Hoboken University Medical Center -TCU Statement of Operations FYE 12/31/23

DRAFT

FYE 12/31/23

rating Revenues

Net Patient Service Revenue TCU

4,400,499

Operating Expenses

Salaries	1,555,685
Benefits	334,858
Supplies/Other Expenses	33,048
Allocated Expenses	2,435,860
Total Operating Expenses	4,359,451

Net Income (Loss) TCU 41,048

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 31-0040 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/31/2024 12:06 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/31/2024 Time: 12:06 pm] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor use only

number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HOBOKEN UNIVERSITY MEDICAL CENTER (31-0040) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Ric	hard Sarli	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Ri chard Sarl i			2
3	Signatory Title	CF0			3
4	Date	05/31/2024 12: 06: 57 PM			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	1, 014, 333	434, 534	0	75, 131	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		-9, 324	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10. 00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12. 00
200.00	TOTAL	0	1, 014, 333	434, 534	0	65, 807	200. 00
The ab	ove amounts represent "due to" or "due from"	the applicable	program for th	e element of t	he above comple	ex 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.

In Lieu of Form CMS-2552-10 Health Financial Systems HOBOKEN UNIVERSITY MEDICAL CENTER HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 31-0040 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 12:06 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 308 WILLOW AVENUE 1.00 PO Box: 1.00 State: NJ Zi p Code: 07030 2.00 City: HOBOKEN County 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Number Number Certi fi ed Type 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 Hospi tal HOBOKEN UNIVERSITY 310040 35614 01/01/1965 Ν Р Т 3.00 1 MEDICAL CENTER Subprovi der - IPF HOBOKEN PSYCH Р Т 4.00 315040 35614 4 01/01/1965 Ν 4.00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF HOBOKEN SNF 315512 35614 10/23/2012 Ρ Ν 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 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 3.00 2.00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 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) 22.02 Is this a newly merged hospital that requires a final UCP to be 22.02 Ν Ν 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. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν N 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 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.

OSPI T	Financial Systems HOBOKEN UNI AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provi der CC		Peri od:			eet S-2	
					From 01/0 To 12/3		Part I Date/T 5/31/2	ime Pre 024 12:	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	aid (ays Me	Other di cai d days	
		1.00	2. 00	3. 00	4. 00	5. 00		6. 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. 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 eligible unpaid 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.	1, 209			0	2,	0	98	24.
			•		Urban/R				
6 00	Enter your standard geographic classification (not wa	ano) etatue	at the bee	ninning of t	1. (00 1	2.	00	26.
	cost reporting period. Enter "1" for urban or "2" for	rural.	_			1			
	Enter your standard geographic classification (not wareporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassification is a sole community hospital (SCH), enter the	"2" for r cation in	ural. If ap column 2.	opl i cabl e,		0			35.
J. 00	effect in the cost reporting period.	e number of	perious so						33.
					Begi ni			i ng: 00	
6. 00	Enter applicable beginning and ending dates of SCH sof periods in excess of one and enter subsequent date		cript line	36 for numb	er				36.
7. 00	If this is a Medicare dependent hospital (MDH), enter		r of period	ds MDH statu	ıs	0			37
7. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for								37
8. 00	<pre>instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.</pre>								38
					Υ/			/N	
9. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i)1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent requiremen	ter in colum nts in	n			<u>00</u> N	39.
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1.	oer 1. Ente	r "Y" for y			l		Y	40
						V 1. 00	XVIII 2. 00		
5. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	nt for disn	roporti opat	to share in	accordance	N	Y	N	45.
	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exceptions and the section of the section o	eption for	extraordi na	ary circumst	ances	N	N	N	46
	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS (Is the facility electing full federal capital paymen	capital? E	nter "Y for	yes or "N'	for no.	N N	N N	N N	47 48
	Teachi ng Hospi tal s		•					- "	
6. 00	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after December the instructions. For column 2, if the response to convolved in training residents in approved GME program are you are impacted by CR 11642 (or applicable C"Y" for yes; otherwise, enter "N" for no in column 2.	'Y" for yes 27, 2020, olumn 1 is ams in the CRs) MA dir	or "N" for under 42 ("Y", or if prior year	no in colu CFR 413.78(b this hospit or penultin	umn 1. For b)(2), see cal was nate year,	Y	Y		56
7. 00	For cost reporting periods beginning prior to December is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete	er 27, 2020 residents n column 1. cost report e Worksheet	in approved If column ing period? E-4. If co	d GME progra 1 is "Y", o ? Enter "Y' olumn 2 is '	nms trained lid for yes or N",	Y			57
	complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not comple If line 56 is yes, did this facility elect cost reimb	R 413.77(e on duty, i ete column)(1)(iv) ar f the respo 2, and comp	nd (v), rega onse to line olete Worksh	e 56 is "Y" neet E-4.				58

			MEDICAL CENTE				2552-10
HOSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der CC		eriod: rom 01/01/2023 o 12/31/2023	Worksheet S-2 Part I Date/Time Pre 5/31/2024 12:0	pared:
					V	XVIII XIX	·
59 00	Are costs claimed on line 100 of Worksheet A? If yes	compl	ete Wkst D-2	Pt. I.	1. 00 N	2.00 3.00	59. 00
37. 00	ALC COSTS CLATIFICA OF THIC TOO OF WOLKSHEET A: 11 yes	s, compr	rete mot. b 2,	NAHE 413. 85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1. 00	2. 00	3.00	
	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis" "Y", are you impacted by CR 11642 (or subsequent Cadjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. CR) NAHE	see If column 1	N			60. 00
		Y/N	IME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4.00	5. 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	2. 00	0.00	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
	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
	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
		Pro	ogram Name	Program Code	Unwei ghted IME FTE Count	Unweighted Direct GME FTE Count	
(1 10	Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3.00	4.00	61. 10
	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	01. 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	0. 00	61. 20
						1.00	
	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital	trai nec			od for which	0.00	62. 00
	MOUL DOSDITAL FECELVED HRZA PURE TUDNIDA 1888 INSTRUM					1	
62. 01	your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	n Teachi ıram. (s	see instruction		your hospital	0.00	62. 01

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)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO		Period: From 01/01/2023 To 12/31/2023		repared:
			V 1.00	XI X 2. 00	_
98.00 Does title V or XIX follow Medicare (title XVIII) for the i	nterns and resi	idents post	1. 00 Y	Y Y	98. 00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t	Y	Y	98. 01		
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the close costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes			Y	N	98. 02
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y 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 outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.			N	N	98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.			Y	Y	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			Y	Y	98. 06
Rural Providers 105.00 Does this hospital qualify as a CAH? 106.00 on this facility qualifies as a CAH, has it elected the all	-inclusive meth	hod of payment	N N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for outpating programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded I	cost reimbursemonn 1. (see ins o you train I&R PF and/or IRF (ent for I&R tructions) s in an			107. 00
Enter "Y" for yes or "N" for no in column 2. (see instruct 107.01 If this facility is a REH (line 3, column 4, is "12"), is i reimbursement for I&R training programs? Enter "Y" for yes instructions)	t eligible for				107. 0
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108. 00
	Physi cal 1.00	Occupati onal 2.00	Speech 3.00	Respiratory 4.00	4
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.		N	N N	N	109.00
				1.00	-
110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. I	f yes,	N	110.00
			1. 00	2.00	
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.	cost reporting p column 1 is Y, o articipating in	period? Enter enter the column 2.	N		111.00
		1. 00	2. 00	3.00	_
112.00 Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable.	reporting column 1 is pating in the	N N	2.30	0.00	112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either "for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide	B, or E only) 93" percent (includes	N			0115.00
the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y"	for ves or	N			116. 00
"N" for no	101 ycs 01				
"N" for no. 117.00 Is this facility legally-required to carry malpractice insu "Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence po	urance? Enter	Y	1		117. 00

		1.00	
144.00 Are provider based physicians' costs included in Worksheet A?	Υ	144. 00	
	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	Υ		145. 00
period? Enter "Y" for yes or "N" for no in column 2. 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

Health Financial Systems	HOBOKEN UNIVERSITY	MEDICAL CENTE	R	In Li€	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	Provi der CC	:N: 31-0040	Period: From 01/01/2023 To 12/31/2023		repared:	
					3/31/2024 12	2. 06 pili
					1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y" for y	es or "N" for	no.		N	147. 00
148.00 Was there a change in the order of	fallocation? Enter "Y" for	yes or "N" fo	or no.		N	148. 00
149.00 Was there a change to the simplifi	ed cost finding method? En	iter "Y" for ye	s or "N" fo	r 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 prov or charges? Enter "Y" for yes or						
155. 00 Hospi tal	TO THE TOT GUOTE COMPONE	N	N N	N N	l N	155. 00
156.00 Subprovider - IPF		N	l N	N	N	156, 00
157.00 Subprovider - IRF		N	N	N	N	157. 00
158. 00 SUBPROVI DER						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
161. 10 CORF			N	N	N	161. 10
Multicampus					1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has one	or more campu	ses in diff	erent CBSAs?	N	165. 00
Enter 1 101 years 1 10 101 1101	Name	County	State Z	ip Code CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00 4.00	5.00	
166.00 If line 165 is yes, for each					0. (00 166. 00
campus enter the name in column						
O, county in column 1, state in						
column 2, zip code in column 3,						
CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
					1.00	_
Health Information Technology (HI	Γ) incentive in the America	an Recovery and	d Reinvestme	nt Act	1.00	
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 10			e 167 is "Y"), enter the		168. 00
reasonable cost incurred for the I						
168.01 If this provider is a CAH and is i						168. 01
exception under §413.70(a)(6)(ii)						
169.00 If this provider is a meaningful transition factor. (see instruction		is not a CAH (line 105 is	"N"), enter the	9.	99169. 00
transition factor. (see instruction	ins)			Begi nni ng	Endi ng	
				1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	peginning date and ending d	late for the re	porti ng			170. 00
				1. 00	2.00	
171.00 If line 167 is "Y", does this prov	uider have any days for ind	li vi dual s parol	led in	1.00 N	2.00	0171.00
section 1876 Medicare cost plans I "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, col	. 6? Enter			0171.00

