

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED

OMB NO. 0938-0050

EXPIRES 09-30-2025

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet S Parts I-III Date/Time Prepared: 5/30/2024 10:12 am
--------------------------------------------------------------------------------------------	-----------------------	---------------------------------------------	-------------------------------------------------------------------------

PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically prepared cost report	Date: 5/30/2024	Time: 10:12 am
	2. <input type="checkbox"/> Manually prepared cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input checked="" type="checkbox"/> Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.		
Contractor use only	5. <input checked="" type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input checked="" type="checkbox"/> Initial Report for this Provider CCN 9. <input checked="" type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

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 FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1	Rich Henwood	<input checked="" type="checkbox"/>	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	Rich Henwood		2
3	Signatory Title	VP CORP REIMBURSEMENT		3
4	Date	(Dated when report is electronic)		4

	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00	HOSPITAL	0	137,445	725,582	0	905,069
2.00	SUBPROVIDER - IPF	0	-70,766	0	0	0
3.00	SUBPROVIDER - IRF	0	0	0	0	0
4.00	SUBPROVIDER (OTHER)	0	0	0	0	0
5.00	SWING BED - SNF	0	0	0	0	0
6.00	SWING BED - NF	0	0	0	0	0
7.00	SKILLED NURSING FACILITY	0	0	0	0	0
8.00	NURSING FACILITY	0	0	0	0	0
200.00	TOTAL	0	66,679	725,582	0	905,069

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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 31-0027		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 10:12 am	
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 225 WILLIAMSON STREET			PO Box:				1.00		
2.00	City: ELIZABETH			State: NJ		Zip Code: 07201		County: UNION		
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
								V	XVIII	XIX
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		TRINITY HOSPITAL	310027	35084	1	01/31/1975	N	P	T
4.00	Subprovider - IPF		PSYCH EXCLUDED UNIT	315027	35084	4	01/31/1999	N	P	T
5.00	Subprovider - IRF									
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF		SKILLED NURSING LTC SOUTH 5	315442	35084		01/29/1998	N	P	N
10.00	Hospital-Based NF		NURSING FACILITY	315442	35084		01/29/1998	N		N
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA									
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
18.00	Renal Dialysis		TRINITY RENAL DIALYSIS	312318	35084		01/01/2004			
18.01	Renal Dialysis		TRINITY LINDEN RENAL DIALYSIS	313503	35084		01/01/1994			
18.02	Renal Dialysis		TRINITY CRANFORD RENAL DIALYSIS	313521	35084		05/01/2019			
19.00	Other									
							From:	To:		
							1.00	2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						01/01/2023	12/31/2023		20.00
21.00	Type of Control (see instructions)						2			21.00
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for 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.					Y	N			22.00
22.01	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 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	N			22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N			22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to 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, "Y" for yes or "N" for no.									22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N			23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023Worksheet S-2
Part I
Date/Time Prepared:
5/30/2024 10:12 am

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	4,603	1,547	0	0	8,728	498	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section 412.320? (see instructions)					N	Y	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR 412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR 412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y	
57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete 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.					Y		
58.00 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.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 10:12 am	
			V	XVIII	XIX
			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.	N			59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for 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.	N			60.00
		Y/N	IME	Direct GME	
		1.00	2.00	3.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N		0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)				61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count
		1.00	2.00	3.00	4.00
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	61.20
				1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)				
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings					
63.00	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)			Y	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023Worksheet S-2
Part I
Date/Time Prepared:
5/30/2024 10:12 am

			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	64.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (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)			0.00	0.00	0.000000	65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.47	30.32	0.015265	66.00	
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 10:12 am		
			1.00			
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022) For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?				68.00	
			1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y	70.00	
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			Y N 0	71.00	
Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N	75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N N 0	76.00	
			1.00			
Long Term Care Hospital PPS						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00	
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00	
TEFRA Providers						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00	
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00	
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00	
			Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments		
			1.00	2.00		
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			N 0	88.00	
			Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge	
			1.00	2.00	3.00	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.			0.00	0	89.00
			V	XIX		
			1.00	2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	Y	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	10.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	5.80	97.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 10:12 am
		V 1.00	XIX 2.00	
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
		Physical 1.00	Occupational 2.00	Speech 3.00
				Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			109.00
				1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (\$410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.		N	110.00
				1.00
				2.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
				1.00
				2.00
				3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2		118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 10:12 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	2,235,782	0	0
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	N	N	123.00
Certified Transplant Center Information				
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00
		1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name:	Contractor's Name:	Contractor's Number:	
142.00	Street:	PO Box:		
143.00	City:	State:	Zip Code:	
				1.00
144.00	Are provider based physicians' costs included in Worksheet A?			Y
				1.00
				2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	N	Y	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 31-0027		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part I Date/Time Prepared: 5/30/2024 10:12 am		
						1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N		155.00	
156.00	Subprovider - IPF	N	N	N	N		156.00	
157.00	Subprovider - IRF	N	N	N	N		157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N		159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N		160.00	
161.00	CMHC		N	N	N		161.00	
						1.00		
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	
						1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00
				Beginning	Ending			
				1.00	2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)							170.00
				1.00	2.00			
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 31-0027		Period: From 01/01/2023 To 12/31/2023		Worksheet S-2 Part II Date/Time Prepared: 5/30/2024 10:12 am	
				Y/N	Date		
				1.00	2.00		
PART II - HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE							
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	12/31/2023			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?	Y	Y				6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y					7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	Y					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	Y					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y				12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N				13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.		N				14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y				15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/26/2024	Y	04/26/2024		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023Worksheet S-2
Part II
Date/Time Prepared:
5/30/2024 10:12 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	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
21.00	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 (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		N		27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		N		31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		N		35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RI CHARD	HENWOOD		41.00
42.00	Enter the employer/company name of the cost report preparer.	RWJ BARNABAS HEALTH			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	609-865-0694	RI CH. HENWOOD@RWJBH. ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023Worksheet S-2
Part II
Date/Time Prepared:
5/30/2024 10:12 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VP CORPORATE REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 31-0027

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

Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	I/P Days / O/P	12.00
	Line No.		Avai l a b l e	Hours	Vi s i t s / T r i p s	
	1.00	2.00	3.00	4.00	5.00	
PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	157	57,305	0.00	1.00
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 beds) (see instructions)		157	57,305	0.00	7.00
8.00	INTENSIVE CARE UNIT	31.00	25	9,125	0.00	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	14.00
15.00	CAH visits				0	15.00
15.10	REH hours and visits				0.00	15.10
16.00	SUBPROVIDER - IPF	40.00	74	27,010	0	16.00
17.00	SUBPROVIDER - IRF	41.00	0	0	0	17.00
18.00	SUBPROVIDER	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	0		21.00
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00	HOSPICE					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	Ambulance 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)		0	0		32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)					32.01
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	0	0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 31-0027

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

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	7,028	3,921	34,078			1.00
2.00	HMO and other (see instructions)	11,221	8,778				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	7,028	3,921	34,078			7.00
8.00	INTENSIVE CARE UNIT	1,409	530	5,602			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		1,849	3,332			13.00
14.00	Total (see instructions)	8,437	6,300	43,012	55.49	1,737.85	14.00
15.00	CAH visits	0	0	0			15.00
15.10	REH hours and visits	0	0	0			15.10
16.00	SUBPROVIDER - IPF	2,238	1,593	19,391	8.60	97.77	16.00
17.00	SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00	SUBPROVIDER		6,065	6,808	0.00	29.54	18.00
19.00	SKILLED NURSING FACILITY	2,325	0	4,311	0.00	10.13	19.00
20.00	NURSING FACILITY		1,096	27,408	0.00	64.37	20.00
21.00	OTHER LONG TERM CARE			0	0.00	34.82	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				64.09	1,974.48	27.00
28.00	Observation Bed Days		0	4,624			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			15			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	4	298	739			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 31-0027

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

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
	Nonpaid Workers					
	11.00	12.00	13.00	14.00	15.00	
PART I - STATISTICAL DATA						
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,329	1,750	8,119	1.00
2.00 HMO and other (see instructions)			1,597	1,795		2.00
3.00 HMO IPF Subprovider				815		3.00
4.00 HMO IRF Subprovider				0		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 beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						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						13.00
14.00 Total (see instructions)	0.00	0	1,329	1,750	8,119	14.00
15.00 CAH visits						15.00
15.10 REH hours and visits						15.10
16.00 SUBPROVIDER - IPF	0.00	0	166	176	1,886	16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
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	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						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 Ambulance 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 outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01
34.00 Temporary Expansion COVID-19 PHE Acute Care						34.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 31-0027

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

	Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 + col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	161,062,483	6,820,279	167,882,762	4,044,982.40	41.50
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		864,065	0	864,065	7,356.00	117.46
4.01	Physicians - Part A - Teaching		923,665	0	923,665	9,454.00	97.70
5.00	Physician and Non-Physician-Part B		12,774,942	0	12,774,942	86,657.00	147.42
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	4,012,012	4,012,012	117,148.68	34.25
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	296,530	0	296,530	10,333.44	28.70
10.00	Excluded area salaries (see instructions)		25,916,175	1,692,922	27,609,097	583,654.01	47.30
OTHER WAGES & RELATED COSTS							
11.00	Contract Labor: Direct Patient Care		5,304,663	0	5,304,663	43,762.00	121.22
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		19,283,755	0	19,283,755	239,493.98	80.52
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		30,021,585	0	30,021,585		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		5,381,151	0	5,381,151		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		62,296	0	62,296		
22.01	Physician Part A - Teaching		77,522	0	77,522		
23.00	Physician Part B		759,129	0	759,129		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		992,093	0	992,093		
25.50	Home office wage-related (core)		3,586,993	0	3,586,993		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 31-0027

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

		Wkst. A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	103,038	0	103,038	5,779.45	17.83	26.00
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 contract (see inst.)		488,096	0	488,096	2,016.00	242.11	28.00
29.00	Maintenance & Repairs	6.00	347,089	0	347,089	13,997.59	24.80	29.00
30.00	Operation of Plant	7.00	1,853,646	-104,191	1,749,455	64,002.06	27.33	30.00
31.00	Laundry & Linen Service	8.00	84,407	0	84,407	4,321.35	19.53	31.00
32.00	Housekeeping	9.00	2,972,122	0	2,972,122	173,589.98	17.12	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,365,039	-1,016,967	1,348,072	68,712.76	19.62	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,016,967	1,016,967	47,749.54	21.30	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	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
39.00	Central Services and Supply	14.00	1,210,445	0	1,210,445	47,550.44	25.46	39.00
40.00	Pharmacy	15.00	3,544,530	-12,303	3,532,227	72,057.83	49.02	40.00
41.00	Medical Records & Medical Records Library	16.00	1,692,811	-20,514	1,672,297	62,453.39	26.78	41.00
42.00	Social Service	17.00	1,349,814	-253,469	1,096,345	21,983.23	49.87	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 31-0027

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

	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	147,851,972	2,808,267	150,660,239	3,833,738.72	39.30	1.00
2.00	Excluded area salaries (see instructions)	26,212,705	1,692,922	27,905,627	593,987.45	46.98	2.00
3.00	Subtotal salaries (line 1 minus line 2)	121,639,267	1,115,345	122,754,612	3,239,751.27	37.89	3.00
4.00	Subtotal other wages & related costs (see inst.)	24,588,418	0	24,588,418	283,255.98	86.81	4.00
5.00	Subtotal wage-related costs (see inst.)	33,670,874	0	33,670,874	0.00	27.43	5.00
6.00	Total (sum of lines 3 thru 5)	179,898,559	1,115,345	181,013,904	3,523,007.25	51.38	6.00
7.00	Total overhead cost (see instructions)	37,252,750	3,756,256	41,009,006	1,272,445.49	32.23	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 31-0027

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

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
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. Noncumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	11,523,732	17.00
18.00	Medicare Taxes - Employers Portion Only	164,998	18.00
19.00	Unemployment Insurance	450,322	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	442,933	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	37,293,776	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 31-0027

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

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	Hospital	5,304,663	37,293,776	2.00
3.00	SUBPROVIDER - IPF	0	0	3.00
4.00	SUBPROVIDER - IRF	0	0	4.00
5.00	Subprovider - (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	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet S-5

Date/Time Prepared:
5/30/2024 10:12 am

		Outpatient		Training		Home					
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis	CAPD / CCPD				
		1.00	2.00	3.00	4.00	5.00	6.00				
1.00	Number of patients in program at end of cost reporting period	226	0	0	3	0	0	1.00			
2.00	Number of times per week patient receives dialysis	3.00	0.00	0.00	7.00	0.00	0.00	2.00			
3.00	Average patient dialysis time including setup	4.50	0.00	0.00	0.00			3.00			
4.00	CAPD exchanges per day				0.00		0.00	4.00			
5.00	Number of days in year dialysis furnished	312	0					5.00			
6.00	Number of stations	52	0	0	0			6.00			
7.00	Treatment capacity per day per station	3	0					7.00			
8.00	Utilization (see instructions)	0.00	0.00					8.00			
9.00	Average times dialyzers re-used	0.00	0.00					9.00			
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00			
							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" for yes or "N" for no. (see instructions)						N	10.01			
10.02	Did your facility elect 100% PPS effective January 1, 2011? Enter "Y" for yes or "N" for no. (See instructions for "new" providers.)						Y	10.02			
						Prior to 1/1	After 12/31				
						1.00	2.00				
10.03	If you responded "N" to line 10.02, enter in column 1 the year of transition for periods prior to January 1 and enter in column 2 the year of transition for periods after December 31. (see instructions)						0	0	10.03		
TRANSPLANT INFORMATION											
11.00	Number of patients on transplant list						25		11.00		
12.00	Number of patients transplanted during the cost reporting period						8		12.00		
EPOETIN											
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.								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								15.00		
16.00	Number of EPO units furnished relating to the home dialysis department								16.00		
ARANESP											
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.								17.00		
18.00	ARANESP amount from Worksheet A for Home Dialysis program								18.00		
19.00	Number of ARANESP units furnished relating to the renal dialysis department								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 ESAs for Renal Patients	Net Cost of ESAs for Home Patients	Number of ESA Units - Renal Dialysis Dept.	Number of ESA Units - Home Dialysis Dept.					
		1.00	2.00	3.00	4.00	5.00					
ESAs											
22.00	Enter in column 1 the ESA description. Enter in column 2 the net costs of ESAs furnished to all renal dialysis patients. Enter in column 3 the net cost of ESAs furnished to all home dialysis program patients. Enter in column 4 the number of ESA units furnished to patients in the renal dialysis department. Enter in column 5 the number of units furnished to patients in the home dialysis program. (see instructions)						0	0	0	0	22.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet S-5 Date/Time Prepared: 5/30/2024 10:12 am
			CCN	Treatments
			1.00	2.00
23.00	If line 10.01 is yes, enter in column 1 the CCN for each renal dialysis facility listed on Worksheet S-2, Part I, line 18, and its subscripts. Enter in column 2, the total treatments for each CCN. (see instructions)			0 23.00
23.01	TRINITAS LINDEN RENAL DIALYSIS			0 23.01
23.02	TRINITAS CRANFORD RENAL DIALYSIS			0 23.02

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/30/2024 10:12 am
				1.00
PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.234902	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		79,277,000	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		38,080,251	5.00
6.00	Medicaid charges		474,004,093	6.00
7.00	Medicaid cost (line 1 times line 6)		111,344,509	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)		0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	176,714,205	53,089	176,767,294
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	41,510,520	53,089	41,563,609
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	41,510,520	53,089	41,563,609
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		0	25.01
26.00	Bad debt amount (see instructions)		17,023,927	26.00
27.00	Medicare reimbursable bad debts (see instructions)		406,194	27.00
27.01	Medicare allowable bad debts (see instructions)		624,913	27.01
28.00	Non-Medicare bad debt amount (see instructions)		16,399,014	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		4,070,880	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		45,634,489	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		45,634,489	31.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet S-10 Parts I & II Date/Time Prepared: 5/30/2024 10:12 am
				1.00
PART II - HOSPITAL DATA				
Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)		0.216329	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			5.00
6.00	Medicaid charges			6.00
7.00	Medicaid cost (line 1 times line 6)			7.00
8.00	Difference between net revenue and costs for Medicaid program (see instructions)			8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			9.00
10.00	Stand-alone CHIP charges			10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instructions)			12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			14.00
15.00	State or local indigent care program cost (line 1 times line 14)			15.00
16.00	Difference between net revenue and costs for state or local indigent care program (see instructions)			16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care			17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated care cost (see instructions for each line)				
20.00	Charity care charges and uninsured discounts (see instructions)	156,826,241	36,225	156,862,466
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	33,926,064	36,225	33,962,289
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (see instructions)	33,926,064	36,225	33,962,289
				1.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
25.01	Charges for insured patients' liability (see instructions)		0	25.01
26.00	Bad debt amount (see instructions)		16,182,500	26.00
27.00	Medicare reimbursable bad debts (see instructions)		353,482	27.00
27.01	Medicare allowable bad debts (see instructions)		543,818	27.01
28.00	Non-Medicare bad debt amount (see instructions)		15,638,682	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)		3,573,436	29.00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)		37,535,725	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		37,535,725	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 31-0027

Period:

From 01/01/2023

To 12/31/2023

Worksheet A

Date/Time Prepared:
5/30/2024 10:12 am

	Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		6,252,168	0	6,252,168	1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP		7,377,136	281,628	7,658,764	2.00	
3.00	00300	OTHER CAP REL COSTS		0	0	0	3.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	103,038	34,136,151	2,478,949	36,718,138	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	16,055,099	34,555,832	-1,909,971	48,700,960	5.00	
6.00	00600	MAINTENANCE & REPAIRS	347,089	2,430,281	0	2,777,370	6.00	
7.00	00700	OPERATION OF PLANT	1,853,646	12,042,867	0	13,896,513	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	84,407	1,159,935	0	1,244,342	8.00	
9.00	00900	HOUSEKEEPING	2,972,122	2,661,395	0	5,633,517	9.00	
10.00	01000	DIETARY	2,365,039	3,930,853	6,295,892	-2,707,234	3,588,658	10.00
11.00	01100	CAFETERIA	0	0	0	2,707,234	2,707,234	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	5,186,614	261,392	5,448,006	-28,683	5,419,323	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,210,445	2,275,644	3,486,089	0	3,486,089	14.00
15.00	01500	PHARMACY	3,544,530	15,345,435	18,889,965	-15,362,789	3,527,176	15.00
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	2,048,287	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	3,041,580	987,451	4,029,031	-21,894	4,007,137	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	4,012,012	4,012,012	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	4,124,585	1,211,153	5,335,738	-2,625,999	2,709,739	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,688,232	6,086,010	25,774,242	-2,926,300	22,847,942	30.00
31.00	03100	INTENSIVE CARE UNIT	5,159,408	2,321,652	7,481,060	-452,780	7,028,280	31.00
40.00	04000	SUBPROVIDER - I PF	12,440,970	802,371	13,243,341	-40,157	13,203,184	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	2,794,587	77,263	2,871,850	3,504	2,875,354	42.00
43.00	04300	NURSERY	1,186,521	179,039	1,365,560	-64,460	1,301,100	43.00
44.00	04400	SKILLED NURSING FACILITY	296,530	544	297,074	0	297,074	44.00
45.00	04500	NURSING FACILITY	5,300,235	2,276,164	7,576,399	-9,500	7,566,899	45.00
46.00	04600	OTHER LONG TERM CARE	2,317,697	241,038	2,558,735	2,808	2,561,543	46.00
ANCILLARY SERVICE COST CENTERS								
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	1,344,090	-20,807	1,323,283	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,657,739	468,212	5,125,951	-259,680	4,866,271	52.00
53.00	05300	ANESTHESIOLOGY	0	2,427,899	2,427,899	2,703,928	5,131,827	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,400,297	3,085,437	6,485,734	-478,090	6,007,644	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,109,780	2,166,395	5,276,175	-152,423	5,123,752	55.00
56.00	05600	RADIOISOTOPE	343,154	422,806	765,960	-132,432	633,528	56.00
57.00	05700	CT SCAN	756,430	453,981	1,210,411	-59,554	1,150,857	57.00
58.00	05800	MRI	276,878	181,645	458,523	-17,654	440,869	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,090,876	1,567,918	2,658,794	-933,664	1,725,130	59.00
60.00	06000	LABORATORY	247,037	9,337,632	9,584,669	-13,912	9,570,757	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	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,882,295	1,216,154	4,098,449	-290,644	3,807,805	65.00
66.00	06600	PHYSICAL THERAPY	1,552,715	140,202	1,692,917	-23,296	1,669,621	66.00
67.00	06700	OCCUPATIONAL THERAPY	156,326	54,528	210,854	-118	210,736	67.00
68.00	06800	SPEECH PATHOLOGY	162,763	2,054	164,817	-889	163,928	68.00
69.00	06900	ELECTROCARDIOLOGY	885,775	373,412	1,259,187	-105,334	1,153,853	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,061,053	9,061,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,949,662	6,949,662	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	14,617,585	14,617,585	73.00
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	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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
OUTPATIENT SERVICE COST CENTERS								
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	90.01
90.02	09001	PSYCH CLINIC	15,140,189	3,763,982	18,904,171	-1,727,489	17,176,682	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0	0	90.03
90.04	09003	WORKFIRST	0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	811,949	150,615	962,564	-39,313	923,251	90.06
90.07	09006	WOMENS CLINIC	1,902,080	305,808	2,207,888	-28,223	2,179,665	90.07
90.08	09007	THERAPEUTIC SCHOOL	403,812	100,094	503,906	-94,983	408,923	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Recl assi fi cati ons (See A-6)	Recl assi fi ed Tri al Balance (col. 3 +- col. 4)	
			1. 00	2. 00	3. 00	4. 00	5. 00	
90.10	09017	CLINIC-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	DIABETES CENTER	0	0	0	0	0	90.14
90.15	09013	WOUND CENTER	467,938	323,003	790,941	-167,298	623,643	90.15
90.16	09014	MICA	187,249	22,647	209,896	-209,896	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	968,923	143,237	1,112,160	-709	1,111,451	90.17
90.18	09018	CLINIC	210,682	53,477	264,159	-48,838	215,321	90.18
91.00	09100	EMERGENCY	9,257,929	3,564,882	12,822,811	-590,449	12,232,362	91.00
91.01	09101	PSYCH EMERGENCY	3,851,141	232,770	4,083,911	-135,389	3,948,522	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	1,064,493	1,064,493	-346,926	717,567	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		281,628	281,628	-281,628	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	161,041,377	190,468,717	351,510,094	-31,112	351,478,982	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	21,106	4,144,363	4,165,469	2,160	4,167,629	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	NON REIMBURSABLE	0	462,562	462,562	28,952	491,514	194.00
194.01	07951	RETAIL PHARMACY	0	2,991,474	2,991,474	0	2,991,474	194.01
200.00		TOTAL (SUM OF LINES 118 through 199)	161,062,483	198,067,116	359,129,599	0	359,129,599	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	6,252,168	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-281,628	7,377,136	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-10	36,718,128	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	35,206,465	83,907,425	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	HOUSEKEEPING	0	5,633,517	9.00
10.00	01000	DIETARY	0	3,588,658	10.00
11.00	01100	CAFETERIA	-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	3,521,660	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-796	3,345,042	16.00
17.00	01700	SOCIAL SERVICE	-1,416	2,046,871	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING PROGRAM	-6,419,730	-2,412,593	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	4,012,012	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-838,493	1,871,246	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-6,407,421	16,440,521	30.00
31.00	03100	INTENSIVE CARE UNIT	-675,608	6,352,672	31.00
40.00	04000	SUBPROVIDER - IPF	-2,035,907	11,167,277	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	-1,096	2,874,258	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	ANESTHESIOLOGY	-4,595,902	535,925	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,401,950	4,605,694	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	-32,870	5,090,882	55.00
56.00	05600	RADIOISOTOPE	0	633,528	56.00
57.00	05700	CT SCAN	0	1,150,857	57.00
58.00	05800	MRI	0	440,869	58.00
59.00	05900	CARDIAC CATHETERIZATION	-109,736	1,615,394	59.00
60.00	06000	LABORATORY	-194,300	9,376,457	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	06500	RESPIRATORY THERAPY	-287	3,807,518	65.00
66.00	06600	PHYSICAL THERAPY	-34,518	1,635,103	66.00
67.00	06700	OCCUPATIONAL THERAPY	-25,440	185,296	67.00
68.00	06800	SPEECH PATHOLOGY	0	163,928	68.00
69.00	06900	ELECTROCARDIOLOGY	-101,586	1,052,267	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,061,053	71.00
72.00	07200	IMPL. 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	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-210,100	1,544,057	90.00
90.01	09016	CLINIC-NOT USED	0	0	90.01
90.02	09001	PSYCH CLINIC	-2,139,219	15,037,463	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	90.03
90.04	09003	WORKFIRST	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	-300,560	622,691	90.06
90.07	09006	WOMENS CLINIC	-243,329	1,936,336	90.07
90.08	09007	THERAPEUTIC SCHOOL	-341,255	67,668	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	90.09
90.10	09017	CLINIC-NOT USED	0	0	90.10
90.11	09009	PERINATAL ADDICTION	0	0	90.11

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
90.12	09010	THERAPEUTIC NURSERY	0	0	90.12
90.13	09011	CHILD DAY TREATMENT	0	0	90.13
90.14	09012	DIABETES CENTER	0	0	90.14
90.15	09013	WOUND CENTER	-34,400	589,243	90.15
90.16	09014	MICA	0	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	-175,243	936,208	90.17
90.18	09018	CLINIC	-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	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	657,603	352,136,585	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	4,167,629	192.00
193.00	19300	NONPAID WORKERS	0	0	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

RECLASSIFICATIONS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-6

Date/Time Prepared:
5/30/2024 10:12 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - CAFETERIA					
1.00	CAFETERIA	11.00	1,016,967	1,690,267		1.00
	TOTALS		1,016,967	1,690,267		
	B - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	15,830,933		1.00
2.00	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00	0	2,178		2.00
3.00		0.00	0	0		3.00
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
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		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		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		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		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
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
	TOTALS		0	15,833,111		
	C - INTEREST EXPENSE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	281,628		1.00
	TOTALS		0	281,628		
	D - RECLASS MED SURGICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	9,061,053		1.00
2.00	RADIOISOTOPE	56.00	0	0		2.00
3.00		0.00	0	0		3.00
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
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		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		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		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		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
32.00		0.00	0	0		32.00

RECLASSIFICATIONS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-6

Date/Time Prepared:
5/30/2024 10:12 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
33.00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
	TOTALS		0	9,061,053		
	E - RECLASS MALPRACTICE					
1.00	ADULTS & PEDIATRICS	30.00	0	43,949		1.00
2.00	SUBPROVIDER - IPF	40.00	0	23,596		2.00
3.00	SUBPROVIDER	42.00	0	5,266		3.00
4.00	OTHER LONG TERM CARE	46.00	0	2,808		4.00
5.00	RESPIRATORY THERAPY	65.00	0	17		5.00
6.00	CLINIC	90.00	0	2,896		6.00
7.00	PSYCH CLINIC	90.02	0	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	MICA	90.16	0	586		10.00
11.00	BAYONNE MENTAL HEALTH CENTER	90.17	0	4		11.00
12.00	PSYCH EMERGENCY	91.01	0	4,969		12.00
	TOTALS		0	114,357		
	F - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,949,662		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		0.00	0	0		5.00
6.00		0.00	0	0		6.00
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		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
	TOTALS		0	6,949,662		
	G - PUB RELATIONS TO NON REIMB					
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		0.00	0	0		5.00
	TOTALS		0	28,952		
	H - RECLASS AMBULANCE TO EMERGENCY					
1.00	EMERGENCY	91.00	0	345,968		1.00
	TOTALS		0	345,968		
	I - RECLASS EPOTEIN					
1.00	RENAL DIALYSIS	74.00	0	1,213,348		1.00
	TOTALS		0	1,213,348		
	J - RECLASS MICA TO PSYCH CLINIC					
1.00	PSYCH CLINIC	90.02	187,249	18,477		1.00
	TOTALS		187,249	18,477		
	K - CANCER CENTER PHYSICIAN					
1.00	PHYSICIANS PRIVATE OFFICES	192.00	0	2,160		1.00
	TOTALS		0	2,160		
	L - PSYCH ADMIN TO CLINICS					
1.00	SUBPROVIDER - IPF	40.00	188,410	0		1.00
2.00	SUBPROVIDER	42.00	65,534	0		2.00
3.00	PSYCH EMERGENCY	91.01	73,726	0		3.00
	TOTALS		327,670	0		
	Q - FRINGE GRANT FUNDED					
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		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	TOTALS		0	2,489,354		
	S - PROPERTY & AUTO INSURANCE					
1.00		0.00	0	0		1.00
	TOTALS		0	0		
	T - TEACHING RECLASS					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	278,167	0		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00

