. 98
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00	Subtotal (see instructions) Sequestration adjustment (see instructions)			6, 417, 017 128, 340	40. 00 40. 01
40. 01	Demonstration payment adjustment amount after sequestration			120, 340	40. 01
40. 03	Sequestration adjustment-PARHM pass-throughs			, , ,	40. 03
41.00	Interim payments			5, 563, 095	1
	1 Interim payments-PARHM				41. 01
42.00	, , , , , , , , , , , , , , , , , , , ,				42.00
42. 01	Tentative settlement-PARHM (for contractor use only)			725, 582	42. 01
43.00					•
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2 4	hanter 1	0	43. 01 44. 00
44.00	\$115. 2	SC WITH GWIS FUD. 10-2, (	παρισι Ι,		44.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)	<u> </u>		0	•
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	•
93.00	Time Value of Money (see instructions)			U	93. 00

Health Financial Systems	TRINITAS HOSPITAL			u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0027	Peri od: From 01/01/2023	Worksheet E Part B	
			To 12/31/2023		
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94. 00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Health Financial Systems

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 31-0027

			'	0 12/31/2023	5/30/2024 10: 1	
		Title XVIII Inpatient Part A		Hospi tal	PPS	
				Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		26, 869, 327		5, 563, 095	1. 00
2.00	Interim payments payable on individual bills, either				0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	08/30/2023	565, 723		0	3. 01
3. 02			C		0	3. 02
3.03			C		0	3. 03
3.04			C		0	3. 04
3.05			C	)	0	3. 05
0 50	Provi der to Program	40 (07 (0000	200 004			0 50
3.50	ADJUSTMENTS TO PROGRAM	12/07/2023	392, 981		0	3. 50
3. 51 3. 52					0	3. 51 3. 52
3. 52					0	3. 52
3. 54					0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		172, 742	1	0	3. 99
3. 77	3. 50-3. 98)		172,742	-		3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		27, 042, 069	)	5, 563, 095	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as				2, 222, 212	
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	1	1			
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02			C		0	5. 02
5. 03	Danisi dan da Baranan		C	)	0	5. 03
E E0	Provider to Program TENTATIVE TO PROGRAM	I	T c	\	0	5. 50
5. 50 5. 51	TENTATIVE TO PROGRAM	•			0	5. 5t
5. 52					0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
J. 77	5. 50-5. 98)			,		J. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
5. 50	the cost report. (1)					5. 50
6. 01	SETTLEMENT TO PROVIDER		137, 445	5	725, 582	6. 01
6. 02	SETTLEMENT TO PROGRAM				0	6. 02
7.00	Total Medicare program liability (see instructions)		27, 179, 514		6, 288, 677	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	To the second se		0	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Component CCN: 31-S027 Subprovi der -Title XVIII

		Title	Title XVIII		PPS	
		Inpatien	Inpatient Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2, 067, 432 C		0	1. 00 2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER	10/26/2023	13, 987		0	3. 01
3. 02			0		l ol	3. 02
3. 03			l d		l ol	3. 03
3. 04			l d		l ol	3. 04
3. 05			d		l ol	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	3.50
3.51			C		0	3. 51
3.52			C		0	3. 52
3.53			C		0	3. 53
3.54			C		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		13, 987		0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 081, 419		0	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02			C		0	5. 02
5.03			C		0	5. 03
E	Provider to Program TENTATIVE TO PROGRAM				0	E E0
5. 50 5. 51	IENTATIVE TO PROGRAM		[			5. 50 5. 51
5. 51			1 0			5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		1 0			5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVI DER		0		0	6. 01
6.02	SETTLEMENT TO PROGRAM		70, 766		0	6. 02
7.00	Total Medicare program liability (see instructions)		2, 010, 653		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
0.00		(	)	1. 00	2. 00	0.00
8. 00	Name of Contractor			I	l l	8. 00

Provider CCN: 31-0027 Component CCN: 31-5442 Title XVIII Skilled Nursing PPS

		11 11 6	AVIII	Facility	PPS	
		Inpatient Part A			t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 167, 449		0	
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	T		T		
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3. 02			0		0	
3. 03 3. 04			0		0	
3. 04			0			
3.03	Provider to Program		0		0	3.00
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51	7.BOSCIMENTO TO TROCKS III		Ö		o o	
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)				_	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		1, 167, 449		0	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					1
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					1
5. 01	TENTATI VE TO PROVI DER		0		0	
5. 02			0		0	
5. 03	Dravi dan ta Dragnam		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 51	IENTATIVE TO PROGRAW		0		0	
5. 52			0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		ő		o o	
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		0	
6. 02	SETTLEMENT TO PROGRAM		0		0	
7.00	Total Medicare program liability (see instructions)		1, 167, 449		NPR Date	7. 00
				Contractor Number	(Mo/Day/Yr)	
		(	 )	1. 00	2. 00	

Health Financial Systems TRINITAS HOSPITAL In Lieu				u of Form CMS-	2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 31-0027	Peri od:	Worksheet E-1		
From 01/01/2023 To 12/31/2023						
				5/30/2024 10:		
		Title XVIII	Hospi tal	PPS		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		1. 00			
2.00	Medicare days (see instructions)		2. 00			
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3. 00			
4.00	Total inpatient days (see instructions)		4. 00			
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5. 00			
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 l		6. 00 7. 00			
7. 00						
0.00	line 168				8. 00	
8.00	Calculation of the HIT incentive payment (see instructions)					
9.00	Sequestration adjustment amount (see instructions)		9. 00 10. 00			
10. 00						
20.00	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH					
	Initial/interim HIT payment adjustment (see instructions)		30. 00 31. 00			
	00 Other Adjustment (specify) 00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)					
32.00	Improved the state of the state	ine 31) (See Instruction	IS)		32. 00	

Health Financial Systems	TRINITAS HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0027	Peri od: From 01/01/2023	Worksheet E-3 Part II
	Component CCN: 31-S027	To 12/31/2023	Date/Time Prepared: 5/30/2024 10:12 am
	Title XVIII	Subprovi der -	PPS

	I PF	113	
		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS	1, 55	
. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	2, 164, 635	1. (
. 00	Net IPF PPS Outlier Payments	0	2. (
00	Net IPF PPS ECT Payments	0	3.0
00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	2. 26	4. (
01	15, 2004. (see instructions)	0.00	١,,
. 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	0. 00	4. (
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		
00	New Teaching program adjustment. (see instructions)	0.00	5. (
00	Current year's unweighted FTE count of L&R excluding FTEs in the new program growth period of a "new	8. 60	
	teaching program" (see instuctions)		
00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	7. (
	teaching program" (see instuctions)		
00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	2. 26	•
00	Average Daily Census (see instructions)	53. 126027	9. (
0.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 021687	
. 00	Teaching Adjustment (line 1 multiplied by line 10). Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	46, 944 2, 211, 579	
. 00	Nursing and Allied Health Managed Care payment (see instruction)	2, 211, 579	13.
. 00	Organ acquisition (DO NOT USE THIS LINE)		14.
. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.
. 00	Subtotal (see instructions)	2, 211, 579	
. 00	Primary payer payments	0	17.
. 00	Subtotal (line 16 less line 17).	2, 211, 579	
. 00	Deducti bl es	156, 536	
. 00	Subtotal (line 18 minus line 19)	2, 055, 043	20.
. 00	Coi nsurance	33, 512	
. 00	Subtotal (line 20 minus line 21)	2, 021, 531	
. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	46, 394	
. 00	Adjusted reimbursable bad debts (see instructions)	30, 156	
. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	46, 394	•
. 00	Subtotal (sum of lines 22 and 24)	2, 051, 687	26.
. 00	Direct graduate medical education payments (see instructions)	0	27.
. 00	Other pass through costs (see instructions) Outlier payments reconciliation	0	28. 29.
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.
. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.
. 98	Recovery of accelerated depreciation.	ő	30.
. 99	Demonstration payment adjustment amount before sequestration	o	30.
. 00	Total amount payable to the provider (see instructions)	2, 051, 687	•
. 01	Sequestration adjustment (see instructions)	41, 034	31.
. 02	Demonstration payment adjustment amount after sequestration	0	31.
. 00	Interim payments	2, 081, 419	32.
. 00	Tentative settlement (for contractor use only)	0	33.
. 00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	-70, 766	
. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	35.
	§115. 2		
00	TO BE COMPLETED BY CONTRACTOR		F^
. 00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50. 51.
. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money	0 0. 00	
. 00	Time Value of Money (see instructions)	0.00	52. 53.
. 00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE		, 55.
	THE COVID-19 PHE)	LIND OI	
			4
9. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.

ealth Financial Systems TRINITAS HOSPITAL In Lieu				2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-0027	Peri od:	Worksheet E-3		
		From 01/01/2023			
	Component CCN: 31-5442	To 12/31/2023	Date/Time Pre	pared:	
	'		5/30/2024 10:		
	Title XVIII Skilled Nursi				
		Facility			
	1. 00				
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF					
SERVI CES					
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCT	I UNC)			1	

		1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART	A PPS SNF	
	SERVICES		l
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		l
1.00	Resource Utilization Group Payment (RUGS)	1, 484, 075	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3. 00
4.00	Subtotal (sum of lines 1 through 3)	1, 484, 075	4. 00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E,		5. 00
	Part B. This line is now shaded.)		
6.00	Deducti bl e	0	6. 00
7.00	Coi nsurance	292, 800	7. 00
8.00	Allowable bad debts (see instructions)	0	8. 00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9. 00
10.00	Adjusted reimbursable bad debts (see instructions)	0	10.00
11. 00	Utilization review	0	11. 00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	1, 191, 275	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14. 00
14. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14. 50
14. 98	Recovery of accelerated depreciation.	0	14. 98
14. 99	Demonstration payment adjustment amount before sequestration	0	14. 99
15.00	Subtotal (see instructions	1, 191, 275	15. 00
15. 01	Sequestration adjustment (see instructions)	23, 826	15. 01
15. 02	Demonstration payment adjustment amount after sequestration	0	15. 02
15. 75	Sequestration for non-claims based amounts (see instructions)	0	15. 75
16.00	Interim payments	1, 167, 449	16.00
17.00	Tentative settlement (for contractor use only)	o	17. 00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	o	18. 00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1,	0	19. 00
	§115. 2		1