Heal th	Financial Systems HOBOKEN UNIVERSIT	Y MEDICAL CENT	FR	In lie	eu of Form CMS-	2552-10
	THIRDITIAL SYSTEMS HODGEN UNIVERSIT		CN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre	pared:
				Y/N	5/31/2024 12: Date	06 pm
				1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter Nmm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			r all dates in	the	
1.00	Provider Organization and Operation Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1.00
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare F	Program? If	1.00 N	2. 00	3. 00	2. 00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for				
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.00
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4. 00 5. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avaccolumn 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference.	for Compiled, ailable in	Y	A		4.00
J. 00	those on the filed financial statements? If yes, submit received		IN .			3.00
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Column 1: Are costs claimed for a nursing program? Column the Legal operator of the program?	2: If yes, is	the provider	N		6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during the	N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved		cal education	Υ		9. 00
10. 00	program in the current cost report? If yes, see instruction was an approved Internal and Resident GME program initiated of		the current	Υ		10. 00
11. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 00
	reaching riogram on norksheet A: IT yes, see histractions.				Y/N	
	la casa				1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	see instruct	ions		Y	12. 00
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			st reporting	N N	13. 00
14. 00	If line 12 is yes, were patient deductibles and/or coinsural instructions. Bed Complement	ance amounts wa	nived? If yes,	see	N	14. 00
15. 00	Did total beds available change from the prior cost reporti				N	15. 00
		Par Y/N	T A	Par Y/N	T B	
		1.00	2.00	3. 00	Date 4. 00	
4/ 25	PS&R Data	. ,,	05 (46 (222 :		05 /40 /222 :	4, 25
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)	Y	05/12/2024	Y	05/12/2024	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)	N		N		17. 00
18. 00	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

Health Financial Systems HOBOKEN UNIVERSITY HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		ER CN: 31-0040	Peri od:	u of Form CMS- Worksheet S-2	
			From 01/01/2023 To 12/31/2023	Part II Date/Time Pre 5/31/2024 12:	
	Descr	i pti on	Y/N	Y/N	J piii
		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	
21 00 Wes the seat assess assessed as leaves as the assessional a	1.00	2.00	3.00	4. 00	21 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 (EXCEP Capital Related Cost	PI CHILDRENS F	(OSPITALS)			+
22.00 Have assets been relifed for Medicare purposes? If yes, see	i nstructi ons				22. 00
23.00 Have changes occurred in the Medicare depreciation expense of reporting period? If yes, see instructions.		sals made dur	ing the cost		23. 00
24.00 Were new leases and/or amendments to existing leases entered lf yes, see instructions	d into during	this cost re	porting period?		24. 00
25.00 Have there been new capitalized leases entered into during tinstructions.	the cost repor	rting period?	'If yes, see		25. 00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	e cost reporti	ng period? I	f yes, see		26. 00
27.00 Has the provider's capitalization policy changed during the copy.	cost reportir	ng period? If	yes, submit		27. 00
Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit en	tered into dur	ing the cost	reporting		28. 00
period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or be	bond funds (De	ebt Service R	Reserve Fund)		29. 00
treated as a funded depreciation account? If yes, see instru 30.00 Has existing debt been replaced prior to its scheduled matur		debt? If yes	s, see		30.00
instructions. 31.00 Has debt been recalled before scheduled maturity without iss instructions.	suance of new	debt? If yes	s, see		31. 00
Purchased Services 32.00 Have changes or new agreements occurred in patient care serv	vices furnishe	ed through co	ntractual		32. 00
arrangements with suppliers of services? If yes, see instructions. arrangements with suppliers of services? If yes, see instructions.	ctions.	-			33. 00
Provi der-Based Physi ci ans					
34.00 Were services furnished at the provider facility under an ar If yes, see instructions.	rrangement wit	th provider-b	based physicians?		34. 00
35.00 If line 34 is yes, were there new agreements or amended exist physicians during the cost reporting period? If yes, see instance.		nts with the	provi der-based		35. 00
			Y/N	Date	
Home Office Costs			1. 00	2. 00	
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 pre-	epared by the	home office?			37. 00
If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home offi			N		38. 00
the provider? If yes, enter in column 2 the fiscal year end 39.00 If line 36 is yes, did the provider render services to other			s, N		39. 00
see instructions. 40.00 If line 36 is yes, did the provider render services to the hinstructions.	home office?	If yes, see	N		40. 00
, mort dott sine.					
Coat Deport Droporon Contact Information	1.	00	2.	00	
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	TINA		FORD		41. 00
respecti vel y.	HOBOKEN UNI VER	SITY MEDICAL			42. 00
preparer.	CENTER	CITI WEDI CAL			
43.00 Enter the telephone number and email address of the cost	973-951-2304		TI NA. FORD@CARE	DOLDER TH OD	43.00

Heal th	Financial Systems	HOBOKEN UNIVERSITY	Y MEDICAL CENTER	₹	In Lie	u of Form CMS-	2552-10
HOSPI 1	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi der CCI		Period: From 01/01/2023 To 12/31/2023		pared:
			3. C	10			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the t	itle/position	GOVERNMENT REIM	BURSEMENT			41. 00
	held by the cost report preparer in column	ns 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the co	st report					42. 00
	preparer.						
43.00	Enter the telephone number and email addre	ess of the cost					43.00
	report preparer in columns 1 and 2, respec	cti vel y.					

 Heal th Financial
 Systems
 HOBOKEN UNI

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: Provider CCN: 31-0040

Component						'	0 12/31/2023	5/31/2024 12:	
Component Worksheet A No. of Beds Bed Days Available CAHI/REH Hours Title V									о р
Component Worksheet A No. of Beds Bed Days CAH/REH Hours Title V									
PART I - STATISTICAL DATA 1.00 2.00 3.00 4.00 5.00		Component	Worksheet A	No.	of Beds	Bed Days			
BART I - STATISTICAL DATA									
PART I - STATISTICAL DATA 1.00 Hospital Adult is & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospite days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 1.00					2.00		4. 00	5. 00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 8 exclude Swing Bed, Observation Bed and Hospic ed days) (see instructions for col. 2 2		PART I - STATISTICAL DATA							
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00	1.00		30. 00		99	36, 135	0.00	0	1. 00
For the portion of LDP room available beds) 3.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00									
2.00 MMO and other (see instructions) 2.00 4.00 4.00 4.00 6.		Hospice days) (see instructions for col. 2							
3.00 HMO IPF Subprovi der		for the portion of LDP room available beds)							
HMO IRF Subprovi der 0	2.00	HMO and other (see instructions)							2. 00
5.00 Hospi tal Adult s & Peds. Swing Bed NF 0 6.00 0 7.00 0 7.00 0 7.00 0 7.00 0 0 7.00 0 0 7.00 0 0 0 0 0 0 0 0 0	3.00	HMO IPF Subprovider							3. 00
6.00 Hospi tal Adult s & Peds. Swing Bed NF 9 36, 135 0.00 0 7.00	4.00	HMO IRF Subprovider							4.00
Total Adults and Peds (exclude observation beds) (see instructions) Structions	5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
beds) (see instructions) 8. 00	6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
8. 00 INTENSIVE CARE UNIT 31. 00 15 5,475 0. 00 0 8. 00 0 0 0 0 0 0 0 0 0	7.00	Total Adults and Peds. (exclude observation			99	36, 135	0.00	0	7. 00
9.00 CORONARY CARE UNIT 32.00 0 0.00 0.00 0 9.00 10.00 BURN INTERSIVE CARE UNIT 33.00 0 0 0.00 0 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 14.00 Total (see instructions) 43.00 114 41,610 0.00 0 14.00 15.00 CAH visits 0 15.00 16.00 SUBPROVIDER - IPF 40.00 47 17,155 0 16.00 18.00 SUBPROVIDER - IRF 41.00 0 0 0 18.00 SUBPROVIDER - IRR 41.00 0 0 0 18.00 SUBPROVIDER - IRR 44.00 15 5,475 0 19.00 20.00 NURSING FACILITY 44.00 15 5,475 0 19.00 21.00 OTHER LONG TERM CARE 46.00 0 0 0 22.00 OTHER LONG TERM CARE 46.00 0 0 23.00 AMBULATORY SURGICAL CENTER (D.P.) 115.00 24.10 HOSPICE (non-distinct part) 30.00 24.100 25.00 CMIC - CMIC CMIC CMIC CMIC 26.00 RURAL HEALTH CLINIC 88.00 26.25 27.00 Total (sum of lines 14-26) 0 0 0 28.00 Employee discount days (see instructions) 30.00 30.00 Employee discount days (see instructions) 30.00 Total ancillary labor & delivery como outpatient days (see instructions) 33.00 33.00 LTCH non-covered days 33.00 CLTCH site neutral days and discharges 33.00		beds) (see instructions)							
10.00 BURN INTENSIVE CARE UNIT 33.00 0 0 0.00 0 10.00	8.00	INTENSIVE CARE UNIT	31. 00		15	5, 475	0.00	0	8. 00
11.00 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 0 0 0 0 11.00 12.00 13.00 14.00 14.00 15.00 14.00 14.00 15.00	9.00	CORONARY CARE UNIT	32. 00		0	C	0.00	0	9. 00
12.00 OTHER SPECIAL CARE (SPECIFY)	10.00	BURN INTENSIVE CARE UNIT	33. 00		0	C	0.00	0	10.00
13.00 NURSERY 14.00 Total (see instructions) 15.01 CAH visits 15.00 CAH visits 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 19.00 SKILLED NURSING FACILITY 19.00 SKILLED NURSING FACILITY 19.00 OTHER LONG TERM CARE 10.00 OTHER LONG TERM C	11.00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	C	0.00	0	11. 00
14. 00 Total (see instructions) 114 41,610 0.00 0 14.00 15. 00 CAH visits 0.00 0 15.00 16. 00 SUBPROVIDER - IPF 40.00 47 17,155 0 16.00 18. 00 SUBPROVIDER - IRF 41.00 0 0 0 19. 00 SUBPROVIDER VISIT	12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
15. 00 CAH visits	13.00	NURSERY	43. 00					0	13.00
15. 10 REH hours and visits	14.00	Total (see instructions)			114	41, 610	0.00	0	14.00
16. 00 SUBPROVI DER - I PF	15.00	CAH visits						0	15. 00
17. 00 SUBPROVIDER - IRF	15. 10	REH hours and visits					0.00	0	15. 10
18. 00 SUBPROVIDER 18. 00 19. 00 SKILLED NURSING FACILITY 44. 00 15 5, 475 0 19. 00 0 0 0 0 0 0 0 0 0	16.00	SUBPROVI DER - I PF	40. 00		47	17, 155	5	0	16. 00
19. 00	17.00	SUBPROVI DER - I RF	41. 00		o	C		0	17. 00
20. 00	18.00	SUBPROVI DER							18. 00
21.00 OTHER LONG TERM CARE	19.00	SKILLED NURSING FACILITY	44. 00		15	5, 475	5	0	19. 00
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 21. 00 24. 00 HOSPI CE 24. 00 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 00 Labor & delivery days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges	20.00	NURSING FACILITY	45. 00		o	C		0	20. 00
23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 30. 00 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 10 CMHC - CORF 30. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 37. 00 Observation Bed Days 39. 00 Ambul ance Trips 30. 00 31. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges	21.00	OTHER LONG TERM CARE	46. 00		o	C			21. 00
24. 00 HOSPICE	22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CORF 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 00 Labor & delivery days (see instructions) 33. 00 LTCH non-covered days 31. 00 33. 01 LTCH site neutral days and discharges	23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00						23. 00
25. 00 CMHC - CMHC 99. 00 99. 10 0 25. 00 25. 10 CMHC - CORF 99. 10 99. 10 0 25. 10 26. 00 RURAL HEALTH CLINIC 88. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 7 Total (sum of lines 14-26) 27. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 99. 00 Ambul ance Trips 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 29. 00 Employee discount days - IRF 31. 00 Employee discount days (see instructions) 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges	24.00	HOSPI CE	116. 00		o	C			24. 00
25. 00 CMHC - CMHC 99. 00 99. 10 0 25. 00 25. 10 CMHC - CORF 99. 10 99. 10 0 25. 10 26. 00 RURAL HEALTH CLINIC 88. 00 0 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 7 Total (sum of lines 14-26) 27. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 99. 00 28. 00 29. 00 Ambulance Trips 29. 00 Employee discount days (see instruction) 29. 00 Employee discount days - IRF 31. 00 Employee discount days (see instructions) 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 33. 01 LTCH site neutral days and discharges	24. 10	HOSPICE (non-distinct part)	30.00						24. 10
26. 00 RURAL HEALTH CLINIC 88. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 27. 00 Total (sum of lines 14-26) 176 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 29. 00 Employee discount days - IRF 31. 00 32. 00 Labor & delivery days (see instructions) 31. 00 Unique and interest and i	25.00		99. 00					0	25. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER	25. 10	CMHC - CORF	99. 10					0	25. 10
27.00 Total (sum of lines 14-26) 27.00 28.00 0bservation Bed Days 0 28.00 29.00 Ambulance Trips 29.00 29.0	26.00	RURAL HEALTH CLINIC	88. 00					0	26. 00
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 LTCH non-covered days 33.00 LTCH site neutral days and discharges	26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges	27.00	Total (sum of lines 14-26)			176				27. 00
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days 33.00 LTCH site neutral days and discharges 30.00 0 0 0 0 32.00 32.01 33.00 LTCH site neutral days and discharges	28.00	Observation Bed Days						0	28. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 31.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29. 00	Ambul ance Trips							29. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 31.00 O O O O O O O O O O O O O O O O O O	30.00	Employee discount days (see instruction)							30. 00
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges									
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 32.01	32.00				o	C			32. 00
outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 33.01					آ ا				
33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 33.00 33.01									
33.01 LTCH site neutral days and discharges 33.01	33.00								33. 00
34 00 Temporary Expansion COVID-19 PHE Acute Care 30 00 0 0 0	33. 01	LTCH site neutral days and discharges							33. 01
34.00 reliporary Expansion Covid-17 File Acute Care 30.00 of of of of the first o	34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	C		0	34. 00