RECLASSIFICATIONS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-6

Date/Time Prepared:
5/30/2024 10:12 am

Increases					
	Cost Center	Line #	Salary	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	
V - I&R SALARY RECLASS					
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	4,012,012	0	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		0.00	0	0	5.00
	TOTALS		4,012,012	0	
W - ANESTHESIA FEES					
1.00	ANESTHESIOLOGY	53.00	0	3,013,220	1.00
	TOTALS		0	3,013,220	
X - I&R SUPERVISION					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	815,269	0	1.00
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	52.00	0	2,664	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	NURSING ADMINISTRATION	13.00	0	128,687	3.00
4.00	PHARMACY	15.00	0	12,303	4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	0	20,514	5.00
6.00	SOCIAL SERVICE	17.00	0	253,469	6.00
7.00	NURSING PROGRAM	20.00	0	58,500	7.00
8.00	ADULTS & PEDIATRICS	30.00	0	89,567	8.00
9.00	INTENSIVE CARE UNIT	31.00	0	107,224	9.00
10.00	SUBPROVIDER	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	0	306,860	14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	80,127	15.00
16.00	RADIOLOGY-THERAPEUTIC	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	ELECTROCARDIOLOGY	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	
ZZ - PHYSICIAN RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	429,660	816,587	1.00
2.00	PSYCH CLINIC	90.02	0	16,787	2.00
	TOTALS		429,660	833,374	
500.00	Grand Total: Increases		15,974,193	44,717,896	500.00

RECLASSIFICATIONS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-6

Date/Time Prepared:
5/30/2024 10:12 am

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00			
1.00	A - CAFETERIA						1.00
	DIETARY	10.00	1,016,967	1,690,267	0		
	TOTALS		1,016,967	1,690,267			
	B - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	15,100,222	0	1.00	
2.00	NURSING PROGRAM	20.00	0	244	0	2.00	
3.00	ADULTS & PEDIATRICS	30.00	0	215,104	0	3.00	
4.00	INTENSIVE CARE UNIT	31.00	0	69,675	0	4.00	
5.00	SUBPROVIDER - IPF	40.00	0	10,045	0	5.00	
6.00	SUBPROVIDER	42.00	0	1,037	0	6.00	
7.00	NURSERY	43.00	0	2,074	0	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	0	25,158	0	10.00	
11.00	ANESTHESIOLOGY	53.00	0	28,467	0	11.00	
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	8,312	0	12.00	
13.00	RADIOLOGY-THERAPEUTIC	55.00	0	25,878	0	13.00	
14.00	RADIOISOTOPE	56.00	0	440	0	14.00	
15.00	CT SCAN	57.00	0	1,825	0	15.00	
16.00	MRI	58.00	0	1,269	0	16.00	
17.00	CARDIAC CATHETERIZATION	59.00	0	4,939	0	17.00	
18.00	LABORATORY	60.00	0	2,673	0	18.00	
19.00	RESPIRATORY THERAPY	65.00	0	21,963	0	19.00	
20.00	PHYSICAL THERAPY	66.00	0	320	0	20.00	
21.00	ELECTROCARDIOLOGY	69.00	0	1,431	0	21.00	
22.00	CLINIC	90.00	0	639	0	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	0	1,240	0	26.00	
27.00	EMERGENCY	91.00	0	178,010	0	27.00	
28.00	PSYCH EMERGENCY	91.01	0	10	0	28.00	
29.00	AMBULANCE SERVICES	95.00	0	958	0	29.00	
31.00	ANESTHESIOLOGY	53.00	0	106	0	31.00	
32.00	LABORATORY	60.00	0	2,072	0	32.00	
	TOTALS		0	15,833,111			
C - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	281,628	11	1.00	
	TOTALS		0	281,628			
D - RECLASS MED SURGICAL SUPPLIES							
1.00	PHARMACY	15.00	0	262,567	0	1.00	
2.00	NURSING PROGRAM	20.00	0	21,650	0	2.00	
3.00	I&R SERVICES-OTHER PRGM	22.00	0	886	0	3.00	
	COSTS APPRV						
4.00	ADULTS & PEDIATRICS	30.00	0	791,561	0	4.00	
5.00	INTENSIVE CARE UNIT	31.00	0	387,249	0	5.00	
6.00	SUBPROVIDER - IPF	40.00	0	156,830	0	6.00	
7.00	SUBPROVIDER	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	ANESTHESIOLOGY	53.00	0	280,585	0	12.00	
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	339,093	0	13.00	
14.00	RADIOLOGY-THERAPEUTIC	55.00	0	105,568	0	14.00	
15.00	RADIOISOTOPE	56.00	0	131,975	0	15.00	
16.00	CT SCAN	57.00	0	57,729	0	16.00	
17.00	MRI	58.00	0	16,359	0	17.00	
18.00	CARDIAC CATHETERIZATION	59.00	0	443,624	0	18.00	
19.00	LABORATORY	60.00	0	9,167	0	19.00	
20.00	RESPIRATORY THERAPY	65.00	0	268,513	0	20.00	
21.00	PHYSICAL THERAPY	66.00	0	22,976	0	21.00	
22.00	OCCUPATIONAL THERAPY	67.00	0	118	0	22.00	
23.00	SPEECH PATHOLOGY	68.00	0	889	0	23.00	
24.00	ELECTROCARDIOLOGY	69.00	0	26,942	0	24.00	
25.00	CLINIC	90.00	0	16,130	0	25.00	
26.00	PSYCH CLINIC	90.02	0	13,631	0	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	0	135,986	0	29.00	
30.00	MICA	90.16	0	4,756	0	30.00	
31.00	BAYONNE MENTAL HEALTH CENTER	90.17	0	713	0	31.00	
32.00	EMERGENCY	91.00	0	750,939	0	32.00	
33.00	PSYCH EMERGENCY	91.01	0	28,557	0	33.00	

RECLASSIFICATIONS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-6

Date/Time Prepared:
5/30/2024 10:12 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
34.00	AMBULANCE SERVICES	95.00	0	0	0		34.00
	TOTALS		0	9,061,053			
E - RECLASS MALPRACTICE							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	114,357	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		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		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
	TOTALS		0	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	0		2.00
3.00	OPERATING ROOM	50.00	0	6,355,229	0		3.00
4.00	ANESTHESIOLOGY	53.00	0	134	0		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	127,672	0		5.00
6.00	RADIOLOGY-THERAPEUTIC	55.00	0	18,817	0		6.00
7.00	RADIOISOTOPE	56.00	0	17	0		7.00
8.00	MRI	58.00	0	26	0		8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	406,822	0		9.00
10.00	RESPIRATORY THERAPY	65.00	0	185	0		10.00
11.00	ELECTROCARDIOLOGY	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	0		13.00
14.00	PSYCH EMERGENCY	91.01	0	98	0		14.00
	TOTALS		0	6,949,662			
G - PUB RELATIONS TO NON REIMB							
1.00	PEDIATRIC CLINIC	90.06	0	199	0		1.00
2.00	WOMENS CLINIC	90.07	0	199	0		2.00
3.00	NURSING FACILITY	45.00	0	9,500	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	8,649	0		4.00
5.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	10,405	0		5.00
	TOTALS		0	28,952			
H - RECLASS AMBULANCE TO EMERGENCY							
1.00	AMBULANCE SERVICES	95.00	0	345,968	0		1.00
	TOTALS		0	345,968			
I - RECLASS EPOTEIN							
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,213,348	0		1.00
	TOTALS		0	1,213,348			
J - RECLASS MICA TO PSYCH CLINIC							
1.00	MICA	90.16	187,249	18,477	0		1.00
	TOTALS		187,249	18,477			
K - CANCER CENTER PHYSICIAN							
1.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,160	0		1.00
	TOTALS		0	2,160			
L - PSYCH ADMIN TO CLINICS							
1.00	PSYCH CLINIC	90.02	327,670	0	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
	TOTALS		327,670	0			
Q - FRINGE GRANT FUNDED							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	493,102	0		1.00
2.00	CLINIC	90.00	0	230,853	0		2.00
3.00	PSYCH CLINIC	90.02	0	1,619,298	0		3.00
4.00	CLINIC	90.18	0	48,838	0		4.00
5.00	THERAPEUTIC SCHOOL	90.08	0	94,250	0		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,013	0		6.00
	TOTALS		0	2,489,354			
S - PROPERTY & AUTO INSURANCE							
1.00		0.00	0	0	0		1.00
	TOTALS		0	0			
T - TEACHING RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	151,931	0	0		2.00
3.00	SUBPROVIDER - IPF	40.00	85,288	0	0		3.00
4.00	SUBPROVIDER	42.00	0	0	0		4.00
5.00	CLINIC	90.00	0	0	0		5.00
6.00	PSYCH CLINIC	90.02	17,120	0	0		6.00

RECLASSIFICATIONS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-6

Date/Time Prepared:
5/30/2024 10:12 am

	Decreases						
	Cost Center	Line #	Salary	Other	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	CARDI AC CATHETERI ZATION	59.00	78,279	0	0		2.00
3.00	ELECTROCARDIOLOGY	69.00	76,315	0	0		3.00
4.00	THERAPEUTIC SCHOOL	90.08	1,106	0	0		4.00
5.00	PSYCH EMERGENCY	91.01	137,763	0	0		5.00
	TOTALS		4,012,012	0			
W - ANESTHESIA FEES							
1.00	ADULTS & PEDIATRICS	30.00	0	3,013,220	0		1.00
	TOTALS		0	3,013,220			
X - I&R SUPERVISION							
1.00	ADULTS & PEDIATRICS	30.00	791,441	0	0		1.00
2.00	PSYCH EMERGENCY	91.01	23,828	0	0		2.00
	TOTALS		815,269	0			
Y - CONTRACT LABOR							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	30,829	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	28,683	0		2.00
3.00	SOCIAL SERVICE	17.00	0	696,533	0		3.00
	TOTALS		0	756,045			
Z - WAGE INDEX							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,705,080	0		1.00
2.00	OPERATION OF PLANT	7.00	104,191	0	0		2.00
3.00	NURSING ADMINISTRATION	13.00	128,687	0	0		3.00
4.00	PHARMACY	15.00	12,303	0	0		4.00
5.00	MEDICAL RECORDS & LIBRARY	16.00	20,514	0	0		5.00
6.00	SOCIAL SERVICE	17.00	253,469	0	0		6.00
7.00	NURSING PROGRAM	20.00	58,500	0	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	SUBPROVIDER	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	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	RADIOLOGY-DIAGNOSTIC	54.00	80,127	0	0		15.00
16.00	RADIOLOGY-THERAPEUTIC	55.00	0	2,502,679	0		16.00
17.00	CARDIAC CATHETERIZATION	59.00	5,035	0	0		17.00
18.00	RESPIRATORY THERAPY	65.00	50,080	0	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	31,524	0	0		19.00
20.00	RENAL DIALYSIS	74.00	102,655	0	0		20.00
21.00	CLINIC	90.00	20,833	0	0		21.00
22.00	PSYCH CLINIC	90.02	124,399	0	0		22.00
23.00	WOUND CENTER	90.15	25,384	0	0		23.00
24.00	CLINIC	90.18	1,138	0	0		24.00
25.00	EMERGENCY	91.00	116,373	0	0		25.00
26.00	PSYCH EMERGENCY	91.01	55,950	0	0		26.00
27.00	PHYSICIANS PRIVATE OFFICES	192.00	0	1,699,440	0		27.00
	TOTALS		2,086,920	8,907,199			
ZZ - PHYSICIAN RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	429,660	833,374	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		429,660	833,374			
500.00	Grand Total: Decreases		9,153,914	51,538,175			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023Worksheet A-7
Part I
Date/Time Prepared:
5/30/2024 10:12 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	1,783,178	0	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	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	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	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
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023Worksheet A-7
Part II
Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 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
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of col s. 9 through 14)				
		14.00	15.00				
		PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2					
1.00	CAP REL COSTS-BLDG & FIXT	0	6,252,168				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	7,377,136				2.00
3.00	Total (sum of lines 1-2)	0	13,629,304				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023Worksheet A-7
Part III
Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	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
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital -Related Costs	Total (sum of col.s. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	6,252,168	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,377,136	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	13,629,304	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital -Related Costs (see instructions)	Total (2) (sum of col.s. 9 through 14)	
		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	0	6,252,168	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	7,377,136	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	13,629,304	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	B	-281,628	CAP REL COSTS-MVBLE EQUIP	2.00	11	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	B	0	ADMINISTRATIVE & GENERAL	5.00	0	7.00
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. (chapter 23)	B	-388	ADMINISTRATIVE & GENERAL	5.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	39,871,997			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-829,845	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)	B	-6,419,730	NURSING PROGRAM	20.00	0	19.00
20.00	Vending machines	B	0	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	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	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	MICU/CPR/AHA/IHCE	B	0	AMBULANCE SERVICES	95.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A		Wkst. A-7 Ref.	
				To/From Which the Amount is to be Adjusted			
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
34.00	HOBOKEN RAD CONTRACT	B	-209,286	RADIOLOGY-DIAGNOSTIC	54.00	0	34.00
35.00	GARNISH	B	-2,030	ADMINISTRATIVE & GENERAL	5.00	0	35.00
36.00	RENT	B	-168,255	WOMENS CLINIC	90.07	0	36.00
37.00	PARKING GARAGE	B	-589,190	OPERATION OF PLANT	7.00	0	37.00
38.00	CARDIO DIAG STUDENTS	B	0	I&R SERVICES-OTHER PRGM	22.00	0	38.00
				COSTS APPRV			
39.00	TOURO COLLEGE	B	0	I&R SERVICES-OTHER PRGM	22.00	0	39.00
				COSTS APPRV			
40.00	SETON HALL PA PROG	B	0	I&R SERVICES-OTHER PRGM	22.00	0	40.00
				COSTS APPRV			
40.01	MED STUDENTS OTHER	B	-837,243	I&R SERVICES-OTHER PRGM	22.00	0	40.01
				COSTS APPRV			
40.02	I&R VERIFICATION FEE	B	-1,250	I&R SERVICES-OTHER PRGM	22.00	0	40.02
				COSTS APPRV			
40.03	DR. APPLICATION FEE	B	-67,500	ADMINISTRATIVE & GENERAL	5.00	0	40.03
40.04	GAIN/LOSS SALE OF EQ	B	-16,698	ADMINISTRATIVE & GENERAL	5.00	0	40.04
41.00	PROFESS CONSULTATION	B	0	SPEECH PATHOLOGY	68.00	0	41.00
42.00	MEDICAL RECORDS FEES	B	-796	MEDICAL RECORDS & LIBRARY	16.00	0	42.00
43.00	OTHER MISC.	B	-1,005,286	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	PSE&G PROJECT	B	-203,902	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.00	INSURANCE RECOVERY	B	-3,026,258	ADMINISTRATIVE & GENERAL	5.00	0	45.00
46.00	UNION CO EDUC SERV C	B	-324,723	THERAPEUTIC SCHOOL	90.08	0	46.00
47.00	GENERAL CONTRIBUTION	B	0	ADMINISTRATIVE & GENERAL	5.00	0	47.00
48.00	LOAN FORGIVENESS	B	-11,370	ADMINISTRATIVE & GENERAL	5.00	0	48.00
49.00	MARILAC OVRHD. REIMBR	B	-11,114	ADMINISTRATIVE & GENERAL	5.00	0	49.00
49.01	INTERCOMPANY RENTAL	B	-20,000	ADMINISTRATIVE & GENERAL	5.00	0	49.01
49.02	340B REBATE	B	0	ADMINISTRATIVE & GENERAL	5.00	0	49.02
49.03	CAPITATION	B	-10	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49.03
49.04	REMEDY PARTNERS	B	-440	ADMINISTRATIVE & GENERAL	5.00	0	49.04
49.05	USE OF AUTO	B	-2,460	ADMINISTRATIVE & GENERAL	5.00	0	49.05
49.06	TRANSPORT	B	-9	SOCIAL SERVICE	17.00	0	49.06
49.07	TRANSPORT	B	-2,850	RADIOLOGY-THERAPEUTIC	55.00	0	49.07
49.08	TRANSPORT	B	-1,649	PHYSICAL THERAPY	66.00	0	49.08
49.09	TRANSPORT	B	-1,530	CLINIC	90.00	0	49.09
49.10	TRANSPORT	B	-28,639	PSYCH CLINIC	90.02	0	49.10
49.11	TRANSPORT	B	-780	CLINIC	90.18	0	49.11
49.12	TRANSPORT	B	-717,567	AMBULANCE SERVICES	95.00	0	49.12
49.13	TRANSPORT	B	-11,417	ADMINISTRATIVE & GENERAL	5.00	0	49.13
49.15	LOBBYING DUES	A	-54,041	ADMINISTRATIVE & GENERAL	5.00	0	49.15
49.16	LINDEN CAB	A	-915	RENAL DIALYSIS	74.00	0	49.16
49.17	LINDEN CAB	A	-22,996	RADIOLOGY-THERAPEUTIC	55.00	0	49.17
49.18	LINDEN CAB	A	-5,516	PHARMACY	15.00	0	49.18
49.19	LINDEN CAB	A	-4,238	SUBPROVIDER - IPF	40.00	0	49.19
49.20	LINDEN CAB	A	-816	PSYCH CLINIC	90.02	0	49.20
49.21	LINDEN CAB	A	-2,348	PSYCH EMERGENCY	91.01	0	49.21
49.22	LINDEN CAB	A	-1,407	SOCIAL SERVICE	17.00	0	49.22
49.23	APN	A	-411,101	ADMINISTRATIVE & GENERAL	5.00	0	49.23
49.24	APN	A	-17,338	NURSING ADMINISTRATION	13.00	0	49.24
49.25	APN	A	-459,020	ADULTS & PEDIATRICS	30.00	0	49.25
49.26	APN	A	-62,424	SUBPROVIDER - IPF	40.00	0	49.26
49.27	APN	A	-1,096	SUBPROVIDER	42.00	0	49.27
49.28	APN	A	-19,799	OTHER LONG TERM CARE	46.00	0	49.28
49.29	APN	A	-11,072	RADIOLOGY-DIAGNOSTIC	54.00	0	49.29
49.31	APN	A	-7,024	RADIOLOGY-THERAPEUTIC	55.00	0	49.31
49.32	APN	A	-133,278	RENAL DIALYSIS	74.00	0	49.32
49.33	APN	A	-8,100	CLINIC	90.00	0	49.33
49.34	APN	A	-121,446	PSYCH CLINIC	90.02	0	49.34
49.35	APN	A	-38,941	PEDIATRIC CLINIC	90.06	0	49.35
49.36	APN	A	-1,679	THERAPEUTIC SCHOOL	90.08	0	49.36
49.37	APN	A	-10,328	PSYCH CLINIC	90.02	0	49.37
49.38	APN	A	-79,680	PSYCH CLINIC	90.02	0	49.38
49.39	APN	A	-175,243	BAYONNE MENTAL HEALTH CENTER	90.17	0	49.39
49.40	APN	A	-20,894	PSYCH EMERGENCY	91.01	0	49.40
49.41	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.41
49.42	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.42
49.43	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.43

ADJUSTMENTS TO EXPENSES

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
49.44	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.44
49.45	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.45
49.46	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.46
49.47	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.47
49.48	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.48
49.49	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.49
49.50	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.50
49.51	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.51
49.52	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.52
49.53	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.53
49.54	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.54
49.55	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	49.55
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		657,603				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8-1

Date/Time Prepared:
5/30/2024 10:12 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	S-COPE	14,225	28,386	1.00
2.00	30.00	ADULTS & PEDIATRICS		21,542	46,048	2.00
3.00	54.00	RADIOLOGY-DIAGNOSTIC		3,105	3,077	3.00
4.00	59.00	CARDIAC CATHETERIZATION		2,924	5,650	4.00
4.01	66.00	PHYSICAL THERAPY		31,916	64,785	4.01
4.02	67.00	OCCUPATIONAL THERAPY		21,671	47,111	4.02
4.03	74.00	RENAL DIALYSIS		6,210	12,000	4.03
4.04	90.02	PSYCH CLINIC		7,556	14,732	4.04
4.05	90.06	PEDIATRIC CLINIC		21,548	48,297	4.05
4.06	90.07	WOMENS CLINIC		63,466	82,311	4.06
4.07	90.15	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). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			53,283,914	13,411,917	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.

	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	B		0.00	RWJBH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					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.

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

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8-1

Date/Time Prepared:
5/30/2024 10:12 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-14,161	0		1.00
2.00	-24,506	0		2.00
3.00	28	0		3.00
4.00	-2,726	0		4.00
4.01	-32,869	0		4.01
4.02	-25,440	0		4.02
4.03	-5,790	0		4.03
4.04	-7,176	0		4.04
4.05	-26,749	0		4.05
4.06	-18,845	0		4.06
4.07	-34,400	0		4.07
4.08	40,064,631	0		4.08
4.09	0	0		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 RELATED ORGANIZATION(S) AND/OR HOME OFFICE:			

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00	HOSPITAL		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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8-2

Date/Time Prepared:
5/30/2024 10:12 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	17.00	SOCIAL SERVICE	321,259	0	321,259	211,500	3,310	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	6,521,000	5,923,895	597,105	211,500	10,153	4.00
5.00	31.00	INTENSIVE CARE UNIT	675,608	675,608	0	0	0	5.00
6.00	40.00	SUBPROVIDER - IPF	1,996,115	1,969,245	26,870	211,500	386	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	8.00
9.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	9.00
10.00	53.00	ANESTHESIOLOGY	5,106,558	4,595,902	510,656	271,900	4,255	10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	1,209,333	1,164,933	44,400	271,900	212	11.00
12.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	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	0	0	0	14.00
15.00	69.00	ELECTROCARDIOLOGY	101,586	101,586	0	0	0	15.00
16.00	74.00	RENAL DIALYSIS	231,029	50,000	181,029	211,500	1,040	16.00
17.00	90.00	CLINIC	200,470	200,470	0	0	0	17.00
18.00	90.02	PSYCH CLINIC	1,983,041	1,697,108	285,933	181,300	1,004	18.00
19.00	90.06	PEDIATRIC CLINIC	234,870	234,870	0	0	0	19.00
22.00	91.00	EMERGENCY	1,133,540	1,133,540	0	0	0	22.00
23.00	91.01	PSYCH EMERGENCY	1,110,390	1,080,843	29,547	211,500	614	23.00
24.00	90.07	WOMENS CLINIC	56,229	56,229	0	0	0	24.00
25.00	59.00	CARDIAC CATHETERIZATION	107,010	107,010	0	0	0	25.00
26.00	52.00	DELIVERY ROOM & LABOR ROOM	1,443,201	1,443,201	0	0	0	26.00
27.00	50.00	OPERATING ROOM	1,823,905	1,811,200	12,705	211,500	39	27.00
28.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	28.00
29.00	90.08	THERAPEUTIC SCHOOL	14,853	14,853	0	0	0	29.00
200.00			24,539,626	22,441,239	2,098,387		21,751	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8-2

Date/Time Prepared:
5/30/2024 10:12 am

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	17.00	SOCIAL SERVICE	336,570	16,829	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	1,032,384	51,619	0	0	43,949	4.00
5.00	31.00	INTENSIVE CARE UNIT	0	0	0	0	0	5.00
6.00	40.00	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	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	8.00
9.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	9.00
10.00	53.00	ANESTHESIOLOGY	556,218	27,811	0	0	0	10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	27,713	1,386	0	0	0	11.00
12.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	12.00
13.00	60.00	LABORATORY	75,042	3,752	0	0	0	13.00
14.00	65.00	RESPIRATORY THERAPY	0	0	0	0	17	14.00
15.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	15.00
16.00	74.00	RENAL DIALYSIS	105,750	5,288	0	0	0	16.00
17.00	90.00	CLINIC	0	0	0	0	2,896	17.00
18.00	90.02	PSYCH CLINIC	87,512	4,376	0	0	30,483	18.00
19.00	90.06	PEDIATRIC CLINIC	0	0	0	0	0	19.00
22.00	91.00	EMERGENCY	0	0	0	0	0	22.00
23.00	91.01	PSYCH EMERGENCY	62,433	3,122	0	0	4,969	23.00
24.00	90.07	WOMENS CLINIC	0	0	0	0	0	24.00
25.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	25.00
26.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	26.00
27.00	50.00	OPERATING ROOM	3,966	198	0	0	0	27.00
28.00	59.00	CARDIAC CATHETERIZATION	0	0	0	0	0	28.00
29.00	90.08	THERAPEUTIC SCHOOL	0	0	0	0	373	29.00
200.00			2,326,838	116,344	0	0	106,283	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet A-8-2

Date/Time Prepared:
5/30/2024 10:12 am

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	17.00	SOCIAL SERVICE	0	336,570	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	30.00	ADULTS & PEDIATRICS	4,024	1,036,408	0	5,923,895		4.00
5.00	31.00	INTENSIVE CARE UNIT	0	0	0	675,608		5.00
6.00	40.00	SUBPROVIDER - IPF	318	39,568	0	1,969,245		6.00
7.00	0.00		0	0	0	0		7.00
8.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		8.00
9.00	30.00	ADULTS & PEDIATRICS	0	0	0	0		9.00
10.00	53.00	ANESTHESIOLOGY	0	556,218	0	4,595,902		10.00
11.00	54.00	RADIOLOGY-DIAGNOSTIC	0	27,713	16,687	1,181,620		11.00
12.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0		12.00
13.00	60.00	LABORATORY	0	75,042	13,841	194,300		13.00
14.00	65.00	RESPIRATORY THERAPY	0	0	0	287		14.00
15.00	69.00	ELECTROCARDIOLOGY	0	0	0	101,586		15.00
16.00	74.00	RENAL DIALYSIS	0	105,750	75,279	125,279		16.00
17.00	90.00	CLINIC	0	0	0	200,470		17.00
18.00	90.02	PSYCH CLINIC	4,395	91,907	194,026	1,891,134		18.00
19.00	90.06	PEDIATRIC CLINIC	0	0	0	234,870		19.00
22.00	91.00	EMERGENCY	0	0	0	1,133,540		22.00
23.00	91.01	PSYCH EMERGENCY	132	62,565	0	1,080,843		23.00
24.00	90.07	WOMENS CLINIC	0	0	0	56,229		24.00
25.00	59.00	CARDIAC CATHETERIZATION	0	0	0	107,010		25.00
26.00	52.00	DELIVERY ROOM & LABOR ROOM	0	0	0	1,443,201		26.00
27.00	50.00	OPERATING ROOM	0	3,966	8,739	1,819,939		27.00
28.00	59.00	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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0027

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

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
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	7,377,136			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	36,718,128	26,591	31,375	36,776,094	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	83,907,425	668,905	789,262	4,456,260	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,777,370	73,720	86,985	76,079	6.00
7.00	00700	OPERATION OF PLANT	13,307,323	2,299,339	2,713,067	383,468	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,244,342	19,186	22,638	18,501	8.00
9.00	00900	HOUSEKEEPING	5,633,517	97,663	115,236	651,468	9.00
10.00	01000	DIETARY	3,588,658	83,376	98,378	295,488	10.00
11.00	01100	CAFETERIA	1,877,389	65,514	77,302	222,912	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	5,401,985	6,479	7,644	1,108,662	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,486,089	34,479	40,683	265,321	14.00
15.00	01500	PHARMACY	3,521,660	28,006	33,045	774,239	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,345,042	32,928	38,852	366,556	16.00
17.00	01700	SOCIAL SERVICE	2,046,871	6,683	7,886	240,311	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	-2,412,593	53,648	63,301	653,870	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	4,012,012	32,479	38,322	879,405	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,871,246	60,070	70,878	328,674	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	16,440,521	501,761	592,044	4,183,288	30.00
31.00	03100	INTENSIVE CARE UNIT	6,352,672	91,463	107,920	1,107,403	31.00
40.00	04000	SUBPROVIDER - IPF	11,167,277	189,921	224,094	2,749,577	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	2,874,258	70,754	83,485	619,226	42.00
43.00	04300	NURSERY	1,301,100	40,645	47,958	238,358	43.00
44.00	04400	SKILLED NURSING FACILITY	297,074	43,293	51,083	64,997	44.00
45.00	04500	NURSING FACILITY	7,566,899	177,680	209,650	1,143,893	45.00
46.00	04600	OTHER LONG TERM CARE	2,541,744	59,160	69,805	508,023	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	9,529,737	210,250	248,080	1,278,548	50.00
51.00	05100	RECOVERY ROOM	1,323,283	16,469	19,433	288,446	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,423,070	48,164	56,830	953,682	52.00
53.00	05300	ANESTHESIOLOGY	535,925	3,120	3,681	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,605,694	85,950	101,415	727,758	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,090,882	203,419	240,020	1,230,212	55.00
56.00	05600	RADIOISOTOPE	633,528	2,319	2,736	75,217	56.00
57.00	05700	CT SCAN	1,150,857	6,268	7,396	165,804	57.00
58.00	05800	MRI	440,869	7,109	8,389	60,690	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,615,394	31,103	36,700	220,851	59.00
60.00	06000	LABORATORY	9,376,457	60,877	71,830	54,149	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,423	4,103	4,841	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,807,518	17,981	21,217	620,802	65.00
66.00	06600	PHYSICAL THERAPY	1,635,103	45,578	53,779	340,344	66.00
67.00	06700	OCCUPATIONAL THERAPY	185,296	0	0	34,266	67.00
68.00	06800	SPEECH PATHOLOGY	163,928	568	671	35,677	68.00
69.00	06900	ELECTROCARDIOLOGY	1,052,267	14,145	16,690	170,518	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,061,053	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,949,662	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	14,617,585	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	9,544,275	89,445	105,539	1,336,402	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	1,544,057	71,083	83,874	363,147	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	15,037,463	197,309	232,812	3,256,824	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0	90.03
90.04	09003	WORKFIRST	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	622,691	0	0	177,974	90.06
90.07	09006	WOMENS CLINIC	1,936,336	0	0	416,923	90.07