Health Financial Systems	TRINITAS HOSPITAL	In Lieu of Form CMS-2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0027	Period: Worksheet E-3 From 01/01/2023 Part VII			

To 12/31/2023 Date/Time Prepared: 5/30/2024 10:12 am Hospi tal Title XIX TEFRA Inpati ent Outpati ent 1.00 2.00 PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES COMPUTATION OF NET COST OF COVERED SERVICES 1.00 Inpatient hospital/SNF/NF services 11, 015, 171 1.00 Medical and other services 2.00 4, 254, 688 2 00 3.00 Organ acquisition (certified transplant programs only) 3.00 Subtotal (sum of lines 1, 2 and 3) 4.00 11, 015, 171 4, 254, 688 4.00 5.00 Inpatient primary payer payments 5.00 Outpatient primary payer payments 6.00 6.00 7.00 Subtotal (line 4 less sum of lines 5 and 6) 11, 015, 171 4, 254, 688 7.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges 8.00 Routine service charges 47, 141, 955 8.00 Ancillary service charges 27, 142, 798 19, 102, 638 9.00 9.00 10.00 Organ acquisition charges, net of revenue 10.00 0 11 00 Incentive from target amount computation 11 00 12.00 Total reasonable charges (sum of lines 8 through 11) 74, 284, 753 19, 102, 638 12.00 CUSTOMARY CHARGES 13.00 Amount actually collected from patients liable for payment for services on a charge 0 13.00 basi s Amounts that would have been realized from patients liable for payment for services on 14.00 0 0 14.00 a charge basis had such payment been made in accordance with 42 CFR §413.13(e) 15.00 Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 0.000000 15.00 16.00 Total customary charges (see instructions) 74, 284, 753 19, 102, 638 16.00 63, 269, 582 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 14, 847, 950 17 00 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 18.00 0 (see instructions) 19.00 Interns and Residents (see instructions) 19.00 20.00 Cost of physicians' services in a teaching hospital (see instructions) 20.00 0 4, 254, 688 21.00 Cost of covered services (enter the lesser of line 4 or line 16) 11, 015, 171 21.00 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers 22.00 0 0 22.00 Other than outlier payments Outlier payments 0 23.00 0 23.00 24.00 Program capital payments 0 24.00 0 25.00 Capital exception payments (see instructions) 25.00 o 26 00 Routine and Ancillary service other pass through costs 0 26 00 0 27.00 Subtotal (sum of lines 22 through 26) Λ 27.00 Customary charges (title V or XIX PPS covered services only) 28.00 28.00 0 29.00 Titles V or XIX (sum of lines 21 and 27) 11, 015, 171 4, 254, 688 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 11, 015, 171 4, 254, 688 31.00 32.00 Deducti bl es 0 32.00 33 00 Coi nsurance 0 0 33 00 34.00 Allowable bad debts (see instructions) 0 0 34.00 Utilization review 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 11, 015, 171 4, 254, 688 36, 00 36, 00 328, 213 37.00 PROFESSIONAL SVCS D3 617, 097 37.00 38.00 Subtotal (line 36  $\pm$  line 37) 11, 632, 268 4, 582, 901 38.00 39.00 Direct graduate medical education payments (from Wkst. E-4) 39.00 4, 582, 901 40.00 Total amount payable to the provider (sum of lines 38 and 39) 11, 632, 268 40.00 41.00 Interim payments 13, 174, 522 2, 135, 578 41.00 Balance due provider/program (line 40 minus line 41) 42.00 -1, 542, 254 2, 447, 323 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00 43.00

chapter 1, §115.2

Health Financial Systems	TRINITAS HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-0027 Component CCN: 31-S027	From 01/01/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 10:12 am
	Title XIX	Subprovi der -	TEFRA

		II tie xix	I PF	IEFRA	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	OLO TOR TITLLO V OR XIX	OLIVI OLO		1
1.00	Inpatient hospital/SNF/NF services		77, 229		1.00
2.00	Medical and other services		77,227	0	
3.00	Organ acquisition (certified transplant programs only)		0	Ü	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		77, 229	0	
5. 00	Inpatient primary payer payments		0	ŭ	5. 00
6. 00	Outpatient primary payer payments		, and the second	0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		77, 229	0	
	COMPUTATION OF LESSER OF COST OR CHARGES		, == .		
	Reasonabl e Charges				1
8.00	Routine service charges		0		8.00
9. 00	Ancillary service charges		o	0	
10.00	Organ acquisition charges, net of revenue		o		10.00
11. 00	Incentive from target amount computation		o		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		o	0	12. 00
	CUSTOMARY CHARGES		<u> </u>		
13.00	Amount actually collected from patients liable for payment for s	ervices on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for p		0	0	14. 00
	a charge basis had such payment been made in accordance with 42	CFR §413. 13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	
16. 00	Total customary charges (see instructions)		0	0	
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	0	0	17. 00
	line 4) (see instructions)			_	
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	77, 229	0	18. 00
10.00	16) (see instructions)			0	10.00
19. 00 20. 00	Interns and Residents (see instructions) Cost of physicians' services in a teaching hospital (see instruc	tions)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be con		-	0	21.00
22. 00	Other than outlier payments	ilipreted for 113 provide	0	0	22. 00
	Outlier payments		Ö	0	
24. 00	Program capital payments		0	ŭ	24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		o	0	
27. 00			o	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		O	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		o	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		· · · · · · · · ·		
30.00	Excess of reasonable cost (from line 18)		77, 229	0	30. 00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31. 00
32.00	Deducti bl es		o	0	32. 00
33.00	Coinsurance		O	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	3)	0	0	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		0	0	38. 00
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
41. 00	Interim payments		0	0	
42. 00	Balance due provider/program (line 40 minus line 41)		0	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				I