33.01

34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

Provider CCN: 31-0040

0

0

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

5/31/2024 12:06 pm Full Time Equivalents I/P Days / O/P Visits / Trips Component Title XVIII Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 2,092 369 13, 214 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 2,709 4, 142 2.00 3.00 HMO IPF Subprovider 1, 519 3.00 4.00 HMO IRF Subprovider 0 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 0 C 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 2,092 369 13, 214 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 395 1, 180 50 8.00 CORONARY CARE UNIT 9.00 0 C 0 9.00 10.00 BURN INTENSIVE CARE UNIT 0 0 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 258 1,943 13.00 Total (see instructions) 14.00 2, 487 677 16, 337 32.40 701.42 14.00 15.00 CAH visits C 15.00 15.10 REH hours and visits 15.10 16.00 SUBPROVIDER - IPF 1.462 341 11, 216 0.00 74.64 16.00 SUBPROVIDER - IRF 17.00 0.00 0.00 17.00 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 19.00 1,670 C 3,812 0.00 18.94 19.00 20.00 NURSING FACILITY 0 0.00 0.00 20.00 21.00 OTHER LONG TERM CARE 0 0.00 0.00 21.00 HOME HEALTH AGENCY 0 Ω 22 00 0 0 00 0.00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 0.00 0.00 23.00 HOSPI CE 0 0.00 0.00 24.00 24.00 C 24.10 HOSPICE (non-distinct part) 47 24. 10 CMHC - CMHC CMHC - CORF 25.00 0.00 0.00 25.00 0 Ω 0 0 25. 10 0 0 0.00 0.00 25. 10 26.00 RURAL HEALTH CLINIC 0 0.00 0.00 26.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0.00 26, 25 0 0 0.00 26, 25 Total (sum of lines 14-26) 27 00 32.40 795.00 27 00 28. 00 Observation Bed Days 57 3, 359 28.00 29.00 Ambul ance Trips 0 29.00 Employee discount days (see instruction) 30.00 0 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 32.00 0 66 765 32.00 Total ancillary labor & delivery room 32.01 32. 01 C outpatient days (see instructions) 33.00 33.00 LTCH non-covered days

Heal th Fi nancialSystemsHOBOKEN UNIVERSITYMEDICAL CENTERHOSPITALANDHOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider CCN: Provider CCN: 31-0040

In Lieu of Form CMS-2552-10

Period: Worksheet S-3

From 01/01/2023 Part I

To 12/31/2023 Date/Time Prepared: 5/31/2024 12:06 pm

						5/31/2024 12:	06 pm
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	12.00	12.00	14.00	Pati ents	
	PART I - STATISTICAL DATA	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	401	228	3, 120	1.00
1.00	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	401	220	3, 120	1.00
2.00	HMO and other (see instructions)			484	0		2.00
3.00	HMO IPF Subprovider				0		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						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	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	401	228	3, 120	
15. 00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF	0.00	0		44	1, 360	16. 00
17. 00	SUBPROVI DER - I RF	0. 00	0	0	0	0	17. 00
18. 00	SUBPROVI DER						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	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0. 00					23. 00
24. 00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC	0.00					25. 00
25. 10	CMHC - CORF	0.00					25. 10
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00 28. 00	Total (sum of lines 14-26)	0. 00					27. 00 28. 00
	Observation Bed Days						
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00 32. 00	Employee discount days - IRF						31. 00 32. 00
	Labor & delivery days (see instructions)						
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days			o			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
	Temporary Expansion COVID-19 PHE Acute Care						34. 00
5 50	1.1p.1.2.3 Expansion don't in the houte out o	1		1	ı		, 555

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 31-0040 Peri od: Worksheet S-3 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/31/2024 12:06 pm Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col.2 ± col (from Wkst. Salaries in col. 5) A-6)3) col. 4 2.00 5.00 6. 00 1.00 3.00 4.00 PART II - WAGE DATA SALARI ES 1.00 200. 00 64, 920, 857 64, 920, 857 1, 649, 646. 00 39. 35 1.00 Total salaries (see instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0 0.00 0.00 3.00 4.00 Physician-Part A -0 0.00 0.00 4.00 Administrative 4.01 Physicians - Part A - Teaching 0 0.00 0.00 4.01 Physician and Non 0 0.00 5.00 0.00 5.00 Physician-Part B Non-physician-Part B for 6.00 O 0.00 0.00 6.00 hospital-based RHC and FQHC servi ces 7.00 Interns & residents (in an 21.00 2, 963, 212 -381, 227 2, 581, 985 78, 664. 00 32.82 7.00 approved program) 7.01 Contracted interns and 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office and/or related 0 0.00 0.00 8.00 organization personnel 9.00 44.00 1, 552, 116 3, 569 1, 555, 685 39, 392. 00 39.49 9.00 7, 193, 471 10.00 Excluded area salaries (see 7, 168, 424 25, 047 177, 941. 00 40. 43 10.00 instructions) OTHER WAGES & RELATED COSTS 11.00 Contract labor: Direct Patient 0 0 0.00 0.00 11.00 0 0.00 12.00 Contract labor: Top level 0.00 12.00 management and other management and administrative servi ces Contract Labor: Physician-Part 13.00 471, 616 471, 616 2, 208. 00 213. 59 13.00 A - Administrative Home office and/or related 14.00 0.00 0.00 14.00 organization salaries and wage-related costs 101, 790. 00 14.01 Home office salaries 4, 923, 142 4, 923, 142 48.37 14.01 14.02 Related organization salaries 0.00 0.00 14.02 15.00 Home office: Physician Part A 0 0 0.00 0.00 15.00 - Administrative Home office and Contract 0 0 0.00 0.00 16.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A 0 0.00 0.00 16.01 Teachi ng 16.02 Home office contract 0 0.00 0.00 16.02 Physicians <u>Part A - Teaching</u> WAGE-RELATED COSTS 10, 671, 290 10, 671, 290 17.00 Wage-related costs (core) (see 17.00 instructions) 18.00 Wage-related costs (other) 18.00 (see instructions) 19.00 Excluded areas 1, 748, 016 1, 748, 016 19.00 Non-physician anesthetist Part 20.00 20.00 21.00 Non-physician anesthetist Part 0 21.00 22.00 Physician Part A -22.00 C Admi ni strati ve 22.01 Physician Part A - Teaching 0 0 22 01 23.00 Physician Part B 0 0 23.00 24.00 Wage-related costs (RHC/FQHC) 24.00 Interns & residents (in an 549, 828 25.00 0 549, 828 25.00 approved program) 25.50 Home office wage-related 1,029,648 0 1,029,648 25.50 (core) 25.51 Related organization 0 25.51 wage-related (core) Home office: Physician Part A 0 0 25, 52 25. 52