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0027

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

	Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
90.08	09007	THERAPEUTIC SCHOOL	67,668	0	0	88,270	155,938	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09
90.10	09017	CLINIC-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	DIABETES CENTER	0	0	0	0	0	90.14
90.15	09013	WOUND CENTER	589,243	6,308	7,443	97,005	699,999	90.15
90.16	09014	MICA	0	29,950	35,338	0	65,288	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	936,208	0	0	212,381	1,148,589	90.17
90.18	09018	CLINIC	214,541	0	0	45,931	260,472	90.18
91.00	09100	EMERGENCY	11,098,822	142,565	168,217	2,003,765	13,413,369	91.00
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	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	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	352,136,585	6,088,082	7,183,525	36,398,962	351,401,756	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	4,167,629	22,107	26,085	377,132	4,592,953	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	NON REIMBURSABLE	491,514	134,250	158,406	0	784,170	194.00
194.01	07951	RETAIL PHARMACY	2,991,474	7,729	9,120	0	3,008,323	194.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0027

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

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
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	ADMINISTRATIVE & GENERAL	89,821,852					5.00
6.00	00600	MAINTENANCE & REPAIRS	996,796	4,010,950				6.00
7.00	00700	OPERATION OF PLANT	6,185,241	1,682,037	26,570,475			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	431,460	14,035	160,126	1,910,288		8.00
9.00	00900	HOUSEKEEPING	2,148,883	71,443	815,096	58,957	9,592,263	9.00
10.00	01000	DIETARY	1,344,613	60,992	695,855	50,332	260,784	10.00
11.00	01100	CAFETERIA	741,810	47,926	546,781	39,549	204,916	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
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
15.00	01500	PHARMACY	1,440,865	20,487	233,738	16,907	87,597	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,251,182	24,087	274,813	19,878	102,991	16.00
17.00	01700	SOCIAL SERVICE	761,201	4,889	55,778	4,035	20,904	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	39,245	447,746	32,386	167,800	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,641,030	23,759	271,066	19,607	101,587	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	770,830	43,943	501,342	36,263	187,887	22.00
23.00	02300	PARAMED ED PRGM-(SPECIALTY)	0	0	0	0	0	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	4,739,290	138,933	1,585,086	114,651	594,038	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	1,206,320	51,759	590,512	42,712	221,305	42.00
43.00	04300	NURSERY	538,408	29,733	339,224	24,536	127,130	43.00
44.00	04400	SKILLED NURSING FACILITY	150,949	31,670	361,327	26,135	135,413	44.00
45.00	04500	NURSING FACILITY	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
51.00	05100	RECOVERY ROOM	544,880	12,048	137,454	9,942	51,513	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,482,136	35,233	401,975	29,075	150,647	52.00
53.00	05300	ANESTHESIOLOGY	179,482	2,282	26,039	1,883	9,759	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,825,762	62,875	717,342	51,886	268,836	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,237,065	148,807	1,697,734	122,799	636,255	55.00
56.00	05600	RADIOISOTOPE	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
59.00	05900	CARDIAC CATHETERIZATION	629,678	22,753	259,588	18,776	97,285	59.00
60.00	06000	LABORATORY	3,162,635	44,533	508,077	36,750	190,411	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	4,751	3,002	34,245	2,477	12,834	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,477,431	13,154	150,071	10,855	56,242	65.00
66.00	06600	PHYSICAL THERAPY	686,148	33,342	380,394	27,514	142,559	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,610	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	66,420	416	4,743	343	1,778	68.00
69.00	06900	ELECTROCARDIOLOGY	414,578	10,348	118,055	8,539	44,243	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,996,536	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,298,288	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,834,108	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,662,776	65,432	746,511	53,996	279,768	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	681,967	52,000	593,263	42,911	222,336	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	6,192,255	144,338	1,646,746	119,111	617,146	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0	0	90.03
90.04	09003	WORKFIRST	0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	264,784	0	0	0	0	90.06
90.07	09006	WOMENS CLINIC	778,235	0	0	0	0	90.07
90.08	09007	THERAPEUTIC SCHOOL	51,569	0	0	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09
90.10	09017	CLINIC-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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0027

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

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			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	DIABETES 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	MICA	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	CLINIC	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	INTEREST 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
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	1,518,913	16,172	184,505	13,345	69,147	192.00
193.00	19300	NONPAID 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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0027

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

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & 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
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	HOUSEKEEPING						9.00
10.00	01000	DIETARY	6,478,476					10.00
11.00	01100	CAFETERIA	0	3,824,099				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	130,877	0	8,896,406		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	59,763	0	15,971	5,609,414	14.00
15.00	01500	PHARMACY	0	90,561	0	0	56,361	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	78,481	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	27,619	0	100,566	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	73,395	0	2,852	4,647	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	152,232	0	0	190	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,008,611	460,828	0	2,207,103	169,912	30.00
31.00	03100	INTENSIVE CARE UNIT	189,639	120,536	0	696,510	83,125	31.00
40.00	04000	SUBPROVIDER - IPF	1,210,187	308,222	0	868,288	33,664	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	362,932	77,210	0	208,107	14,223	42.00
43.00	04300	NURSERY	0	22,551	0	175,246	13,391	43.00
44.00	04400	SKILLED NURSING FACILITY	0	12,977	0	19,801	30	44.00
45.00	04500	NURSING FACILITY	1,846,529	177,251	0	349,241	44,015	45.00
46.00	04600	OTHER LONG TERM CARE	0	91,010	0	27,957	402	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	47,474	161,525	0	718,274	938,058	50.00
51.00	05100	RECOVERY ROOM	0	29,788	0	195,134	3,388	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,284	85,344	0	488,227	50,913	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	60,229	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	94,488	0	44,241	72,788	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	103,632	0	155,172	22,661	55.00
56.00	05600	RADIOISOTOPE	0	7,087	0	0	28,329	56.00
57.00	05700	CT SCAN	0	18,419	0	0	12,392	57.00
58.00	05800	MRI	0	7,910	0	0	3,512	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	25,225	0	79,046	95,226	59.00
60.00	06000	LABORATORY	0	6,788	0	35,362	1,968	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	74,274	0	0	57,637	65.00
66.00	06600	PHYSICAL THERAPY	0	39,138	0	19,048	4,932	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	4,301	0	0	25	67.00
68.00	06800	SPEECH PATHOLOGY	0	4,974	0	0	191	68.00
69.00	06900	ELECTROCARDIOLOGY	0	31,396	0	33,779	5,783	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,944,869	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,491,773	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	169,977	0	678,243	183,205	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	63,653	0	109,055	3,462	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	254,334	503,053	0	232,137	3,947	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0	0	90.03
90.04	09003	WORKFIRST	0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	0	19,017	0	86,412	1,466	90.06
90.07	09006	WOMENS CLINIC	0	67,598	0	130,819	5,908	90.07
90.08	09007	THERAPEUTIC SCHOOL	0	11,238	0	20,660	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09
90.10	09017	CLINIC-NOT USED	0	0	0	0	0	90.10
90.11	09009	PERINATAL ADDICTION	0	0	0	0	0	90.11

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0027

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

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & 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	09011	CHILD DAY TREATMENT	0	0	0	0	0	90.13
90.14	09012	DIABETES 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	MICA	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	CLINIC	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	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	INTEREST 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
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	127	192.00
193.00	19300	NONPAID 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						200.00
201.00		Negative Cost Centers	0	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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0027

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

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
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	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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	6,303,466					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,534,810				16.00
17.00	01700	SOCIAL SERVICE	0	0	3,276,743			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		-873,703	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	2,988,797	3,276,743	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	442,785	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	55,348	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	4,599	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
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	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	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	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,742,271	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	556,596	719,525	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	442,785	0	0	0	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	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	WORKFIRST	0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	0	0	0	0	0	90.06
90.07	09006	WOMENS CLINIC	0	0	0	0	0	90.07
90.08	09007	THERAPEUTIC SCHOOL	0	0	0	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09
90.10	09017	CLINIC-NOT USED	0	0	0	0	0	90.10
90.11	09009	PERINATAL ADDICTION	0	0	0	0	0	90.11

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0027

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

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
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	DIABETES CENTER	0	0	0	0	0	90.14
90.15	09013	WOUND CENTER	0	0	0	0	0	90.15
90.16	09014	MICA	0	0	0	0	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	0	0	0	0	90.17
90.18	09018	CLINIC	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	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST 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
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID 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					0	200.00
201.00		Negative Cost Centers	0	0	0	0	-873,703	201.00
202.00		TOTAL (sum lines 118 through 201)	6,303,466	5,534,810	3,276,743	0	-873,703	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0027

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

Cost Center Description		INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
		21.00	22.00				
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	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	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
12.00	01200	MAINTENANCE OF PERSONNEL					12.00
13.00	01300	NURSING ADMINISTRATION					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	NURSING PROGRAM					20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	7,019,267				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		4,023,555			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,053,872	2,896,960	0	54,389,653	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	12,896,623	31.00
40.00	04000	SUBPROVIDER - IPF	1,544,239	885,182	0	26,407,997	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	6,422,803	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	04500	NURSING FACILITY	0	0	0	16,804,461	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	5,107,112	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	19,550,965	50.00
51.00	05100	RECOVERY ROOM	0	0	0	2,631,778	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	7,240,580	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	822,400	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,659,035	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	11,888,658	55.00
56.00	05600	RADIOISOTOPE	0	0	0	1,014,973	56.00
57.00	05700	CT SCAN	0	0	0	1,881,373	57.00
58.00	05800	MRI	0	0	0	790,538	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	3,131,625	59.00
60.00	06000	LABORATORY	0	0	0	13,549,837	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	71,676	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	6,307,182	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,407,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	296,498	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	279,709	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,920,341	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,002,458	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	07400	RENAL DIALYSIS	0	0	0	18,191,690	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	421,156	241,413	0	4,936,162	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	0	0	0	28,437,475	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0	90.03
90.04	09003	WORKFIRST	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	0	0	0	1,172,344	90.06
90.07	09006	WOMENS CLINIC	0	0	0	3,335,819	90.07

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0027

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

Cost Center Description			INTERNS & RESIDENTS		PARAMETERED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00		23.00	24.00	25.00
90.08	09007	THERAPEUTIC SCHOOL	0	0	0	239,405	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09
90.10	09017	CLINIC-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	DIABETES CENTER	0	0	0	0	0	90.14
90.15	09013	WOUND CENTER	0	0	0	1,103,510	0	90.15
90.16	09014	MICA	0	0	0	470,505	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	0	0	1,589,505	0	90.17
90.18	09018	CLINIC	0	0	0	348,612	0	90.18
91.00	09100	EMERGENCY	0	0	0	22,225,137	0	91.00
91.01	09101	PSYCH EMERGENCY	0	0	0	5,847,402	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	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
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
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	6,395,162	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	NON REIMBURSABLE	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	0	200.00
201.00		Negative Cost Centers	0	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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0027

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

Cost Center Description		Total	
		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	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	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	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	NURSING 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 & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
42.00	04200	SUBPROVIDER	42.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
45.00	04500	NURSING FACILITY	45.00
46.00	04600	OTHER LONG TERM CARE	46.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	78.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09016	CLINIC-NOT USED	90.01
90.02	09001	PSYCH CLINIC	90.02
90.03	09002	PSYCH CLINIC FEE BASED	90.03
90.04	09003	WORKFIRST	90.04
90.05	09004	CANCER CLINIC	90.05
90.06	09005	PEDIATRIC CLINIC	90.06
90.07	09006	WOMENS CLINIC	90.07
90.08	09007	THERAPEUTIC SCHOOL	90.08
90.09	09008	AFTER SCHOOL PROGRAM	90.09
90.10	09017	CLINIC-NOT USED	90.10
90.11	09009	PERINATAL ADDICTION	90.11
90.12	09010	THERAPEUTIC NURSERY	90.12
90.13	09011	CHILD DAY TREATMENT	90.13

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0027

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

Cost Center Description		Total	
		26.00	
90.14	09012 DIABETES CENTER	0	90.14
90.15	09013 WOUND CENTER	1,103,510	90.15
90.16	09014 MICA	470,505	90.16
90.17	09015 BAYONNE MENTAL HEALTH CENTER	1,589,505	90.17
90.18	09018 CLINIC	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	0	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 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	336,357,614	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200 PHYSICIANS PRIVATE OFFICES	6,395,162	192.00
193.00	19300 NONPAID 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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0027

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

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
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	0	26,591	31,375	57,966	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	668,905	789,262	1,458,167	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	73,720	86,985	160,705	6.00
7.00	00700	OPERATION OF PLANT	0	2,299,339	2,713,067	5,012,406	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	19,186	22,638	41,824	8.00
9.00	00900	HOUSEKEEPING	0	97,663	115,236	212,899	9.00
10.00	01000	DIETARY	0	83,376	98,378	181,754	10.00
11.00	01100	CAFETERIA	0	65,514	77,302	142,816	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	6,479	7,644	14,123	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	34,479	40,683	75,162	14.00
15.00	01500	PHARMACY	0	28,006	33,045	61,051	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	32,928	38,852	71,780	16.00
17.00	01700	SOCIAL SERVICE	0	6,683	7,886	14,569	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	53,648	63,301	116,949	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	32,479	38,322	70,801	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	60,070	70,878	130,948	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	501,761	592,044	1,093,805	30.00
31.00	03100	INTENSIVE CARE UNIT	0	91,463	107,920	199,383	31.00
40.00	04000	SUBPROVIDER - IPF	0	189,921	224,094	414,015	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	70,754	83,485	154,239	42.00
43.00	04300	NURSERY	0	40,645	47,958	88,603	43.00
44.00	04400	SKILLED NURSING FACILITY	0	43,293	51,083	94,376	44.00
45.00	04500	NURSING FACILITY	0	177,680	209,650	387,330	45.00
46.00	04600	OTHER LONG TERM CARE	0	59,160	69,805	128,965	46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	210,250	248,080	458,330	50.00
51.00	05100	RECOVERY ROOM	0	16,469	19,433	35,902	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	48,164	56,830	104,994	52.00
53.00	05300	ANESTHESIOLOGY	0	3,120	3,681	6,801	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	85,950	101,415	187,365	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	203,419	240,020	443,439	55.00
56.00	05600	RADIOISOTOPE	0	2,319	2,736	5,055	56.00
57.00	05700	CT SCAN	0	6,268	7,396	13,664	57.00
58.00	05800	MRI	0	7,109	8,389	15,498	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	31,103	36,700	67,803	59.00
60.00	06000	LABORATORY	0	60,877	71,830	132,707	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	4,103	4,841	8,944	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	17,981	21,217	39,198	65.00
66.00	06600	PHYSICAL THERAPY	0	45,578	53,779	99,357	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	568	671	1,239	68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,145	16,690	30,835	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	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	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	89,445	105,539	194,984	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	71,083	83,874	154,957	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	0	197,309	232,812	430,121	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0	90.03
90.04	09003	WORKFIRST	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	0	0	0	0	90.06
90.07	09006	WOMENS CLINIC	0	0	0	0	90.07
90.08	09007	THERAPEUTIC SCHOOL	0	0	0	0	90.08

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0027

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

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09
90.10	09017	CLINIC-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	DIABETES CENTER	0	0	0	0	0	90.14
90.15	09013	WOUND CENTER	0	6,308	7,443	13,751	153	90.15
90.16	09014	MICA	0	29,950	35,338	65,288	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	0	0	0	334	90.17
90.18	09018	CLINIC	0	0	0	0	72	90.18
91.00	09100	EMERGENCY	0	142,565	168,217	310,782	3,154	91.00
91.01	09101	PSYCH EMERGENCY	0	30,256	35,701	65,957	1,271	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		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	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
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	22,107	26,085	48,192	594	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	NON REIMBURSABLE	0	134,250	158,406	292,656	0	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	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	6,252,168	7,377,136	13,629,304	57,966	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0027

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

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
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	ADMINISTRATIVE & GENERAL	1,465,264					5.00
6.00	00600	MAINTENANCE & REPAIRS	16,261	177,086				6.00
7.00	00700	OPERATION OF PLANT	100,904	74,259	5,188,173			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	7,039	620	31,266	80,778		8.00
9.00	00900	HOUSEKEEPING	35,056	3,154	159,156	2,493	413,783	9.00
10.00	01000	DIETARY	21,936	2,693	135,873	2,128	11,249	10.00
11.00	01100	CAFETERIA	12,102	2,116	106,765	1,672	8,839	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
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
15.00	01500	PHARMACY	23,506	905	45,640	715	3,779	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	20,411	1,063	53,660	841	4,443	16.00
17.00	01700	SOCIAL SERVICE	12,418	216	10,891	171	902	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	1,733	87,427	1,369	7,238	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	26,771	1,049	52,929	829	4,382	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	12,575	1,940	97,893	1,533	8,105	22.00
23.00	02300	PARAMED ED PRGM- (SPECLFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	117,111	16,206	817,696	12,810	67,700	30.00
31.00	03100	INTENSIVE CARE UNIT	41,323	2,954	149,052	2,335	12,341	31.00
40.00	04000	SUBPROVIDER - IPF	77,315	6,134	309,505	4,848	25,625	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	19,679	2,285	115,304	1,806	9,546	42.00
43.00	04300	NURSERY	8,783	1,313	66,237	1,038	5,484	43.00
44.00	04400	SKILLED NURSING FACILITY	2,463	1,398	70,553	1,105	5,841	44.00
45.00	04500	NURSING FACILITY	49,084	5,739	289,556	4,536	23,973	45.00
46.00	04600	OTHER LONG TERM CARE	17,149	1,911	96,411	1,510	7,982	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	60,783	6,791	342,633	5,367	28,368	50.00
51.00	05100	RECOVERY ROOM	8,889	532	26,839	420	2,222	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	24,179	1,556	78,490	1,229	6,498	52.00
53.00	05300	ANESTHESIOLOGY	2,928	101	5,084	80	421	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,785	2,776	140,069	2,194	11,597	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	36,495	6,570	331,501	5,193	27,446	55.00
56.00	05600	RADIOISOTOPE	3,851	75	3,779	59	313	56.00
57.00	05700	CT SCAN	7,177	202	10,215	160	846	57.00
58.00	05800	MRI	2,790	230	11,586	181	959	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,272	1,005	50,687	794	4,197	59.00
60.00	06000	LABORATORY	51,594	1,966	99,208	1,554	8,214	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	78	133	6,687	105	554	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	24,102	581	29,303	459	2,426	65.00
66.00	06600	PHYSICAL THERAPY	11,194	1,472	74,276	1,163	6,150	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,185	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,084	18	926	15	77	68.00
69.00	06900	ELECTROCARDIOLOGY	6,763	457	23,052	361	1,909	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	48,884	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,493	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	78,862	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	59,753	2,889	145,764	2,283	12,068	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,125	2,296	115,841	1,815	9,591	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	101,018	6,373	321,545	5,037	26,622	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0	0	90.03
90.04	09003	WORKFIRST	0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	4,320	0	0	0	0	90.06
90.07	09006	WOMENS CLINIC	12,696	0	0	0	0	90.07
90.08	09007	THERAPEUTIC SCHOOL	841	0	0	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09
90.10	09017	CLINIC-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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0027

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

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			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	DIABETES CENTER	0	0	0	0	0	90.14
90.15	09013	WOUND CENTER	3,776	204	10,280	161	851	90.15
90.16	09014	MICA	352	967	48,807	765	4,041	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	6,197	0	0	0	0	90.17
90.18	09018	CLINIC	1,405	0	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
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	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,420,024	171,786	4,920,770	76,590	391,643	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	24,779	714	36,027	564	2,983	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	NON REIMBURSABLE	4,231	4,336	218,781	3,427	18,114	194.00
194.01	07951	RETAIL PHARMACY	16,230	250	12,595	197	1,043	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)	1,465,264	177,086	5,188,173	80,778	413,783	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0027

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

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & 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
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	HOUSEKEEPING						9.00
10.00	01000	DIETARY	356,098					10.00
11.00	01100	CAFETERIA	0	274,661				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	9,400	0	72,275		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	4,292	0	130	163,481	14.00
15.00	01500	PHARMACY	0	6,504	0	0	1,643	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,637	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,984	0	817	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	5,272	0	23	135	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	10,934	0	0	6	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	110,407	33,098	0	17,932	4,952	30.00
31.00	03100	INTENSIVE CARE UNIT	10,424	8,657	0	5,659	2,423	31.00
40.00	04000	SUBPROVIDER - IPF	66,519	22,138	0	7,054	981	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	19,949	5,545	0	1,691	415	42.00
43.00	04300	NURSERY	0	1,620	0	1,424	390	43.00
44.00	04400	SKILLED NURSING FACILITY	0	932	0	161	1	44.00
45.00	04500	NURSING FACILITY	101,497	12,731	0	2,837	1,283	45.00
46.00	04600	OTHER LONG TERM CARE	0	6,537	0	227	12	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,609	11,601	0	5,835	27,339	50.00
51.00	05100	RECOVERY ROOM	0	2,139	0	1,585	99	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,939	6,130	0	3,966	1,484	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,755	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,786	0	359	2,121	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	7,443	0	1,261	660	55.00
56.00	05600	RADIOISOTOPE	0	509	0	0	826	56.00
57.00	05700	CT SCAN	0	1,323	0	0	361	57.00
58.00	05800	MRI	0	568	0	0	102	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,812	0	642	2,775	59.00
60.00	06000	LABORATORY	0	488	0	287	57	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	5,335	0	0	1,680	65.00
66.00	06600	PHYSICAL THERAPY	0	2,811	0	155	144	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	309	0	0	1	67.00
68.00	06800	SPEECH PATHOLOGY	0	357	0	0	6	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,255	0	274	169	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	56,678	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	43,477	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	12,208	0	5,510	5,339	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,572	0	886	101	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	13,980	36,131	0	1,886	115	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0	0	90.03
90.04	09003	WORKFIRST	0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	0	1,366	0	702	43	90.06
90.07	09006	WOMENS CLINIC	0	4,855	0	1,063	172	90.07
90.08	09007	THERAPEUTIC SCHOOL	0	807	0	168	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09
90.10	09017	CLINIC-NOT USED	0	0	0	0	0	90.10
90.11	09009	PERINATAL ADDICTION	0	0	0	0	0	90.11

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0027

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

Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & 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	09011	CHILD DAY TREATMENT	0	0	0	0	0	90.13
90.14	09012	DIABETES CENTER	0	0	0	0	0	90.14
90.15	09013	WOUND CENTER	0	962	0	395	851	90.15
90.16	09014	MICA	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	CLINIC	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	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	356,098	274,661	0	72,275	163,477	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	4	192.00
193.00	19300	NONPAID 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						200.00
201.00		Negative Cost Centers	0	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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0027

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

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
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	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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	144,962					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	158,412				16.00
17.00	01700	SOCIAL SERVICE	0	0	42,346			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		221,175	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			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
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	85,542	42,346			30.00
31.00	03100	INTENSIVE CARE UNIT	0	12,673	0			31.00
40.00	04000	SUBPROVIDER - IPF	0	1,584	0			40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0			41.00
42.00	04200	SUBPROVIDER	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
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0			50.00
51.00	05100	RECOVERY ROOM	0	0	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0			52.00
53.00	05300	ANESTHESIOLOGY	0	0	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0			55.00
56.00	05600	RADIOISOTOPE	0	0	0			56.00
57.00	05700	CT SCAN	0	0	0			57.00
58.00	05800	MRI	0	0	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0			59.00
60.00	06000	LABORATORY	0	0	0			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0			65.00
66.00	06600	PHYSICAL THERAPY	0	0	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	132,056	0	0			73.00
74.00	07400	RENAL DIALYSIS	12,800	20,594	0			74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0			77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0			78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	12,673	0			90.00
90.01	09016	CLINIC-NOT USED	0	0	0			90.01
90.02	09001	PSYCH CLINIC	0	0	0			90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0			90.03
90.04	09003	WORKFIRST	0	0	0			90.04
90.05	09004	CANCER CLINIC	0	0	0			90.05
90.06	09005	PEDIATRIC CLINIC	0	0	0			90.06
90.07	09006	WOMENS CLINIC	0	0	0			90.07
90.08	09007	THERAPEUTIC SCHOOL	0	0	0			90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0			90.09
90.10	09017	CLINIC-NOT USED	0	0	0			90.10
90.11	09009	PERINATAL ADDICTION	0	0	0			90.11

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0027

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

Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
90.12	09010	THERAPEUTIC NURSERY	0	0	0			90.12
90.13	09011	CHILD DAY TREATMENT	0	0	0			90.13
90.14	09012	DIABETES CENTER	0	0	0			90.14
90.15	09013	WOUND CENTER	0	0	0			90.15
90.16	09014	MICA	0	0	0			90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	0	0			90.17
90.18	09018	CLINIC	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	OPIOID TREATMENT PROGRAM	0	0	0			102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	144,962	158,412	42,346	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0			192.00
193.00	19300	NONPAID WORKERS	0	0	0			193.00
194.00	07950	NON REIMBURSABLE	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	221,175	201.00
202.00		TOTAL (sum lines 118 through 201)	144,962	158,412	42,346	0	221,175	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0027

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

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
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	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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						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	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	158,145					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		264,451				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				2,426,189	0	30.00
31.00	03100	INTENSIVE CARE UNIT				448,967	0	31.00
40.00	04000	SUBPROVIDER - IPF				940,046	0	40.00
41.00	04100	SUBPROVIDER - IRF				0	0	41.00
42.00	04200	SUBPROVIDER				331,434	0	42.00
43.00	04300	NURSERY				175,267	0	43.00
44.00	04400	SKILLED NURSING FACILITY				176,932	0	44.00
45.00	04500	NURSING FACILITY				880,472	0	45.00
46.00	04600	OTHER LONG TERM CARE				261,504	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				951,668	0	50.00
51.00	05100	RECOVERY ROOM				79,081	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				231,966	0	52.00
53.00	05300	ANESTHESIOLOGY				17,170	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				384,197	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC				861,944	0	55.00
56.00	05600	RADIOISOTOPE				14,585	0	56.00
57.00	05700	CT SCAN				34,209	0	57.00
58.00	05800	MRI				32,010	0	58.00
59.00	05900	CARDIAC CATHETERIZATION				140,335	0	59.00
60.00	06000	LABORATORY				296,160	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL				16,501	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				104,061	0	65.00
66.00	06600	PHYSICAL THERAPY				197,258	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				1,549	0	67.00
68.00	06800	SPEECH PATHOLOGY				3,778	0	68.00
69.00	06900	ELECTROCARDIOLOGY				66,343	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				105,562	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				80,970	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				210,918	0	73.00
74.00	07400	RENAL DIALYSIS				476,295	0	74.00
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION				0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY				0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC				314,429	0	90.00
90.01	09016	CLINIC-NOT USED				0	0	90.01
90.02	09001	PSYCH CLINIC				947,954	0	90.02
90.03	09002	PSYCH CLINIC FEE BASED				0	0	90.03
90.04	09003	WORKFIRST				0	0	90.04
90.05	09004	CANCER CLINIC				0	0	90.05
90.06	09005	PEDIATRIC CLINIC				6,711	0	90.06
90.07	09006	WOMENS CLINIC				19,442	0	90.07

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0027

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

Cost Center Description			INTERNS & RESIDENTS		PARAMETERED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
90.08	09007	THERAPEUTIC SCHOOL				1,955	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM				0	0	90.09
90.10	09017	CLINIC-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	CHILD DAY TREATMENT				0	0	90.13
90.14	09012	DIABETES CENTER				0	0	90.14
90.15	09013	WOUND CENTER				31,384	0	90.15
90.16	09014	MICA				120,220	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER				9,221	0	90.17
90.18	09018	CLINIC				1,621	0	90.18
91.00	09100	EMERGENCY				724,400	0	91.00
91.01	09101	PSYCH EMERGENCY				158,259	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM				0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES				0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM				0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	12,282,967	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES				113,857	0	192.00
193.00	19300	NONPAID WORKERS				0	0	193.00
194.00	07950	NON REIMBURSABLE				541,545	0	194.00
194.01	07951	RETAIL PHARMACY				47,164	0	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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0027