Heal th	Financial Systems TRINITAS HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CC	CN: 31-0027	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Pre	
					5/30/2024 10:	
		litle	XVIII	Hospi tal	PPS	
					1. 00	
1 00	COMPUTATION OF TOTAL DIRECT GME AMOUNT	nnagnama fan	anat manamti	na nori ada	32. 92	1 00
1. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng perious	32. 92	1.00
1. 01	FTE cap adjustment under §131 of the CAA 2021 (see instruction				0. 00	
2. 00 2. 26	Unweighted FTE resident cap add-on for new programs per 42 CF Rural track program FTE cap Limitation adjustment after the				0. 00 0. 00	
2. 20	the CAA 2021 (see instructions)	sap-builtuilig	willdow crosec	a under 3127 of	0.00	2. 20
3.00	Amount of reduction to Direct GME cap under section 422 of MM				4. 41	3. 00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)	e with 42 CFR	§413.79 (m).	(see	0. 00	3. 01
3. 02	Adjustment (increase or decrease) to the hospital's rural tra	ack FTE limit	ation(s) for	rural track	0. 00	3. 02
	programs with a rural track Medicare GME affiliation agreemen	nt in accorda	nce with 413.	75(b) and 87 FR		
4. 00	49075 (August 10, 2022) (see instructions)   Adjustment (plus or minus) to the FTE cap for allopathic and	osteonathic	nrograms due	to a Medicare	7. 50	4. 00
1. 00	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs ade	to a mearcare	7.00	1.00
4. 01	ACA Section 5503 increase to the Direct GME FTE Cap (see instantial translations 7.74, (2011)	tructions for	cost reporti	ng periods	0. 00	4. 01
4. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slot	ts (see inst	ructions for	cost reporting	1. 46	4. 02
	periods straddling 7/1/2011)	•				
4. 21	The amount of increase if the hospital was awarded FTE cap slinstructions)	ots under §1	26 of the CAA	A 2021 (see	0. 00	4. 21
5. 00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lir	nes 2.26 thro	ugh 2.49, mir	nus lines 3 and	37. 47	5. 00
	3.01, plus or minus line 3.02, plus or minus line 4, plus lir	nes 4.01 thro	ugh 4. 27			
6. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	58. 38	6. 00
7.00	Enter the lesser of line 5 or line 6				37. 47	7. 00
			Dri maru Car	0+1	T	
		-	Primary Care		Total	
8. 00	Weighted FTF count for physicians in an allopathic and osteor	oathi c	1. 00	2. 00	3. 00	8. 00
	Weighted FTE count for physicians in an allopathic and osteopprogram for the current year.		1. 00 36. <sup>0</sup>	2. 00	3. 00 57. 83	
	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherwards.	vi se	1. 00	2. 00	3. 00 57. 83	
	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwill multiply line 8 times the result of line 5 divided by the amount from line 8 times the result of line 5 divided by the amount from line 8.	vise ount on line	1. 00 36. <sup>0</sup>	2. 00	3. 00 57. 83	
9. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwind the strength of line 5 divided by the amount for cost reporting periods beginning on or after October of Worksheet S-2, Part I, line 68, is "Y", see instructions.	vise ount on line 1, 2022, or	1. 00 36. <sup>0</sup>	2. 00 99 20. 84 97 13. 50	3. 00 57. 83	9. 00
9. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwind tiply line 8 times the result of line 5 divided by the amount from 1 to 2 to 3 to 4 to 5 to 5 to 5 to 5 to 5 to 5 to 5	vise ount on line 1, 2022, or rent year	1. 00 36. <sup>0</sup>	2. 00 99 20. 84 97 13. 50 5. 71	3. 00 57. 83	9. 00
9. 00 10. 00 10. 01	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwind the strength of line 5 divided by the amount for cost reporting periods beginning on or after October of Worksheet S-2, Part I, line 68, is "Y", see instructions.	vise ount on line 1, 2022, or rent year	1. 00 36. <sup>0</sup>	2. 00 99 20. 84 97 13. 50 5. 71 53. 71	3. 00 57. 83	9. 00
9. 00 10. 00 10. 01 11. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwall tiply line 8 times the result of line 5 divided by the amount from cost reporting periods beginning on or after October of if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current unweighted dental and podiatric resident FTE count for the current weighted FTE count for the current weighted FTE count.	vise Dunt on line 1, 2022, or Tent year Urrent year	1.00 36.0 23.0	2. 00 20. 84 27 13. 50 5. 71 53. 71 19. 21	3. 00 57. 83	9. 00 10. 00 10. 01
9. 00 10. 00 10. 01 11. 00 12. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwind tiply line 8 times the result of line 5 divided by the amount from the second of the sec	vise bunt on line 1, 2022, or rent year urrent year ng year (see	1.00 36.0 23.0 23.0 20.8	2. 00 29 20. 84 27 13. 50 5. 71 53. 71 19. 21 22. 64	3. 00 57. 83 37. 47	9. 00 10. 00 10. 01 11. 00 12. 00
9. 00 10. 00 10. 01 11. 00 12. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwall tiply line 8 times the result of line 5 divided by the amount from cost reporting periods beginning on or after October of if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current unweighted dental and podiatric resident FTE count for the current weighted FTE count for the current weighted FTE count.	vise bunt on line 1, 2022, or rent year urrent year ng year (see	1.00 36.4 23.4	2. 00 29 20. 84 27 13. 50 5. 71 53. 71 19. 21 22. 64	3. 00 57. 83 37. 47	9. 00 10. 00 10. 01 11. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwind tiply line 8 times the result of line 5 divided by the amount from the second of the sec	vise ount on line 1, 2022, or rent year urrent year ng year (see	23. 4 23. 4 23. 4 25. 4 23. 4	2. 00 29 20. 84 27 13. 50 5. 71 53. 71 19. 21 22. 64 49 17. 40 13 19. 75	3. 00 57. 83 37. 47	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwall tiply line 8 times the result of line 5 divided by the amount for cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current unweighted dental and podiatric resident FTE count for the current weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost respectively and the penultimate cost respectively see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	vise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3).	23. 4 23. 4 25. 4 20. 8	2.00 29 20.84 27 13.50 5.71 53.71 19.21 22.64 49 17.40 43 19.75 50 0.00	3. 00 57. 83 37. 47	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwall tiply line 8 times the result of line 5 divided by the amount from cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current unweighted dental and podiatric resident FTE count for the current weighted FTE count for the current weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost reveal (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs.	wise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms	23. 6 23. 6 23. 6 25. 4 25. 4 26. 6 27. 6	2. 00 29 20. 84 27 13. 50 5. 71 53. 71 19. 21 22. 64 49 17. 40 43 19. 75 50 0. 00 0. 00	3. 00 57. 83 37. 47	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwall tiply line 8 times the result of line 5 divided by the amount for cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current unweighted dental and podiatric resident FTE count for the current weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost respectively and the penultimate cost respectively see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	wise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms bsure	23. 4 23. 4 25. 4 20. 8	2. 00 29 20. 84 27 13. 50 5. 71 53. 71 19. 21 22. 64 49 17. 40 49 17. 40 49 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	3. 00 57. 83 37. 47	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 01	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwind tiply line 8 times the result of line 5 divided by the amount from cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the currence unique of the count for the currence of the count weighted free count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost reyear (see instructions)  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs unweighted adjustment for residents displaced by program or hospital cloud on the country of the penultimate cost residents and initial years of new programs or hospital cloud on the country of the penultimate cost residents and in the country of the penultimate cost residents of the penultimate cost residents of the penultimate cost residents of the penultimate cost residents and penultimate cost residents of the penultimate	wise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms bsure	23. 4 23. 4 23. 4 20. 8 25. 4 23. 0. 0 0. 0	2.00 29 20.84 27 13.50 5.71 53.71 19.21 22.64 49 17.40 43 19.75 0.00 0.00 0.00 0.00 0.00 0.00	3. 00 57. 83 37. 47	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 01
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 01 17. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwood of the control	wise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms bsure	23. 4 23. 4 23. 4 25. 4 26. 6 27. 6 28. 6 29. 6 20. 6	2.00 29 20.84 27 13.50 5.71 53.71 19.21 22.64 49 17.40 43 19.75 00 0.00 0.00 0.00 0.00 0.00 0.00 13 19.75	3. 00 57. 83 37. 47	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 01 17. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwind tiply line 8 times the result of line 5 divided by the amount for cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current unweighted dental and podiatric resident FTE count for the current weighted FTE count.  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost respectively average for the penultimate cost respectively. Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs. Unweighted adjustment for residents in initial years of new part Adjustment for residents displaced by program or hospital clouweighted adjustment for residents displaced by program or hospital clouweighted adjustment for residents displaced by program or hospital clouweighted residents amount.	wise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms bsure	23. 6 23. 6 23. 6 20. 8 25. 4 20. 0 0. 0 0. 0 122, 851. 7	2.00 29 20.84 27 13.50 5.71 53.71 19.21 22.64 49 17.40 43 19.75 00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	3. 00 57. 83 37. 47	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5.  6. For cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currence of the control line in the second line of the prior cost reporting instructions.  Total weighted resident FTE count for the prior cost reporting instructions.  Total weighted resident FTE count for the penultimate cost respectively line and line seems line in the penultimate cost respectively.  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs. Unweighted adjustment for residents in initial years of new part adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for reside	wise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms bsure	23. 4 23. 4 23. 4 25. 4 25. 4 26. 6 0. 6 0. 6 27. 6 28. 6 29. 6 29. 6 20. 8	2.00 29 20.84 27 13.50 5.71 53.71 19.21 22.64 49 17.40 43 19.75 00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	3. 00 57. 83 37. 47	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherwind tiply line 8 times the result of line 5 divided by the amount for cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the current unweighted dental and podiatric resident FTE count for the current weighted FTE count.  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost respectively average for the penultimate cost respectively. Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs. Unweighted adjustment for residents in initial years of new part Adjustment for residents displaced by program or hospital clouweighted adjustment for residents displaced by program or hospital clouweighted adjustment for residents displaced by program or hospital clouweighted residents amount.	wise bunt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). brograms bsure	23. 6 23. 6 23. 6 20. 8 25. 4 20. 0 0. 0 0. 0 122, 851. 7	2.00 29 20.84 27 13.50 5.71 53.71 19.21 22.64 49 17.40 43 19.75 00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	3. 00 57. 83 37. 47	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 19. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount for cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the currence of the contact weighted FTE count for the prior cost reporting instructions).  Total weighted resident FTE count for the penultimate cost respectively line average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs unweighted adjustment for residents in initial years of new padjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted amount under §131 of the CAA 2021 Approved amount for resident costs  Additional unweighted allopathic and osteopathic direct GME for the contact of the contact costs.	wise ount on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). programs psure nospital	1.00 36.0 23.0 20.8 25.4 23.0 0.0 0.0 0.1 23.0 0.1 23.0 0.1 23.0 0.1 23.0 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0	2. 00 29 20. 84 27 13. 50 5. 71 53. 71 19. 21 22. 64 49 17. 40 43 19. 75 0. 00 0. 0	3. 00 57. 83 37. 47 5, 304, 740	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 19. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter line 5 divided by the amount for cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the currence line of the control line of the prior cost reporting instructions.  Total weighted FTE count for the prior cost reporting instructions.  Total weighted resident FTE count for the penultimate cost respectively line of the penultimate cost respectively.  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs. Unweighted adjustment for residents in initial years of new part adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted adjustment for residents displaced by program or hospital cloud unweighted amount under §131 of the CAA 2021  Approved amount for resident costs  Additional unweighted allopathic and osteopathic direct GME for the count of t	wise ount on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). orograms osure nospital	1.00 36.0 23.0 20.8 25.4 23.0 0.0 0.0 0.1 23.0 0.1 23.0 0.1 23.0 0.1 23.0 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0	2. 00 29 20. 84 27 13. 50 5. 71 53. 71 19. 21 22. 64 49 17. 40 43 19. 75 0. 00 0. 0	3. 00 57. 83 37. 47 5, 304, 740 1. 00 0. 00	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 19. 00
9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 19. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount for cost reporting periods beginning on or after October 6 if Worksheet S-2, Part I, line 68, is "Y", see instructions.  Weighted dental and podiatric resident FTE count for the currence of the control weighted for the podiatric resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost respectively line and see instructions.  Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs. Unweighted adjustment for residents in initial years of new part Adjustment for residents displaced by program or hospital clouweighted adjustment for residents displaced by program or locusure.  Adjusted rolling average FTE count  Per resident amount  Per resident amount under §131 of the CAA 2021  Approved amount for resident costs.  Additional unweighted allopathic and osteopathic direct GME for Sec. 413.79(c)(4)  Direct GME FTE unweighted resident count over cap (see instructions)	vise punt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). programs psure nospital	1.00 36.0 23.0 20.8 25.4 23.0 0.0 0.0 0.1 23.0 0.1 23.0 0.1 23.0 0.1 23.0 0.1 0.1 0.1 0.1 0.1 0.1 0.1 0	2. 00 29 20. 84 27 13. 50 5. 71 53. 71 19. 21 22. 64 49 17. 40 43 19. 75 0. 00 0. 0	3. 00 57. 83 37. 47 5, 304, 740 1. 00 0. 00	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00
15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount from line 8, otherword line 6 is less than 5 enter the amount for cost reporting periods beginning on or after October 6. For cost reporting line for the content for the content for the content for the content for the content for the given for the prior cost reporting instructions.  Weighted dental and podiatric resident FTE count for the prior cost reporting instructions.  Total weighted FTE count for the penultimate cost respectively line for line for the penultimate cost respectively line for resident for the penultimate cost respectively line for resident for the penultimate cost respectively line for resident for the penultimate cost respectively line for the penultimate cost respectively. The penultimate cost respectively line for the penultimate cost respectively line for the penultimate cost respectively line for the penultimate cost respectivel	vise punt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). programs psure nospital  FTE resident outions)	23.4 20.8 25.4 20.6 0.0 0.0 122,851. 2,878,4	2. 00 29 20. 84 27 13. 50 5. 71 53. 71 19. 21 22. 64 49 17. 40 43 19. 75 0. 00 0. 0	3. 00 57. 83 37. 47 5, 304, 740 1. 00 0. 00 20. 91 0. 00 144, 531. 45	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 17. 00 18. 01 19. 00 20. 00 21. 00 22. 00 23. 00
9. 00  10. 00 11. 00 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 24. 00	program for the current year.  If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amount for cost reporting periods beginning on or after October if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currence unweighted dental and podiatric resident FTE count for the currence weighted FTE count to the prior cost reporting instructions)  Total weighted resident FTE count for the prior cost reporting instructions)  Total weighted resident FTE count for the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively and the penultimate cost respectively.  Adjustment for residents displaced by program or hospital closure  Adjustment for residents displaced by program or hospital closure  Adjustment for residents displaced by program or hospital closure  Adjustment for residents displaced by program or hospital closure  Adjustment for residents displaced by program or hospital closure  Adjustment for residents displaced by program or hospital closure  Adjustment for residents displaced by program or hospital closure  Adjustment for residents displaced by program or hospital closure  Adjustment for residents displaced by program or hospital closure  Adjustment for residents displaced by program or hospital closure displaced by program or hospita	vise punt on line 1, 2022, or rent year urrent year ng year (see eporting d by 3). programs psure nospital  FTE resident outions)	23.4 20.8 25.4 20.6 0.0 0.0 122,851. 2,878,4	2. 00 29 20. 84 27 13. 50 5. 71 53. 71 19. 21 22. 64 49 17. 40 43 19. 75 0. 00 0. 0	3. 00 57. 83 37. 47 5, 304, 740 1. 00 0. 00 20. 91 0. 00	9. 00 10. 00 10. 01 11. 00 12. 00 13. 00 14. 00 15. 01 16. 00 16. 01 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00