- Administrative wage-related (core) 40.00

41.00

42.00

Pharmacy

Records Library Social Service

43.00 Other General Service

Medical Records & Medical

40.00

41.00

0.00 42.00

0.00 43.00

51, 52

31. 22

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 31-0040 Peri od: Worksheet S-3 From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/31/2024 12:06 pm Wkst. A Line Amount Recl assi fi cati Adj usted Paid Hours Average Hourly Number on of Salaries Sal ari es Related to Wage (col. 4 Reported col . 5) (from Wkst. (col.2 ± col. Salaries in A-6)3) col. 4 2.00 1.00 5.00 6.00 3.00 4.00 25.53 Home office: Physicians Part A 0 25.53 - Teaching - wage-related (core) OVERHÉAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4 00 395, 416 395, 416 8, 973. 00 44. 07 26.00 27.00 Administrative & General 5.00 4, 116, 584 1, 794 4, 118, 378 125, 452. 00 32.83 27.00 28.00 Administrative & General under 0 0.00 0.00 28.00 contract (see inst.) Maintenance & Repairs 29.00 0.00 0.00 29.00 6.00 Operation of Plant 2, 296, 499 2, 296, 708 82, 523. 00 27. 83 30.00 7.00 209 30.00 31.00 Laundry & Linen Service 8.00 128, 694 128, 694 5, 675. 00 22. 68 31.00 67, 973. 00 32.00 Housekeepi ng 9.00 1, 424, 872 3, 343 1, 428, 215 21. 01 32.00 33.00 Housekeeping under contract 0 0.00 0.00 33.00 (see instructions) 34.00 Di etary 10.00 1, 519, 862 -573, 380 946, 482 44, 042. 00 21. 49 34.00 Di etary under contract (see instructions) 0.00 35.00 0.00 35.00 26, 680. 00 36, 00 Cafeteri a 11.00 0 573, 380 573, 380 21. 49 36.00 Maintenance of Personnel 0.00 37.00 12.00 0 0.00 37 00 38.00 Nursing Administration 13.00 3, 270, 066 1,691 3, 271, 757 59, 151. 00 55. 31 38.00 25.06 39.00 Central Services and Supply 14.00 503, 383 503, 383 20, 090. 00 39.00 C

2, 646, 835

792, 053

0

o

15.00

16.00

17.00

18.00

2, 646, 835

792, 053

0

0

0

0

ol

51, 374. 00

25, 369. 00

0.00

0 00

Total overhead cost (see

instructions)

7.00

Provider CCN: 31-0040

7,037

17, 101, 301

517, 302. 00

Peri od:

33.06

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: From 01/01/2023 To 12/31/2023 5/31/2024 12:06 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . (from Salaries in col . 5) Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 61, 957, 645 381, 227 62, 338, 872 1, 570, 982. 00 1.00 39. 68 instructions) 2.00 Excluded area salaries (see 8, 720, 540 28, 616 8, 749, 156 217, 333.00 40. 26 2.00 instructions) 3.00 Subtotal salaries (line 1 53, 237, 105 352, 611 53, 589, 716 1, 353, 649. 00 39.59 3.00 minus line 2) 4.00 Subtotal other wages & related 5, 394, 758 5, 394, 758 103, 998. 00 51.87 4.00 costs (see inst.) Subtotal wage-related costs 5.00 11, 700, 938 Ω 11, 700, 938 0.00 21.83 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 70, 332, 801 352, 611 70, 685, 412 1, 457, 647. 00 48 49

17, 094, 264

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | Date/Time Prepared: | To 12/31/2024 | To

	10 12/31/2023	5/31/2024 12:0	
		Amount	
		Reported	1
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	922, 733	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	o	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	o	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	o	6. 00
7.00	Employee Managed Care Program Administration Fees	246	7. 00
	HEALTH AND INSURANCE COST		
8.00	Heal th Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	ol	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	ol	8. 02
8.03	Health Insurance (Purchased)	4, 083, 384	8. 03
9.00	Prescription Drug Plan	1, 718, 204	9. 00
10.00	Dental, Hearing and Vision Plan	-20, 934	10. 00
11.00	Life Insurance (If employee is owner or beneficiary)	131, 507	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	o	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	270, 184	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	782, 418	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	ol	16. 00
	Noncumul ati ve porti on)		
	TAXES		
17. 00	FICA-Employers Portion Only	3, 989, 830	
18. 00	Medicare Taxes - Employers Portion Only	916, 545	
19. 00	Unempl oyment Insurance	273, 529	
20.00	State or Federal Unemployment Taxes	46, 753	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		1
22. 00	Day Care Cost and Allowances	0	
23. 00	Tuition Reimbursement	-145, 265	
24. 00	Total Wage Related cost (Sum of lines 1 -23)	12, 969, 134	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	, J	25. 00

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL CENT	ER	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der C	CN: 31-0040		Worksheet S-3
			From 01/01/2023	

	To 12/31/2023		
	0 1 1 1		06 pm
Cost Center Description			
	1.00	2.00	
			4
			4
,	0		1
Hospi tal	0	12, 969, 134	2. 00
SUBPROVI DER - I PF	0	0	3. 00
SUBPROVI DER - I RF	0	0	4. 00
Subprovi der - (0ther)	0	0	5. 00
Swing Beds - SNF	0	0	6. 00
Swing Beds - NF	0	0	7. 00
SKILLED NURSING FACILITY	0	0	8. 00
NURSING FACILITY	0	0	9. 00
OTHER LONG TERM CARE I			10.00
Hospi tal -Based HHA	0	0	11. 00
AMBULATORY SURGICAL CENTER (D.P.) I	0	0	12.00
Hospi tal -Based Hospi ce	0	0	13.00
Hospital-Based Health Clinic RHC	0	0	14.00
Hospital-Based Health Clinic FQHC	0	0	15. 00
·	0	0	16. 00
· ·	0	l o	16. 10
	0	0	17. 00
Other			18. 00
	SUBPROVIDER - IRF Subprovider - (Other) Swing Beds - SNF Swing Beds - NF SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE I Hospital-Based HHA AMBULATORY SURGICAL CENTER (D.P.) I Hospital-Based Health Clinic RHC Hospital-Based Health Clinic FQHC Hospital-Based-CMHC Hospital-Based-CMHC 10 RENAL DIALYSIS I	Cost Center Description PART V - Contract Labor and Benefit Cost Hospital and Hospital - Based Component Identification: Total facility's contract labor and benefit cost Hospital SUBPROVI DER - IPF SUBPROVI DER - IRF Subprovider - (Other) Swing Beds - SNF Swing Beds - SNF SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE I Hospital - Based HHA AMBULATORY SURGICAL CENTER (D. P.) I Hospital - Based Health Clinic RHC Hospital - Based - CMHC Hosp	S/31/2024 12: Cost Center Description

	Financial Systems HOBOKEN UNIVERSITY MEDI				u of Form CMS-2	
HOSPI T	TAL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CC		Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II Date/Time Pre 5/31/2024 12:	pared:
	DADT I WOODLTH AND WOODLTH COMPLEY DATA				1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA					-
1 00	Uncompensated and Indigent Care Cost-to-Charge Ratio Cost to charge ratio (see instructions)				0 0E7021	1 00
1. 00	Medicaid (see instructions for each line)				0. 057931	1.00
2. 00	Net revenue from Medicaid				17, 524, 603	2.00
2. 00 3. 00	Did you receive DSH or supplemental payments from Medicaid?				17, 324, 603	3.00
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental	l navmonts	from Modica	i d2		4.00
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from			i u :	12, 495, 318	5.00
6. 00	Medicaid charges	iii wear car c	•		933, 836, 265	
7. 00	Medicaid cost (line 1 times line 6)				54, 098, 069	
8. 00	Difference between net revenue and costs for Medicaid program (so	ee instruc	tions)		24, 078, 148	
3. 00	Children's Health Insurance Program (CHIP) (see instructions for				21,070,110	0.00
9. 00	Net revenue from stand-alone CHIP	00011 11110	7		0	9. 00
	Stand-alone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10)				0	11. 00
12. 00	Difference between net revenue and costs for stand-alone CHIP (se	ee instruc	tions)		0	12. 00
	Other state or local government indigent care program (see instru	uctions fo	r each line)			
13.00	Net revenue from state or local indigent care program (Not include	ded on lir	es 2, 5 or 9)	0	13. 00
14. 00	Charges for patients covered under state or local indigent care 10)	program (N	lot included	in lines 6 or	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 indig	gent care	program (see	instructions)	0	16. 00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)		J	ent care program	ns (see	
	Private grants, donations, or endowment income restricted to fund				0	
	Government grants, appropriations or transfers for support of hos				0	1
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16)	indigent o			24, 078, 148	19. 00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
			1.00	2. 00	3. 00	
20.00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions)		282, 823, 40	0	282, 823, 403	20.00
20.00	,	ts (see	16, 384, 24	-	16, 384, 243	
21.00	instructions)	12 (266	10, 304, 24	0	10, 304, 243	21.00
22. 00	,	ff as		0	0	22. 00
00	charity care					50
23. 00	Cost of charity care (see instructions)	j	16, 384, 24	3 0	16, 384, 243	23. 00