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

Cost Center Description		Total	
		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	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	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	12.00
13.00	01300	NURSING ADMINISTRATION	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	NURSING 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 & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
42.00	04200	SUBPROVIDER	42.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
45.00	04500	NURSING FACILITY	45.00
46.00	04600	OTHER LONG TERM CARE	46.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	78.00
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09016	CLINIC-NOT USED	90.01
90.02	09001	PSYCH CLINIC	90.02
90.03	09002	PSYCH CLINIC FEE BASED	90.03
90.04	09003	WORKFIRST	90.04
90.05	09004	CANCER CLINIC	90.05
90.06	09005	PEDIATRIC CLINIC	90.06
90.07	09006	WOMENS CLINIC	90.07
90.08	09007	THERAPEUTIC SCHOOL	90.08
90.09	09008	AFTER SCHOOL PROGRAM	90.09
90.10	09017	CLINIC-NOT USED	90.10
90.11	09009	PERINATAL ADDICTION	90.11
90.12	09010	THERAPEUTIC NURSERY	90.12
90.13	09011	CHILD DAY TREATMENT	90.13

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0027

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

Cost Center Description		Total	
		26.00	
90.14	09012 DIABETES CENTER	0	90.14
90.15	09013 WOUND CENTER	31,384	90.15
90.16	09014 MICA	120,220	90.16
90.17	09015 BAYONNE MENTAL HEALTH CENTER	9,221	90.17
90.18	09018 CLINIC	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 OPIOID TREATMENT PROGRAM	0	102.00
SPECIAL PURPOSE COST CENTERS			
113.00	11300 INTEREST EXPENSE		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	12,282,967	118.00
NONREIMBURSABLE COST CENTERS			
192.00	19200 PHYSICIANS PRIVATE OFFICES	113,857	192.00
193.00	19300 NONPAID 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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	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	00400	EMPLOYEE BENEFITS DEPARTMENT	4,679	4,679	167,779,724			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	117,702	117,702	20,330,519	-89,821,852	271,607,124	5.00
6.00	00600	MAINTENANCE & REPAIRS	12,972	12,972	347,089	0	3,014,154	6.00
7.00	00700	OPERATION OF PLANT	404,597	404,597	1,749,455	0	18,703,197	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,376	3,376	84,407	0	1,304,667	8.00
9.00	00900	HOUSEKEEPING	17,185	17,185	2,972,122	0	6,497,884	9.00
10.00	01000	DIETARY	14,671	14,671	1,348,072	0	4,065,900	10.00
11.00	01100	CAFETERIA	11,528	11,528	1,016,967	0	2,243,117	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,140	1,140	5,057,927	0	6,524,770	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	6,067	6,067	1,210,445	0	3,826,572	14.00
15.00	01500	PHARMACY	4,928	4,928	3,532,227	0	4,356,950	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,794	5,794	1,672,297	0	3,783,378	16.00
17.00	01700	SOCIAL SERVICE	1,176	1,176	1,096,345	0	2,301,751	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	9,440	9,440	2,983,080	1,641,774	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	5,715	5,715	4,012,012	0	4,962,218	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	10,570	10,570	1,499,472	0	2,330,868	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	88,291	88,291	19,084,953	0	21,717,614	30.00
31.00	03100	INTENSIVE CARE UNIT	16,094	16,094	5,052,184	0	7,659,458	31.00
40.00	04000	SUBPROVIDER - IPF	33,419	33,419	12,544,092	0	14,330,869	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	12,450	12,450	2,825,027	0	3,647,723	42.00
43.00	04300	NURSERY	7,152	7,152	1,087,434	0	1,628,061	43.00
44.00	04400	SKILLED NURSING FACILITY	7,618	7,618	296,530	0	456,447	44.00
45.00	04500	NURSING FACILITY	31,265	31,265	5,218,655	0	9,098,122	45.00
46.00	04600	OTHER LONG TERM CARE	10,410	10,410	2,317,697	0	3,178,732	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	36,996	36,996	5,832,976	0	11,266,615	50.00
51.00	05100	RECOVERY ROOM	2,898	2,898	1,315,947	0	1,647,631	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,475	8,475	4,350,879	0	4,481,746	52.00
53.00	05300	ANESTHESIOLOGY	549	549	0	0	542,726	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,124	15,124	3,320,170	0	5,520,817	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	35,794	35,794	5,612,459	0	6,764,533	55.00
56.00	05600	RADIOISOTOPE	408	408	343,154	0	713,800	56.00
57.00	05700	CT SCAN	1,103	1,103	756,430	0	1,330,325	57.00
58.00	05800	MRI	1,251	1,251	276,878	0	517,057	58.00
59.00	05900	CARDIAC CATHETERIZATION	5,473	5,473	1,007,562	0	1,904,048	59.00
60.00	06000	LABORATORY	10,712	10,712	247,037	0	9,563,313	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	722	722	0	0	14,367	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,164	3,164	2,832,215	0	4,467,518	65.00
66.00	06600	PHYSICAL THERAPY	8,020	8,020	1,552,715	0	2,074,804	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	156,326	0	219,562	67.00
68.00	06800	SPEECH PATHOLOGY	100	100	162,763	0	200,844	68.00
69.00	06900	ELECTROCARDIOLOGY	2,489	2,489	777,936	0	1,253,620	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	9,061,053	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6,949,662	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	14,617,585	73.00
74.00	07400	RENAL DIALYSIS	15,739	15,739	6,096,920	0	11,075,661	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	12,508	12,508	1,656,744	0	2,062,161	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	34,719	34,719	14,858,249	0	18,724,408	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0	0	90.03
90.04	09003	WORKFIRST	0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	0	0	811,949	0	800,665	90.06
90.07	09006	WOMENS CLINIC	0	0	1,902,080	0	2,353,259	90.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
90.08	09007	THERAPEUTIC SCHOOL	0	0	402,706	0	155,938	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09
90.10	09017	CLINIC-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	DIABETES CENTER	0	0	0	0	0	90.14
90.15	09013	WOUND CENTER	1,110	1,110	442,554	0	699,999	90.15
90.16	09014	MICA	5,270	5,270	0	0	65,288	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	0	968,923	0	1,148,589	90.17
90.18	09018	CLINIC	0	0	209,544	0	260,472	90.18
91.00	09100	EMERGENCY	25,086	25,086	9,141,556	0	13,413,369	91.00
91.01	09101	PSYCH EMERGENCY	5,324	5,324	3,683,498	0	3,717,791	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	INTEREST EXPENSE						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
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,890	3,890	1,720,546	0	4,592,953	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	NON REIMBURSABLE	23,623	23,623	0	0	784,170	194.00
194.01	07951	RETAIL PHARMACY	1,360	1,360	0	0	3,008,323	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, 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	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			57,966		1,465,264	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000345		0.005395	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
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	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	964,793					6.00
7.00	00700	OPERATION OF PLANT	404,597	560,196				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,376	3,376	556,820			8.00
9.00	00900	HOUSEKEEPING	17,185	17,185	17,185	539,635		9.00
10.00	01000	DIETARY	14,671	14,671	14,671	14,671	377,321	10.00
11.00	01100	CAFETERIA	11,528	11,528	11,528	11,528	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	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
15.00	01500	PHARMACY	4,928	4,928	4,928	4,928	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	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
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	9,440	9,440	9,440	9,440	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	5,715	5,715	5,715	5,715	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	10,570	10,570	10,570	10,570	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	88,291	88,291	88,291	88,291	116,986	30.00
31.00	03100	INTENSIVE CARE UNIT	16,094	16,094	16,094	16,094	11,045	31.00
40.00	04000	SUBPROVIDER - IPF	33,419	33,419	33,419	33,419	70,484	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	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
44.00	04400	SKILLED NURSING FACILITY	7,618	7,618	7,618	7,618	0	44.00
45.00	04500	NURSING FACILITY	31,265	31,265	31,265	31,265	107,546	45.00
46.00	04600	OTHER LONG TERM CARE	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
51.00	05100	RECOVERY ROOM	2,898	2,898	2,898	2,898	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,475	8,475	8,475	8,475	2,055	52.00
53.00	05300	ANESTHESIOLOGY	549	549	549	549	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,124	15,124	15,124	15,124	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	35,794	35,794	35,794	35,794	0	55.00
56.00	05600	RADIOISOTOPE	408	408	408	408	0	56.00
57.00	05700	CT SCAN	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
60.00	06000	LABORATORY	10,712	10,712	10,712	10,712	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	722	722	722	722	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	3,164	3,164	3,164	3,164	0	65.00
66.00	06600	PHYSICAL THERAPY	8,020	8,020	8,020	8,020	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	100	100	100	100	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,489	2,489	2,489	2,489	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	15,739	15,739	15,739	15,739	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	12,508	12,508	12,508	12,508	0	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	34,719	34,719	34,719	34,719	14,813	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0	0	90.03
90.04	09003	WORKFIRST	0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	0	0	0	0	0	90.06
90.07	09006	WOMENS CLINIC	0	0	0	0	0	90.07
90.08	09007	THERAPEUTIC SCHOOL	0	0	0	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09
90.10	09017	CLINIC-NOT USED	0	0	0	0	0	90.10
90.11	09009	PERINATAL ADDICTION	0	0	0	0	0	90.11

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (SQUARE FEET)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
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	DIABETES CENTER	0	0	0	0	0	90.14
90.15	09013	WOUND CENTER	1,110	1,110	1,110	1,110	0	90.15
90.16	09014	MICA	5,270	5,270	5,270	5,270	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	0	0	0	0	90.17
90.18	09018	CLINIC	0	0	0	0	0	90.18
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
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	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	935,920	531,323	527,947	510,762	377,321	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	3,890	3,890	3,890	3,890	0	192.00
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	NON REIMBURSABLE	23,623	23,623	23,623	23,623	0	194.00
194.01	07951	RETAIL PHARMACY	1,360	1,360	1,360	1,360	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, Part I)	4,010,950	26,570,475	1,910,288	9,592,263	6,478,476	202.00
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, Part II)	177,086	5,188,173	80,778	413,783	356,098	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.183548	9.261353	0.145070	0.766783	0.943753	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description			CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
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	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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	204,504					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	6,999	0	910,729			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,196	0	1,635	26,132,327		14.00
15.00	01500	PHARMACY	4,843	0	0	262,567	16,046,167	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,197	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,477	0	10,295	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	3,925	0	292	21,650	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	8,141	0	0	886	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	24,644	0	225,942	791,561	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,446	0	71,302	387,249	0	31.00
40.00	04000	SUBPROVIDER - IPF	16,483	0	88,887	156,830	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	4,129	0	21,304	66,259	0	42.00
43.00	04300	NURSERY	1,206	0	17,940	62,386	0	43.00
44.00	04400	SKILLED NURSING FACILITY	694	0	2,027	138	0	44.00
45.00	04500	NURSING FACILITY	9,479	0	35,752	205,051	11,706	45.00
46.00	04600	OTHER LONG TERM CARE	4,867	0	2,862	1,874	0	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,638	0	73,530	4,370,092	0	50.00
51.00	05100	RECOVERY ROOM	1,593	0	19,976	15,783	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,564	0	49,980	237,186	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	280,585	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,053	0	4,529	339,093	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,542	0	15,885	105,568	0	55.00
56.00	05600	RADIOISOTOPE	379	0	0	131,975	0	56.00
57.00	05700	CT SCAN	985	0	0	57,729	0	57.00
58.00	05800	MRI	423	0	0	16,359	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,349	0	8,092	443,624	0	59.00
60.00	06000	LABORATORY	363	0	3,620	9,167	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	3,972	0	0	268,513	0	65.00
66.00	06600	PHYSICAL THERAPY	2,093	0	1,950	22,976	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	230	0	0	118	0	67.00
68.00	06800	SPEECH PATHOLOGY	266	0	0	889	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,679	0	3,458	26,942	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,060,466	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,949,662	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	14,617,585	73.00
74.00	07400	RENAL DIALYSIS	9,090	0	69,432	853,490	1,416,876	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,404	0	11,164	16,130	0	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	26,902	0	23,764	18,387	0	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0	0	90.03
90.04	09003	WORKFIRST	0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	1,017	0	8,846	6,829	0	90.06
90.07	09006	WOMENS CLINIC	3,615	0	13,392	27,525	0	90.07
90.08	09007	THERAPEUTIC SCHOOL	601	0	2,115	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description		CAFETERIA (MEALS SERVED)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
		11.00	12.00	13.00	14.00	15.00	
90.10	09017	CLINIC-NOT USED	0	0	0	0	90.10
90.11	09009	PERINATAL ADDICTION	0	0	0	0	90.11
90.12	09010	THERAPEUTIC NURSERY	0	0	0	0	90.12
90.13	09011	CHILD DAY TREATMENT	0	0	0	0	90.13
90.14	09012	DIABETES CENTER	0	0	0	0	90.14
90.15	09013	WOUND CENTER	716	0	4,979	135,986	90.15
90.16	09014	MICA	0	0	0	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	1,840	0	2,714	713	90.17
90.18	09018	CLINIC	107	0	0	0	90.18
91.00	09100	EMERGENCY	14,429	0	100,985	750,939	91.00
91.01	09101	PSYCH EMERGENCY	4,928	0	14,080	28,557	91.01
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	0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	204,504	0	910,729	26,131,734	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	593	0	192.00
193.00	19300	NONPAID 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					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,824,099	0	8,896,406	5,609,414	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.699385	0.000000	9.768445	0.214654	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	274,661	0	72,275	163,481	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.343059	0.000000	0.079360	0.006256	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
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	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	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	100					16.00
17.00	01700	SOCIAL SERVICE	0	100				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING PROGRAM	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			100	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	54	100	0	0	72	30.00
31.00	03100	INTENSIVE CARE UNIT	8	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	1	0	0	0	22	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
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	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	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	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	13	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	8	0	0	0	6	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	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	WORKFIRST	0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	0	0	0	0	0	90.06
90.07	09006	WOMENS CLINIC	0	0	0	0	0	90.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
90.08	09007	THERAPEUTIC SCHOOL	0	0	0	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09
90.10	09017	CLINIC-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	DIABETES CENTER	0	0	0	0	0	90.14
90.15	09013	WOUND CENTER	0	0	0	0	0	90.15
90.16	09014	MICA	0	0	0	0	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	0	0	0	0	90.17
90.18	09018	CLINIC	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						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	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	0	0	100	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
193.00	19300	NONPAID 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						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,534,810	3,276,743	0	-873,703	7,019,267	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, Part II)	158,412	42,346	0	221,175	158,145	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1,584.120000	423.460000	0.000000	0.000000	1,581.450000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023Worksheet B-1
Date/Time Prepared:
5/30/2024 10:12 am

	Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	
		SERVICES-OTHER		
		PRGM COSTS		
		APPRV (ASSIGNED TIME)		
		22.00	23.00	
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	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	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		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	NURSING PROGRAM		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	100	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED PRGM-(SPECIFY)	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	72	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	22	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
45.00	04500	NURSING FACILITY	0	45.00
46.00	04600	OTHER LONG TERM CARE	0	46.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	6	90.00
90.01	09016	CLINIC-NOT USED	0	90.01
90.02	09001	PSYCH CLINIC	0	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	90.03
90.04	09003	WORKFIRST	0	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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet B-1

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description			INTERNS & RESIDENTS	PARAMETERED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPROV (ASSIGNED TIME)		
			22.00	23.00	
90.08	09007	THERAPEUTIC SCHOOL	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	90.09
90.10	09017	CLINIC-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	CHILD DAY TREATMENT	0	0	90.13
90.14	09012	DIABETES CENTER	0	0	90.14
90.15	09013	WOUND CENTER	0	0	90.15
90.16	09014	MICA	0	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	0	90.17
90.18	09018	CLINIC	0	0	90.18
91.00	09100	EMERGENCY	0	0	91.00
91.01	09101	PSYCH EMERGENCY	0	0	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	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	0	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	NON REIMBURSABLE	0	0	194.00
194.01	07951	RETAIL PHARMACY	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, Part I)	4,023,555	0	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, Part II)	264,451	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2,644.510000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0027

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

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (From Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	46,438,821		46,438,821	0	46,438,821	30.00
31.00	03100	INTENSIVE CARE UNIT	12,896,623		12,896,623	0	12,896,623	31.00
40.00	04000	SUBPROVIDER - IPF	23,978,576		23,978,576	0	23,978,576	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	6,422,803		6,422,803	0	6,422,803	42.00
43.00	04300	NURSERY	2,898,280		2,898,280	0	2,898,280	43.00
44.00	04400	SKILLED NURSING FACILITY	1,194,749		1,194,749	0	1,194,749	44.00
45.00	04500	NURSING FACILITY	16,804,461		16,804,461	0	16,804,461	45.00
46.00	04600	OTHER LONG TERM CARE	5,107,112		5,107,112	0	5,107,112	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,550,965		19,550,965	8,739	19,559,704	50.00
51.00	05100	RECOVERY ROOM	2,631,778		2,631,778	0	2,631,778	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,240,580		7,240,580	0	7,240,580	52.00
53.00	05300	ANESTHESIOLOGY	822,400		822,400	0	822,400	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,659,035		8,659,035	16,687	8,675,722	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,888,658		11,888,658	0	11,888,658	55.00
56.00	05600	RADIOISOTOPE	1,014,973		1,014,973	0	1,014,973	56.00
57.00	05700	CT SCAN	1,881,373		1,881,373	0	1,881,373	57.00
58.00	05800	MRI	790,538		790,538	0	790,538	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,131,625		3,131,625	0	3,131,625	59.00
60.00	06000	LABORATORY	13,549,837		13,549,837	13,841	13,563,678	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	71,676		71,676	0	71,676	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	6,307,182	0	6,307,182	0	6,307,182	65.00
66.00	06600	PHYSICAL THERAPY	3,407,879	0	3,407,879	0	3,407,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	296,498	0	296,498	0	296,498	67.00
68.00	06800	SPEECH PATHOLOGY	279,709	0	279,709	0	279,709	68.00
69.00	06900	ELECTROCARDIOLOGY	1,920,341		1,920,341	0	1,920,341	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,002,458		14,002,458	0	14,002,458	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,739,723		10,739,723	0	10,739,723	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,193,964		25,193,964	0	25,193,964	73.00
74.00	07400	RENAL DIALYSIS	18,191,690		18,191,690	75,279	18,266,969	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIpsy	0		0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,273,593		4,273,593	0	4,273,593	90.00
90.01	09016	CLINIC-NOT USED	0		0	0	0	90.01
90.02	09001	PSYCH CLINIC	28,437,475		28,437,475	194,026	28,631,501	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0		0	0	0	90.03
90.04	09003	WORKFIRST	0		0	0	0	90.04
90.05	09004	CANCER CLINIC	0		0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	1,172,344		1,172,344	0	1,172,344	90.06
90.07	09006	WOMENS CLINIC	3,335,819		3,335,819	0	3,335,819	90.07
90.08	09007	THERAPEUTIC SCHOOL	239,405		239,405	0	239,405	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0		0	0	0	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
90.12	09010	THERAPEUTIC NURSERY	0		0	0	0	90.12
90.13	09011	CHILD DAY TREATMENT	0		0	0	0	90.13
90.14	09012	DIABETES CENTER	0		0	0	0	90.14
90.15	09013	WOUND CENTER	1,103,510		1,103,510	0	1,103,510	90.15
90.16	09014	MICA	470,505		470,505	0	470,505	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	1,589,505		1,589,505	0	1,589,505	90.17
90.18	09018	CLINIC	348,612		348,612	0	348,612	90.18
91.00	09100	EMERGENCY	22,225,137		22,225,137	0	22,225,137	91.00
91.01	09101	PSYCH EMERGENCY	5,847,402		5,847,402	0	5,847,402	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,548,384		5,548,384	0	5,548,384	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	341,905,998	0	341,905,998	308,572	342,214,570	200.00
201.00		Less Observation Beds	5,548,384		5,548,384		5,548,384	201.00
202.00		Total (see instructions)	336,357,614	0	336,357,614	308,572	336,666,186	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0027

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

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	186,974,568		186,974,568		30.00
31.00	03100	INTENSIVE CARE UNIT	73,857,962		73,857,962		31.00
40.00	04000	SUBPROVIDER - IPF	100,767,772		100,767,772		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	11,098,076		11,098,076		42.00
43.00	04300	NURSERY	23,694,120		23,694,120		43.00
44.00	04400	SKILLED NURSING FACILITY	1,122,409		1,122,409		44.00
45.00	04500	NURSING FACILITY	7,135,927		7,135,927		45.00
46.00	04600	OTHER LONG TERM CARE	4,285,995		4,285,995		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23,833,277	85,087,425	108,920,702	0.179497	0.000000
51.00	05100	RECOVERY ROOM	2,621,235	6,965,415	9,586,650	0.274525	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,760,217	1,342,336	11,102,553	0.652155	0.000000
53.00	05300	ANESTHESIOLOGY	2,926,973	3,853,391	6,780,364	0.121291	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,701,307	35,497,953	46,199,260	0.187428	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	584,577	14,353,277	14,937,854	0.795875	0.000000
56.00	05600	RADIOISOTOPE	2,792,004	16,320,452	19,112,456	0.053105	0.000000
57.00	05700	CT SCAN	22,935,668	48,617,334	71,553,002	0.026293	0.000000
58.00	05800	MRI	5,953,817	6,698,182	12,651,999	0.062483	0.000000
59.00	05900	CARDIAC CATHETERIZATION	9,269,226	8,237,528	17,506,754	0.178881	0.000000
60.00	06000	LABORATORY	47,377,798	73,680,633	121,058,431	0.111928	0.000000
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,612,466	6,853,363	14,465,829	0.004955	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	9,975,983	7,501,336	17,477,319	0.360878	0.000000
66.00	06600	PHYSICAL THERAPY	3,048,077	5,522,991	8,571,068	0.397603	0.000000
67.00	06700	OCCUPATIONAL THERAPY	1,345,949	840,463	2,186,412	0.135609	0.000000
68.00	06800	SPEECH PATHOLOGY	1,136,933	111,941	1,248,874	0.223969	0.000000
69.00	06900	ELECTROCARDIOLOGY	25,270,743	17,236,535	42,507,278	0.045177	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,223,625	18,415,418	28,639,043	0.488929	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,958,023	9,749,541	15,707,564	0.683729	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	42,513,329	103,489,218	146,002,547	0.172558	0.000000
74.00	07400	RENAL DIALYSIS	2,123,118	56,597,545	58,720,663	0.309800	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	837,132	837,132	5.105041	0.000000
90.01	09016	CLINIC-NOT USED	0	0	0	0.000000	0.000000
90.02	09001	PSYCH CLINIC	0	26,356,648	26,356,648	1.078949	0.000000
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0.000000	0.000000
90.04	09003	WORKFIRST	0	0	0	0.000000	0.000000
90.05	09004	CANCER CLINIC	0	0	0	0.000000	0.000000
90.06	09005	PEDIATRIC CLINIC	0	746,405	746,405	1.570654	0.000000
90.07	09006	WOMENS CLINIC	0	18,558,723	18,558,723	0.179744	0.000000
90.08	09007	THERAPEUTIC SCHOOL	0	916,100	916,100	0.261331	0.000000
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0.000000	0.000000
90.10	09017	CLINIC-NOT USED	0	0	0	0.000000	0.000000
90.11	09009	PERINATAL ADDICTION	0	0	0	0.000000	0.000000
90.12	09010	THERAPEUTIC NURSERY	0	0	0	0.000000	0.000000
90.13	09011	CHILD DAY TREATMENT	0	0	0	0.000000	0.000000
90.14	09012	DIABETES CENTER	0	0	0	0.000000	0.000000
90.15	09013	WOUND CENTER	0	7,629,736	7,629,736	0.144633	0.000000
90.16	09014	MICA	0	0	0	0.000000	0.000000
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	2,369,779	2,369,779	0.670740	0.000000
90.18	09018	CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	26,345,025	133,282,234	159,627,259	0.139231	0.000000
91.01	09101	PSYCH EMERGENCY	309,197	947,146	1,256,343	4.654304	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	501,450	29,235,394	29,736,844	0.186583	0.000000
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0.000000	0.000000
SPECIAL PURPOSE COST CENTERS							
113.00	11300	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

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/30/2024 10:12 am
			Title XVIII	Hospital	PPS
Cost Center Description		PPS Inpatient Ratio			
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
46.00	04600	OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.179577		50.00
51.00	05100	RECOVERY ROOM	0.274525		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.652155		52.00
53.00	05300	ANESTHESIOLOGY	0.121291		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187789		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.795875		55.00
56.00	05600	RADIOISOTOPE	0.053105		56.00
57.00	05700	CT SCAN	0.026293		57.00
58.00	05800	MRI	0.062483		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.178881		59.00
60.00	06000	LABORATORY	0.112042		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.004955		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.360878		65.00
66.00	06600	PHYSICAL THERAPY	0.397603		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.135609		67.00
68.00	06800	SPEECH PATHOLOGY	0.223969		68.00
69.00	06900	ELECTROCARDIOLOGY	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		73.00
74.00	07400	RENAL DIALYSIS	0.311082		74.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIpsy	0.000000		76.99
77.00	07700	ALLOGENEI C 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		90.00
90.01	09016	CLINIC-NOT USED	0.000000		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	WORKFIRST	0.000000		90.04
90.05	09004	CANCER CLINIC	0.000000		90.05
90.06	09005	PEDIATRIC CLINIC	1.570654		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	CLINIC-NOT USED	0.000000		90.10
90.11	09009	PERINATAL ADDICTION	0.000000		90.11
90.12	09010	THERAPEUTIC NURSERY	0.000000		90.12
90.13	09011	CHILD DAY TREATMENT	0.000000		90.13
90.14	09012	DIABETES CENTER	0.000000		90.14
90.15	09013	WOUND CENTER	0.144633		90.15
90.16	09014	MICA	0.000000		90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0.670740		90.17
90.18	09018	CLINIC	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		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		93.99
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
102.00	10200	OPIOID TREATMENT PROGRAM			102.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0027

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

			Title XIX		Hospital		TEFRA	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	46,438,821		46,438,821	0	46,438,821	30.00
31.00	03100	INTENSIVE CARE UNIT	12,896,623		12,896,623	0	12,896,623	31.00
40.00	04000	SUBPROVIDER - IPF	23,978,576		23,978,576	0	23,978,576	40.00
41.00	04100	SUBPROVIDER - IRF	0		0	0	0	41.00
42.00	04200	SUBPROVIDER	6,422,803		6,422,803	0	6,422,803	42.00
43.00	04300	NURSERY	2,898,280		2,898,280	0	2,898,280	43.00
44.00	04400	SKILLED NURSING FACILITY	1,194,749		1,194,749	0	1,194,749	44.00
45.00	04500	NURSING FACILITY	16,804,461		16,804,461	0	16,804,461	45.00
46.00	04600	OTHER LONG TERM CARE	5,107,112		5,107,112	0	5,107,112	46.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	19,550,965		19,550,965	8,739	19,559,704	50.00
51.00	05100	RECOVERY ROOM	2,631,778		2,631,778	0	2,631,778	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,240,580		7,240,580	0	7,240,580	52.00
53.00	05300	ANESTHESIOLOGY	822,400		822,400	0	822,400	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,659,035		8,659,035	16,687	8,675,722	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,888,658		11,888,658	0	11,888,658	55.00
56.00	05600	RADIOISOTOPE	1,014,973		1,014,973	0	1,014,973	56.00
57.00	05700	CT SCAN	1,881,373		1,881,373	0	1,881,373	57.00
58.00	05800	MRI	790,538		790,538	0	790,538	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,131,625		3,131,625	0	3,131,625	59.00
60.00	06000	LABORATORY	13,549,837		13,549,837	13,841	13,563,678	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	71,676		71,676	0	71,676	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	6,307,182	0	6,307,182	0	6,307,182	65.00
66.00	06600	PHYSICAL THERAPY	3,407,879	0	3,407,879	0	3,407,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	296,498	0	296,498	0	296,498	67.00
68.00	06800	SPEECH PATHOLOGY	279,709	0	279,709	0	279,709	68.00
69.00	06900	ELECTROCARDIOLOGY	1,920,341		1,920,341	0	1,920,341	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,002,458		14,002,458	0	14,002,458	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,739,723		10,739,723	0	10,739,723	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,193,964		25,193,964	0	25,193,964	73.00
74.00	07400	RENAL DIALYSIS	18,191,690		18,191,690	75,279	18,266,969	74.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,273,593		4,273,593	0	4,273,593	90.00
90.01	09016	CLINIC-NOT USED	0		0	0	0	90.01
90.02	09001	PSYCH CLINIC	28,437,475		28,437,475	194,026	28,631,501	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0		0	0	0	90.03
90.04	09003	WORKFIRST	0		0	0	0	90.04
90.05	09004	CANCER CLINIC	0		0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	1,172,344		1,172,344	0	1,172,344	90.06
90.07	09006	WOMENS CLINIC	3,335,819		3,335,819	0	3,335,819	90.07
90.08	09007	THERAPEUTIC SCHOOL	239,405		239,405	0	239,405	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0		0	0	0	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
90.12	09010	THERAPEUTIC NURSERY	0		0	0	0	90.12
90.13	09011	CHILD DAY TREATMENT	0		0	0	0	90.13
90.14	09012	DIABETES CENTER	0		0	0	0	90.14
90.15	09013	WOUND CENTER	1,103,510		1,103,510	0	1,103,510	90.15
90.16	09014	MICA	470,505		470,505	0	470,505	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	1,589,505		1,589,505	0	1,589,505	90.17
90.18	09018	CLINIC	348,612		348,612	0	348,612	90.18
91.00	09100	EMERGENCY	22,225,137		22,225,137	0	22,225,137	91.00
91.01	09101	PSYCH EMERGENCY	5,847,402		5,847,402	0	5,847,402	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,548,384		5,548,384	0	5,548,384	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0		0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0		0	0	0	95.00
102.00	10200	OPIOID TREATMENT PROGRAM	0		0	0	0	102.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	341,905,998	0	341,905,998	308,572	342,214,570	200.00
201.00		Less Observation Beds	5,548,384		5,548,384		5,548,384	201.00
202.00		Total (see instructions)	336,357,614	0	336,357,614	308,572	336,666,186	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0027