	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der Co	CN: 31-0027	Peri od:	Worksheet E-4	
EDI CA	L EDUCATION COSTS			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 10:	pared 12 am
		Title	XVIII	Hospi tal	PPS	
			Inpatient Par A	rt Managed Care	Total	
			1, 00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	0.00	
5. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I) 3.02, column 2)	X, line	10, 6	79 11, 221		26. (
7. 00	Total Inpatient Days (see instructions)		66, 6	18 66, 618		27.
3. 00	Ratio of inpatient days to total inpatient days		0. 16030			28.
9. 00	Program direct GME amount		850, 36		1, 743, 880	29.
9. 01	Percent reduction for MA DGME			3. 27		29.
0. 00	Reduction for direct GME payments for Medicare Advantage			29, 218	29, 218	30.
. 00	Net Program direct GME amount				1, 714, 662	31.
					1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	E XVIII ONLY	(NURSING PRO	OGRAM AND PARAMED	OI CAL	
2. 00	· · · · · · · · · · · · · · · · · · ·				0	32.
3. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I	l, col. 8, s	um of lines 7	74 and 94)	58, 720, 663	33.
. 00	Ratio of direct medical education costs to total charges (line			,	0.000000	34.
5. 00	Medicare outpatient ESRD charges (see instructions)				0	35.
5. 00	Medicare outpatient ESRD direct medical education costs (line		5)		0	36.
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
	Part A Reasonable Cost					
. 00	Reasonable cost (see instructions)				35, 493, 417	1
3. 00	Organ acquisition and HSCT acquisition costs (see instructions				0	
. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)			0	
. 00	Primary payer payments (see instructions)	11 40)			0 0 117	1
. 00	Total Part A reasonable cost (sum of lines 37 through 39 minus Part B Reasonable Cost	s line 40)			35, 493, 417	41.
. 00	Reasonable cost (see instructions)				13, 609, 834	42.
3. 00	Primary payer payments (see instructions)				13, 609, 634	1
. 00	Total Part B reasonable cost (line 42 minus line 43)				13, 609, 552	
. 00	Total reasonable cost (sum of lines 41 and 44)				49, 102, 969	
. 00	Ratio of Part A reasonable cost to total reasonable cost (line	- 41 ∸ line	45)		0. 722836	1
	Ratio of Part B reasonable cost to total reasonable cost (line		,		0. 277164	
. 00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR		,		0.277104	l '''
. 00	Total program GME payment (line 31)	<del>_</del>			1, 714, 662	48.
9. 00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)	(see instru	ictions)		1, 239, 419	
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)				475, 243	1 50

Health Financial Systems TRINITAS HOSPITAL In Lieu					552-10
OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCN: 31-0027 Period: W					
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 10:1	ared: 2 am
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00 Operating outlier reconciliation adjustment amount (see instructions)					3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)				0	4.00
5.00 The rate used to calculate the time value of money (see instructions)				0.00	5.00
6.00 Time value of money for operating expenses (see instructions)					6.00
7.00 Time value of money for capital related expenses (see instructions)					7. 00

Health Financial Systems TRINITAS HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems

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

Provider CCN: 31-0027 Period: From 01/01

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 10: 12 am

13.00   Land improvements	oni y)					5/30/2024 10:	
CUBRENT ASSETS   1.00   2.00   3.00   1.00			General Fund		Endowment Fund	Plant Fund	
Cash on hand in Danks			1.00		3. 00	4.00	
Temporary   Investments		CURRENT ASSETS					
Notes receivable   0			3, 606, 022	1	0		
A.COUNTS receivable		1 ' "		1			
Other receivable   0			30 953 101	1	1		
All owances for uncollectible notes and accounts receivable   -9, 706, 852   0   0   0   0			0 0				
Prepair of expenses			-9, 706, 852		o o		
Other current assets	7.00	Inventory	3, 888, 687	' (	0		
10.00   Due from other Funds				1	0		
Total current assets (sun of lines 1-10)				1	1		
IXED ASSETS							1
12.00   Land   1,783,178   0   0   0   0   1   1   1   1   1   1	11.00		100, 101, 730	)  (	<u>J</u>		11. 00
13.00   Land improvements	12. 00		1, 783, 178	3 (	0	0	12. 00
15.00   Buil drings   95,028,583   0   0   0   0   0   17.00				1	0		
16.00   Accumul ated depreciation   -12, 710, 0.27   0   0   0   0   0   0   0   0   0	14. 00	Accumulated depreciation	-170, 286		0	0	14. 00
17.00   Leasehol d Improvements				1	-		
18.00   Accumulated depreciation   -377.965   0   0   0   0   0   0   0   0   0				1	-		•
19.00   Fixed equipment		•		1	-		
20.00   Accumul ated depreciation   -427,653   0   0   0   0   0   0   0   0   0		1		1	-		•
21.00		1				1	
1.0		1	0	1	o o		
24.00   Accumul ated depreciation   -11,678,705   0   0   0   0   0   0   0   0   0	22. 00	Accumul ated depreciation	0		0	0	22. 00
25.00   Minor equipment depreciable   0   0   0   0   0   0   0   0   0	23. 00	Major movable equipment	41, 086, 568	3	0	0	23.00
26. 00 Accumul ated depreciation		1	-11, 678, 705		-		
27. 00   HIT designated Assets   0   0   0   0   0   0   0   0   0			0	1	-		
Accumulated depreciation		· •	0		0		
29.00   Minor equipment-nondepreciable   0   0   0   0   0   0   0   0   0							
30. 00   Total fived assets (sum of lines 12-29)   126,908,387   0   0   0		· •		1	-		
OTHER ASSETS		1	126, 908, 387		-		
32.00   Deposits on leases   0   0   0   0   0   0   0   0   0							
33.00   Due from owners/officers   0   0   0   0   0   0   0   0   0			0			-	
34.00   Other assets   24,303,010   0   0   0   0   0   0   0   0   0		·	0	1	-		
35. 00			24 202 010	1	-	•	1
Total assets (sum of lines 11, 30, and 35)   316, 393, 133   0   0   0				1			
CURRENT LIABILITIES		1		1	-		
37.00   Accounts payable   14,777,490   0   0   0   0   0   38.00   Sal arles, wages, and fees payable   9,174,007   0   0   0   0   0   0   0   0   0	00.00		1 010/070/100	<u> </u>	51 5		1 00.00
39.00   Payroll taxes payable	37. 00		14, 777, 490	) (	0	0	37. 00
40.00   Notes and Loans payable (short term)   11, 368   0   0   0   0   0   0   0   0   0				1	0		
A1.00   Deferred income   8,104,536   0   0   0   0   0   0   0   0   0				1			•
42.00       Accelerated payments       0         43.00       Due to other funds       4,402,366       0       0         44.00       Other current liabilities       24,615,911       0       0         45.00       Total current liabilities (sum of lines 37 thru 44)       61,627,096       0       0       0         LONG TERM LIABILITIES       46.00       Mortgage payable       0       0       0       0       0         47.00       Notes payable       11,367       0       0       0       0       0         49.00       Unsecured loans       0       0       0       0       0       0         49.00       Other long term liabilities (sum of lines 46 thru 49)       68,282,612       0       0       0       0         50.00       Total long term liabilities (sum of lines 45 and 50)       129,921,075       0       0       0       0         51.00       General fund balance       186,472,058       0       0       0       0         52.00       General fund balance       0       0       0       0       0       0         53.00       Specific purpose fund       0       0       0       0       0       0				1	0		
43.00 Due to other funds 44.00 Other current liabilities 45.00 Other current liabilities (Sum of lines 37 thru 44)			8, 104, 536		J U	0	41. 00 42. 00
44.00     Other current liabilities     24,615,911     0     0       45.00     Total current liabilities (sum of lines 37 thru 44)     61,627,096     0     0       46.00     Mortgage payable     0     0     0     0       47.00     Notes payable     0     0     0     0       48.00     Unsecured loans     0     0     0     0       49.00     Other long term liabilities     68,282,612     0     0       50.00     Total long term liabilities (sum of lines 46 thru 49)     68,293,979     0     0       50.00     Total liabilities (sum of lines 45 and 50)     129,921,075     0     0       60     Oeneral fund balance     0     0     0       52.00     General fund balance     186,472,058     0       53.00     Specific purpose fund     0     0       54.00     Donor created - endowment fund balance - restricted     0     0       55.00     Governing body created - endowment fund balance     0     0       57.00     Plant fund balance - invested in plant     0     0       58.00     Plant fund balance - reserve for plant improvement, replacement, and expansion     0     0       59.00     Total liabilities and fund balances (sum of lines 51 and     316,393,133			4 402 366		0	0	•
Total current liabilities (sum of lines 37 thru 44)   61,627,096   0   0   0				1	o o		
46.00       Mortgage payable       0       0       0       0         47.00       Notes payable       11,367       0       0       0         48.00       Unsecured loans       0       0       0       0         49.00       Other long term liabilities       68,282,612       0       0       0         50.00       Total long term liabilities (sum of lines 46 thru 49)       68,293,979       0       0       0         51.00       Total liabilities (sum of lines 45 and 50)       129,921,075       0       0       0         6eneral fund balance       Specific purpose fund       0       0       0         52.00       Donor created - endowment fund balance - restricted       0       0         55.00       Donor created - endowment fund balance - unrestricted       0       0         56.00       Governing body created - endowment fund balance       0       0         57.00       Plant fund balance - invested in plant       0       0         58.00       Plant fund balance - reserve for plant improvement, replacement, and expansion       0       0         59.00       Total liabilities and fund balances (sum of lines 52 thru 58)       186,472,058       0       0         60.00       Total liabili	45. 00			1	0	0	•
47.00       Notes payable       11,367       0       0       0         48.00       Unsecured Loans       0       0       0       0         49.00       Other Long term Liabilities       68,282,612       0       0       0         50.00       Total long term Liabilities (sum of Lines 46 thru 49)       68,293,979       0       0       0         51.00       Total Liabilities (sum of Lines 45 and 50)       129,921,075       0       0       0         CAPLTAL ACCOUNTS       Total Fund balance         52.00       General Fund balance         Specific purpose fund       Donor created - endowment fund balance - restricted         Donor created - endowment fund balance - unrestricted       0         55.00       Donor created - endowment fund balance       0         Flant fund balance - invested in plant       0         Flant fund balance - reserve for plant improvement, replacement, and expansion       0         Total fund balances (sum of Lines 52 thru 58)       186,472,058       0       0         59.00       Total Liabilities and fund balances (sum of Lines 51 and       316,393,133       0       0							
48.00 Unsecured Loans			0	1	٦		
49.00 Other long term liabilities			11, 367	1			•
50.00         Total long term liabilities (sum of lines 46 thru 49)         68, 293, 979         0         0         0           51.00         Total liabilities (sum of lines 45 and 50)         129, 921, 075         0         0         0           CAPITAL ACCOUNTS         52.00         General fund balance         186, 472, 058         0<			60 202 612		-	-	
51.00 Total liabilities (sum of lines 45 and 50)				1			
CAPITAL ACCOUNTS  52.00 General fund balance  53.00 Specific purpose fund  54.00 Donor created - endowment fund balance - restricted  55.00 Donor created - endowment fund balance - unrestricted  56.00 Governing body created - endowment fund balance  57.00 Plant fund balance - invested in plant  58.00 Plant fund balance - reserve for plant improvement, replacement, and expansi on  59.00 Total fund balances (sum of lines 52 thru 58)  Total liabilities and fund balances (sum of lines 51 and 316, 393, 133)  186, 472, 058  0 0 0  0 0		,		1			
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 66.00 Governing body created - endowment fund balance 77.00 Plant fund balance - invested in plant 78.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 79.00 Total fund balances (sum of lines 52 thru 58) 70 Total liabilities and fund balances (sum of lines 51 and 70 Total liabilities and fund balances (sum of lines 51 and 70 Total liabilities and fund balances (sum of lines 51 and 70 Total liabilities and fund balances (sum of lines 51 and 70 Total liabilities and fund balances (sum of lines 51 and 70 Total liabilities and fund balances (sum of lines 51 and 70 Total liabilities and fund balances (sum of lines 51 and 70 Total liabilities and fund balances (sum of lines 51 and						•	
54.00 Donor created - endowment fund balance - restricted  55.00 Donor created - endowment fund balance - unrestricted  56.00 Governing body created - endowment fund balance  57.00 Plant fund balance - invested in plant  58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion  59.00 Total fund balances (sum of lines 52 thru 58)  Total liabilities and fund balances (sum of lines 51 and 316, 393, 133 0 0 0	52. 00		186, 472, 058	3			52. 00
55.00 Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance Flant fund balance - invested in plant Flant fund balance - reserve for plant improvement, replacement, and expansion For total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and 316, 393, 133 0 0 0		' ' '			O C		53. 00
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 186,472,058 0 0 0 0 0 0 0 0					0		54.00
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 186,472,058 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0		55.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion  59.00 Total fund balances (sum of lines 52 thru 58)  Total liabilities and fund balances (sum of lines 51 and 316, 393, 133 0 0 0						_	56. 00 57. 00
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 316,393,133 0 0 0		•					
59.00       Total fund balances (sum of lines 52 thru 58)       186, 472, 058       0       0         60.00       Total liabilities and fund balances (sum of lines 51 and 316, 393, 133       0       0						I	55. 50
	59. 00		186, 472, 058	3	0	0	59. 00
[59]	60. 00		316, 393, 133	3	0	0	60.00
		[59]	I			I	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES TRINITAS HOSPITAL