22. 00	.00 Payments received from patients for amounts previously written off as charity care		0	0	22. 00	
23. 00	Cost of charity care (see instructions)	16, 384, 243	0	16, 384, 243	23. 00	
				1.00		
24.00	Does the amount on line 20 col. 2, include charges for patient days beyon	d a length of s	stay limit	N	24. 00	
	imposed on patients covered by Medicaid or other indigent care program?					
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent	care program's	s Length of	0	25. 00	
	stay limit					
25. 01	25.01 Charges for insured patients' liability (see instructions)					
26.00	Bad debt amount (see instructions)			11, 272, 073	26. 00	
27.00	Medicare reimbursable bad debts (see instructions)			0	27. 00	
27. 01	Medicare allowable bad debts (see instructions)			0	27. 01	
28.00	Non-Medicare bad debt amount (see instructions)	11, 272, 073	28. 00			
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	653, 002	29. 00			
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	17, 037, 245	30. 00			
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			41, 115, 393	31. 00	

Heal th	Financial Systems	HOBOKEN UNIVERSITY M	EDICAL CENTER		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DA	.TA	Provider CCN: 31-	F	eriod: rom 01/01/2023 o 12/31/2023		pared:
						1. 00	
	PART II - HOSPITAL DATA					1.00	
	Uncompensated and Indigent Care Cost	-to-Charge Ratio					1
1.00	Cost to charge ratio (see instructio					0. 055307	1.00
	Medicaid (see instructions for each	line)					
2.00	Net revenue from Medicaid						2.00
3. 00 4. 00	Did you receive DSH or supplemental If line 3 is yes, does line 2 includ		stal navmonts from	Modi cai	42		3. 00 4. 00
5. 00	If line 4 is no, then enter DSH and/			ii weui cai	u:		5.00
6. 00	Medi cai d charges	or suppremental payments i	Tom mear ear a				6. 00
7.00	Medicaid cost (line 1 times line 6)						7. 00
8.00	Difference between net revenue and c			s)			8. 00
	Children's Health Insurance Program	(CHIP) (see instructions f	for each line)				
9.00	Net revenue from stand-alone CHIP Stand-alone CHIP charges						9.00
	Stand-alone CHIP cost (line 1 times	line 10)					10.00
	, ,						12.00
	Other state or local government indi						1
13.00	Net revenue from state or local indi						13. 00
14. 00	Charges for patients covered under s	tate or local indigent car	re program (Not ir	ncl uded i	n lines 6 or		14. 00
15 00	10) State or local indigent care program	cost (line 1 times line 1	14)				15. 00
	Difference between net revenue and c			am (saa	instructions)		16.00
10.00	Grants, donations and total unreimbulinstructions for each line)					ns (see	10.00
17. 00	Private grants, donations, or endowm	ent income restricted to f	funding charity ca	are			17. 00
	Government grants, appropriations or						18. 00
19. 00	Total unreimbursed cost for Medicaid 8, 12 and 16)	, CHIP and state and loca	al indigent care p	programs	(sum of lines		19. 00
	10, 12 and 10,		Uni	nsured	Insured	Total (col. 1	
				tients	pati ents	+ col . 2)	
			1	1. 00	2. 00	3. 00	
20. 00	Uncompensated care cost (see instruction of the control of the con) 201	2, 823, 403	0	282, 823, 403	20.00
21. 00	Cost of patients approved for charit		, I	2, 823, 403 5, 642, 114			1
21.00	instructions)	y care and annisared arset	(300	J, UTZ, 114		15, 572, 114	1 21.00
22. 00	Payments received from patients for	amounts previously writter	n off as	0	0	0	22. 00
22 00	charity care (see instruction	ne)	1.0	5 6/10 11/		15 440 114	22 00
23.00	3.00 Cost of charity care (see instructions) 15,642,114 0 15,642,114 2						23.00

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?

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00 \mid Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Medicare reimbursable bad debts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

Medicare allowable bad debts (see instructions)

Non-Medicare bad debt amount (see instructions)

Bad debt amount (see instructions)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