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

			Title XIX		Hospital	TEFRA	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	186,974,568		186,974,568		30.00
31.00	03100	INTENSIVE CARE UNIT	73,857,962		73,857,962		31.00
40.00	04000	SUBPROVIDER - IPF	100,767,772		100,767,772		40.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	11,098,076		11,098,076		42.00
43.00	04300	NURSERY	23,694,120		23,694,120		43.00
44.00	04400	SKILLED NURSING FACILITY	1,122,409		1,122,409		44.00
45.00	04500	NURSING FACILITY	7,135,927		7,135,927		45.00
46.00	04600	OTHER LONG TERM CARE	4,285,995		4,285,995		46.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23,833,277	85,087,425	108,920,702	0.179497	0.179497
51.00	05100	RECOVERY ROOM	2,621,235	6,965,415	9,586,650	0.274525	0.274525
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,760,217	1,342,336	11,102,553	0.652155	0.652155
53.00	05300	ANESTHESIOLOGY	2,926,973	3,853,391	6,780,364	0.121291	0.121291
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,701,307	35,497,953	46,199,260	0.187428	0.187428
55.00	05500	RADIOLOGY-THERAPEUTIC	584,577	14,353,277	14,937,854	0.795875	0.795875
56.00	05600	RADIOISOTOPE	2,792,004	16,320,452	19,112,456	0.053105	0.053105
57.00	05700	CT SCAN	22,935,668	48,617,334	71,553,002	0.026293	0.026293
58.00	05800	MRI	5,953,817	6,698,182	12,651,999	0.062483	0.062483
59.00	05900	CARDIAC CATHETERIZATION	9,269,226	8,237,528	17,506,754	0.178881	0.178881
60.00	06000	LABORATORY	47,377,798	73,680,633	121,058,431	0.111928	0.111928
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,612,466	6,853,363	14,465,829	0.004955	0.004955
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	9,975,983	7,501,336	17,477,319	0.360878	0.360878
66.00	06600	PHYSICAL THERAPY	3,048,077	5,522,991	8,571,068	0.397603	0.397603
67.00	06700	OCCUPATIONAL THERAPY	1,345,949	840,463	2,186,412	0.135609	0.135609
68.00	06800	SPEECH PATHOLOGY	1,136,933	111,941	1,248,874	0.223969	0.223969
69.00	06900	ELECTROCARDIOLOGY	25,270,743	17,236,535	42,507,278	0.045177	0.045177
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,223,625	18,415,418	28,639,043	0.488929	0.488929
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,958,023	9,749,541	15,707,564	0.683729	0.683729
73.00	07300	DRUGS CHARGED TO PATIENTS	42,513,329	103,489,218	146,002,547	0.172558	0.172558
74.00	07400	RENAL DIALYSIS	2,123,118	56,597,545	58,720,663	0.309800	0.309800
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	837,132	837,132	5.105041	5.105041
90.01	09016	CLINIC-NOT USED	0	0	0	0.000000	0.000000
90.02	09001	PSYCH CLINIC	0	26,356,648	26,356,648	1.078949	1.078949
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0.000000	0.000000
90.04	09003	WORKFIRST	0	0	0	0.000000	0.000000
90.05	09004	CANCER CLINIC	0	0	0	0.000000	0.000000
90.06	09005	PEDIATRIC CLINIC	0	746,405	746,405	1.570654	1.570654
90.07	09006	WOMENS CLINIC	0	18,558,723	18,558,723	0.179744	0.179744
90.08	09007	THERAPEUTIC SCHOOL	0	916,100	916,100	0.261331	0.261331
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0.000000	0.000000
90.10	09017	CLINIC-NOT USED	0	0	0	0.000000	0.000000
90.11	09009	PERINATAL ADDICTION	0	0	0	0.000000	0.000000
90.12	09010	THERAPEUTIC NURSERY	0	0	0	0.000000	0.000000
90.13	09011	CHILD DAY TREATMENT	0	0	0	0.000000	0.000000
90.14	09012	DIABETES CENTER	0	0	0	0.000000	0.000000
90.15	09013	WOUND CENTER	0	7,629,736	7,629,736	0.144633	0.144633
90.16	09014	MICA	0	0	0	0.000000	0.000000
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	2,369,779	2,369,779	0.670740	0.670740
90.18	09018	CLINIC	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	26,345,025	133,282,234	159,627,259	0.139231	0.139231
91.01	09101	PSYCH EMERGENCY	309,197	947,146	1,256,343	4.654304	4.654304
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	501,450	29,235,394	29,736,844	0.186583	0.186583
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0.000000	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0		
SPECIAL PURPOSE COST CENTERS							
113.00	11300	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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0027

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

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	TEFRA
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
45.00	04500	NURSING FACILITY				45.00
46.00	04600	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			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	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000			62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			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	0.000000			90.00
90.01	09016	CLINIC-NOT USED	0.000000			90.01
90.02	09001	PSYCH CLINIC	0.000000			90.02
90.03	09002	PSYCH CLINIC FEE BASED	0.000000			90.03
90.04	09003	WORKFIRST	0.000000			90.04
90.05	09004	CANCER CLINIC	0.000000			90.05
90.06	09005	PEDIATRIC CLINIC	0.000000			90.06
90.07	09006	WOMENS CLINIC	0.000000			90.07
90.08	09007	THERAPEUTIC SCHOOL	0.000000			90.08
90.09	09008	AFTER SCHOOL PROGRAM	0.000000			90.09
90.10	09017	CLINIC-NOT USED	0.000000			90.10
90.11	09009	PERINATAL ADDICTION	0.000000			90.11
90.12	09010	THERAPEUTIC NURSERY	0.000000			90.12
90.13	09011	CHILD DAY TREATMENT	0.000000			90.13
90.14	09012	DIABETES CENTER	0.000000			90.14
90.15	09013	WOUND CENTER	0.000000			90.15
90.16	09014	MICA	0.000000			90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0.000000			90.17
90.18	09018	CLINIC	0.000000			90.18
91.00	09100	EMERGENCY	0.000000			91.00
91.01	09101	PSYCH EMERGENCY	0.000000			91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000			93.99
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
102.00	10200	OPIOID TREATMENT PROGRAM				102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 31-0027

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

			Title XIX		Hospital		TEFRA	
Cost Center Description			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	19,550,965	951,668	18,599,297	95,167	1,078,759	50.00
51.00	05100	RECOVERY ROOM	2,631,778	79,081	2,552,697	7,908	148,056	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,240,580	231,966	7,008,614	23,197	406,500	52.00
53.00	05300	ANESTHESIOLOGY	822,400	17,170	805,230	1,717	46,703	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,659,035	384,197	8,274,838	38,420	479,941	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	11,888,658	861,944	11,026,714	86,194	639,549	55.00
56.00	05600	RADIOISOTOPE	1,014,973	14,585	1,000,388	1,459	58,023	56.00
57.00	05700	CT SCAN	1,881,373	34,209	1,847,164	3,421	107,136	57.00
58.00	05800	MRI	790,538	32,010	758,528	3,201	43,995	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,131,625	140,335	2,991,290	14,034	173,495	59.00
60.00	06000	LABORATORY	13,549,837	296,160	13,253,677	29,616	768,713	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	71,676	16,501	55,175	1,650	3,200	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	6,307,182	104,061	6,203,121	10,406	359,781	65.00
66.00	06600	PHYSICAL THERAPY	3,407,879	197,258	3,210,621	19,726	186,216	66.00
67.00	06700	OCCUPATIONAL THERAPY	296,498	1,549	294,949	155	17,107	67.00
68.00	06800	SPEECH PATHOLOGY	279,709	3,778	275,931	378	16,004	68.00
69.00	06900	ELECTROCARDIOLOGY	1,920,341	66,343	1,853,998	6,634	107,532	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,002,458	105,562	13,896,896	10,556	806,020	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,739,723	80,970	10,658,753	8,097	618,208	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	25,193,964	210,918	24,983,046	21,092	1,449,017	73.00
74.00	07400	RENAL DIALYSIS	18,191,690	476,295	17,715,395	47,630	1,027,493	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,273,593	314,429	3,959,164	31,443	229,632	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	28,437,475	947,954	27,489,521	94,795	1,594,392	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0	0	90.03
90.04	09003	WORKFIRST	0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	1,172,344	6,711	1,165,633	671	67,607	90.06
90.07	09006	WOMENS CLINIC	3,335,819	19,442	3,316,377	1,944	192,350	90.07
90.08	09007	THERAPEUTIC SCHOOL	239,405	1,955	237,450	196	13,772	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09
90.10	09017	CLINIC-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	DIABETES CENTER	0	0	0	0	0	90.14
90.15	09013	WOUND CENTER	1,103,510	31,384	1,072,126	3,138	62,183	90.15
90.16	09014	MICA	470,505	120,220	350,285	12,022	20,317	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	1,589,505	9,221	1,580,284	922	91,656	90.17
90.18	09018	CLINIC	348,612	1,621	346,991	162	20,125	90.18
91.00	09100	EMERGENCY	22,225,137	724,400	21,500,737	72,440	1,247,043	91.00
91.01	09101	PSYCH EMERGENCY	5,847,402	158,259	5,689,143	15,826	329,970	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,548,384	289,875	5,258,509	28,988	304,994	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	INTEREST EXPENSE						113.00
200.00		Subtotal (sum of lines 50 thru 199)	226,164,573	6,932,031	219,232,542	693,205	12,715,489	200.00
201.00		Less Observation Beds	5,548,384	289,875	5,258,509	28,988	304,994	201.00
202.00		Total (line 200 minus line 201)	220,616,189	6,642,156	213,974,033	664,217	12,410,495	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
REDUCTIONS FOR MEDICAID ONLY

Provider CCN: 31-0027

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

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	TEFRA
		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	11,102,553	0.613452		52.00
53.00	05300 ANESTHESIOLOGY	773,980	6,780,364	0.114150		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	8,140,674	46,199,260	0.176208		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	11,162,915	14,937,854	0.747290		55.00
56.00	05600 RADIOISOTOPE	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	12,651,999	0.058753		58.00
59.00	05900 CARDIAC CATHETERIZATION	2,944,096	17,506,754	0.168169		59.00
60.00	06000 LABORATORY	12,751,508	121,058,431	0.105333		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 PHYSICAL THERAPY	3,201,937	8,571,068	0.373575		66.00
67.00	06700 OCCUPATIONAL THERAPY	279,236	2,186,412	0.127714		67.00
68.00	06800 SPEECH PATHOLOGY	263,327	1,248,874	0.210852		68.00
69.00	06900 ELECTROCARDIOLOGY	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	15,707,564	0.643857		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	23,723,855	146,002,547	0.162489		73.00
74.00	07400 RENAL DIALYSIS	17,116,567	58,720,663	0.291491		74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000		76.97
76.98	07698 HYPERBARIC 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	0	0.000000		78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	4,012,518	837,132	4.793172		90.00
90.01	09016 CLINIC-NOT USED	0	0	0.000000		90.01
90.02	09001 PSYCH CLINIC	26,748,288	26,356,648	1.014859		90.02
90.03	09002 PSYCH CLINIC FEE BASED	0	0	0.000000		90.03
90.04	09003 WORKFIRST	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	18,558,723	0.169275		90.07
90.08	09007 THERAPEUTIC SCHOOL	225,437	916,100	0.246083		90.08
90.09	09008 AFTER SCHOOL PROGRAM	0	0	0.000000		90.09
90.10	09017 CLINIC-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	0.000000		90.13
90.14	09012 DIABETES CENTER	0	0	0.000000		90.14
90.15	09013 WOUND CENTER	1,038,189	7,629,736	0.136071		90.15
90.16	09014 MICA	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 CLINIC	328,325	0	0.000000		90.18
91.00	09100 EMERGENCY	20,905,654	159,627,259	0.130965		91.00
91.01	09101 PSYCH EMERGENCY	5,501,606	1,256,343	4.379064		91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	5,214,402	29,736,844	0.175352		92.00
93.99	09399 PARTIAL HOSPITALIZATION 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	0	0.000000		102.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (sum of lines 50 thru 199)	212,755,879	1,022,971,591			200.00
201.00	Less Observation Beds	5,214,402	0			201.00
202.00	Total (line 200 minus line 201)	207,541,477	1,022,971,591			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 31-0027

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

			Title VIII		Hospital	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)	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 & PEDIATRICS	2,426,189	0	2,426,189	38,702	62.69	30.00
31.00	INTENSIVE CARE UNIT	448,967		448,967	5,602	80.14	31.00
40.00	SUBPROVIDER - IPF	940,046	0	940,046	19,391	48.48	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	331,434	0	331,434	6,808	48.68	42.00
43.00	NURSERY	175,267		175,267	3,332	52.60	43.00
44.00	SKILLED NURSING FACILITY	176,932		176,932	4,311	41.04	44.00
45.00	NURSING FACILITY	880,472		880,472	27,408	32.12	45.00
200.00	Total (lines 30 through 199)	5,379,307		5,379,307	105,554		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	7,028	440,585				
31.00	INTENSIVE CARE UNIT	1,409	112,917				
40.00	SUBPROVIDER - IPF	2,238	108,498				
41.00	SUBPROVIDER - IRF	0	0				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	2,325	95,418				
45.00	NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	13,000	757,418				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/30/2024 10:12 am	
				Title XVIII		Hospital	PPS
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	951,668	108,920,702	0.008737	11,218,355	98,015	50.00
51.00	05100 RECOVERY ROOM	79,081	9,586,650	0.008249	1,190,712	9,822	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	231,966	11,102,553	0.020893	31,330	655	52.00
53.00	05300 ANESTHESIOLOGY	17,170	6,780,364	0.002532	600,422	1,520	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	384,197	46,199,260	0.008316	5,084,841	42,286	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	861,944	14,937,854	0.057702	97,797	5,643	55.00
56.00	05600 RADIOISOTOPE	14,585	19,112,456	0.000763	870,673	664	56.00
57.00	05700 CT SCAN	34,209	71,553,002	0.000478	10,760,600	5,144	57.00
58.00	05800 MRI	32,010	12,651,999	0.002530	2,608,982	6,601	58.00
59.00	05900 CARDIAC CATHETERIZATION	140,335	17,506,754	0.008016	3,516,803	28,191	59.00
60.00	06000 LABORATORY	296,160	121,058,431	0.002446	20,275,152	49,593	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	16,501	14,465,829	0.001141	1,103,312	1,259	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	104,061	17,477,319	0.005954	5,590,823	33,288	65.00
66.00	06600 PHYSICAL THERAPY	197,258	8,571,068	0.023014	1,300,980	29,941	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,549	2,186,412	0.000708	153,139	108	67.00
68.00	06800 SPEECH PATHOLOGY	3,778	1,248,874	0.003025	542,234	1,640	68.00
69.00	06900 ELECTROCARDIOLOGY	66,343	42,507,278	0.001561	13,585,698	21,207	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	105,562	28,639,043	0.003686	4,373,413	16,120	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	80,970	15,707,564	0.005155	2,533,006	13,058	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	210,918	146,002,547	0.001445	17,044,041	24,629	73.00
74.00	07400 RENAL DIALYSIS	476,295	58,720,663	0.008111	1,392,763	11,297	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	314,429	837,132	0.375603	0	0	90.00
90.01	09016 CLINIC-NOT USED	0	0	0.000000	0	0	90.01
90.02	09001 PSYCH CLINIC	947,954	26,356,648	0.035966	0	0	90.02
90.03	09002 PSYCH CLINIC FEE BASED	0	0	0.000000	0	0	90.03
90.04	09003 WORKFIRST	0	0	0.000000	0	0	90.04
90.05	09004 CANCER CLINIC	0	0	0.000000	0	0	90.05
90.06	09005 PEDIATRIC CLINIC	6,711	746,405	0.008991	0	0	90.06
90.07	09006 WOMENS CLINIC	19,442	18,558,723	0.001048	0	0	90.07
90.08	09007 THERAPEUTIC SCHOOL	1,955	916,100	0.002134	0	0	90.08
90.09	09008 AFTER SCHOOL PROGRAM	0	0	0.000000	0	0	90.09
90.10	09017 CLINIC-NOT USED	0	0	0.000000	0	0	90.10
90.11	09009 PERINATAL ADDICTION	0	0	0.000000	0	0	90.11
90.12	09010 THERAPEUTIC NURSERY	0	0	0.000000	0	0	90.12
90.13	09011 CHILD DAY TREATMENT	0	0	0.000000	0	0	90.13
90.14	09012 DIABETES CENTER	0	0	0.000000	0	0	90.14
90.15	09013 WOUND CENTER	31,384	7,629,736	0.004113	0	0	90.15
90.16	09014 MICA	120,220	0	0.000000	0	0	90.16
90.17	09015 BAYONNE MENTAL HEALTH CENTER	9,221	2,369,779	0.003891	0	0	90.17
90.18	09018 CLINIC	1,621	0	0.000000	0	0	90.18
91.00	09100 EMERGENCY	724,400	159,627,259	0.004538	9,380,265	42,568	91.00
91.01	09101 PSYCH EMERGENCY	158,259	1,256,343	0.125968	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	289,875	29,736,844	0.009748	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
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 INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 31-0027		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part III Date/Time Prepared: 5/30/2024 10:12 am	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00		
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00		
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			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	0	0	5,602	0.00	1,409	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	19,391	0.00	2,238	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00		
42.00	04200	SUBPROVIDER	0	0	6,808	0.00	0	42.00		
43.00	04300	NURSERY	0	0	3,332	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	4,311	0.00	2,325	44.00		
45.00	04500	NURSING FACILITY	0	0	27,408	0.00	0	45.00		
200.00		Total (lines 30 through 199)	0	0	105,554		13,000	200.00		
Cost Center Description			Inpatient 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	SUBPROVIDER - IPF	0						40.00	
41.00	04100	SUBPROVIDER - IRF	0						41.00	
42.00	04200	SUBPROVIDER	0						42.00	
43.00	04300	NURSERY	0						43.00	
44.00	04400	SKILLED NURSING FACILITY	0						44.00	
45.00	04500	NURSING FACILITY	0						45.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-0027

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

Cost Center Description			Title XVIII			Hospital		PPS
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			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	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	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	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	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	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	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	WORKFIRST	0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	0	0	0	0	0	90.06
90.07	09006	WOMENS CLINIC	0	0	0	0	0	90.07
90.08	09007	THERAPEUTIC SCHOOL	0	0	0	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09
90.10	09017	CLINIC-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	DIABETES CENTER	0	0	0	0	0	90.14
90.15	09013	WOUND CENTER	0	0	0	0	0	90.15
90.16	09014	MICA	0	0	0	0	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	0	0	0	0	90.17
90.18	09018	CLINIC	0	0	0	0	0	90.18
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	PSYCH EMERGENCY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	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
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-0027

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

Cost Center Description		Title XVIII			Hospital		PPS	
		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, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	108,920,702	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,586,650	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	11,102,553	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,780,364	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	46,199,260	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	14,937,854	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	19,112,456	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	71,553,002	0.000000	57.00
58.00	05800	MRI	0	0	0	12,651,999	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	17,506,754	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	121,058,431	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	14,465,829	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,477,319	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,571,068	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	1,248,874	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,707,564	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	146,002,547	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	58,720,663	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	837,132	0.000000	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	0	0.000000	90.01
90.02	09001	PSYCH CLINIC	0	0	0	26,356,648	0.000000	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0	0.000000	90.03
90.04	09003	WORKFIRST	0	0	0	0	0.000000	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0.000000	90.05
90.06	09005	PEDIATRIC CLINIC	0	0	0	746,405	0.000000	90.06
90.07	09006	WOMENS CLINIC	0	0	0	18,558,723	0.000000	90.07
90.08	09007	THERAPEUTIC SCHOOL	0	0	0	916,100	0.000000	90.08
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	PERINATAL ADDICTION	0	0	0	0	0.000000	90.11
90.12	09010	THERAPEUTIC NURSERY	0	0	0	0	0.000000	90.12
90.13	09011	CHILD DAY TREATMENT	0	0	0	0	0.000000	90.13
90.14	09012	DIABETES CENTER	0	0	0	0	0.000000	90.14
90.15	09013	WOUND CENTER	0	0	0	7,629,736	0.000000	90.15
90.16	09014	MICA	0	0	0	0	0.000000	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	0	0	2,369,779	0.000000	90.17
90.18	09018	CLINIC	0	0	0	0	0.000000	90.18
91.00	09100	EMERGENCY	0	0	0	159,627,259	0.000000	91.00
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	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	1,022,971,591		95.00
200.00		Total (lines 50 through 199)	0	0	0	1,022,971,591		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-0027

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

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING 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 ANESTHESIOLOGY	0.000000	600,422	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.000000	5,084,841	0	2,230,711	0	54.00	
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	97,797	0	2,677,787	0	55.00	
56.00	05600 RADIOISOTOPE	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 CARDIAC CATHETERIZATION	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 RESPIRATORY THERAPY	0.000000	5,590,823	0	321,826	0	65.00	
66.00	06600 PHYSICAL THERAPY	0.000000	1,300,980	0	52,606	0	66.00	
67.00	06700 OCCUPATIONAL 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 ELECTROCARDIOLOGY	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	0	76.97	
76.98	07698 HYPERBARIIC 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 CLINIC	0.000000	0	0	545,394	0	90.00	
90.01	09016 CLINIC-NOT USED	0.000000	0	0	0	0	90.01	
90.02	09001 PSYCH CLINIC	0.000000	0	0	1,105,014	0	90.02	
90.03	09002 PSYCH CLINIC FEE BASED	0.000000	0	0	0	0	90.03	
90.04	09003 WORKFIRST	0.000000	0	0	0	0	90.04	
90.05	09004 CANCER CLINIC	0.000000	0	0	0	0	90.05	
90.06	09005 PEDIATRIC CLINIC	0.000000	0	0	0	0	90.06	
90.07	09006 WOMENS CLINIC	0.000000	0	0	262	0	90.07	
90.08	09007 THERAPEUTIC SCHOOL	0.000000	0	0	0	0	90.08	
90.09	09008 AFTER SCHOOL PROGRAM	0.000000	0	0	0	0	90.09	
90.10	09017 CLINIC-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 THERAPEUTIC NURSERY	0.000000	0	0	0	0	90.12	
90.13	09011 CHILD DAY TREATMENT	0.000000	0	0	0	0	90.13	
90.14	09012 DIABETES CENTER	0.000000	0	0	0	0	90.14	
90.15	09013 WOUND CENTER	0.000000	0	0	1,579,996	0	90.15	
90.16	09014 MICA	0.000000	0	0	0	0	90.16	
90.17	09015 BAYONNE MENTAL HEALTH CENTER	0.000000	0	0	0	0	90.17	
90.18	09018 CLINIC	0.000000	0	0	0	0	90.18	
91.00	09100 EMERGENCY	0.000000	9,380,265	0	7,031,590	0	91.00	
91.01	09101 PSYCH EMERGENCY	0.000000	0	0	0	0	91.01	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00	
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99	
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES						95.00	
200.00	Total (lines 50 through 199)		113,255,341	0	47,091,862	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 31-0027

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

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.179497	7,858,550	0	0	1,410,586	50.00
51.00	05100	RECOVERY ROOM	0.274525	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.652155	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.121291	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187428	2,230,711	0	0	418,098	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.795875	2,677,787	0	0	2,131,184	55.00
56.00	05600	RADIOISOTOPE	0.053105	936,398	0	0	49,727	56.00
57.00	05700	CT SCAN	0.026293	3,990,797	0	0	104,930	57.00
58.00	05800	MRI	0.062483	566,165	0	0	35,376	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.178881	1,840,299	0	0	329,195	59.00
60.00	06000	LABORATORY	0.111928	3,494,749	0	0	391,160	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.004955	135,744	0	0	673	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.360878	321,826	0	0	116,140	65.00
66.00	06600	PHYSICAL THERAPY	0.397603	52,606	0	0	20,916	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.135609	200	0	0	27	67.00
68.00	06800	SPEECH PATHOLOGY	0.223969	450	0	0	101	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045177	894,780	0	0	40,423	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.488929	1,548,980	0	0	757,341	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.683729	1,310,233	146,771	0	895,844	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.172558	8,966,776	0	0	1,547,289	73.00
74.00	07400	RENAL DIALYSIS	0.309800	2,555	0	0	792	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	5.105041	545,394	14,806	0	2,784,259	90.00
90.01	09016	CLINIC-NOT USED	0.000000	0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	1.078949	1,105,014	0	0	1,192,254	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0.000000	0	0	0	0	90.03
90.04	09003	WORKFIRST	0.000000	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0.000000	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	1.570654	0	0	0	0	90.06
90.07	09006	WOMENS CLINIC	0.179744	262	0	0	47	90.07
90.08	09007	THERAPEUTIC SCHOOL	0.261331	0	0	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0.000000	0	0	0	0	90.09
90.10	09017	CLINIC-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	THERAPEUTIC NURSERY	0.000000	0	0	0	0	90.12
90.13	09011	CHILD DAY TREATMENT	0.000000	0	0	0	0	90.13
90.14	09012	DIABETES CENTER	0.000000	0	0	0	0	90.14
90.15	09013	WOUND CENTER	0.144633	1,579,996	0	0	228,520	90.15
90.16	09014	MICA	0.000000	0	0	0	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0.670740	0	0	0	0	90.17
90.18	09018	CLINIC	0.000000	0	0	0	0	90.18
91.00	09100	EMERGENCY	0.139231	7,031,590	0	0	979,015	91.00
91.01	09101	PSYCH EMERGENCY	4.654304	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.186583	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00
200.00		Subtotal (see instructions)		47,091,862	161,577	0	13,433,897	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		47,091,862	161,577	0	13,433,897	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 31-0027		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/30/2024 10:12 am
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	100,352	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	75,585	0		90.00
90.01	09016	CLINIC-NOT USED	0	0		90.01
90.02	09001	PSYCH CLINIC	0	0		90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0		90.03
90.04	09003	WORKFIRST	0	0		90.04
90.05	09004	CANCER CLINIC	0	0		90.05
90.06	09005	PEDIATRIC CLINIC	0	0		90.06
90.07	09006	WOMENS CLINIC	0	0		90.07
90.08	09007	THERAPEUTIC SCHOOL	0	0		90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0		90.09
90.10	09017	CLINIC-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	CHILD DAY TREATMENT	0	0		90.13
90.14	09012	DIABETES CENTER	0	0		90.14
90.15	09013	WOUND CENTER	0	0		90.15
90.16	09014	MICA	0	0		90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	0		90.17
90.18	09018	CLINIC	0	0		90.18
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	PSYCH EMERGENCY	0	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0		95.00
200.00		Subtotal (see instructions)	175,937	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	175,937	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 31-0027

Period:

From 01/01/2023
To 12/31/2023

Worksheet D

Part II
Date/Time Prepared:
5/30/2024 10:12 am

Component CCN: 31-S027

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	951,668	108,920,702	0.008737	0	0	50.00
51.00	05100 RECOVERY ROOM	79,081	9,586,650	0.008249	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	231,966	11,102,553	0.020893	0	0	52.00
53.00	05300 ANESTHESIOLOGY	17,170	6,780,364	0.002532	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	384,197	46,199,260	0.008316	21,876	182	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	861,944	14,937,854	0.057702	0	0	55.00
56.00	05600 RADIOISOTOPE	14,585	19,112,456	0.000763	0	0	56.00
57.00	05700 CT SCAN	34,209	71,553,002	0.000478	48,367	23	57.00
58.00	05800 MRI	32,010	12,651,999	0.002530	3,000	8	58.00
59.00	05900 CARDIAC CATHETERIZATION	140,335	17,506,754	0.008016	0	0	59.00
60.00	06000 LABORATORY	296,160	121,058,431	0.002446	439,159	1,074	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	16,501	14,465,829	0.001141	0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	104,061	17,477,319	0.005954	0	0	65.00
66.00	06600 PHYSICAL THERAPY	197,258	8,571,068	0.023014	19,225	442	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,549	2,186,412	0.000708	38,616	27	67.00
68.00	06800 SPEECH PATHOLOGY	3,778	1,248,874	0.003025	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	66,343	42,507,278	0.001561	25,169	39	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	105,562	28,639,043	0.003686	288	1	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	80,970	15,707,564	0.005155	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	210,918	146,002,547	0.001445	470,641	680	73.00
74.00	07400 RENAL DIALYSIS	476,295	58,720,663	0.008111	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LIOTHOTROPY	0	0	0.000000	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	314,429	837,132	0.375603	0	0	90.00
90.01	09016 CLINIC-NOT USED	0	0	0.000000	0	0	90.01
90.02	09001 PSYCH CLINIC	947,954	26,356,648	0.035966	0	0	90.02
90.03	09002 PSYCH CLINIC FEE BASED	0	0	0.000000	0	0	90.03
90.04	09003 WORKFIRST	0	0	0.000000	0	0	90.04
90.05	09004 CANCER CLINIC	0	0	0.000000	0	0	90.05
90.06	09005 PEDIATRIC CLINIC	6,711	746,405	0.008991	0	0	90.06
90.07	09006 WOMENS CLINIC	19,442	18,558,723	0.001048	0	0	90.07
90.08	09007 THERAPEUTIC SCHOOL	1,955	916,100	0.002134	0	0	90.08
90.09	09008 AFTER SCHOOL PROGRAM	0	0	0.000000	0	0	90.09
90.10	09017 CLINIC-NOT USED	0	0	0.000000	0	0	90.10
90.11	09009 PERINATAL ADDICTION	0	0	0.000000	0	0	90.11
90.12	09010 THERAPEUTIC NURSERY	0	0	0.000000	0	0	90.12
90.13	09011 CHILD DAY TREATMENT	0	0	0.000000	0	0	90.13
90.14	09012 DIABETES CENTER	0	0	0.000000	0	0	90.14
90.15	09013 WOUND CENTER	31,384	7,629,736	0.004113	0	0	90.15
90.16	09014 MICA	120,220	0	0.000000	0	0	90.16
90.17	09015 BAYONNE MENTAL HEALTH CENTER	9,221	2,369,779	0.003891	0	0	90.17
90.18	09018 CLINIC	1,621	0	0.000000	0	0	90.18
91.00	09100 EMERGENCY	724,400	159,627,259	0.004538	455,856	2,069	91.00
91.01	09101 PSYCH EMERGENCY	158,259	1,256,343	0.125968	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	29,736,844	0.000000	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	6,642,156	1,022,971,591		1,522,197	4,545	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0027 Component CCN: 31-S027		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/30/2024 10:12 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				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	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	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	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	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	0	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		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
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09016	CLINIC-NOT USED		0	0	0	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	WORKFIRST		0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC		0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC		0	0	0	0	0	90.06
90.07	09006	WOMENS CLINIC		0	0	0	0	0	90.07
90.08	09007	THERAPEUTIC SCHOOL		0	0	0	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM		0	0	0	0	0	90.09
90.10	09017	CLINIC-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	DIABETES CENTER		0	0	0	0	0	90.14
90.15	09013	WOUND CENTER		0	0	0	0	0	90.15
90.16	09014	MICA		0	0	0	0	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER		0	0	0	0	0	90.17
90.18	09018	CLINIC		0	0	0	0	0	90.18
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
91.01	09101	PSYCH EMERGENCY		0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	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
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0027 Component CCN: 31-S027		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/30/2024 10:12 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	108,920,702	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	9,586,650	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	11,102,553	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	6,780,364	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	46,199,260	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	14,937,854	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	19,112,456	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	71,553,002	0.000000	57.00
58.00	05800	MRI		0	0	0	12,651,999	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	17,506,754	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	121,058,431	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	14,465,829	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	17,477,319	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	8,571,068	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	1,248,874	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		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	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	15,707,564	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	146,002,547	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	58,720,663	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	837,132	0.000000	90.00
90.01	09016	CLINIC-NOT USED		0	0	0	0	0.000000	90.01
90.02	09001	PSYCH CLINIC		0	0	0	26,356,648	0.000000	90.02
90.03	09002	PSYCH CLINIC FEE BASED		0	0	0	0	0.000000	90.03
90.04	09003	WORKFIRST		0	0	0	0	0.000000	90.04
90.05	09004	CANCER CLINIC		0	0	0	0	0.000000	90.05
90.06	09005	PEDIATRIC CLINIC		0	0	0	746,405	0.000000	90.06
90.07	09006	WOMENS CLINIC		0	0	0	18,558,723	0.000000	90.07
90.08	09007	THERAPEUTIC SCHOOL		0	0	0	916,100	0.000000	90.08
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	PERINATAL ADDICTION		0	0	0	0	0.000000	90.11
90.12	09010	THERAPEUTIC NURSERY		0	0	0	0	0.000000	90.12
90.13	09011	CHILD DAY TREATMENT		0	0	0	0	0.000000	90.13
90.14	09012	DIABETES CENTER		0	0	0	0	0.000000	90.14
90.15	09013	WOUND CENTER		0	0	0	7,629,736	0.000000	90.15
90.16	09014	MICA		0	0	0	0	0.000000	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER		0	0	0	2,369,779	0.000000	90.17
90.18	09018	CLINIC		0	0	0	0	0.000000	90.18
91.00	09100	EMERGENCY		0	0	0	159,627,259	0.000000	91.00
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	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0	0	0	1,022,971,591		95.00
200.00		Total (lines 50 through 199)		0	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0027 Component CCN: 31-S027		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/30/2024 10:12 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	21,876	0	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00	
57.00	05700	CT SCAN	0.000000	48,367	0	0	0	57.00	
58.00	05800	MRI	0.000000	3,000	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.000000	439,159	0	0	0	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	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	PHYSICAL THERAPY	0.000000	19,225	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	38,616	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	25,169	0	0	0	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	288	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	470,641	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	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	CLINIC	0.000000	0	0	0	0	90.00	
90.01	09016	CLINIC-NOT USED	0.000000	0	0	0	0	90.01	
90.02	09001	PSYCH CLINIC	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	WORKFIRST	0.000000	0	0	0	0	90.04	
90.05	09004	CANCER CLINIC	0.000000	0	0	0	0	90.05	
90.06	09005	PEDIATRIC CLINIC	0.000000	0	0	0	0	90.06	
90.07	09006	WOMENS CLINIC	0.000000	0	0	0	0	90.07	
90.08	09007	THERAPEUTIC SCHOOL	0.000000	0	0	0	0	90.08	
90.09	09008	AFTER SCHOOL PROGRAM	0.000000	0	0	0	0	90.09	
90.10	09017	CLINIC-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	THERAPEUTIC NURSERY	0.000000	0	0	0	0	90.12	
90.13	09011	CHILD DAY TREATMENT	0.000000	0	0	0	0	90.13	
90.14	09012	DIABETES CENTER	0.000000	0	0	0	0	90.14	
90.15	09013	WOUND CENTER	0.000000	0	0	0	0	90.15	
90.16	09014	MICA	0.000000	0	0	0	0	90.16	
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0.000000	0	0	0	0	90.17	
90.18	09018	CLINIC	0.000000	0	0	0	0	90.18	
91.00	09100	EMERGENCY	0.000000	455,856	0	0	0	91.00	
91.01	09101	PSYCH EMERGENCY	0.000000	0	0	0	0	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50 through 199)		1,522,197	0	0	0	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0027 Component CCN: 31-5442		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/30/2024 10:12 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				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	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	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	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	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	0	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		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
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09016	CLINIC-NOT USED		0	0	0	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	WORKFIRST		0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC		0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC		0	0	0	0	0	90.06
90.07	09006	WOMENS CLINIC		0	0	0	0	0	90.07
90.08	09007	THERAPEUTIC SCHOOL		0	0	0	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM		0	0	0	0	0	90.09
90.10	09017	CLINIC-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	DIABETES CENTER		0	0	0	0	0	90.14
90.15	09013	WOUND CENTER		0	0	0	0	0	90.15
90.16	09014	MICA		0	0	0	0	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER		0	0	0	0	0	90.17
90.18	09018	CLINIC		0	0	0	0	0	90.18
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
91.01	09101	PSYCH EMERGENCY		0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	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
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0027 Component CCN: 31-5442		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/30/2024 10:12 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	108,920,702	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	9,586,650	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	11,102,553	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	6,780,364	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	46,199,260	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	14,937,854	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	19,112,456	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	71,553,002	0.000000	57.00
58.00	05800	MRI	0	0	0	0	12,651,999	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	17,506,754	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0	121,058,431	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	14,465,829	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	17,477,319	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	8,571,068	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	2,186,412	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,248,874	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	42,507,278	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	28,639,043	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	15,707,564	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	146,002,547	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	58,720,663	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0.000000	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	837,132	0.000000	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	0	0	0.000000	90.01
90.02	09001	PSYCH CLINIC	0	0	0	0	26,356,648	0.000000	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0	0	0.000000	90.03
90.04	09003	WORKFIRST	0	0	0	0	0	0.000000	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0	0.000000	90.05
90.06	09005	PEDIATRIC CLINIC	0	0	0	0	746,405	0.000000	90.06
90.07	09006	WOMENS CLINIC	0	0	0	0	18,558,723	0.000000	90.07
90.08	09007	THERAPEUTIC SCHOOL	0	0	0	0	916,100	0.000000	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	0.000000	90.09
90.10	09017	CLINIC-NOT USED	0	0	0	0	0	0.000000	90.10
90.11	09009	PERINATAL ADDICTION	0	0	0	0	0	0.000000	90.11
90.12	09010	THERAPEUTIC NURSERY	0	0	0	0	0	0.000000	90.12
90.13	09011	CHILD DAY TREATMENT	0	0	0	0	0	0.000000	90.13
90.14	09012	DIABETES CENTER	0	0	0	0	0	0.000000	90.14
90.15	09013	WOUND CENTER	0	0	0	0	7,629,736	0.000000	90.15
90.16	09014	MICA	0	0	0	0	0	0.000000	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	0	0	0	2,369,779	0.000000	90.17
90.18	09018	CLINIC	0	0	0	0	0	0.000000	90.18
91.00	09100	EMERGENCY	0	0	0	0	159,627,259	0.000000	91.00
91.01	09101	PSYCH EMERGENCY	0	0	0	0	1,256,343	0.000000	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	29,736,844	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,022,971,591		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0027 Component CCN: 31-5442		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/30/2024 10:12 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00						
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	81,712	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	550,370	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	184,820	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	14,720	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	580	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	0	78.00
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09016	CLINIC-NOT USED	0.000000	0	0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	0.000000	0	0	0	0	0	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0.000000	0	0	0	0	0	90.03
90.04	09003	WORKFIRST	0.000000	0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0.000000	0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	0.000000	0	0	0	0	0	90.06
90.07	09006	WOMENS CLINIC	0.000000	0	0	0	0	0	90.07
90.08	09007	THERAPEUTIC SCHOOL	0.000000	0	0	0	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0.000000	0	0	0	0	0	90.09
90.10	09017	CLINIC-NOT USED	0.000000	0	0	0	0	0	90.10
90.11	09009	PERINATAL ADDICTION	0.000000	0	0	0	0	0	90.11
90.12	09010	THERAPEUTIC NURSERY	0.000000	0	0	0	0	0	90.12
90.13	09011	CHILD DAY TREATMENT	0.000000	0	0	0	0	0	90.13
90.14	09012	DIABETES CENTER	0.000000	0	0	0	0	0	90.14
90.15	09013	WOUND CENTER	0.000000	0	0	0	0	0	90.15
90.16	09014	MICA	0.000000	0	0	0	0	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0.000000	0	0	0	0	0	90.17
90.18	09018	CLINIC	0.000000	0	0	0	0	0	90.18
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
91.01	09101	PSYCH EMERGENCY	0.000000	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	93.99
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)		832,202	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 31-0027

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

			Title XIX		Hospital	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 & PEDIATRICS	2,426,189	0	2,426,189	38,702	62.69	30.00
31.00	INTENSIVE CARE UNIT	448,967		448,967	5,602	80.14	31.00
40.00	SUBPROVIDER - IPF	940,046	0	940,046	19,391	48.48	40.00
41.00	SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	SUBPROVIDER	331,434	0	331,434	6,808	48.68	42.00
43.00	NURSERY	175,267		175,267	3,332	52.60	43.00
44.00	SKILLED NURSING FACILITY	176,932		176,932	4,311	41.04	44.00
45.00	NURSING FACILITY	880,472		880,472	27,408	32.12	45.00
200.00	Total (lines 30 through 199)	5,379,307		5,379,307	105,554		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	3,921	245,807				30.00
31.00	INTENSIVE CARE UNIT	530	42,474				31.00
40.00	SUBPROVIDER - IPF	1,593	77,229				40.00
41.00	SUBPROVIDER - IRF	0	0				41.00
42.00	SUBPROVIDER	6,065	295,244				42.00
43.00	NURSERY	1,849	97,257				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
45.00	NURSING FACILITY	1,096	35,204				45.00
200.00	Total (lines 30 through 199)	15,054	793,215				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Prepared: 5/30/2024 10:12 am			
				Title XIX		Hospital		TEFRA	
Cost Center Description				Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	951,668	108,920,702	0.008737	1,666,737	14,562	50.00	
51.00	05100	RECOVERY ROOM	79,081	9,586,650	0.008249	132,512	1,093	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	231,966	11,102,553	0.020893	3,739,086	78,121	52.00	
53.00	05300	ANESTHESIOLOGY	17,170	6,780,364	0.002532	711,542	1,802	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	384,197	46,199,260	0.008316	1,353,551	11,256	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	861,944	14,937,854	0.057702	0	0	55.00	
56.00	05600	RADIOISOTOPE	14,585	19,112,456	0.000763	102,051	78	56.00	
57.00	05700	CT SCAN	34,209	71,553,002	0.000478	1,673,800	800	57.00	
58.00	05800	MRI	32,010	12,651,999	0.002530	450,993	1,141	58.00	
59.00	05900	CARDIAC CATHETERIZATION	140,335	17,506,754	0.008016	713,130	5,716	59.00	
60.00	06000	LABORATORY	296,160	121,058,431	0.002446	5,879,840	14,382	60.00	
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	16,501	14,465,829	0.001141	313,201	357	62.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	104,061	17,477,319	0.005954	769,582	4,582	65.00	
66.00	06600	PHYSICAL THERAPY	197,258	8,571,068	0.023014	159,117	3,662	66.00	
67.00	06700	OCCUPATIONAL THERAPY	1,549	2,186,412	0.000708	93,221	66	67.00	
68.00	06800	SPEECH PATHOLOGY	3,778	1,248,874	0.003025	247,473	749	68.00	
69.00	06900	ELECTROCARDIOLOGY	66,343	42,507,278	0.001561	1,569,371	2,450	69.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	105,562	28,639,043	0.003686	802,537	2,958	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	80,970	15,707,564	0.005155	160,084	825	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	210,918	146,002,547	0.001445	4,488,627	6,486	73.00	
74.00	07400	RENAL DIALYSIS	476,295	58,720,663	0.008111	135,690	1,101	74.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99	
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00	
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	314,429	837,132	0.375603	0	0	90.00	
90.01	09016	CLINIC-NOT USED	0	0	0.000000	0	0	90.01	
90.02	09001	PSYCH CLINIC	947,954	26,356,648	0.035966	0	0	90.02	
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0.000000	0	0	90.03	
90.04	09003	WORKFIRST	0	0	0.000000	0	0	90.04	
90.05	09004	CANCER CLINIC	0	0	0.000000	0	0	90.05	
90.06	09005	PEDIATRIC CLINIC	6,711	746,405	0.008991	0	0	90.06	
90.07	09006	WOMENS CLINIC	19,442	18,558,723	0.001048	0	0	90.07	
90.08	09007	THERAPEUTIC SCHOOL	1,955	916,100	0.002134	0	0	90.08	
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0.000000	0	0	90.09	
90.10	09017	CLINIC-NOT USED	0	0	0.000000	0	0	90.10	
90.11	09009	PERINATAL ADDICTION	0	0	0.000000	0	0	90.11	
90.12	09010	THERAPEUTIC NURSERY	0	0	0.000000	0	0	90.12	
90.13	09011	CHILD DAY TREATMENT	0	0	0.000000	0	0	90.13	
90.14	09012	DIABETES CENTER	0	0	0.000000	0	0	90.14	
90.15	09013	WOUND CENTER	31,384	7,629,736	0.004113	0	0	90.15	
90.16	09014	MICA	120,220	0	0.000000	0	0	90.16	
90.17	09015	BAYONNE MENTAL HEALTH CENTER	9,221	2,369,779	0.003891	0	0	90.17	
90.18	09018	CLINIC	1,621	0	0.000000	0	0	90.18	
91.00	09100	EMERGENCY	724,400	159,627,259	0.004538	1,980,653	8,988	91.00	
91.01	09101	PSYCH EMERGENCY	158,259	1,256,343	0.125968	0	0	91.01	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	289,875	29,736,844	0.009748	0	0	92.00	
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES						95.00	
200.00		Total (lines 50 through 199)	6,932,031	1,022,971,591		27,142,798	161,175	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 31-0027		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part III Date/Time Prepared: 5/30/2024 10:12 am	
					Title XIX		Hospital		TEFRA	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00		
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00		
43.00	04300	NURSERY	0	0	0	0	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00		
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00		
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00		
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			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	3,921	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	5,602	0.00	530	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	19,391	0.00	1,593	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	0	0.00	0	41.00		
42.00	04200	SUBPROVIDER	0	0	6,808	0.00	6,065	42.00		
43.00	04300	NURSERY	0	0	3,332	0.00	1,849	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	4,311	0.00	0	44.00		
45.00	04500	NURSING FACILITY	0	0	27,408	0.00	1,096	45.00		
200.00		Total (lines 30 through 199)	0	0	105,554		15,054	200.00		
Cost Center Description			Inpatient 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	SUBPROVIDER - IPF	0					40.00		
41.00	04100	SUBPROVIDER - IRF	0					41.00		
42.00	04200	SUBPROVIDER	0					42.00		
43.00	04300	NURSERY	0					43.00		
44.00	04400	SKILLED NURSING FACILITY	0					44.00		
45.00	04500	NURSING FACILITY	0					45.00		
200.00		Total (lines 30 through 199)	0					200.00		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-0027

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

Cost Center Description			Title XIX			Hospital	TEFRA	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			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	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	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	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	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	0	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	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	WORKFIRST	0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	0	0	0	0	0	90.06
90.07	09006	WOMENS CLINIC	0	0	0	0	0	90.07
90.08	09007	THERAPEUTIC SCHOOL	0	0	0	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0	0	0	0	0	90.09
90.10	09017	CLINIC-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	DIABETES CENTER	0	0	0	0	0	90.14
90.15	09013	WOUND CENTER	0	0	0	0	0	90.15
90.16	09014	MICA	0	0	0	0	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	0	0	0	0	90.17
90.18	09018	CLINIC	0	0	0	0	0	90.18
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
91.01	09101	PSYCH EMERGENCY	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	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
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 31-0027

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

			Title XIX		Hospital	TEFRA		
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, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	108,920,702	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	9,586,650	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	11,102,553	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	6,780,364	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	46,199,260	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	14,937,854	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	19,112,456	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	71,553,002	0.000000	57.00
58.00	05800	MRI	0	0	0	12,651,999	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	17,506,754	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	121,058,431	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	14,465,829	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	17,477,319	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	8,571,068	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	1,248,874	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	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	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	15,707,564	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	146,002,547	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	58,720,663	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	837,132	0.000000	90.00
90.01	09016	CLINIC-NOT USED	0	0	0	0	0.000000	90.01
90.02	09001	PSYCH CLINIC	0	0	0	26,356,648	0.000000	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0	0	0	0.000000	90.03
90.04	09003	WORKFIRST	0	0	0	0	0.000000	90.04
90.05	09004	CANCER CLINIC	0	0	0	0	0.000000	90.05
90.06	09005	PEDIATRIC CLINIC	0	0	0	746,405	0.000000	90.06
90.07	09006	WOMENS CLINIC	0	0	0	18,558,723	0.000000	90.07
90.08	09007	THERAPEUTIC SCHOOL	0	0	0	916,100	0.000000	90.08
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	PERINATAL ADDICTION	0	0	0	0	0.000000	90.11
90.12	09010	THERAPEUTIC NURSERY	0	0	0	0	0.000000	90.12
90.13	09011	CHILD DAY TREATMENT	0	0	0	0	0.000000	90.13
90.14	09012	DIABETES CENTER	0	0	0	0	0.000000	90.14
90.15	09013	WOUND CENTER	0	0	0	7,629,736	0.000000	90.15
90.16	09014	MICA	0	0	0	0	0.000000	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	0	0	2,369,779	0.000000	90.17
90.18	09018	CLINIC	0	0	0	0	0.000000	90.18
91.00	09100	EMERGENCY	0	0	0	159,627,259	0.000000	91.00
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	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	1,022,971,591		95.00
200.00		Total (lines 50 through 199)	0	0	0	1,022,971,591		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0027		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/30/2024 10:12 am	
				Title XIX		Hospital		TEFRA	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000		1,666,737	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		132,512	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		3,739,086	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000		711,542	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		1,353,551	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000		0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	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	CARDIAC CATHETERIZATION	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	PHYSICAL THERAPY	0.000000		159,117	0	0	0	66.00
67.00	06700	OCCUPATIONAL 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	ELECTROCARDIOLOGY	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	HYPERBARIC OXYGEN THERAPY	0.000000		0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	0.000000		0	0	0	0	90.00
90.01	09016	CLINIC-NOT USED	0.000000		0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	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	WORKFIRST	0.000000		0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0.000000		0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	0.000000		0	0	0	0	90.06
90.07	09006	WOMENS CLINIC	0.000000		0	0	0	0	90.07
90.08	09007	THERAPEUTIC SCHOOL	0.000000		0	0	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0.000000		0	0	0	0	90.09
90.10	09017	CLINIC-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	THERAPEUTIC NURSERY	0.000000		0	0	0	0	90.12
90.13	09011	CHILD DAY TREATMENT	0.000000		0	0	0	0	90.13
90.14	09012	DIABETES CENTER	0.000000		0	0	0	0	90.14
90.15	09013	WOUND CENTER	0.000000		0	0	0	0	90.15
90.16	09014	MICA	0.000000		0	0	0	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0.000000		0	0	0	0	90.17
90.18	09018	CLINIC	0.000000		0	0	0	0	90.18
91.00	09100	EMERGENCY	0.000000		1,980,653	0	0	0	91.00
91.01	09101	PSYCH EMERGENCY	0.000000		0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000		0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			27,142,798	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 31-0027

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

			Title XIX		Hospital		TEFRA	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.168719	0	706,540	0	0	50.00
51.00	05100	RECOVERY ROOM	0.258256	0	1,465	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.613452	0	562,589	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.114150	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176208	0	1,197,036	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.747290	0	183,834	0	0	55.00
56.00	05600	RADIOISOTOPE	0.049993	0	137,045	0	0	56.00
57.00	05700	CT SCAN	0.024748	0	711,676	0	0	57.00
58.00	05800	MRI	0.058753	0	142,618	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.168169	0	55,526	0	0	59.00
60.00	06000	LABORATORY	0.105333	0	90,091	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.004620	0	25,659	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.339697	0	13,626	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.373575	0	61,038	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.127714	0	3,927	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.210852	0	2,638	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.042491	0	541,200	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.460416	0	149,456	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.643857	0	64,236	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.162489	0	1,605,461	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.291491	0	1,696	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	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	CLINIC	4.793172	0	28,515	0	0	90.00
90.01	09016	CLINIC-NOT USED	0.000000	0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	1.014859	0	470,189	0	0	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0.000000	0	0	0	0	90.03
90.04	09003	WORKFIRST	0.000000	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0.000000	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	1.479178	0	56,889	0	0	90.06
90.07	09006	WOMENS CLINIC	0.169275	0	5,370,539	0	0	90.07
90.08	09007	THERAPEUTIC SCHOOL	0.246083	0	0	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0.000000	0	0	0	0	90.09
90.10	09017	CLINIC-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	THERAPEUTIC NURSERY	0.000000	0	0	0	0	90.12
90.13	09011	CHILD DAY TREATMENT	0.000000	0	0	0	0	90.13
90.14	09012	DIABETES CENTER	0.000000	0	0	0	0	90.14
90.15	09013	WOUND CENTER	0.136071	0	16,396	0	0	90.15
90.16	09014	MICA	0.000000	0	0	0	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0.631674	0	0	0	0	90.17
90.18	09018	CLINIC	0.000000	0	0	0	0	90.18
91.00	09100	EMERGENCY	0.130965	0	6,795,995	0	0	91.00
91.01	09101	PSYCH EMERGENCY	4.379064	0	106,758	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.175352	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0	0	95.00
200.00		Subtotal (see instructions)		0	19,102,638	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		0	19,102,638	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 31-0027		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part V Date/Time Prepared: 5/30/2024 10:12 am
			Title XIX		Hospital	TEFRA
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (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
52.00	05200	DELIVERY ROOM & LABOR ROOM	345,121	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	210,927	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	137,377	0		55.00
56.00	05600	RADIOISOTOPE	6,851	0		56.00
57.00	05700	CT SCAN	17,613	0		57.00
58.00	05800	MRI	8,379	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	9,338	0		59.00
60.00	06000	LABORATORY	9,490	0		60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	119	0		62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	4,629	0		65.00
66.00	06600	PHYSICAL THERAPY	22,802	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	502	0		67.00
68.00	06800	SPEECH PATHOLOGY	556	0		68.00
69.00	06900	ELECTROCARDIOLOGY	22,996	0		69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,812	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	41,359	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	260,870	0		73.00
74.00	07400	RENAL DIALYSIS	494	0		74.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0		77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0		78.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	136,677	0		90.00
90.01	09016	CLINIC-NOT USED	0	0		90.01
90.02	09001	PSYCH CLINIC	477,176	0		90.02
90.03	09002	PSYCH CLINIC FEE BASED	0	0		90.03
90.04	09003	WORKFIRST	0	0		90.04
90.05	09004	CANCER CLINIC	0	0		90.05
90.06	09005	PEDIATRIC CLINIC	84,149	0		90.06
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	0		90.09
90.10	09017	CLINIC-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	CHILD DAY TREATMENT	0	0		90.13
90.14	09012	DIABETES CENTER	0	0		90.14
90.15	09013	WOUND CENTER	2,231	0		90.15
90.16	09014	MICA	0	0		90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0	0		90.17
90.18	09018	CLINIC	0	0		90.18
91.00	09100	EMERGENCY	890,037	0		91.00
91.01	09101	PSYCH EMERGENCY	467,500	0		91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0	0		93.99
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	4,254,688	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	4,254,688	0		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 31-0027

Period:

Worksheet D

Component CCN: 31-S027

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

Title XIX

Subprovider -
IPF

TEFRA

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	951,668	108,920,702	0.008737	0	0	50.00
51.00	05100 RECOVERY ROOM	79,081	9,586,650	0.008249	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	231,966	11,102,553	0.020893	0	0	52.00
53.00	05300 ANESTHESIOLOGY	17,170	6,780,364	0.002532	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	384,197	46,199,260	0.008316	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	861,944	14,937,854	0.057702	0	0	55.00
56.00	05600 RADIOISOTOPE	14,585	19,112,456	0.000763	0	0	56.00
57.00	05700 CT SCAN	34,209	71,553,002	0.000478	0	0	57.00
58.00	05800 MRI	32,010	12,651,999	0.002530	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	140,335	17,506,754	0.008016	0	0	59.00
60.00	06000 LABORATORY	296,160	121,058,431	0.002446	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	16,501	14,465,829	0.001141	0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	104,061	17,477,319	0.005954	0	0	65.00
66.00	06600 PHYSICAL THERAPY	197,258	8,571,068	0.023014	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	1,549	2,186,412	0.000708	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	3,778	1,248,874	0.003025	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	66,343	42,507,278	0.001561	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	105,562	28,639,043	0.003686	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	80,970	15,707,564	0.005155	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	210,918	146,002,547	0.001445	0	0	73.00
74.00	07400 RENAL DIALYSIS	476,295	58,720,663	0.008111	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	314,429	837,132	0.375603	0	0	90.00
90.01	09016 CLINIC-NOT USED	0	0	0.000000	0	0	90.01
90.02	09001 PSYCH CLINIC	947,954	26,356,648	0.035966	0	0	90.02
90.03	09002 PSYCH CLINIC FEE BASED	0	0	0.000000	0	0	90.03
90.04	09003 WORKFIRST	0	0	0.000000	0	0	90.04
90.05	09004 CANCER CLINIC	0	0	0.000000	0	0	90.05
90.06	09005 PEDIATRIC CLINIC	6,711	746,405	0.008991	0	0	90.06
90.07	09006 WOMENS CLINIC	19,442	18,558,723	0.001048	0	0	90.07
90.08	09007 THERAPEUTIC SCHOOL	1,955	916,100	0.002134	0	0	90.08
90.09	09008 AFTER SCHOOL PROGRAM	0	0	0.000000	0	0	90.09
90.10	09017 CLINIC-NOT USED	0	0	0.000000	0	0	90.10
90.11	09009 PERINATAL ADDICTION	0	0	0.000000	0	0	90.11
90.12	09010 THERAPEUTIC NURSERY	0	0	0.000000	0	0	90.12
90.13	09011 CHILD DAY TREATMENT	0	0	0.000000	0	0	90.13
90.14	09012 DIABETES CENTER	0	0	0.000000	0	0	90.14
90.15	09013 WOUND CENTER	31,384	7,629,736	0.004113	0	0	90.15
90.16	09014 MICA	120,220	0	0.000000	0	0	90.16
90.17	09015 BAYONNE MENTAL HEALTH CENTER	9,221	2,369,779	0.003891	0	0	90.17
90.18	09018 CLINIC	1,621	0	0.000000	0	0	90.18
91.00	09100 EMERGENCY	724,400	159,627,259	0.004538	0	0	91.00
91.01	09101 PSYCH EMERGENCY	158,259	1,256,343	0.125968	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	29,736,844	0.000000	0	0	92.00
93.99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0.000000	0	0	93.99
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	6,642,156	1,022,971,591		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0027 Component CCN: 31-S027		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/30/2024 10:12 am	
				Title XIX		Subprovider - IPF		TEFRA	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				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	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	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	PHYSICAL THERAPY		0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	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	0	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		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
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09016	CLINIC-NOT USED		0	0	0	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	WORKFIRST		0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC		0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC		0	0	0	0	0	90.06
90.07	09006	WOMENS CLINIC		0	0	0	0	0	90.07
90.08	09007	THERAPEUTIC SCHOOL		0	0	0	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM		0	0	0	0	0	90.09
90.10	09017	CLINIC-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	DIABETES CENTER		0	0	0	0	0	90.14
90.15	09013	WOUND CENTER		0	0	0	0	0	90.15
90.16	09014	MICA		0	0	0	0	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER		0	0	0	0	0	90.17
90.18	09018	CLINIC		0	0	0	0	0	90.18
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
91.01	09101	PSYCH EMERGENCY		0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	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
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0027 Component CCN: 31-S027		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/30/2024 10:12 am	
				Title XIX		Subprovider - IPF		TEFRA	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of col.s. 1, 2, 3, and 4)	Total Outpatient Cost (sum of col.s. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	108,920,702	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	9,586,650	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	11,102,553	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	6,780,364	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	46,199,260	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	14,937,854	0.000000	55.00
56.00	05600	RADIOISOTOPE		0	0	0	19,112,456	0.000000	56.00
57.00	05700	CT SCAN		0	0	0	71,553,002	0.000000	57.00
58.00	05800	MRI		0	0	0	12,651,999	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	17,506,754	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	121,058,431	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		0	0	0	14,465,829	0.000000	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	17,477,319	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	8,571,068	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	1,248,874	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		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	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	15,707,564	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	146,002,547	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	58,720,663	0.000000	74.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARI C OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION		0	0	0	0	0.000000	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY		0	0	0	0	0.000000	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	837,132	0.000000	90.00
90.01	09016	CLINIC-NOT USED		0	0	0	0	0.000000	90.01
90.02	09001	PSYCH CLINIC		0	0	0	26,356,648	0.000000	90.02
90.03	09002	PSYCH CLINIC FEE BASED		0	0	0	0	0.000000	90.03
90.04	09003	WORKFIRST		0	0	0	0	0.000000	90.04
90.05	09004	CANCER CLINIC		0	0	0	0	0.000000	90.05
90.06	09005	PEDIATRIC CLINIC		0	0	0	746,405	0.000000	90.06
90.07	09006	WOMENS CLINIC		0	0	0	18,558,723	0.000000	90.07
90.08	09007	THERAPEUTIC SCHOOL		0	0	0	916,100	0.000000	90.08
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	PERINATAL ADDICTION		0	0	0	0	0.000000	90.11
90.12	09010	THERAPEUTIC NURSERY		0	0	0	0	0.000000	90.12
90.13	09011	CHILD DAY TREATMENT		0	0	0	0	0.000000	90.13
90.14	09012	DIABETES CENTER		0	0	0	0	0.000000	90.14
90.15	09013	WOUND CENTER		0	0	0	7,629,736	0.000000	90.15
90.16	09014	MICA		0	0	0	0	0.000000	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER		0	0	0	2,369,779	0.000000	90.17
90.18	09018	CLINIC		0	0	0	0	0.000000	90.18
91.00	09100	EMERGENCY		0	0	0	159,627,259	0.000000	91.00
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	0.000000	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM		0	0	0	0	0.000000	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0	0	0	1,022,971,591		95.00
200.00		Total (lines 50 through 199)		0	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 31-0027 Component CCN: 31-S027		Period: From 01/01/2023 To 12/31/2023		Worksheet D Part IV Date/Time Prepared: 5/30/2024 10:12 am	
				Title XIX		Subprovider - IPF		TEFRA	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	0	0	0	0	0	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	0	0	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	0	0	0	78.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09016	CLINIC-NOT USED	0.000000	0	0	0	0	0	90.01
90.02	09001	PSYCH CLINIC	0.000000	0	0	0	0	0	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0.000000	0	0	0	0	0	90.03
90.04	09003	WORKFIRST	0.000000	0	0	0	0	0	90.04
90.05	09004	CANCER CLINIC	0.000000	0	0	0	0	0	90.05
90.06	09005	PEDIATRIC CLINIC	0.000000	0	0	0	0	0	90.06
90.07	09006	WOMENS CLINIC	0.000000	0	0	0	0	0	90.07
90.08	09007	THERAPEUTIC SCHOOL	0.000000	0	0	0	0	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0.000000	0	0	0	0	0	90.09
90.10	09017	CLINIC-NOT USED	0.000000	0	0	0	0	0	90.10
90.11	09009	PERINATAL ADDICTION	0.000000	0	0	0	0	0	90.11
90.12	09010	THERAPEUTIC NURSERY	0.000000	0	0	0	0	0	90.12
90.13	09011	CHILD DAY TREATMENT	0.000000	0	0	0	0	0	90.13
90.14	09012	DIABETES CENTER	0.000000	0	0	0	0	0	90.14
90.15	09013	WOUND CENTER	0.000000	0	0	0	0	0	90.15
90.16	09014	MICA	0.000000	0	0	0	0	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0.000000	0	0	0	0	0	90.17
90.18	09018	CLINIC	0.000000	0	0	0	0	0	90.18
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
91.01	09101	PSYCH EMERGENCY	0.000000	0	0	0	0	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	0	0	0	0	93.99
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0	0	0			95.00
200.00		Total (lines 50 through 199)		0	0	0		0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 10:12 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		38,702	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		38,702	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed 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		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		7,028	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		46,438,821	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		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)		46,438,821	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
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	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
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 and private room cost differential (line 27 minus line 36)		46,438,821	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,199.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,432,967	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		8,432,967	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet D-1

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	Program Cost (col. 3 x col. 4)	PPS
			1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)		0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT		12,896,623	5,602	2,302.15	1,409	3,243,729	43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	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)						18,707,217	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)						0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)						30,383,913	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						553,502	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						443,249	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						996,751	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						29,387,162	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
55.01	Permanent adjustment amount per discharge						0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)						0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	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)						0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 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 line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						4,624	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,199.91	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						5,548,384	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet D-1

Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (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	0.052245	5,548,384	289,875	90.00
91.00	Nursing Program cost	0	46,438,821	0.000000	5,548,384	0	91.00
92.00	Allied health cost	0	46,438,821	0.000000	5,548,384	0	92.00
93.00	All other Medical Education	0	46,438,821	0.000000	5,548,384	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0027 Component CCN: 31-S027	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 10:12 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		19,391	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,391	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		19,391	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,238	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		23,978,576	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		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
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
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	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
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 and private room cost differential (line 27 minus line 36)		23,978,576	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,236.58	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,767,466	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,767,466	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1	
				Component CCN: 31-S027		Date/Time Prepared: 5/30/2024 10:12 am	
				Title XVIII		Subprovider - IPF	PPS
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	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)					213,612	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					2,981,078	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					108,498	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					4,545	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					113,043	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,868,035	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	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)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 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 line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 31-0027 Component CCN: 31-S027		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/30/2024 10:12 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description								1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00	
Cost Center Description			Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (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	0.039204	0	0	90.00	
91.00	Nursing Program cost		0	23,978,576	0.000000	0	0	91.00	
92.00	Allied health cost		0	23,978,576	0.000000	0	0	92.00	
93.00	All other Medical Education		0	23,978,576	0.000000	0	0	93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0027 Component CCN: 31-5442	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 10:12 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		4,311	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,311	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		4,311	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,325	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		1,194,749	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		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)		1,194,749	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
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	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
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 and private room cost differential (line 27 minus line 36)		1,194,749	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 31-0027 Component CCN: 31-5442	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 10:12 am
			Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per 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	4.00	5.00
43.00 Intensive Care Type Inpatient Hospital Units					
44.00 INTENSIVE CARE UNIT					
45.00 CORONARY CARE UNIT					
46.00 BURN INTENSIVE CARE UNIT					
47.00 SURGICAL INTENSIVE CARE UNIT					
48.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					48.00
48.01 Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					48.01
49.00 Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					49.00
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					53.00
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					54.00
55.00 Target amount per discharge					55.00
55.01 Permanent adjustment amount per discharge					55.01
55.02 Adjustment amount per discharge (contractor use only)					55.02
56.00 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					57.00
58.00 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 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					60.00
61.00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					61.00
62.00 Relief payment (see instructions)					62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					63.00
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					1,194,749
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					277.14
72.00 Program routine service cost (line 9 x line 71)					644,351
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					644,351
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00
77.00 Program capital-related costs (line 9 x line 76)					0
78.00 Inpatient routine service cost (line 74 minus line 77)					0
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0
81.00 Inpatient routine service cost per diem limitation					0.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0
83.00 Reasonable inpatient routine service costs (see instructions)					644,351
84.00 Program inpatient ancillary services (see instructions)					256,444
85.00 Utilization review - physician compensation (see instructions)					0
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					900,795
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 31-0027 Component CCN: 31-5442		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/30/2024 10:12 am	
				Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description								1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0	89.00	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (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	0.000000	0	0		90.00	
91.00	Nursing Program cost	0	0	0.000000	0	0		91.00	
92.00	Allied health cost	0	0	0.000000	0	0		92.00	
93.00	All other Medical Education	0	0	0.000000	0	0		93.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 10:12 am
		Title XIX	Hospital	TEFRA
Cost Center Description				
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		38,702	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		38,702	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed 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		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		3,921	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		3,332	15.00
16.00	Nursery days (title V or XIX only)		1,849	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		46,438,821	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		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)		46,438,821	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
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	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
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 and private room cost differential (line 27 minus line 36)		46,438,821	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,199.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,704,847	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,704,847	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet D-1

Date/Time Prepared:

5/30/2024 10:12 am

Cost Center Description			Title XIX		Hospital	TEFRA	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	2,898,280	3,332	869.83	1,849	1,608,316	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	12,896,623	5,602	2,302.15	530	1,220,140	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	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)					6,053,004	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					13,586,307	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					385,538	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					161,175	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					546,713	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					13,039,594	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					1,750	54.00
55.00	Target amount per discharge					5,438.16	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					9,516,780	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					-3,522,814	57.00
58.00	Bonus payment (see instructions)					0	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)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					951,678	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					11,015,171	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 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 line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					4,624	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,199.91	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					5,548,384	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0027		Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 10:12 am	
		Title XIX		Hospital	TEFRA	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (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	0.052245	5,548,384	289,875	90.00
91.00 Nursing Program cost	0	46,438,821	0.000000	5,548,384	0	91.00
92.00 Allied health cost	0	46,438,821	0.000000	5,548,384	0	92.00
93.00 All other Medical Education	0	46,438,821	0.000000	5,548,384	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 31-0027 Component CCN: 31-S027	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 10:12 am
		Title XIX	Subprovider - IPF	TEFRA
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		19,391	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		19,391	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		19,391	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,593	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		3,332	15.00
16.00	Nursery days (title V or XIX only)		1,849	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		23,978,576	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		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
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
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	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
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 and private room cost differential (line 27 minus line 36)		23,978,576	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		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 Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,969,872	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1	
				Component CCN: 31-S027		Date/Time Prepared: 5/30/2024 10:12 am	
				Title XIX		Subprovider - IPF	TEFRA
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	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)					0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					1,969,872	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					77,229	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					77,229	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,892,643	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					176	54.00
55.00	Target amount per discharge					0.00	55.00
55.01	Permanent adjustment amount per discharge					0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)					0.00	55.02
56.00	Target amount (line 54 x sum of lines 55, 55.01, and 55.02)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					-1,892,643	57.00
58.00	Bonus payment (see instructions)					0	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)					0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)					0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					77,229	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 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 line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 31-0027 Component CCN: 31-S027		Period: From 01/01/2023 To 12/31/2023		Worksheet D-1 Date/Time Prepared: 5/30/2024 10:12 am	
				Title XIX		Subprovider - IPF		TEFRA	
Cost Center Description									
								1.00	
89.00	Observation bed cost (line 87 x line 88) (see instructions)							0	89.00
Cost Center Description			Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (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	0.039204	0	0	90.00
91.00	Nursing Program cost			0	23,978,576	0.000000	0	0	91.00
92.00	Allied health cost			0	23,978,576	0.000000	0	0	92.00
93.00	All other Medical Education			0	23,978,576	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/30/2024 10:12 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		87,429,628	30.00
31.00	03100	INTENSIVE CARE UNIT		37,895,841	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.179577	11,218,355	50.00
51.00	05100	RECOVERY ROOM	0.274525	1,190,712	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.652155	31,330	52.00
53.00	05300	ANESTHESIOLOGY	0.121291	600,422	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187789	5,084,841	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.795875	97,797	55.00
56.00	05600	RADIOISOTOPE	0.053105	870,673	56.00
57.00	05700	CT SCAN	0.026293	10,760,600	57.00
58.00	05800	MRI	0.062483	2,608,982	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.178881	3,516,803	59.00
60.00	06000	LABORATORY	0.112042	20,275,152	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.004955	1,103,312	62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.360878	5,590,823	65.00
66.00	06600	PHYSICAL THERAPY	0.397603	1,300,980	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.135609	153,139	67.00
68.00	06800	SPEECH PATHOLOGY	0.223969	542,234	68.00
69.00	06900	ELECTROCARDIOLOGY	0.045177	13,585,698	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.488929	4,373,413	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.683729	2,533,006	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.172558	17,044,041	73.00
74.00	07400	RENAL DIALYSIS	0.311082	1,392,763	74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	5.105041	0	90.00
90.01	09016	CLINIC-NOT USED	0.000000	0	90.01
90.02	09001	PSYCH CLINIC	1.086310	0	90.02
90.03	09002	PSYCH CLINIC FEE BASED	0.000000	0	90.03
90.04	09003	WORKFIRST	0.000000	0	90.04
90.05	09004	CANCER CLINIC	0.000000	0	90.05
90.06	09005	PEDIATRIC CLINIC	1.570654	0	90.06
90.07	09006	WOMENS CLINIC	0.179744	0	90.07
90.08	09007	THERAPEUTIC SCHOOL	0.261331	0	90.08
90.09	09008	AFTER SCHOOL PROGRAM	0.000000	0	90.09
90.10	09017	CLINIC-NOT USED	0.000000	0	90.10
90.11	09009	PERINATAL ADDICTION	0.000000	0	90.11
90.12	09010	THERAPEUTIC NURSERY	0.000000	0	90.12
90.13	09011	CHILD DAY TREATMENT	0.000000	0	90.13
90.14	09012	DIABETES CENTER	0.000000	0	90.14
90.15	09013	WOUND CENTER	0.144633	0	90.15
90.16	09014	MICA	0.000000	0	90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0.670740	0	90.17
90.18	09018	CLINIC	0.000000	0	90.18
91.00	09100	EMERGENCY	0.139231	9,380,265	91.00
91.01	09101	PSYCH EMERGENCY	4.654304	0	91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.186583	0	92.00
93.99	09399	PARTIAL HOSPITALIZATION PROGRAM	0.000000	0	93.99
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		113,255,341	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		113,255,341	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3	
		Component CCN: 31-S027		Date/Time Prepared: 5/30/2024 10:12 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF		10,394,766		40.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.179577	0	0	50.00
51.00	05100 RECOVERY ROOM	0.274525	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.652155	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.121291	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.187789	21,876	4,108	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.795875	0	0	55.00
56.00	05600 RADIOISOTOPE	0.053105	0	0	56.00
57.00	05700 CT SCAN	0.026293	48,367	1,272	57.00
58.00	05800 MRI	0.062483	3,000	187	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.178881	0	0	59.00
60.00	06000 LABORATORY	0.112042	439,159	49,204	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.004955	0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.360878	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.397603	19,225	7,644	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.135609	38,616	5,237	67.00
68.00	06800 SPEECH PATHOLOGY	0.223969	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.045177	25,169	1,137	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.488929	288	141	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.683729	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.172558	470,641	81,213	73.00
74.00	07400 RENAL DIALYSIS	0.311082	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	5.105041	0	0	90.00
90.01	09016 CLINIC-NOT USED	0.000000	0	0	90.01
90.02	09001 PSYCH CLINIC	1.086310	0	0	90.02
90.03	09002 PSYCH CLINIC FEE BASED	0.000000	0	0	90.03
90.04	09003 WORKFIRST	0.000000	0	0	90.04
90.05	09004 CANCER CLINIC	0.000000	0	0	90.05
90.06	09005 PEDIATRIC CLINIC	1.570654	0	0	90.06
90.07	09006 WOMENS CLINIC	0.179744	0	0	90.07
90.08	09007 THERAPEUTIC SCHOOL	0.261331	0	0	90.08
90.09	09008 AFTER SCHOOL PROGRAM	0.000000	0	0	90.09
90.10	09017 CLINIC-NOT USED	0.000000	0	0	90.10
90.11	09009 PERINATAL ADDICTION	0.000000	0	0	90.11
90.12	09010 THERAPEUTIC NURSERY	0.000000	0	0	90.12
90.13	09011 CHILD DAY TREATMENT	0.000000	0	0	90.13
90.14	09012 DIABETES CENTER	0.000000	0	0	90.14
90.15	09013 WOUND CENTER	0.144633	0	0	90.15
90.16	09014 MICA	0.000000	0	0	90.16
90.17	09015 BAYONNE MENTAL HEALTH CENTER	0.670740	0	0	90.17
90.18	09018 CLINIC	0.000000	0	0	90.18
91.00	09100 EMERGENCY	0.139231	455,856	63,469	91.00
91.01	09101 PSYCH EMERGENCY	4.654304	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.186583	0	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
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,522,197	213,612	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,522,197		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3	
		Component CCN: 31-5442		Date/Time Prepared: 5/30/2024 10:12 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF				41.00
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.179577	0	0	50.00
51.00	05100 RECOVERY ROOM	0.274525	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.652155	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.121291	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.187789	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.795875	0	0	55.00
56.00	05600 RADIOISOTOPE	0.053105	0	0	56.00
57.00	05700 CT SCAN	0.026293	0	0	57.00
58.00	05800 MRI	0.062483	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.178881	0	0	59.00
60.00	06000 LABORATORY	0.112042	81,712	9,155	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.004955	0	0	62.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.360878	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.397603	550,370	218,829	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.135609	184,820	25,063	67.00
68.00	06800 SPEECH PATHOLOGY	0.223969	14,720	3,297	68.00
69.00	06900 ELECTROCARDIOLOGY	0.045177	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.488929	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.683729	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.172558	580	100	73.00
74.00	07400 RENAL DIALYSIS	0.311082	0	0	74.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0.000000	0	0	78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	5.105041	0	0	90.00
90.01	09016 CLINIC-NOT USED	0.000000	0	0	90.01
90.02	09001 PSYCH CLINIC	1.086310	0	0	90.02
90.03	09002 PSYCH CLINIC FEE BASED	0.000000	0	0	90.03
90.04	09003 WORKFIRST	0.000000	0	0	90.04
90.05	09004 CANCER CLINIC	0.000000	0	0	90.05
90.06	09005 PEDIATRIC CLINIC	1.570654	0	0	90.06
90.07	09006 WOMENS CLINIC	0.179744	0	0	90.07
90.08	09007 THERAPEUTIC SCHOOL	0.261331	0	0	90.08
90.09	09008 AFTER SCHOOL PROGRAM	0.000000	0	0	90.09
90.10	09017 CLINIC-NOT USED	0.000000	0	0	90.10
90.11	09009 PERINATAL ADDICTION	0.000000	0	0	90.11
90.12	09010 THERAPEUTIC NURSERY	0.000000	0	0	90.12
90.13	09011 CHILD DAY TREATMENT	0.000000	0	0	90.13
90.14	09012 DIABETES CENTER	0.000000	0	0	90.14
90.15	09013 WOUND CENTER	0.144633	0	0	90.15
90.16	09014 MICA	0.000000	0	0	90.16
90.17	09015 BAYONNE MENTAL HEALTH CENTER	0.670740	0	0	90.17
90.18	09018 CLINIC	0.000000	0	0	90.18
91.00	09100 EMERGENCY	0.139231	0	0	91.00
91.01	09101 PSYCH EMERGENCY	4.654304	0	0	91.01
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.186583	0	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
200.00	Total (sum of lines 50 through 94 and 96 through 98)		832,202	256,444	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		832,202		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Prepared: 5/30/2024 10:12 am
			Title XIX	Hospital	TEFRA
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		19,477,289	30.00
31.00	03100	INTENSIVE CARE UNIT		5,232,623	31.00
40.00	04000	SUBPROVIDER - IPF		8,994,391	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		13,437,652	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.179497	1,666,737	299,174 50.00
51.00	05100	RECOVERY ROOM	0.274525	132,512	36,378 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.652155	3,739,086	2,438,464 52.00
53.00	05300	ANESTHESIOLOGY	0.121291	711,542	86,304 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.187428	1,353,551	253,693 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.795875	0	0 55.00
56.00	05600	RADIOISOTOPE	0.053105	102,051	5,419 56.00
57.00	05700	CT SCAN	0.026293	1,673,800	44,009 57.00
58.00	05800	MRI	0.062483	450,993	28,179 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.178881	713,130	127,565 59.00
60.00	06000	LABORATORY	0.111928	5,879,840	658,119 60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.004955	313,201	1,552 62.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	0.360878	769,582	277,725 65.00
66.00	06600	PHYSICAL THERAPY	0.397603	159,117	63,265 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.135609	93,221	12,642 67.00
68.00	06800	SPEECH PATHOLOGY	0.223969	247,473	55,426 68.00
69.00	06900	ELECTROCARDIOLOGY	0.045177	1,569,371	70,899 69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.488929	802,537	392,384 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.683729	160,084	109,454 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.172558	4,488,627	774,548 73.00
74.00	07400	RENAL DIALYSIS	0.309800	135,690	42,037 74.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0 76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0 76.99
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0.000000	0	0 77.00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0.000000	0	0 78.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	5.105041	0	0 90.00
90.01	09016	CLINIC-NOT USED	0.000000	0	0 90.01
90.02	09001	PSYCH CLINIC	1.078949	0	0 90.02
90.03	09002	PSYCH CLINIC FEE BASED	0.000000	0	0 90.03
90.04	09003	WORKFIRST	0.000000	0	0 90.04
90.05	09004	CANCER CLINIC	0.000000	0	0 90.05
90.06	09005	PEDIATRIC CLINIC	1.570654	0	0 90.06
90.07	09006	WOMENS CLINIC	0.179744	0	0 90.07
90.08	09007	THERAPEUTIC SCHOOL	0.261331	0	0 90.08
90.09	09008	AFTER SCHOOL PROGRAM	0.000000	0	0 90.09
90.10	09017	CLINIC-NOT USED	0.000000	0	0 90.10
90.11	09009	PERINATAL ADDICTION	0.000000	0	0 90.11
90.12	09010	THERAPEUTIC NURSERY	0.000000	0	0 90.12
90.13	09011	CHILD DAY TREATMENT	0.000000	0	0 90.13
90.14	09012	DIABETES CENTER	0.000000	0	0 90.14
90.15	09013	WOUND CENTER	0.144633	0	0 90.15
90.16	09014	MICA	0.000000	0	0 90.16
90.17	09015	BAYONNE MENTAL HEALTH CENTER	0.670740	0	0 90.17
90.18	09018	CLINIC	0.000000	0	0 90.18
91.00	09100	EMERGENCY	0.139231	1,980,653	275,768 91.00
91.01	09101	PSYCH EMERGENCY	4.654304	0	0 91.01
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.186583	0	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
200.00		Total (sum of lines 50 through 94 and 96 through 98)		27,142,798	6,053,004 200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		27,142,798	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 10:12 am
		Title XVIII	Hospital	PPS
				1.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	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 instructions)		10,339,220	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		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)		0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		93,583	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		17,748	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
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		32.92	5.00
5.01	FTE cap adjustment for qualifying hospitals under §131 of the CAA 2021 (see instructions)		0.00	5.01
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
6.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)		0.00	6.26
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.81	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
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, 1998), and 67 FR 50069 (August 1, 2002).		7.50	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		1.23	8.02
8.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)		0.00	8.21
9.00	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 minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		40.84	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		49.78	10.00
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	12.00
13.00	Total allowable FTE count for the prior year.		46.84	13.00
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	Sum of lines 12 through 14 divided by 3.		46.58	15.00
16.00	Adjustment for residents in initial years of the program (see instructions)		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		46.58	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.275084	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.261544	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.261544	21.00
22.00	IME payment adjustment (see instructions)		1,897,455	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		2,503,640	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	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	25.00
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	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	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	29.01
Disproportionate Share Adjustment				
30.00	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	31.00
32.00	Sum of lines 30 and 31		51.01	32.00
33.00	Allowable disproportionate share percentage (see instructions)		31.30	33.00
34.00	Disproportionate share adjustment (see instructions)		1,114,700	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 10:12 am
		Title XVIII	Hospital	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)		6,874,403,459	5,938,006,757
35.01	Factor 3 (see instructions)		0.000933984	0.000901147
35.02	Hospital UCP, including supplemental UCP (see instructions)		6,420,583	5,351,017
35.03	Pro rata share of the hospital UCP, including supplemental UCP (see instructions)		4,802,243	1,345,064
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		6,147,307	
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges (see instructions)		2,740	
41.00	Total ESRD Medicare discharges (see instructions)		298	
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		298	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		10.88	
43.00	Total Medicare ESRD inpatient days (see instructions)		2,507	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		1.201822	
45.00	Average weekly cost for dialysis treatments (see instructions)		796.71	
46.00	Total additional payment (line 45 times line 44 times line 41.01)		285,335	
47.00	Subtotal (see instructions)		23,801,496	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		26,305,136	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,333,089	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		1,239,419	
53.00	Nursing and Allied Health Managed Care payment		0	
54.00	Special add-on payments for new technologies		0	
54.01	Islet isolation add-on payment		0	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	
55.01	Cellular therapy acquisition cost (see instructions)		0	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	
59.00	Total (sum of amounts on lines 49 through 58)		28,877,644	
60.00	Primary payer payments		0	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		28,877,644	
62.00	Deductibles billed to program beneficiaries		1,190,944	
63.00	Coinurance billed to program beneficiaries		92,800	
64.00	Allowable bad debts (see instructions)		332,906	
65.00	Adjusted reimbursable bad debts (see instructions)		216,389	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		313,653	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		27,810,289	
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0	
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0	
70.75	N95 respirator payment adjustment amount (see instructions)		0	
70.87	Demonstration payment adjustment amount before sequestration		0	
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	
70.92	Bundled Model 1 discount amount (see instructions)		0	
70.93	HVBP payment adjustment amount (see instructions)		-32,711	
70.94	HRR adjustment amount (see instructions)		-43,380	
70.95	Recovery of accelerated depreciation		0	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prepared: 5/30/2024 10:12 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3	0	0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		27,734,198	71.00
71.01	Sequestration adjustment (see instructions)		554,684	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs			71.03
72.00	Interim payments		27,042,069	72.00
72.01	Interim payments-PARHM			72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)			73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		137,445	74.00
74.01	Balance due provider/program-PARHM (see instructions)			74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,823,834	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/30/2024 10:12 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (col s. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					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 discharges occurring on or after October 1	1.02	3,906,148		3,906,148	3,906,148	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	93,583	93,583		93,583	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	17,748		17,748	17,748	2.03
3.00	Operating outlier reconciliation	2.01	0	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 (see instructions)	21.00	0.261544	0.261544	0.261544		5.00
6.00	IME payment adjustment (see instructions)	22.00	1,897,455	1,377,164	520,291	1,897,455	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	2,503,640	1,877,730	625,910	2,503,640	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
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	0	0	0	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 lines 6.01 and 8.01)	29.01	2,503,640	1,877,730	625,910	2,503,640	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.3130	0.3130	0.3130		10.00
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 ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	285,335	213,415	71,920	285,335	12.00
13.00	Subtotal (see instructions)	47.00	23,801,496	17,634,669	6,166,827	23,801,496	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	26,305,136	19,512,399	6,792,737	26,305,136	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,333,089	997,077	336,012	1,333,089	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			20,509,476	7,128,749	27,638,225	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023Worksheet E
Part A Exhibit 5
Date/Time Prepared:
5/30/2024 10:12 am