| Period: | Worksheet G-1 | From 01/01/2023 | To 12/21/2023 | Provider CCN: 31-0027

					To	12/31/2023	Date/Time Pre 5/30/2024 10:	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1.00	2.00	3. 00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NON OPERATING REVENUE OTHER CHANGES IN RESTRICED ASSETS  Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 592, 146 1, 720, 963 0 0 0	226, 943, 074 -42, 784, 125 184, 158, 949 2, 313, 109 186, 472, 058		0 0 0 0 0	0	0 0 0 0 0	5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
15. 00 16. 00 17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0	0 186, 472, 058 Pl ant		0 0 0	0	0	15. 00 16. 00
		Litaowiiicite Tana	Traire	Tunu				
		6. 00	7. 00	8. 00				
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NON OPERATING REVENUE OTHER CHANGES IN RESTRICED ASSETS	0	0 0 0 0		0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17)	0 0	0 0 0 0 0		0			10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Peri od: | Worksheet G-2 | From 01/01/2023 | Parts | & | I | | To | 12/31/2023 | Date/Time | Prepared: Provider CCN: 31-0027

			Γο 12/31/2023	Date/Time Prep 5/30/2024 10:	
	Cost Center Description	Inpati ent	Outpati ent	Total	12 (1111
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	210, 750, 550		210, 750, 556	1. 00
2.00	SUBPROVI DER - I PF	104, 693, 028	3	104, 693, 028	2. 00
3.00	SUBPROVI DER - I RF	(	0	0	3. 00
4.00	SUBPROVI DER	11, 098, 07		11, 098, 076	4. 00
5.00	Swing bed - SNF	1	)	0	5.00
6.00	Swing bed - NF	1 100 10	)	0	6. 00
7.00	SKILLED NURSING FACILITY	1, 122, 40		1, 122, 409	7. 00
8.00	NURSING FACILITY	7, 135, 92		7, 135, 927	8. 00
9.00	OTHER LONG TERM CARE	4, 285, 99		4, 285, 995	9.00
10. 00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services	339, 085, 99	I	339, 085, 991	10. 00
11. 00	INTENSIVE CARE UNIT	73, 857, 96	2	73, 857, 962	11. 00
12. 00	CORONARY CARE UNIT	73,037, 40.	2	13, 651, 702	12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	73, 857, 96		73, 857, 962	16. 00
	11-15)			, ,	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	412, 943, 95	3	412, 943, 953	17. 00
18.00	Ancillary services	248, 017, 850	531, 918, 533	779, 936, 383	18. 00
19.00	Outpatient services	27, 166, 07	244, 695, 514	271, 861, 586	19. 00
20.00	RURAL HEALTH CLINIC		0	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES		0	0	23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGI CAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE			_	26. 00
27. 00	OTHER (SPECIFY)		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	688, 127, 87	776, 614, 047	1, 464, 741, 922	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		359, 129, 599		29. 00
30. 00	ADD (SPECIFY)	1	339, 129, 399		30.00
31. 00	ADD (SECTIT)	•			31. 00
32. 00					32. 00
33. 00					33. 00
34. 00			o l		34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)		o		37. 00
38. 00			o l		38. 00
39. 00			o l		39. 00
40.00			D		40. 00
41.00					41. 00
42.00	Total deductions (sum of lines 37-41)		0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	·	359, 129, 599		43.00
	to Wkst. G-3, line 4)				

Heal th	Financial Systems TRINITAS HOS	SPI TAI	In lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES	Provider CCN: 31-0027	Peri od:	Worksheet G-3	1002 10
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 10:	
	I			1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			1, 464, 741, 922	1. 00
2.00	Less contractual allowances and discounts on patients' accoun	ts		1, 190, 769, 969	2. 00
3.00	Net patient revenues (line 1 minus line 2)	40)		273, 971, 953	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		359, 129, 599	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			-85, 157, 646	5. 00
	OTHER I NCOME			0	
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8. 00 9. 00	Revenues from telephone and other miscellaneous communication Revenue from television and radio service	Servi ces		0	8. 00 9. 00
10.00	Purchase discounts			ĭ,	9. 00 10. 00
11. 00				0	10.00
	Rebates and refunds of expenses			0	12.00
12. 00 13. 00	Parking lot receipts			0	12.00
14. 00	Revenue from laundry and linen service Revenue from meals sold to employees and guests			- 1	14. 00
15. 00	Revenue from rental of living quarters				15. 00
16. 00	Revenue from sale of medical and surgical supplies to other t	han nationts			16. 00
17. 00	Revenue from sale of drugs to other than patients	nan patrents			17. 00
18. 00	Revenue from sale of medical records and abstracts				17. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	
23. 00	Governmental appropriations			0	
24. 00	TOTAL EXCLUDING COVID			42, 455, 397	
24. 50	COVI D-19 PHE Funding			-81, 876	
25. 00	Total other income (sum of lines 6-24)			42, 373, 521	
26. 00	Total (line 5 plus line 25)			-42, 784, 125	
27. 00	OTHER EXPENSES (SPECIFY)			-42, 764, 125	27. 00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
	Net income (or loss) for the period (line 26 minus line 28)			-42, 784, 125	
27.00	The tricome (or 1033) for the period (trie 20 millios frie 20)		I	72, 704, 125	27.00