1.00

11, 272, 073

11, 272, 073

16, 265, 539

623, 425

16, 265, 539 31. 00

24.00

25.00

25.01

26.00

27.00

0 27.01

28.00

29.00

30.00

25.00

25. 01

27.00

27.01

28. 00

stay limit

2.00	Heal th	Financial Systems HOB	OKEN UNIVERSITY	MEDICAL CENTE	ER	In Lie	u of Form CMS-2	<u> 2552-10</u>
Cost Center Description	RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC	F	rom 01/01/2023	Date/Time Pre	
DEBERBAL SERVICE COST CENTERS 1.09		Cost Center Description	Sal ari es	0ther			Reclassified Trial Balance (col. 3 +-	, p
Description Service Cost Centres Description Descr			1.00	2. 00	3. 00	4. 00		
2.00 000000 000000 000000		GENERAL SERVICE COST CENTERS						
3.00 000000 FUREN CAP BELL COSTS 4.00 000000 EURIPE CAP BELL COSTS 5.00 000000 ADMINISTRATIVE & CENERAL 4.116,584 00,871,577 00,883,140 5,078,283 5,903,010 13,373,001 4,000 8.00 000000 ADMINISTRATIVE & CENERAL 7.00 000000 FUREN CAP BELL COSTS 8.00 000000 ADMINISTRATIVE & CENERAL 8.00 000000000000000000000000000000000								1. 00
4.00				767, 399	767, 399	0		
5.00 DODOOD ANM HISTART IVE & GINIMA 4, 116, BHB 40, BT1, 557 64, 988, 141 5, 1711, 781 50, 999, 188 5.00 7.00 DODOOD OFFRATI (VI) OF PLANT 1, 22, 20, 409 6, 37, 175 70 7.00 DODOOD OFFRATI (VI) OF PLANT 1, 21, 887 1, 21, 887 1, 24, 872 1, 24,			205 414	12 002 040	12 470 205	202 (1(
0.00 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.000			I I					
20000 DOTOD OPERATION OF PLANT 2, 296, 499 6, 371, 870 8, 668, 369 209 8, 668, 578 70, 900 90000 HUNSIKEEPING 1, 243, 877 1, 339, 784 4,666 80, 000 90000 HUNSIKEEPING 1, 243, 877 1, 339, 784 4, 666 80, 000 90000 HUNSIKEEPING 1, 243, 877 1, 339, 784 4, 900 90000 1, 267, 489 2, 233, 879 900 90000 1, 267, 489 2, 233, 879 900 90000 1, 267, 489 2, 233, 879 900 90000 1, 267, 489 2, 233, 879 900 90000 1, 267, 489		00600 MAINTENANCE & REPAIRS	4, 110, 364	00, 671, 557	04, 900, 141	-3, 076, 263 0		
B.00 ODGOOL LAUNDER'S LINEN SERVICE 128,694 337,964 4-06,658 0 4-06,658 0 1-00 1			2 296 499	6 371 870	8 668 369	209		
0.000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000000		1						8. 00
11.00 01100 CAFETERIA		1	1					
12.00 01200 MIX RTENNACT OF FERSONNEL 0	10.00	01000 DI ETARY	1, 519, 862	1, 961, 504	3, 481, 366	-1, 267, 489	2, 213, 877	10. 00
13.00 01300 MURSING ADMINISTRATION 3, 270, 066 268, 990 3, 539, 056 1, 691 3, 540, 747 13.00 13.00 01500 PHARMACY 2, 646, 835 3, 835, 478 6, 482, 373 -3, 477, 794 3, 004, 379 15.00 01500 PHARMACY 772, 053 51, 288 843, 341 -3, 477, 794 3, 004, 379 15.00 15.	11. 00	01100 CAFETERI A	0	0	C	1, 267, 489	1, 267, 489	11. 00
14.00 0 1400 CENTRAL SERVICES & SUPPLY 503, 383 1,992, 388 2,495,771 -838, 303 1,657,468 14.00 0 1600 NEDICAL RECORDS & LIBRARY 792,033 51,288 843,341 0 0 843,341 16.00 0 0 170 0 1700 0 1700 0 1700 0 1700 0 1700 0 1700 0 0 0			0	0	C	0		12. 00
15.00 01500 PHARMACY 2, 646, 835 3, 835, 478 6, 882, 313 -3, 477, 934 3, 004, 379 15, 00			I I					
16.00 10400 MEDICAL RECORDS & LIBRARY 792,033 51,288 843,341 0 0 843,341 16.00 17.00 1700 0100 0 0 0 0 0 0 0			1					
17.00 01700 SOCIAL SERVICE (SPECIFY) 0 0 0 0 0 0 17.00 19.00 01900 MONPHYSI CAM AMESTICIT STS 0 0 0 0 0 0 0 0 0 21.00 02000 O1900 MONPHYSI CAM AMESTICIT STS 0 0 0 0 0 0 0 0 0 21.00 02000 O2000 O2000 O2000 O2000 O2000 23.00 02000 O2000 O2000 O2000 O2000 O2000 O2000 23.00 02000 O2000 O			l l					1
18.00 0 1850 OTHER CRIMENT SERVICE (SPECIFY) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			792,053	51, 288	843, 341	0		1
19.00 0 1900 NONPHYSICI AN ARESTHETISTS 0 0 0 0 0 0 0 0 10 0 10 0 10 0 10 0				0				
20.00		, ,	0	0	ď	Ö		19. 00
21.00 0 2000 AR SERVICES-SALARY & FRINCES APPRVD 0 2, 963, 212 1, 399, 720 4, 362, 932 -1, 715, 160 2, 647, 772 21.00 220.00 220.00 23.00			o	0	d	0	0	20. 00
22.00 02200 RAS SERVICES—OTHER PRGM COSTS APPRVD 0 0 0 0 1,714,909 2,706 23.00 2		02100 I&R SERVICES-SALARY & FRINGES APPRVD	2, 963, 212	1, 399, 720	4, 362, 932	-1, 715, 160	2, 647, 772	21. 00
INPATI ENT ROUTINE SERVICE COST_CENTERS 8.054,653 2.175,504 10,230,157 -1,493,101 8,737,056 30.00 30.00 30.00 03.0	22. 00		0	0	C		1, 714, 909	22. 00
30.00 03000 ADULTS & PEDIATRICS 8,054,653 2,175,504 10,230,157 -1,493,101 8,737,056 30.00 33.00 33.00 03300 COROMARY CARE UNIT 0 0 0 0 0 0 0 0 0 32.00 03.00 33.00 33.00 03300 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 34.00 03.00	23. 00		0	0	C	0	0	23. 00
31.00 03100 INTERSIVE CARE UNIT 0,951,091 435,676 2,386,727 -57,923 2,328,804 31.00 32.00 32.00 03200 CRROMARY CARE UNIT 0 0 0 0 0 0 33.00 33.00								
22 00 03200C CORONARY CARE LINIT 0 0 0 0 0 32 00			I I					
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 3.3.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 3.4.00 40.00 04000 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1, 951, 051	435, 6/6	2, 386, 727	-57, 923		
34. 00 03400 SURPROVIDER - I PF				0		0		
40. 00 04000 SUBPROVI DER - I PF 6, 491, 104 654, 588 7, 145, 692 30, 845 7, 176, 537 40, 00 410, 00 4100 SUBPROVI DER - I RF 0 0 0 0 0 0 0 0 0				0		0	0	
41.00 04100 SUBRROVI DER - 1 RF			6, 491, 104	654, 588	7. 145. 692	30. 845	7. 176. 537	
43.00 04300 NURSERY 2, 484, 508 366, 633 2, 850, 141 -64, 304 2, 785, 837 43.00 44.00 04400 SKILLER NURSING FACILITY 1, 552, 116 34, 479 1, 586, 595 0 0 0 0 0 46.00 04500 OHER LOUNG TEM CARE 0 0 0 0 0 0 0 46.00 04500 OHER LOUNG TEM CARE 0 0 0 0 0 0 0 50.00 OSD00 OHER LOUNG TEM CARE 0 0 0 0 0 0 0 50.00 OSD00 OHER LOUNG TEM CARE 0 0 0 0 0 0 0 0 50.00 OSD00 OHER LOUNG TEM CARE 0 0 0 0 0 0 0 0 50.00 OSD00 OHER LOUNG TEM CARE 0 0 0 0 0 0 0 0 0 50.00 OSD00 OHER LOUNG TEM CARE 0 0 0 0 0 0 0 0 0			0	0 ., 000	77 . 107 072	0 0		41. 00
45.00 04500 OUTS NO FACILITY 0 0 0 0 0 0 45.00 8000 OUTS TENDICARE 0 0 0 0 0 0 46.00 8000 OUTS TENDICARE 0 0 0 0 0 0 0 46.00 8000 OUTS TENDICARE 0 0 0 0 0 0 0 46.00 8000 OUTS TENDICARE 0 0 0 0 0 0 0 46.00 8000 OUTS TENDICARE 0 0 0 0 0 0 0 0 0 8000 OUTS TENDICARE 0 0 0 0 0 0 0 0 0	43.00		2, 484, 508	365, 633	2, 850, 141	-64, 304	2, 785, 837	43. 00
A6. 00 04600 O160 O170 O170 O170 O170 O170	44.00	04400 SKILLED NURSING FACILITY	1, 552, 116	34, 479	1, 586, 595	2, 138	1, 588, 733	44. 00
ANCILLARY SERVICE COST CENTERS Service S			0	0	C	0		45. 00
SOLOD OSDOO OSDOO DELIVERY ROOM S. 383, 186 7, 823, 214 11, 206, 400 -4, 452, 325 6, 754, 075 50. 051. 00 OSDOO DELIVERY ROOM & LABOR ROOM 2, 677, 482 748, 693 3, 426, 175 -360, 612 3, 065, 663 52. 00 OSDOO DELIVERY ROOM & LABOR ROOM 2, 677, 482 748, 693 3, 426, 175 -360, 612 3, 065, 663 52. 00 OSDOO O	46. 00		0	0	C	0	0	46. 00
S1 00 05100 RECOVERY ROOM 809,005 301,136 1,200,141 -34,085 1,166,056 51.05	EO 00		2 202 107	7 000 014	11 207 400	4 452 225	/ 7F/ 07F	F0 00
S2.00 0520								
S3.00 05300 ABSTHESI OLOGY			1 ' 1					1
S4.00 05400 RADI OLOGY-DI AGNOSTI C 1,559,119 1,161,459 2,720,578 -169,619 2,550,959 54.00 05500 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0			0	0	0, 120, 170	0		53. 00
56.00 05600 RADI OI SOTOPE 123,071 35,785 158,856 0 158,856 56.00 57.00 57.00 CT SCAN 582,336 77,438 659,774 -53,292 606,482 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 266,119 14,090 280,209 -2,919 277,290 58.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0 0 0 59.00 0.00			1, 559, 119	1, 161, 459	2, 720, 578	-169, 619	2, 550, 959	
57.00 05700 05700 CT SCAN 582, 336 77, 438 659, 774 -53, 292 606, 482 57.00	55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0	55. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 266, 119 14, 090 280, 209 -2, 919 277, 290 58, 00 05900 CARDI AC CATHETERI ZATION 0 0 0 0 0 0 0 0 0 59. 00 059. 00								
59.00 05900 CARDI AC CATHETERI ZATION 0 0 0 0 0 0 59.00 60.00 06000 LABORATORY 1,872,793 3,054,647 4,927,440 -79,568 4,847,872 60.00 60.01 DOGOOI BLOOD LABORATORY 0<			l l					
60. 00 06000 LABORATORY 1,872,793 3,054,647 4,927,440 -79,568 4,847,872 60.00 060.01 06001 06001 06001 06001 060.01 060.01 061.00 061.00 061.00 060.01 061.00 061.00 061.00 060.01 061.00 0			266, 119	14, 090	280, 209	-2, 919		
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0			1 072 702	2 054 (47	4 007 440	70.540		
61. 00			1,872,793	3, 054, 647	4, 927, 440	- /9, 508		1
62. 00				0		0		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 556, 828 556, 828 -74, 962 481, 866 63. 00 64. 00 64. 00 64. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 65. 00 66. 00			o	O	Ċ	Ö		62. 00
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 64. 00 65. 00 6500 RESPI RATORY THERAPY 1, 167, 720 548, 365 1, 716, 085 -206, 947 1, 509, 138 65. 00 66. 00 67. 00				556, 828	556, 828	-74, 962		
66. 00		06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64. 00
67. 00								
68. 00		· ·	I I	4, 985				
69. 00				0	· ·			
70. 00		1	1	5(214				
71. 00		1	1	50, 214	270, 8/1	-32, 815		
72. 00		1		0		5 396 934		
73. 00			o o	0	ď			
74. 00			l ol	ő				1
75. 00		07400 RENAL DIALYSIS		o	C			1
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 77. 00 078. 00		07500 ASC (NON-DISTINCT PART)	0	o	C	0		75. 00
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 89. 00 09000 CLINIC 896, 372 100, 271 996, 643 -11, 238 985, 405 90. 00 09001 CLINIC CMHC 2, 273, 090 282, 207 2, 555, 297 -109, 539 2, 445, 758 90. 01 09001 CLINIC 2, 273, 090 282, 207 2, 555, 297 -109, 539 2, 445, 758 90. 01 09001 CLINIC 09001 CLINIC 09001 CLINIC 09001 CLINIC 09001 0		07700 ALLOGENEIC HSCT ACQUISITION		O	C	0		77. 00
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 09000 CLINIC 896, 372 100, 271 996, 643 -11, 238 985, 405 90. 00 09001 CLINIC CMHC 2, 273, 090 282, 207 2, 555, 297 -109, 539 2, 445, 758 90. 01 09001 CLINIC CMHC 2, 273, 090 282, 207 2, 555, 297 -109, 539 2, 445, 758 90. 01 09001 CLINIC CMHC 2, 273, 090 282, 207 2, 555, 297 -109, 539 2, 445, 758 90. 01 09001 CLINIC CMHC 2, 273, 090 282, 207 2, 555, 297 -109, 539 2, 445, 758 90. 01 09001 CLINIC CMHC 2, 273, 090 282, 207 2, 555, 297 -109, 539 2, 445, 758 90. 01 09001 CLINIC CMHC 2, 273, 090 282, 207 2, 555, 297 -109, 539 2, 445, 758 90. 01 0900	78. 00		0	0		0	0	78. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00 09000 CLINIC 896, 372 100, 271 996, 643 -11, 238 985, 405 90. 00 09001 CLINIC CMHC 2, 273, 090 282, 207 2, 555, 297 -109, 539 2, 445, 758 90. 01 09001 CLINIC CMHC 2, 273, 090 282, 207 2, 555, 297 -109, 539 2, 445, 758 90. 01 090	00.00			_1	-		_	00.55
90. 00 09000 CLI NI C 896, 372 100, 271 996, 643 -11, 238 985, 405 90. 00 90. 01 09001 CLI NI C CMHC 2, 273, 090 282, 207 2, 555, 297 -109, 539 2, 445, 758 90. 01				0		0		
90. 01 09001 CLINIC CMHC 2, 273, 090 282, 207 2, 555, 297 -109, 539 2, 445, 758 90. 01				100 271	004 443	_11 220		
			l l					1
			1	202, 207 N	2, 555, 297	109, 339		
			<u>. *1 </u>					