		Title XVIII		Hospital		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	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	1,532	1,146	386	1,532	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	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
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. 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	0		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 payment (see instructions)	70.90	0	0	0	0	30.01
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	0	0	0	31.01
						(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		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 10:12 am
		Title XVIII	Hospital	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 instructions)			13,433,897 2.00
3.00	OPPS or REH payments			6,882,904 3.00
4.00	Outlier payment (see instructions)			85,982 4.00
4.01	Outlier reconciliation amount (see instructions)			0 4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.000 5.00
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 graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			175,937 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			161,577 12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			161,577 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)			0 16.00
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 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			14,360 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 instructions)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			6,968,886 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)			1,348,056 26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)			5,782,407 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)			475,243 28.00
28.50	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	Subtotal (sum of lines 27, 28, 28.50 and 29)			6,257,650 30.00
31.00	Primary payer payments			282 31.00
32.00	Subtotal (line 30 minus line 31)			6,257,368 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			22,556 33.00
34.00	Allowable bad debts (see instructions)			210,912 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			137,093 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			197,922 36.00
37.00	Subtotal (see instructions)			6,417,017 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 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 39.75
39.97	Demonstration payment adjustment amount before sequestration			0 39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)			0 39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			6,417,017 40.00
40.01	Sequestration adjustment (see instructions)			128,340 40.01
40.02	Demonstration payment adjustment amount after sequestration			0 40.02
40.03	Sequestration adjustment-PARHM pass-throughs			40.03
41.00	Interim payments			5,563,095 41.00
41.01	Interim payments-PARHM			41.01
42.00	Tentative settlement (for contractors use only)			0 42.00
42.01	Tentative settlement-PARHM (for contractor use only)			42.01
43.00	Balance due provider/program (see instructions)			725,582 43.00
43.01	Balance due provi der/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/30/2024 10:12 am	
		Title XVIII	Hospital	PPS	
				1.00	
94.00	Total (sum of lines 91 and 93)			0	94.00
				1.00	
200.00	MEDICARE PART B ANCILLARY COSTS Part B Combined Billed Days			0	200.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023Worksheet E-1
Part I
Date/Time Prepared:
5/30/2024 10:12 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		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 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	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)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER	08/30/2023	565,723		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	12/07/2023	392,981		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		172,742		0	3.99	
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)		27,042,069		5,563,095	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	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		137,445		725,582	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		27,179,514		6,288,677	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 31-0027

Period:

Worksheet E-1

Component CCN: 31-S027

From 01/01/2023

Part I

To 12/31/2023

Date/Time Prepared:

5/30/2024 10:12 am

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		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				0	1.00
2.00	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		0	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)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	10/26/2023	13,987		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		13,987		0	3.99
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	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		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		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 31-0027

Period:

Worksheet E-1

Component CCN: 31-5442

From 01/01/2023

Part I

To 12/31/2023

Date/Time Prepared:

5/30/2024 10:12 am

Title XVIII

Skilled Nursing

Facility

PPS

		Inpatient Part A		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		1,167,449		0	1.00
2.00	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		0		0	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)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
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)		1,167,449		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	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,167,449		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023Worksheet E-1
Part II
Date/Time Prepared:
5/30/2024 10:12 am

		Title XVIII	Hospital	PPS
			1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			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 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0027 Component CCN: 31-S027	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part II Date/Time Prepared: 5/30/2024 10:12 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,164,635 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			2.26 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			8.60 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			2.26 8.00
9.00	Average Daily Census (see instructions)			53.126027 9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.			0.021687 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			46,944 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,211,579 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,211,579 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,211,579 18.00
19.00	Deductibles			156,536 19.00
20.00	Subtotal (line 18 minus line 19)			2,055,043 20.00
21.00	Coinurance			33,512 21.00
22.00	Subtotal (line 20 minus line 21)			2,021,531 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			46,394 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			30,156 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			46,394 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,051,687 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.98	Recovery of accelerated depreciation.			0 30.98
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,051,687 31.00
31.01	Sequestration adjustment (see instructions)			41,034 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			2,081,419 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)			-70,766 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)				
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.			0.000000 99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)			0.021687 99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0027 Component CCN: 31-5442	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VI Date/Time Prepared: 5/30/2024 10:12 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES			
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			
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, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			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)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)			0 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 10:12 am	
		Title XIX	Hospital	TEFRA	
			Inpatient	Outpatient	
			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
2.00	Medical and other services			4,254,688	2.00
3.00	Organ acquisition (certified transplant programs only)	0			3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	11,015,171		4,254,688	4.00
5.00	Inpatient primary payer payments	0			5.00
6.00	Outpatient primary payer payments			0	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
9.00	Ancillary service charges	27,142,798		19,102,638	9.00
10.00	Organ acquisition charges, net of revenue	0			10.00
11.00	Incentive from target amount computation	0			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 basis	0		0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0		0	14.00
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
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	63,269,582		14,847,950	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0		0	18.00
19.00	Interns and Residents (see instructions)	0		0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0		0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	11,015,171		4,254,688	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments	0		0	22.00
23.00	Outlier payments	0		0	23.00
24.00	Program capital payments	0			24.00
25.00	Capital exception payments (see instructions)	0			25.00
26.00	Routine and Ancillary service other pass through costs	0		0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0		0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0		0	28.00
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)	0		0	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	Deductibles	0		0	32.00
33.00	Coinurance	0		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 33)	11,015,171		4,254,688	36.00
37.00	PROFESSIONAL SVCS D3	617,097		328,213	37.00
38.00	Subtotal (line 36 ± line 37)	11,632,268		4,582,901	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0			39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	11,632,268		4,582,901	40.00
41.00	Interim payments	13,174,522		2,135,578	41.00
42.00	Balance due provider/program (line 40 minus line 41)	-1,542,254		2,447,323	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0		0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 31-0027 Component CCN: 31-S027	Period: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 10:12 am
		Title XIX	Subprovider - IPF	TEFRA
		Inpatient 1.00	Outpatient 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	77,229		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	77,229	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	77,229	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
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)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	77,229	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
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 completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	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	Deductibles	0	0	32.00
33.00	Coinurance	0	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 33)	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
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Prepared: 5/30/2024 10:12 am	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			32.92	1.00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructions)			0.00	1.01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
2.26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of the CAA 2021 (see instructions)			0.00	2.26
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			4.41	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
3.02	Adjustment (increase or decrease) to the hospital's rural track FTE limitation(s) for rural track programs with a rural track Medicare GME affiliation agreement in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)			0.00	3.02
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			7.50	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			1.46	4.02
4.21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)			0.00	4.21
5.00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lines 2.26 through 2.49, minus lines 3 and 3.01, plus or minus line 3.02, plus or minus line 4, plus lines 4.01 through 4.27)			37.47	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			58.38	6.00
7.00	Enter the lesser of line 5 or line 6			37.47	7.00
		Primary Care 1.00	Other 2.00	Total 3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	36.99	20.84	57.83	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6. For cost reporting periods beginning on or after October 1, 2022, or if Worksheet S-2, Part I, line 68, is "Y", see instructions.	23.97	13.50	37.47	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		5.71		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		53.71		10.01
11.00	Total weighted FTE count	23.97	19.21		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	20.83	22.64		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	25.49	17.40		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	23.43	19.75		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	23.43	19.75		17.00
18.00	Per resident amount	0.00	0.00		18.00
18.01	Per resident amount under §131 of the CAA 2021	122,851.78	122,851.78		18.01
19.00	Approved amount for resident costs	2,878,417	2,426,323	5,304,740	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			20.91	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			144,531.45	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			5,304,740	25.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Prepared: 5/30/2024 10:12 am	
		Title XVIII	Hospital	PPS	
		Inpatient Part A	Managed Care	Total	
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	10,679	11,221		26.00
27.00	Total Inpatient Days (see instructions)	66,618	66,618		27.00
28.00	Ratio of inpatient days to total inpatient days	0.160302	0.168438		28.00
29.00	Program direct GME amount	850,360	893,520	1,743,880	29.00
29.01	Percent reduction for MA DGME		3.27		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		29,218	29,218	30.00
31.00	Net Program direct GME amount			1,714,662	31.00
				1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)					
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			58,720,663	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			35,493,417	37.00
38.00	Organ acquisition and HSCT acquisition costs (see instructions)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			35,493,417	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			13,609,834	42.00
43.00	Primary payer payments (see instructions)			282	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			13,609,552	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			49,102,969	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.722836	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.277164	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			1,714,662	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			1,239,419	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			475,243	50.00

OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet E-5 Date/Time Prepared: 5/30/2024 10:12 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 instructions)			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)			0 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)			0 6.00
7.00	Time value of money for capital related expenses (see instructions)			0 7.00

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 01/01/2023
To 12/31/2023

Worksheet G

Date/Time Prepared:
5/30/2024 10:12 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	3,606,022	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	30,953,101	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-9,706,852	0	0	0	6.00
7.00	Inventory	3,888,687	0	0	0	7.00
8.00	Prepaid expenses	2,306,917	0	0	0	8.00
9.00	Other current assets	21,692,184	0	0	0	9.00
10.00	Due from other funds	112,441,677	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	165,181,736	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,783,178	0	0	0	12.00
13.00	Land improvements	1,138,399	0	0	0	13.00
14.00	Accumulated depreciation	-170,286	0	0	0	14.00
15.00	Buildings	95,028,583	0	0	0	15.00
16.00	Accumulated depreciation	-12,710,027	0	0	0	16.00
17.00	Leasehold improvements	1,669,389	0	0	0	17.00
18.00	Accumulated depreciation	-377,975	0	0	0	18.00
19.00	Fixed equipment	11,566,916	0	0	0	19.00
20.00	Accumulated depreciation	-427,653	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	41,086,568	0	0	0	23.00
24.00	Accumulated depreciation	-11,678,705	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	126,908,387	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	24,303,010	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	24,303,010	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	316,393,133	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	14,777,490	0	0	0	37.00
38.00	Salaries, wages, and fees payable	9,174,007	0	0	0	38.00
39.00	Payroll taxes payable	541,418	0	0	0	39.00
40.00	Notes and loans payable (short term)	11,368	0	0	0	40.00
41.00	Deferred income	8,104,536	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	4,402,366	0	0	0	43.00
44.00	Other current liabilities	24,615,911	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	61,627,096	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	11,367	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	68,282,612	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	68,293,979	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	129,921,075	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	186,472,058	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	186,472,058	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	316,393,133	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet G-1

Date/Time Prepared:
5/30/2024 10:12 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		226,943,074		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		-42,784,125				2.00
3.00	Total (sum of line 1 and line 2)		184,158,949		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	NON OPERATING REVENUE	592,146		0		0	5.00
6.00	OTHER CHANGES IN RESTRICTED ASSETS	1,720,963		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		2,313,109		0		10.00
11.00	Subtotal (line 3 plus line 10)		186,472,058		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		186,472,058		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	NON OPERATING REVENUE		0				5.00
6.00	OTHER CHANGES IN RESTRICTED ASSETS		0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023Worksheet G-2
Parts I & II
Date/Time Prepared:
5/30/2024 10:12 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	210,750,556		210,750,556	1.00
2.00	SUBPROVIDER - IPF	104,693,028		104,693,028	2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	11,098,076		11,098,076	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	1,122,409		1,122,409	7.00
8.00	NURSING FACILITY	7,135,927		7,135,927	8.00
9.00	OTHER LONG TERM CARE	4,285,995		4,285,995	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	339,085,991		339,085,991	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	73,857,962		73,857,962	11.00
12.00	CORONARY CARE UNIT				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 11-15)	73,857,962		73,857,962	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	412,943,953		412,943,953	17.00
18.00	Ancillary services	248,017,850	531,918,533	779,936,383	18.00
19.00	Outpatient services	27,166,072	244,695,514	271,861,586	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	688,127,875	776,614,047	1,464,741,922	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		359,129,599		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			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 to Wkst. G-3, line 4)		359,129,599		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 31-0027

Period:
From 01/01/2023
To 12/31/2023

Worksheet G-3

Date/Time Prepared:
5/30/2024 10:12 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,464,741,922	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,190,769,969	2.00
3.00	Net patient revenues (line 1 minus line 2)	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 INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
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	22.00
23.00	Governmental appropriations	0	23.00
24.00	TOTAL EXCLUDING COVID	42,455,397	24.00
24.50	COVID-19 PHE Funding	-81,876	24.50
25.00	Total other income (sum of lines 6-24)	42,373,521	25.00
26.00	Total (line 5 plus line 25)	-42,784,125	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	-42,784,125	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 31-0027

Period:

Worksheet I-1

Component CCN: 31-2318

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

		Total Costs	Basis	Statistics	FTEs per 2080 Hours	
		1.00	2.00	3.00	4.00	
1.00	REGISTERED NURSES	3,914,041	HOURS OF SERVICE	65,532.00	31.51	1.00
2.00	LICENSED PRACTICAL NURSES		HOURS OF SERVICE	0.00	0.00	2.00
3.00	NURSES AIDES		HOURS OF SERVICE	0.00	0.00	3.00
4.00	TECHNICIANS	1,225,967	HOURS OF SERVICE	45,529.00	21.89	4.00
5.00	SOCIAL WORKERS	138,396	HOURS OF SERVICE	3,031.00	1.46	5.00
6.00	DIETICIANS	167,192	HOURS OF SERVICE	4,015.00	1.93	6.00
7.00	PHYSICIANS	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		SALARY			10.00
11.00	CAPITAL RELATED COSTS-BLDGS. & FIXTURES		SQUARE FEET			11.00
12.00	CAPITAL RELATED COSTS-MOV. EQUIP.		PERCENTAGE OF TIME			12.00
13.00	MACHINE COSTS & REPAIRS		PERCENTAGE OF TIME			13.00
14.00	SUPPLIES		REQUISITIONS			14.00
14.01	PEDIATRIC MEDICAL SUPPLIES		REQUISITIONS			14.01
15.00	DRUGS	1,434,189	REQUISITIONS			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	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	REQUISITIONS			24.00
25.00	PHARMACY	556,596	REQUISITIONS			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)		CHARGES	0		28.00
29.00	RESPIRATORY THERAPY (SEE INSTRUCTIONS)		CHARGES	0		29.00
30.00	OTHER ANCILLARY SERVICE COST CENTERS		CHARGES	0		30.00
30.97	CARDIAC REHABILITATION		CHARGES	0		30.97
30.98	HYPERBARIC OXYGEN THERAPY		CHARGES	0		30.98
30.99	LITHOTRIpsy		CHARGES	0		30.99
31.00	TOTAL COSTS (SUM OF LINES 27-30)	18,191,690				31.00

* 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.

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES					Provider CCN: 31-0027 Component CCN: 31-2318	Period: From 01/01/2023 To 12/31/2023	Worksheet 1-2 Date/Time Prepared: 5/30/2024 10:12 am	
						Renal Dialysis		
		Capital Related Costs		Direct Patient Care Salary		Employee Benefits Department	Drugs	
		Building	Equipment	RNs	Other			
		1.00	2.00	3.00	4.00			
1.00	Total Renal Department Costs	1,181,156	105,539	3,914,041	1,531,555	1,336,402	1,990,785	1.00
MAINTENANCE								
2.00	Hemodialysis	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	0	0	0	2.01
2.02	Hemodialysis-Pediatric	0	0	0	0	0	0	2.02
3.00	Intermittent Peritoneal	0	0	0	0	0	0	3.00
3.01	AKI -Intermittent Peritoneal	0	0	0	0	0	0	3.01
3.02	IPD-Pediatric	0	0	0	0	0	0	3.02
TRAINING								
4.00	Hemodialysis	0	0	0	0	0	0	4.00
4.01	Hemodialysis-Pediatric	0	0	0	0	0	0	4.01
5.00	Intermittent Peritoneal	0	0	0	0	0	0	5.00
5.01	IPD-Pediatric	0	0	0	0	0	0	5.01
6.00	CAPD	0	0	0	0	0	0	6.00
6.01	CAPD-Pediatric	0	0	0	0	0	0	6.01
7.00	CCPD	0	0	0	0	0	0	7.00
7.01	CCPD-Pediatric	0	0	0	0	0	0	7.01
HOME								
8.00	Hemodialysis	0	0	0	0	0	0	8.00
8.01	Hemodialysis-Pediatric	0	0	0	0	0	0	8.01
9.00	Intermittent Peritoneal	0	0	0	0	0	0	9.00
9.01	IPD-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	10.01
11.00	CCPD	0	0	0	0	0	0	11.00
11.01	CCPD-Pediatric	0	0	0	0	0	0	11.01
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis	0	0	0	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 Department)							14.00
15.00								15.00
16.00	Other	0	0	0	0	0	0	16.00
17.00	Total (sum of lines 2 through 16)	1,181,156	105,539	3,914,041	1,531,555	1,336,402	1,990,785	17.00
18.00	Medical Educational Program Costs							18.00
19.00	Total Renal Costs (line 17 + line 18)							19.00
		Medical Supplies	Pediatric Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 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
MAINTENANCE								
2.00	Hemodialysis	183,205	0	0	10,242,683	7,949,007	18,191,690	2.00
2.01	AKI -Hemodialysis	0	0	0	0	0	0	2.01
2.02	Hemodialysis-Pediatric	0	0	0	0	0	0	2.02
3.00	Intermittent Peritoneal	0	0	0	0	0	0	3.00
3.01	AKI -Intermittent Peritoneal	0	0	0	0	0	0	3.01
3.02	IPD-Pediatric	0	0	0	0	0	0	3.02
TRAINING								
4.00	Hemodialysis	0	0	0	0	0	0	4.00
4.01	Hemodialysis-Pediatric	0	0	0	0	0	0	4.01
5.00	Intermittent Peritoneal	0	0	0	0	0	0	5.00
5.01	IPD-Pediatric	0	0	0	0	0	0	5.01
6.00	CAPD	0	0	0	0	0	0	6.00
6.01	CAPD-Pediatric	0	0	0	0	0	0	6.01
7.00	CCPD	0	0	0	0	0	0	7.00
7.01	CCPD-Pediatric	0	0	0	0	0	0	7.01
HOME								
8.00	Hemodialysis	0	0	0	0	0	0	8.00
8.01	Hemodialysis-Pediatric	0	0	0	0	0	0	8.01
9.00	Intermittent Peritoneal	0	0	0	0	0	0	9.00
9.01	IPD-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	10.01
11.00	CCPD	0	0	0	0	0	0	11.00
11.01	CCPD-Pediatric	0	0	0	0	0	0	11.01

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES				Provider CCN: 31-0027 Component CCN: 31-2318		Period: From 01/01/2023 To 12/31/2023	Worksheet 1-2 Date/Time Prepared: 5/30/2024 10:12 am	
						Renal Dialysis		
	Medical Supplies	Pediatric Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	Total (col. 9 + col. 10)		
	7.00	7.01	8.00	9.00	10.00	11.00		
OTHER BILLABLE SERVICES								
12.00 Inpatient Dialysis	0	0	0	0	0	0	0	12.00
13.00 Method II Home Patient	0	0	0	0	0	0	0	13.00
14.00 ESAs (included in Renal Department)								14.00
15.00								15.00
16.00 Other	0	0	0	0	0	0	0	16.00
17.00 Total (sum of lines 2 through 16)	183,205	0	0	10,242,683	7,949,007	18,191,690		17.00
18.00 Medical Educational Program Costs						0		18.00
19.00 Total Renal Costs (line 17 + line 18)						18,191,690		19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0027

Period: From 01/01/2023

Worksheet 1-3

Component CCN: 31-2318

To 12/31/2023

Date/Time Prepared:
5/30/2024 10:12 am

		Capital Related Costs		Direct Patient Care Salary		Renal Dialysis		
		Building (Square Feet)	Equipment (% of Time)	RNs (Hours)	Other (Hours)	Employee Benefits Department (Salary)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	Total Renal Department Costs	1,181,156	105,539	3,914,041	1,531,555	1,336,402		1.00
MAINTENANCE								
2.00	Hemodialysis	1,170,897	107,645.00	3,914,041.00	1,531,555.00	1,416,485		2.00
2.01	AKI-Hemodialysis	0	0.00	0.00	0.00	0		2.01
2.02	Hemodialysis-Pediatric	0	0.00	0.00	0.00	0		2.02
3.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0		3.00
3.01	AKI-Intermittent Peritoneal	0	0.00	0.00	0.00	0		3.01
3.02	IPD-Pediatric	0	0.00	0.00	0.00	0		3.02
TRAINING								
4.00	Hemodialysis	0	0.00	0.00	0.00	0		4.00
4.01	Hemodialysis-Pediatric	0	0.00	0.00	0.00	0		4.01
5.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0		5.00
5.01	IPD-Pediatric	0	0.00	0.00	0.00	0		5.01
6.00	CAPD	0	0.00	0.00	0.00	0		6.00
6.01	CAPD-Pediatric	0	0.00	0.00	0.00	0		6.01
7.00	CCPD	0	0.00	0.00	0.00	0		7.00
7.01	CCPD-Pediatric	0	0.00	0.00	0.00	0		7.01
HOME								
8.00	Hemodialysis	0	0.00	0.00	0.00	0		8.00
8.01	Hemodialysis-Pediatric	0	0.00	0.00	0.00	0		8.01
9.00	Intermittent Peritoneal	0	0.00	0.00	0.00	0		9.00
9.01	IPD-Pediatric	0	0.00	0.00	0.00	0		9.01
10.00	CAPD	0	0.00	0.00	0.00	0		10.00
10.01	CAPD-Pediatric	0	0.00	0.00	0.00	0		10.01
11.00	CCPD	0	0.00	0.00	0.00	0		11.00
11.01	CCPD-Pediatric	0	0.00	0.00	0.00	0		11.01
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis Treatments	0	0.00	0.00	0.00	0		12.00
13.00	Method II Home Patient	0	0.00	0.00	0.00	0		13.00
14.00	ESAs							14.00
15.00								15.00
16.00	Other	0	0.00	0.00	0.00	0		16.00
17.00	Total Statistical Basis	1,170,897	107,645.00	3,914,041.00	1,531,555.00	1,416,485		17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	1.008762	0.980436	1.000000	1.000000	0.943464		18.00
		Drugs (Requist.)	Medical Supplies (Requist.)	Pediatric Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal	Overhead (Accum. Cost)	
		6.00	7.00	7.01	8.00	9.00	10.00	
1.00	Total Renal Department Costs	1,990,785	183,205	0	0	10,242,683	7,949,007	1.00
MAINTENANCE								
2.00	Hemodialysis	1,516,602	187,818	0	0			2.00
2.01	AKI-Hemodialysis	0	0	0	0			2.01
2.02	Hemodialysis-Pediatric	0	0	0	0			2.02
3.00	Intermittent Peritoneal	0	0	0	0			3.00
3.01	AKI-Intermittent Peritoneal	0	0	0	0			3.01
3.02	IPD-Pediatric	0	0	0	0			3.02
TRAINING								
4.00	Hemodialysis	0	0	0	0			4.00
4.01	Hemodialysis-Pediatric	0	0	0	0			4.01
5.00	Intermittent Peritoneal	0	0	0	0			5.00
5.01	IPD-Pediatric	0	0	0	0			5.01
6.00	CAPD	0	0	0	0			6.00
6.01	CAPD-Pediatric	0	0	0	0			6.01
7.00	CCPD	0	0	0	0			7.00
7.01	CCPD-Pediatric	0	0	0	0			7.01
HOME								
8.00	Hemodialysis	0	0	0	0			8.00
8.01	Hemodialysis-Pediatric	0	0	0	0			8.01
9.00	Intermittent Peritoneal	0	0	0	0			9.00
9.01	IPD-Pediatric	0	0	0	0			9.01
10.00	CAPD	0	0	0	0			10.00
10.01	CAPD-Pediatric	0	0	0	0			10.01
11.00	CCPD	0	0	0	0			11.00
11.01	CCPD-Pediatric	0	0	0	0			11.01
OTHER BILLABLE SERVICES								
12.00	Inpatient Dialysis Treatments	0	0	0	0			12.00
13.00	Method II Home Patient	0	0	0	0			13.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0027
Component CCN: 31-2318Period:
From 01/01/2023
To 12/31/2023Worksheet 1-3
Date/Time Prepared:
5/30/2024 10:12 am

						Renal Dialysis		
		Drugs (Requist.)	Medical Supplies (Requist.)	Pediatric Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal	Overhead (Accum. Cost)	
		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 ÷ line 17)	1.312661	0.975439	0.000000	0.000000		0.776067	18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 31-0027

Period:

Worksheet 1-4

Component CCN: 31-2318

From 01/01/2023

Date/Time Prepared:

To 12/31/2023

5/30/2024 10:12 am

		Rate 0		Renal Dialysis		
		Number of Total Treatments	Total Cost (from Wkst. 1-2, col. 11)	Average Cost of Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (see instructions)
		1.00	2.00	3.00	4.00	5.00
1.00	Maintenance - Hemodialysis	34,428	18,191,690	528.40	12,670	6,694,828
1.01	Maintenance - AKI Hemodialysis	0	0	0.00	0	0
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0
2.01	Maintenance - AKI Peritoneal Dialysis	0	0	0.00	0	0
3.00	Training - Hemodialysis	0	0	0.00	0	0
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0
5.00	Training - CAPD	0	0	0.00	0	0
6.00	Training - CCPD	0	0	0.00	0	0
7.00	Home Program - Hemodialysis	0	0	0.00	0	0
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0
		Patient Weeks			Patient Weeks	
		1.00	2.00	3.00	4.00	5.00
9.00	Home Program - CAPD	0	0	0.00	0	0
10.00	Home Program - CCPD	0	0	0.00	0	0
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	34,428	18,191,690		12,670	6,694,828
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)	34,428				
ADDITIONAL RENAL FACILITY NUMBERS						
20.00	TRINITY LINDEN RENAL DIALYSIS	313503				
20.01	TRINITY CRANFORD RENAL DIALYSIS	313521				
		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)			
		6.00	7.00			
1.00	Maintenance - Hemodialysis	3,289,998	259.67			1.00
1.01	Maintenance - AKI Hemodialysis	0	0.00			1.01
2.00	Maintenance - Peritoneal Dialysis	0	0.00			2.00
2.01	Maintenance - AKI Peritoneal Dialysis	0	0.00			2.01
3.00	Training - Hemodialysis	0	0.00			3.00
4.00	Training - Peritoneal Dialysis	0	0.00			4.00
5.00	Training - CAPD	0	0.00			5.00
6.00	Training - CCPD	0	0.00			6.00
7.00	Home Program - Hemodialysis	0	0.00			7.00
8.00	Home Program - Peritoneal Dialysis	0	0.00			8.00
		6.00	7.00			
9.00	Home Program - CAPD	0	0.00			9.00
10.00	Home Program - CCPD	0	0.00			10.00
11.00	Totals (sum of lines 1 through 8, cols. 1 and 4) (sum of lines 1 through 10, cols. 2, 5, and 6) (see instruction)	3,289,998				11.00
12.00	Total treatments (sum of lines 1 through 8 plus (sum of lines 9 and 10 times 3)) (see instruction)					12.00
ADDITIONAL RENAL FACILITY NUMBERS						
20.00	TRINITY LINDEN RENAL DIALYSIS					20.00
20.01	TRINITY CRANFORD RENAL DIALYSIS					20.01

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet 1-5 Date/Time Prepared: 5/30/2024 10:12 am	
			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. 1-4, col. 6, line 11) (see instructions)		3,289,998	3,289,998	2.00
2.01	Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)				2.01
2.02	Total payment due (from Wkst. 1-4, 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)		0	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)		0	0	3.03
4.00	Coinsurance billed to Medicare (Part B) patients		0	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 recoveries for services rendered on or after 1/1/2011 but before 1/1/2012				5.01
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013				5.02
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014				5.03
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014		0	0	5.04
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 instructions)		0	-34,701	8.00
9.00	Program payment (see instructions)		0	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. 1-4, 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
PART III - ESRD PAYMENTS - INFORMATION ONLY					
15.00	Low volume payment amount (see instructions)		0		15.00
16.00	TDAPA		0		16.00
17.00	TPNIES		0		17.00
18.00	CRA TPNIES		0		18.00
19.00	HDPAs		0		19.00
20.00	PPA		0		20.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 31-0027	Period: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Prepared: 5/30/2024 10:12 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
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	2.00
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 instructions)		110.78	3.00
4.00	Number of interns & residents (see instructions)		46.58	4.00
5.00	Indirect medical education percentage (see instructions)		12.60	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		135,873	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		15.88	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		35.13	8.00
9.00	Sum of lines 7 and 8		51.01	9.00
10.00	Allowable disproportionate share percentage (see instructions)		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
		1.00		
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
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	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00