Component CCN: 31-2318 To 12/31/2023 Worksheet 1-1

From 01/01/2023 Date/Time Prepared: 5/30/2024 10: 12 am

					5/30/2024 10:	ız am
				Renal Dialysis		
		Total Costs	Basi s	Stati sti cs	FTEs per 2080	
					Hours	
		1.00	2. 00	3. 00	4. 00	
1.00	REGI STERED NURSES	3, 914, 041 H	HOURS OF SERVICE	65, 532. 00	31. 51	1.00
2.00	LI CENSED PRACTI CAL NURSES	0	HOURS OF SERVICE	0.00		2.00
3.00	NURSES AI DES		HOURS OF SERVICE	0.00	0.00	3.00
4.00	TECHNI CI ANS	1, 225, 967 H	HOURS OF SERVICE	45, 529. 00	21. 89	4.00
5.00	SOCI AL WORKERS	138, 396 H	HOURS OF SERVICE	3, 031. 00		5.00
6.00	DI ETI CI ANS	167, 192 H	HOURS OF SERVICE	4, 015. 00	1. 93	6.00
7.00	PHYSI CI ANS	152, 874	ACCUMULATED COST			7.00
8.00	NON-PATIENT CARE SALARY	601, 105	ACCUMULATED COST			8.00
9.00	SUBTOTAL (SUM OF LINES 1-8)	6, 199, 575				9.00
10.00	EMPLOYEE BENEFITS	0 5	SALARY			10.00
11.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	0 5	SQUARE FEET			11.00
12.00	CAPITAL RELATED COSTS-MOV. EQUIP.	OF	PERCENTAGE OF TIME			12.00
13.00	MACHINE COSTS & REPAIRS	OF	PERCENTAGE OF TIME			13.00
14.00	SUPPLIES	OF	REQUI SI TI ONS			14.00
14.01	PEDIATRIC MEDICAL SUPPLIES	OF	REQUI SI TI ONS			14.01
15.00	DRUGS	1, 434, 189 F	REQUI SI TI ONS			15.00
16.00	OTHER	1, 910, 511	ACCUMULATED COST			16.00
17.00	SUBTOTAL (SUM OF LINES 9-16)*	9, 544, 275				17.00
18.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES	89, 445	SQUARE FEET			18.00
19.00	CAPITAL RELATED COSTS-MOV. EQUIP.	105, 539 F	PERCENTAGE OF TIME			19.00
20.00	EMPLOYEE BENEFITS DEPARTMENT	1, 336, 402	SALARY			20.00
21.00	ADMINISTRATIVE & GENERAL	3, 662, 776	ACCUMULATED COST			21.00
22.00	MAINT. / REPAIRS-OPER-HOUSEKEEPING	1, 091, 711	SQUARE FEET			22.00
23.00	MEDICAL EDUCATION PROGRAM COSTS	0				23.00
24.00	CENTRAL SERVICE & SUPPLIES	183, 205 F	REQUI SI TI ONS			24.00
25.00	PHARMACY	556, 596 F	REQUI SI TI ONS			25.00
26.00	OTHER ALLOCATED COSTS	1, 621, 741	ACCUMULATED COST			26.00
27.00	SUBTOTAL (SUM OF LINES 17-26)*	18, 191, 690				27.00
28.00	LABORATORY (SEE INSTRUCTIONS)	olo	CHARGES	0		28.00
29.00	RESPIRATORY THERAPY (SEE INSTRUCTIONS)	olo	CHARGES	0		29.00
30.00	OTHER ANCILLARY SERVICE COST CENTERS	olo	CHARGES	0		30.00
30. 97	CARDIAC REHABILITATION	olo	CHARGES	0		30. 97
30. 98	HYPERBARI C OXYGEN THERAPY	l ok	CHARGES	0		30. 98
30. 99	LI THOTRI PSY	olo	CHARGES	0		30. 99
31.00	TOTAL COSTS (SUM OF LINES 27-30)	18, 191, 690				31.00
					'	

<sup>\*</sup> Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate, and line 27, column 1 should agree with Worksheet B, Part I, column 24, less the sum of columns 21 and 22, for line 74 or line 94 as appropriate.

	Financial Systems	TO TOPATHENT M	TRINITAS H		ON 04 0007 F		eu of Form CMS-2	
ALLUCA	ATION OF RENAL DEPARTMENT COSTS	TO TREATMENT MC	DALITIES	Provi der C		Period: From 01/01/2023	Worksheet I-2	
				Component		Γο 12/31/2023	Date/Time Pre	pared:
						Renal Dialysis	5/30/2024 10:	12 am
		Capital Rel	ated Costs	Direct Patien	it Care Salary	Trendr Bran yor o		
		<u>'</u>						
		Bui I di ng	Equi pment	RNs	0ther	Empl oyee	Drugs	
						Benefits		
		1.00	2.00	3. 00	4.00	Department 5.00	6. 00	
1. 00	Total Renal Department Costs	1, 181, 156	105, 539	3, 914, 041				1.00
00	MAI NTENANCE	17 10 17 100	100,007	5, 7, 1, 5, 1,	1,001,000	1,000,102	1,770,700	
2.00	Hemodi al ysi s	1, 181, 156	105, 539	3, 914, 041	1, 531, 555	1, 336, 402	1, 990, 785	2. 00
2. 01	AKI-Hemodialysis	0	0	0	(	O C	0	2. 01
2. 02	Hemodi al ysi s-Pedi atri c	0	0	0			0	
3. 00 3. 01	Intermittent Peritoneal AKI-Intermittent Peritoneal	0	O O	0			0	
3. 02	I PD-Pedi atri c	0	0	0		-		ł
0.02	TRAI NI NG	<u> </u>	<u> </u>			51		0.02
4.00	Hemodi al ysi s	0	0	0	(	C	0	4. 00
4.01	Hemodi al ysi s-Pedi atri c	0	0	0		o c	0	ı
5.00	Intermittent Peritoneal	0	0	0	(	O C	0	
5. 01	I PD-Pedi atri c	0	0	0	(		0	
6. 00 6. 01	CAPD CAPD-Pedi atri c		0	0			0	
7. 00	CCPD	0	0	0				1
7. 01	CCPD-Pedi atri c	Ö	Ö	0		-		•
	HOME							
8. 00	Hemodi al ysi s	0	0	0				•
8. 01	Hemodi al ysi s-Pedi atri c	0	O	0			_	•
9. 00 9. 01	Intermittent Peritoneal IPD-Pediatric		Ol	0	(		0	
10.00	CAPD		0	0			0	l
10. 01	CAPD-Pedi atri c	Ö	o	0				1
11.00	CCPD	0	0	0	(	o c	0	11. 00
11. 01	CCPD-Pedi atri c	0	0	0	(	0	0	11. 01
40.00	OTHER BILLABLE SERVICES		٥		ı ,	J .	1 0	1 40 00
12. 00 13. 00	Inpatient Dialysis Method II Home Patient	0	O O	0				
14. 00	ESAs (included in Renal		٩	0			0	ı
11.00	Department)							11.00
15.00								15. 00
16. 00	0ther	0	0	0	(	0	0	
17. 00	Total (sum of lines 2 through	1, 181, 156	105, 539	3, 914, 041	1, 531, 555	1, 336, 402	1, 990, 785	17. 00
18. 00	16)   Medical Educational Program							18. 00
10.00	Costs							10.00
19.00	Total Renal Costs (line 17 +							19. 00
	line 18)							
		Medical	Pediatric	Routine	Subtotal (sum		Total (col. 9 + col. 10)	
		Suppl i es	Medi cal Suppl i es	Anci I I ary Servi ces	of cols. 1-8)		+ (01. 10)	
		7. 00	7. 01	8. 00	9. 00	10.00	11.00	
1.00	Total Renal Department Costs	183, 205	0	0	10, 242, 683	7, 949, 007	18, 191, 690	1. 00
	MAI NTENANCE							
2.00	Hemodi al ysi s AKI-Hemodi al ysi s	183, 205	0	0		7, 949, 007	18, 191, 690	
2. 01 2. 02	Hemodi al ysi s-Pedi atri c	0	0	0			0	2. 01 2. 02
3.00	Intermittent Peritoneal	0	0	0	,	1	Ö	
3. 01	AKI-Intermittent Peritoneal	Ö	Ö	0				1
3.02	IPD-Pediatric	0	0	0	(	o c	0	1
	TRAI NI NG							
4.00	Hemodi al ysi s	0	0	0				
4. 01 5. 00	Hemodialysis-Pediatric Intermittent Peritoneal	0	0	0	(		0	•
5. 00	IPD-Pedi atri c		0	0			0	1
6. 00	CAPD	0	o	0			ő	1
6. 01	CAPD-Pedi atri c	0	0	0	(	o c	0	1
7.00	CCPD	0	0	0	(	0		
7. 01	CCPD-Pedi atri c	0	0	0	(	<u> </u>	0	7. 01
0 00	HOME		ام	^	,			0.00
8. 00 8. 01	Hemodi al ysi s Hemodi al ysi s-Pedi atri c	0	0	0		-	l .	ı
9. 00	Intermittent Peritoneal		0	0		1		1
9. 01	I PD-Pedi atri c	o	o	0	1	-		ı
10.00	CAPD	0	O	0		o c		10.00
10. 01	CAPD-Pedi atri c	0	0	0				ı
11.00	CCPD CCPD-Pedi atri c	0	0	0		-		11. 00 11. 01
11.01	COFD-PeulatifC	ı Y	Ч	U	1	ار	ı U	11.01

Heal th	Financial Systems		TRINITAS H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF RENAL DEPARTMENT COSTS	TO TREATMENT MO	DALI TI ES	Provi der C	CN: 31-0027	Peri od:	Worksheet I-2	
				Component	CCN: 31-2318	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 10:	
						Renal Dialysis		
		Medi cal	Pedi atri c	Routi ne	Subtotal (s		Total (col. 9	
		Suppl i es	Medi cal	Ancillary	of cols. 1-	3)	+ col . 10)	
			Suppl i es	Servi ces				
		7.00	7. 01	8. 00	9. 00	10.00	11. 00	
	OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	0	0	O		0 0	0	12.00
13.00	Method II Home Patient	0	0	0	)	0 0	0	13.00
14.00	ESAs (included in Renal							14. 00
	Department)							
15.00								15. 00
16.00	Other	o	0	0	)	0 0	0	16. 00
17.00	Total (sum of lines 2 through	183, 205	O	0	10, 242, 6	83 7, 949, 007	18, 191, 690	17. 00
	16)							
18.00	Medical Educational Program						0	18. 00
	Costs							
19.00	Total Renal Costs (line 17 +						18, 191, 690	19. 00
	line 18)							
		,	·		•	*	•	•

Provider CCN: 31-0027 | Peri od: | Worksheet I-3 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 10: 12 am

Capital National Costs						GON. 31 2310 1	0 12/31/2023	5/30/2024 10:	
Spitching   Spit				Canital Pol	ated Costs		Renal Dialysis		
				Capi tai Rei	ateu costs	Direct Patrer	t care sarary		
Total Renal Department Costs   0   1.00   2.00   3.00   4.00   6.881 arv						RNs (Hours)	Other (Hours)		
100   Total Renel Coper territ Costs   1,181,156   10,539   5,914,041   1,331,555   1,386,402   1,00   1,381,156   1,381,555   1,386,402   1,00   1,381,156   1,381,555   1,386,402   1,00   1,381,156   1,381,555   1,386,402   1,00   1,381,155   1,386,402   1,00   1,381,155   1,386,402   1,00   1,381,155   1,386,402   1,00				(Square Feet)	of lime)				
Total Renal Department Dosts									
MINITERWOOLS			0					5. 00	
	1. 00			1, 181, 156	105, 539	3, 914, 041	1, 531, 555	1, 336, 402	1.00
2.01   Akt - Hemodal alysis	2 00			1 170 897	107 645 00	3 914 041 00	1 531 555 00	1 416 485	2 00
Intermit Start Peri toneal									
AKI - Intermit Intern Peri toneal								0	
IPD-Post atric		1							
MAIN NO									
	3.02			0	0.00	0.00	0.00	0	3.02
Intermittent Peritoneal   0	4.00			0					
DP-Pediatric									
CAPD		1							
APP-Pediatric   0		1							
CCPD						•			
MOME   MOME		CCPD							
Bendial alysis   Serial artic   0   0.00	7. 01			0	0.00	0.00	0.00	0	7. 01
	8 00			0	0.00	0.00	0.00	0	8 00
						•			
10. 00   CAPD	4		0		•		0	9. 00	
10. 01   CAPD-Pediatric   0   0. 0. 0   0. 00   0. 00   0. 00   0. 10. 01		1						_	
11.00		4							
11. 01   CCPD-Pediatric   O   O   O   O   O   O   O   O   O									
12.00   Inpatient Dialysis Treatments   0   0   0.00   0.00   0.00   0.12.00   0.13.00   0.13.00   0.00   0.00   0.00   0.00   0.00   0.13.00   0.00   0.00   0.00   0.13.00   0.00   0.00   0.00   0.00   0.00   0.13.00   0.00		•							
13.00   Method II Home Patient									
14. 00   15. 00   15. 00   16. 00   16. 00   16. 00   17. 00   1			0						
15.00		•		0	0.00	0.00	0.00	0	
16.00		LUAS							
1.00	16.00	Other		0	0.00	0.00	0. 00	0	16. 00
Total Renal Department Costs   1,990,785   183,205   0   0   0   10,242,683   7,949,007   1.00   10,000   1.									
Drugs   Medical Supplies   Supplies   Requist.   Supplies   Requist.   Supplies   Requist.   Requist.   Supplies   Requist.   Requist.   Requist.   Routine   Ancillary   Services   Requist.   Requ	18. 00			1. 008762	0. 980436	1.000000	1. 000000	0. 943464	18.00
Requist.   Supplies   Charges   Ch			Drugs	Medi cal	Pedi atri c	Routi ne	Subtotal	Overhead	
Note   Content   Note		(Requist.)	• •				(Accum. Cost)		
1.00				(Requist.)					
Total Renal Department Costs   1,990,785   183,205   0   0   10,242,683   7,949,007   1.00			6. 00	7. 00			9. 00	10.00	
2.00	1. 00			183, 205			10, 242, 683	7, 949, 007	1. 00
2. 01	2 00		1 51/ /02	107 010	1 0	1	I		2 00
2. 02   Hemodi al ysi s Pedi atri c		1	1,516,602	187, 818	0				1
3.00   Intermittent Peri toneal   0   0   0   0   0   3.00     3.01   AKI-Intermittent Peri toneal   0   0   0   0   0     3.01   IDP-Pedi atric   0   0   0   0   0     5.00   Intermittent Peri toneal   0   0   0   0     6.00   Hemodi al ysis   0   0   0   0   0     7.00   Intermittent Peri toneal   0   0   0   0     8.01   IPD-Pedi atric   0   0   0   0     8.01   IPD-Pedi atric   0   0   0   0     8.02   IPD-Pedi atric   0   0   0     8.00   IPD-Pedi atric   0   0   0     8.00   Hemodi al ysis   0   0   0     8.00   Hemodi al ysis   0   0   0     8.00   Hemodi al ysis   0   0   0     9.00   Intermittent Peri toneal   0   0   0     9.01   IPD-Pedi atric   0   0   0     9.02   IPD-Pedi atric   0   0   0     9.03   IPD-Pedi atric   0   0   0     9.04   Intermittent Peri toneal   0   0   0     9.05   IPD-Pedi atric   0   0   0     9.06   IPD-Pedi atric   0   0   0     9.07   IPD-Pedi atric   0   0   0     9.08   IPD-Pedi atric   0   0   0     9.09   IPD-Pedi atric   0   0   0     10.00   CAPD   0   0   0     10.01   CAPD-Pedi atric   0   0   0   0     10.02   CAPD-Pedi atric   0   0   0     10.03   CAPD-Pedi atric   0   0   0     10.04   CAPD-Pedi atric   0   0   0     10.05   CAPD-Pedi atric   0   0   0     10.06   CAPD-Pedi atric   0   0   0     10.07   CAPD-Pedi atric   0   0   0     10.08   CAPD-Pedi atric   0   0   0     10.09   CAPD-Pedi atric   0   0   0     10.01   CAPD-Pedi			0	0		o c			1
1PD-Pediatric	3.00		0	0	0	C			3. 00
TRAINING			0	-	1	C			
Hemodi al ysi s	3. 02		0	0	0				3.02
Hemodi al ysi s - Pedi atri c	4. 00		0	0	0	0			4.00
S. 01   IPD-Pedi atri c	4. 01	Hemodi al ysi s-Pedi atri c	o o			0			4. 01
6.00 CAPD 6.01 CAPD-Pediatric 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	C			
6.01 CAPD-Pediatric 0 0 0 0 0 0 7.00 7.00 CCPD 0 0 0 0 0 0 0 7.00 7.01 CCPD-Pediatric 0 0 0 0 0 0 7.00  HOME  8.00 Hemodial ysi s   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		4	0	0	0	0			
7.00 CCPD 7.01 CCPD-Pediatric 0 0 0 0 0 0 0 7.00  HOME 8.00 Hemodial ysis S 1 Hemodial ysis-Pediatric O 0 0 0 0 0 8.01 9.00 Intermittent Peritoneal O 0 0 0 0 0 9.00 9.01 IPD-Pediatric O 0 0 0 0 0 9.01 10.00 CAPD O 0 0 0 0 0 0 0 10.00 10.01 CAPD-Pediatric O 0 0 0 0 0 0 10.01 11.00 CCPD O 0 0 0 0 0 11.001 11.00 CCPD-Pediatric O 0 0 0 0 0 11.001 11.01 CCPD-Pediatric O 0 0 0 0 0 11.001 11.01 CTPD-Pediatric O 0 0 0 0 0 11.001 11.01 CTPD-Pediatric O 0 0 0 0 0 11.001 11.01 TOTHER BILLABLE SERVICES			0	0	0				
HOME   S. 00   Hemodial ysis   S. 00   O   O   O   O   O   O   O   O   O			Ö	0	Ö	C			
8.00 8.01 Hemodial ysis - Pediatric 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 01		0	0	0	C			7. 01
8.01   Hemodial ysis - Pediatric   0   0   0   0   0   9.00   9.00   9.01   1PD-Pediatric   0   0   0   0   0   0   9.01   10.00   CAPD   0   0   0   0   0   0   10.00   10.01   CAPD-Pediatric   0   0   0   0   0   0   11.00   11.00   CCPD   0   0   0   0   0   0   11.00   11.00   CCPD-Pediatric   0   0   0   0   0   0   11.00   11.01   CCPD-Pediatric   0   0   0   0   0   0   11.01   0   0   0   0   0   0   0   0   0	0.00		0	0	I 0				0.00
9.00   Intermittent Peritoneal   0   0   0   0   0   9.00   9.01   IPD-Pediatric   0   0   0   0   0   9.01   10.00   CAPD   0   0   0   0   0   10.01   CAPD-Pediatric   0   0   0   0   0   11.00   CCPD   0   0   0   0   0   11.01   CCPD-Pediatric   0   0   0   0   11.01   CTPD-Pediatric   0   0   0   0   11.01   OTHER BILLABLE SERVICES   12.00   Inpatient Dialysis Treatments   0   0   0   0   12.00			0						
9.01   IPD-Pediatric			ő	Ö	0	l d			
10.01 CAPD-Pediatric 0 0 0 0 0 11.00 1 11.00 CCPD 0 0 0 0 0 11.00 1 11.01 CCPD-Pediatric 0 0 0 0 0 11.01 11.01	9. 01	I PD-Pedi atri c	0	0	0	C			9. 01
11. 00   CCPD   0   0   0   0   11. 00   11. 01   CCPD-Pediatric   0   0   0   0   0   11. 01   OTHER BILLABLE SERVICES   12. 00   Inpatient Dialysis Treatments   0   0   0   0   12. 00		4	0	0	0	C			
11. 01     CCPD-Pediatric     0     0     0     11. 01       0THER BILLABLE SERVICES       12. 00     Inpatient Dialysis Treatments     0     0     0     0     12. 00		4	0	0	0				
OTHER BILLABLE SERVICES  12.00 Inpatient Dialysis Treatments 0 0 0 0 12.00			0			0			
		OTHER BILLABLE SERVICES							1
13.00   Method   1 Home Patient   0   0   0   0   13.00									
	13. 00	wethod II Home Patient	0	0	0	C			13.00

Health Financial Systems		TRINITAS H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
DIRECT AND INDIRECT RENAL DIALYSIS CO	OST ALLOCATION -	- STATISTICAL	Provi der CC		Peri od:	Worksheet I-3	
BASIS			Component (		From 01/01/2023 To 12/31/2023	Date/Time Pre	nared.
						5/30/2024 10:	
					Renal Dialysis		
	Drugs	Medi cal	Pedi atri c	Routi ne	Subtotal	0verhead	
	(Requist.)	Suppl i es	Medi cal	Ancillary		(Accum. Cost)	
		(Requist.)	Suppl i es	Servi ces			
			(Requist.)	(Charges)			
	6.00	7.00	7. 01	8. 00	9. 00	10.00	
14. 00 ESAs							14.00
15. 00							15.00
16.00 Other	0	0	0		0		16.00
17.00 Total Statistical Basis	1, 516, 602	187, 818	0		0	10, 242, 683	17.00
18.00 Unit Cost Multiplier (line 1 =	1. 312661	0. 975439	0.000000	0.00000	0	0. 776067	18.00
line 17)							

Health Financial Systems	TRINITAS HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF AVERAGE COST PER TREAT	MENT FOR OUTPATIENT RENAL Provider CCN: 31-0027	Peri od: Worksheet I-4
		From 01/01/2022

DI ALYSI S Component CCN: 31-2318 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/30/2024 10:12 am Rate 0 Renal Dialysis Total Cost Average Cost Total Program Number of Number of Total (from Wkst. of Treatments Expenses (see Program Treatments I-2, col. 11) (col. 2 + col Treatments instructions) 1) 1.00 2.00 3.00 4.00 5.00 Maintenance - Hemodialysis 18, 191, 690 528. 40 6, 694, 828 1.00 34, 428 12,670 1.00 Maintenance - AKI Hemodialysis Maintenance - Peritoneal Dialysis 1.01 0.00 1.01 0 0 0 0 0.00 2.00 C 0 0 2 00 Maintenance - AKI Peritoneal Dialysis 0 2.01 0.00 0 0 2.01 Training - Hemodialysis 0 0.00 3.00 0 0 0 0 0 3.00 Training - Peritoneal Dialysis
Training - CAPD 0 4.00 0.00 0 4.00 5.00 0 0.00 0 5.00 0 6.00 Training - CCPD 0.00 0 0 6.00 Home Program - Hemodialysis Home Program - Peritoneal Dialysis 7.00 0.00 7.00 8.00 8.00 0.00 Λ Patient Weeks Patient Weeks 1.00 2.00 3.00 4. 00 5.00 Home Program - CAPD Home Program - CCPD 9.00 0.00 9. 00 0 0 10.00 0.00 10.00 Λ Totals (sum of lines 1 through 8, cols. 1 11.00 34, 428 18, 191, 690 12, 670 6, 694, 828 11.00 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction) Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see 12.00 12.00 34.428 instruction) ADDITIONAL RENAL FACILITY NUMBERS 20.00 TRINITAS LINDEN RENAL DIALYSIS 313503 20.00 20. 01 TRINITAS CRANFORD RENAL DIALYSIS 313521 20.01 Total Program Average Payment Payment Rate (col. 6 + col. 4) 6.00 7. 00 1.00 Maintenance - Hemodialysis 1.00 3, 289, 998 259.67 1.01 Maintenance - AKI Hemodialysis 0.00 1.01 Maintenance - Peritoneal Dialysis Maintenance - AKI Peritoneal Dialysis 2.00 00000 0.00 2.00 2.01 0 00 2 01 Training - Hemodialysis 0.00 3.00 3.00 Training - Peritoneal Dialysis Training - CAPD 4.00 0.00 4.00 5.00 0.00 5.00 Training - CCPD 6.00 0.00 6 00 Home Program - Hemodialysis Home Program - Peritoneal Dialysis 7.00 0 0.00 7.00 0.00 8. 00 8.00 6.00 7.00 9.00 Home Program - CAPD 0 0.00 9. 00 10.00 Home Program - CCPD 0.00 10.00 Totals (sum of lines 1 through 8, cols. 1 3, 289, 998 11 00 11.00 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction) 12.00 Total treatments (sum of lines 1 through 8 12.00 plus (sum of lines 9 and 10 times 3)) (see instruction) ADDITIONAL RENAL FACILITY NUMBERS 20 00 TRINITAS LINDEN RENAL DIALYSIS 20.00

20.01

20. 01 TRINITAS CRANFORD RENAL DIALYSIS

Health Financial Systems		TRINITAS HOSE	PITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSABLE BAD DEBTS -	TITLE XVIII	- PART B	Provider CCN: 31-0027	Peri od:	Worksheet I-5

CALCUL		eri od:	Worksheet I-5	
		rom 01/01/2023 o 12/31/2023	Date/Time Prep 5/30/2024 10:	
			0,00,2021	
		1. 00	2. 00	
	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B			
1.00	Total expenses related to care of program beneficiaries (see instructions)	6, 694, 828		1. 00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	3, 289, 998	3, 289, 998	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2. 01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions)			2. 02
2.03	Total payment due (see instructions)	3, 289, 998	3, 289, 998	2. 03
2.04	Outlier payments	111, 331		2. 04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	o	0	3.00
3.01	Deductibles billed to Medicare (Part B) patients (see instructions)			3. 01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3. 02
3.03	Total deductibles billed to Medicare (Part B) patients (see instructions)	o	0	3. 03
4.00	Coinsurance billed to Medicare (Part B) patients	o	0	4. 00
4.01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4. 01
4. 02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4. 02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	0	0	4. 03
5. 00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	34, 701	34, 701	5. 00
5. 01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt	.,	,	5. 01
	recoveries for services rendered on or after 1/1/2011 but before 1/1/2012			
5. 02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt			5. 02
	recoveries for services rendered on or after 1/1/2012 but before 1/1/2013			
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt			5. 03
	recoveries for services rendered on or after 1/1/2013 but before 1/1/2014			
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for	o	0	5. 04
	services rendered on or after 1/1/2014			
5.05	Allowable bad debts (sum of lines 5 through line 5.04)	34, 701	34, 701	5. 05
6.00	Adjusted reimbursable bad debts (see instructions)	22, 556	·	6. 00
7.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	33, 691		7. 00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see	0	-34, 701	8. 00
	instructions)		,	
9.00	Program payment (see instructions)	o	2, 631, 998	9. 00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10.00
11. 00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	22, 556		11. 00
	PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			
12. 00	Total allowable expenses (see instructions)	18, 191, 690		12. 00
13. 00	Total composite costs (from Wkst. I-4, col. 2, line 11)	18, 191, 690		13. 00
14. 00	Facility specific composite cost percentage (line 13 divided by line 12)	1. 000000		14. 00
00	PART III - ESRD PAYMENTS - INFORMATION ONLY	11.000000		00
15. 00	Low volume payment amount (see instructions)	0		15. 00
16. 00	TDAPA	0		16. 00
17. 00	TPNI ES	0		17. 00
18. 00	CRA TPNI ES			18. 00
19. 00	HDPA			19. 00
20. 00				20. 00
20.00		ı Y		20.00

Heal th	Financial Systems TRINITAS	HOSPI TAL	Inlie	u of Form CMS-2	2552_10
	ATION OF CAPITAL PAYMENT	Provider CCN: 31-0027	Peri od: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Pre 5/30/2024 10:	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			1, 078, 359	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2. 00	Capital DRG outlier payments			1, 532	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost	reporting period (see inst	ructions)	110. 78	
4.00	Number of interns & residents (see instructions)			46. 58	4.00
5. 00 6. 00	Indirect medical education percentage (see instructions) Indirect medical education adjustment (multiply line 5 by	the sum of lines 1 and 1 01	columns 1 and	12. 60 135, 873	
0.00	1.01) (see instructions)	the sum of filles I and I. Of	, corumns i and	133, 673	6.00
7. 00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)	A patient days (Worksheet E	E, part A line	15. 88	7. 00
8. 00	Percentage of Medicaid patient days to total days (see ins	structions)		35. 13	8. 00
9. 00	Sum of lines 7 and 8	, , , , , , , , , , , , , , , , , , , ,		51. 01	9. 00
10.00	Allowable disproportionate share percentage (see instructi	ons)		10. 88	10.00
11. 00	Disproportionate share adjustment (see instructions)			117, 325	11. 00
12.00	Total prospective capital payments (see instructions)			1, 333, 089	12. 00
	PART II - PAYMENT UNDER REASONABLE COST			1. 00	
1. 00	Program inpatient routine capital cost (see instructions)			0	1.00
2. 00	Program inpatient ancillary capital cost (see instructions	3)		0	
3.00	Total inpatient program capital cost (line 1 plus line 2)	-,		0	
4.00	Capital cost payment factor (see instructions)			0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2. 00	Program inpatient capital costs for extraordinary circumst	cances (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3.00
4. 00 5. 00	Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)			0.00	
6.00	Percentage adjustment for extraordinary circumstances (see	instructions)		0.00	
7. 00	Adjustment to capital minimum payment level for extraordir		(line 6)	0.00	
8. 00	Capital minimum payment level (line 5 plus line 7)	9 0.1 040 (11.1.0 2 7		0	
9.00	Current year capital payments (from Part I, line 12, as ap	oplicable)		0	9. 00
10.00	Current year comparison of capital minimum payment level t	to capital payments (line 8	less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	er capital payment (from pri	or year	0	11. 00
12.00	Net comparison of capital minimum payment level to capital	payments (line 10 plus lir	ne 11)	0	12. 00
13.00	Current year exception payment (if line 12 is positive, er			0	
14. 00	Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	er capital payment for the f	following period	0	14. 00
15. 00	Current year allowable operating and capital payment (see			0	15. 00
	Current year operating and capital costs (see instructions	s)		0	16. 00
16.00	Current year exception offset amount (see instructions)			0	17. 00