64, 920, 857

121, 817, 881

0

186, 738, 738

0

0 194. 01

186, 738, 738 200. 00

194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS

200.00

TOTAL (SUM OF LINES 118 through 199)

eal th	Financial Systems HO	BOKEN UNIVERSIT	Y MEDICAL CENTE	:R	In Lie	u of Form CMS	S-2552-1
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CC	CN: 31-0040	Peri od:	Worksheet A	
					From 01/01/2023 To 12/31/2023	Date/Time Pr	repared:
		1	1			5/31/2024 12	
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS						
. 00	00100 CAP REL COSTS-BLDG & FIXT	-3, 970, 699					1.0
. 00	00200 CAP REL COSTS-MVBLE EQUIP	0					2.0
. 00	00300 OTHER CAP REL COSTS	0					3.0
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	04 104 170					4.0
. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	-24, 184, 178					5.0
. 00 . 00	00700 OPERATION OF PLANT	-12, 496	0 8, 656, 082				6. 0 7. 0
. 00	00800 LAUNDRY & LINEN SERVICE	-12, 470					8. 0
. 00	00900 HOUSEKEEPING						9. 0
0. 00	01000 DI ETARY	0					10.0
1. 00	01100 CAFETERI A	-20, 099					11.0
2. 00	01200 MAINTENANCE OF PERSONNEL	0	0				12.0
3. 00	01300 NURSING ADMINISTRATION	0	3, 540, 747				13.0
1. 00	01400 CENTRAL SERVICES & SUPPLY	0	1, 657, 468				14. 0
5. 00		0					15.0
5. 00	01600 MEDICAL RECORDS & LIBRARY	-51					16.0
7. 00		0	1				17.0
3. 00		0	-				18. 0
9.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0				19. (
0.00		0	0				20. 0
1.00	02100 I &R SERVI CES -SALARY & FRI NGES APPRVD	0					21. (
2. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	.,,				22. 0
5. 00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS		U U				23. (
0. 00	03000 ADULTS & PEDIATRICS	-336, 794	8, 400, 262				30.0
1. 00	03100 NTENSI VE CARE UNIT	-18, 115					31. (
2. 00	03200 CORONARY CARE UNIT	10, 110	_				32. (
3. 00	03300 BURN INTENSIVE CARE UNIT		0				33.
1. 00	03400 SURGI CAL INTENSI VE CARE UNIT	0	o				34. (
0. 00	04000 SUBPROVI DER - I PF	-10, 107	7, 166, 430				40. (
1.00	04100 SUBPROVI DER - I RF	0	0				41. 0
3. 00	04300 NURSERY	-104, 712	2, 681, 125				43. 0
4. 00	04400 SKILLED NURSING FACILITY	0	1, 588, 733				44. 0
5. 00	04500 NURSING FACILITY	0					45. C
6. 00	04600 OTHER LONG TERM CARE	0	0				46. 0
	ANCI LLARY SERVI CE COST CENTERS	100.000					
0.00	05000 OPERATING ROOM	-100, 382					50.0
1. 00 2. 00	05100 RECOVERY ROOM	0	.,				51.0
3. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0					52. C
4. 00	05400 RADI OLOGY-DI AGNOSTI C	-35, 301	· ·				54. 0
5. 00	05500 RADI OLOGY-THERAPEUTI C	00,001					55. 0
5. 00							56. (
	05700 CT SCAN	0					57. (
3. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0					58. (
9. 00	05900 CARDI AC CATHETERI ZATI ON	0	0				59. (
0. 00	06000 LABORATORY	-3, 718	4, 844, 154				60.
0. 01	06001 BLOOD LABORATORY	0	O				60.
. 00	1	0	O				61.
. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.
. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	481, 866				63.
. 00		0	0				64.
. 00	06500 RESPI RATORY THERAPY	0	1, 509, 138				65.
5. 00	1	0	666, 133				66.
. 00	06700 OCCUPATIONAL THERAPY	0	278, 054				67.
3. 00			78, 599				68.
00			564, 056				69.
	07000 ELECTROENCEPHALOGRAPHY		5 206 024				70.
. 00			5, 396, 934				71. 72.
. 00			2, 320, 902 3, 578, 928				73.
. 00	07400 RENAL DIALYSIS		3, 578, 928 824, 511				74.
. 00			024, 511				75.
. 00	07700 ALLOGENEIC HSCT ACQUISITION						77.
. 00							78.
50	OUTPATIENT SERVICE COST CENTERS						- '0'
3. 00		0	0				88.
. 00			1				89.
. 00	1	-1, 140					90.
). 01	1 I	0					90.
	09002 CLINIC CHEMO	0					90.
). 02		1					
0. 02 0. 03	09003 CLINIC RYAN WHITE	-421, 852	710, 430				90. 0

Health FinancialSystemsHOBOKEN UNIVERRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 31-0040

			5/31/2024	
Cost Center Description	Adjustments	Net Expenses		
		or Allocation		
	6. 00	7. 00		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
OTHER REIMBURSABLE COST CENTERS				
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	0	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00 99. 00
99. 10 09910 CORF	0	0		99. 00
100.00 10000 1&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	0		101.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>		102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		105, 00
106. 00 10600 HEART ACQUI SI TI ON		0		106.00
107. 00 10700 LI VER ACQUI SI TI ON		0		107. 00
108. 00 10800 LUNG ACQUISITION		0		108. 00
109. 00 10900 PANCREAS ACQUISITION	l ol	o		109. 00
110.00 11000 INTESTINAL ACQUISITION	o	o		110.00
111.00 11100 I SLET ACQUISITION	o	o		111.00
113. 00 11300 I NTEREST EXPENSE	o	o		113.00
114.00 11400 UTILIZATION REVIEW-SNF	o	O		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	o	o		115. 00
116. 00 11600 HOSPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-30, 408, 844	155, 596, 579		118. 00
NONRE MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
190.01 19001 COMMUNTLY MOBILE	0	0		190. 01
190. 02 19002 FAI TH	0	733, 315		190. 02
191. 00 19100 RESEARCH	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0		193. 00
194. 00 07950 VACANT SPACE	0	0		194. 00
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS	0 100 611	0		194. 01
200.00 TOTAL (SUM OF LINES 118 through 199)	-30, 408, 844	156, 329, 894		200. 00

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/31/2024 12:06 pm Provider CCN: 31-0040

					5/31/2024 12	2:06 pm
		Increases				
	Cost Center	Li ne #	Salary	0ther		
	2. 00	3. 00	4. 00	5. 00		_
1 00	A - SUPPLIES MEDICAL SUPPLIES CHARGED TO	71 00	٥	F 20/ 02/		1 00
1. 00	PATIENTS	71. 00	0	5, 396, 934		1. 00
2.00	FAITENTS	0.00	0	0		2. 00
3.00		0.00	Ö	0		3. 00
4. 00		0.00	Ö	0		4. 00
5. 00		0.00	Ö	Ö		5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	Ö	Ö		7. 00
8.00		0.00	Ö	0		8. 00
9. 00		0.00	Ö	0		9. 00
10.00		0.00	o	0		10.00
11. 00		0.00	Ö	0		11. 00
12. 00		0.00	o	0		12. 00
13. 00		0.00	o	0		13. 00
14.00		0.00	0	0		14. 00
15.00		0.00	o	0		15. 00
16.00		0.00	О	0		16. 00
17.00		0.00	О	0		17. 00
18.00		0.00	О	0		18. 00
19.00		0.00	O	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
	TOTALS		0	5, 396, 934		
	B - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	2, 320, 902		1. 00
	PATI ENTS					
2.00		0. 00	0	0		2. 00
3.00		0.00	•	0		3. 00
	TOTALS		0	2, 320, 902		_
	C - DRUGS	70.00	اه	0.570.000		4
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	3, 578, 928		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4. 00 E. 00		0. 00 0. 00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00 7. 00		0.00	0	0		6. 00 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	Ö	Ö		14. 00
15. 00		0.00	Ö	Ö		15. 00
	TOTALS — — —			3, 578, 928		
	D - CAFETERIA	,	<u>'</u>			1
1.00	CAFETERI A	11. 00	573, 380	694, 109		1. 00
	TOTALS		573, 380	694, 109		1
	E - INTEREST					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	3, 528, 136		1. 00
	TOTALS		0	3, 528, 136		
	F - I&R ADMIN					
1.00	I&R SERVICES-OTHER PRGM	22. 00	381, 227	1, 333, 682		1. 00
	COSTS APPRVD					
	TOTALS		381, 227	1, 333, 682		_
	G - PROPERTY TAX					4
1. 00	CAP REL COSTS-BLDG & FIXT		•	1, 080, 325		1. 00
	TOTALS		0	1, 080, 325		_
	H - MEDICAL DIRECTORS					4
1.00	ADULTS & PEDIATRICS	30.00	0	113, 410		1. 00
2.00	INTENSIVE CARE UNIT	31.00	0	36, 825		2. 00
3.00	SUBPROVI DER – I PF	40.00	0	17, 952		3. 00
4.00	OPERATING ROOM	50.00	0	165, 891		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	101, 969		5. 00
6.00	LABORATORY	60.00	0	9, 975		6. 00
7. 00	EMERGENCY	<u>91.</u> 00	— — <u> </u>	<u>25, 594</u>		7. 00
	TOTALS	ļ	O	471, 616		I

Health Financial Systems RECLASSIFICATIONS HOBOKEN UNIVERSITY MEDICAL CENTER | Period: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/31/2024 12:06 pm Provider CCN: 31-0040

		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3.00	4.00	5.00	
	I - ALLOCATED FRINGES				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	393, 616	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
	TOTALS		0	393, 616	
	J - SITTERS				
1.00	ADMINISTRATIVE & GENERAL	5. 00	1, 794	0	1.00
2.00	OPERATION OF PLANT	7.00	209	0	2.00
3.00	HOUSEKEEPI NG	9. 00	3, 343	0	3.00
4.00	NURSING ADMINISTRATION	13. 00	1, 691	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	24, 086	0	5.00
6.00	SUBPROVI DER - I PF	40.00	25, 047	0	6. 00
7.00	SKILLED NURSING FACILITY	44.00	3, 569	0	7.00
8.00	RECOVERY ROOM	51.00	1, 636	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	19, 338	0	9.00
10.00	CLINIC RYAN WHITE	90. 03	7, 248	0	10.00
11.00	EMERGENCY	91.00	336, 186	0	11.00
	TOTALS		424, 147	— — — ō	
	K - RENAL			·	
1.00	RENAL DIALYSIS	74. 00	0	824, 511	1.00
	TOTALS			82 <u>4, 5</u> 11	
500.00	Grand Total: Increases		1, 378, 754	19, 622, 759	500.00

Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/31/2024 12:06 pm

		Dooroooo				5/31/2024 12:	06 pm
	Coot Conton	Decreases	Calami	0+hox	Wkat A 7 Dof		
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - SUPPLIES	7.00	8.00	9.00	10.00		
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	828, 389	0		1. 00
2.00	PHARMACY	15. 00	0	15, 418			2.00
3.00	I &R SERVICES-SALARY &	21.00	o	175			3. 00
3.00	FRINGES APPRVD	21.00	٥	173			3.00
4.00	ADULTS & PEDIATRICS	30.00	o	313, 563	0		4. 00
5. 00	INTENSIVE CARE UNIT	31.00	ő	113, 938			5. 00
6. 00	SUBPROVI DER - I PF	40.00	ő	11, 434			6. 00
7. 00	NURSERY	43.00	Ö	64, 149			7. 00
8. 00	SKILLED NURSING FACILITY	44. 00	ő	1, 272	- 1		8. 00
9. 00	OPERATING ROOM	50.00	o	2, 303, 879			9. 00
10. 00	RECOVERY ROOM	51.00	0	31, 992			10.00
11. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	353, 608			11. 00
12. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	271, 588			12.00
13. 00	CT SCAN	57.00	0	53, 292			13. 00
14. 00	MAGNETIC RESONANCE I MAGING	58.00	0	2, 919			14. 00
14.00		36.00	۷	2, 919	٥		14.00
15. 00	(MRI) LABORATORY	60.00	o	89, 543	o		15. 00
16. 00	BLOOD STORING, PROCESSING &	63.00	0	74, 962			16. 00
10.00	TRANS.	03.00	٩	74, 702			10.00
17. 00	RESPIRATORY THERAPY	65.00	o	206, 947	o		17. 00
18. 00		•	- 1				1
19. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00	0	2, 030			18. 00 19. 00
20. 00	CLINIC	90.00	0	32, 798			20.00
20.00	l .	90.00	0	11, 213			20.00
21.00	CLINIC CMHC	•	ı,	3 524			21.00
	CLINIC RYAN WHITE	90.03	0	3, 526			
23. 00	EMERGENCY	<u>91.</u> 00	9	610, 296			23. 00
	TOTALS		0	5, 396, 934			
1 00	B - IMPLANTS	F0.00	ما	2 205 557			1 00
1.00	OPERATING ROOM	50.00	0	2, 305, 557			1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	0	11, 802			2.00
3. 00	EMERGENCY	91.00	•	3,543			3. 00
	TOTALS		0	2, 320, 902			ļ
1 00	C - DRUGS	14.00	ما	0.014			1 00
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	9, 914			1.00
2.00	PHARMACY	15.00	0	3, 462, 516			2.00
3. 00	I &R SERVI CES-SALARY &	21. 00	0	76	0		3. 00
4 00	FRI NGES APPRVD	20.00		00.004			4 00
4.00	ADULTS & PEDIATRICS	30.00	0	30, 081	0		4. 00
5.00	INTENSIVE CARE UNIT	31.00	0	4, 896			5. 00
6.00	SUBPROVI DER - I PF	40.00	0	720			6. 00
7.00	NURSERY	43.00	0	155			7. 00
8. 00	SKILLED NURSING FACILITY	44.00	0	159			8. 00
9.00	OPERATING ROOM	50. 00	0	8, 780			9. 00
10. 00	RECOVERY ROOM	51.00	0	3, 729			10.00
11. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	14, 540			11. 00
12.00	ELECTROCARDI OLOGY	69. 00	O	17			12.00
13. 00	CLINIC	90.00	0	25			13. 00
	CLINIC RYAN WHITE	90. 03	0	7, 861			14. 00
15. 00	EMERGENCY	<u>91.</u> 00	•	3 <u>5, 4</u> 59			15. 00
	TOTALS		0	3, 578, 928			
	D - CAFETERIA						
1.00	DI ETARY	1000	57 <u>3, 3</u> 80	69 <u>4, 1</u> 09			1. 00
	TOTALS		573, 380	694, 109			
	E - INTEREST						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0_	<u>3, 528, 1</u> 36			1. 00
	TOTALS		0	3, 528, 136			
	F - I&R ADMIN						
1.00	I&R SERVICES-SALARY &	21.00	381, 227	1, 333, 682	0		1. 00
	FRI_NGES_APPRVD						
	TOTALS		381, 227	1, 333, 682			
	G - PROPERTY TAX						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 080, 325	9		1.00
	TOTALS			1, 080, 325			
	H - MEDICAL DIRECTORS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	471, 616	0		1. 00
2.00		0.00	O	0			2. 00
3.00		0.00	ol	0	0		3. 00
4.00		0.00	ol	0	0		4. 00
5. 00		0.00	ol	0	O		5. 00
6.00		0.00	ol	0	0		6. 00
7.00		0.00	0	0	0		7. 00
	TOTALS			471, 616			1
	•		-1				

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared: Provider CCN: 31-0040

					То	12/31/2023 Date/Time P 5/31/2024 1	repared:
		Decreases				07 017 2021 1	2.00 piii
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	I - ALLOCATED FRINGES						
1.00	ADULTS & PEDIATRICS	30.00	0	14, 209			1. 00
2.00	CLINIC CMHC	90. 01	0	109, 536	0		2. 00
3.00	CLINIC RYAN WHITE	90. 03	0	127, 634	0		3. 00
4.00	FAI_TH	1 <u>90.</u> 02	0	14 <u>2, 2</u> 37			4. 00
	TOTALS		0	393, 616			
	J - SITTERS						
1. 00	ADULTS & PEDIATRICS	30.00	424, 147	0	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	L	0.00	0	0	0		11. 00
	TOTALS		424, 147	0			
	K - RENAL						
1.00	ADULTS & PEDIATRICS	30.00	0	82 <u>4, 5</u> 11			1. 00
	TOTALS		0	824, 511			
500.00	Grand Total: Decreases		1, 378, 754	19, 622, 759			500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 31-0040 Peri od: Worksheet A-7 From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/31/2024 12:06 pm Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 0 1.00 0 2.00 Land Improvements 0 2.00 0 -16, 332, 661 3.00 -16, 332, 661 3.00 Buildings and Fixtures 54, 863, 962 0 0 4.00 Building Improvements 94, 920 94, 920 0 4.00 5.00 Fixed Equipment 14, 646, 232 4, 874, 788 0 4, 874, 788 0 5.00 0 6.00 Movable Equipment 40, 432, 311 -3, 744, 254 -3, 744, 254 0 6.00 0 7.00 HIT designated Assets 7.00 0 0 8.00 Subtotal (sum of lines 1-7) 109, 942, 505 -15, 107, 207 -15, 107, 207 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 109, 942, 505 -15, 107, 207 -15, 107, 207 10.00 10.00 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 0 1.00 2.00 Land Improvements 0 2.00 3.00 Buildings and Fixtures 38, 531, 301 0 3.00 0 4.00 Building Improvements 94, 920 4.00 5.00 Fi xed Equipment 19, 521, 020 0 5.00 Movable Equipment 36, 688, 057 0 6.00 6.00 7.00 HIT designated Assets 0 7.00

94, 835, 298

94, 835, 298

0

0

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL CENTER	In Lieu	Lieu of Form CMS-2552-10	
RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 31-0040	Peri od: From 01/01/2023	Worksheet A-7	

				o 12/31/2023		
		Sl	JMMARY OF CAPIT	TAL		
Cost Center Description	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 WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	6, 926, 691	0	C	0	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	767, 399	0	C	0	0	2. 00
3.00 Total (sum of lines 1-2)	7, 694, 090		C	0	0	3. 00
	SUMMARY 0	F CAPITAL				
	011	T (4) (
Cost Center Description		Total (1) (sum				
	Capi tal -Relate					
	d Costs (see instructions)	through 14)				
	14. 00	15. 00	-			
PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1. 00 CAP REL COSTS-BLDG & FLXT	0	6, 926, 691				1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	767, 399				2. 00
3.00 Total (sum of lines 1-2)	0	7, 694, 090	•			3. 00
			•			•

Heal th	Financial Systems HOB	OKEN UNIVERSIT			In Lie	u of Form CMS-	2552-10	
RECONCILIATION OF CAPITAL COSTS CENTERS					Period: From 01/01/2023 To 12/31/2023	Worksheet A-7 Part III Date/Time Pre 5/31/2024 12:	pared:	
		СОМІ	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance		
		1.00	2. 00	3. 00	4. 00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS CI							
1.00	CAP REL COSTS-BLDG & FLXT	58, 147, 241	0	58, 147, 241		0		
2.00	CAP REL COSTS-MVBLE EQUIP	36, 688, 057		36, 688, 057		0	2.00	
3.00	Total (sum of lines 1-2)	94, 835, 298		94, 835, 298			3. 00	
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease		
			Capi tal -Relate	cols. 5				
			d Costs	through 7)				
		6. 00	7. 00	8. 00	9. 00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(4, 285, 421	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(767, 399	0	2. 00	
3.00	Total (sum of lines 1-2)	0	0	(5, 052, 820	0	3. 00	
	SUMMARY OF CAPITAL							
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
	•		instructions)	instructions)	Capi tal -Rel ate	of cols. 9		
				,	d Costs (see	through 14)		
					instructions)	,		
		11. 00	12. 00	13. 00	14. 00	15. 00		
	DART III DECONCILIATION OF CARITAL COSTS CENTERS							

3, 279, 032

0 3, 279, 032

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT 3

0 0 0

0 0 0

7, 564, 453 1. 00 767, 399 2. 00 8, 331, 852 3. 00

0 0 0

1.00

2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

| Period: | Worksheet A-8 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 31-0040

					o 12/31/2023	Date/Time Prep 5/31/2024 12:0	pared:
				Expense Classification on		3/31/2024 12.	JO PIII
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	В		CAP REL COSTS-BLDG & FIXT	1.00	11	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
	(chapter 2)		-				
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		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay	А	-180, 529	ADMINISTRATIVE & GENERAL	5. 00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service (chapter 21)	A	-7, 845	ADMINISTRATIVE & GENERAL	5. 00	О	8. 00
9.00	Parking Lot (chapter 21)	В		OPERATION OF PLANT	7. 00	0	9.00
10. 00	Provider-based physician adjustment	A-8-2	-646, 267			0	10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	-20, 770, 992			0	12. 00
13. 00	Laundry and linen service		0		0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		0		0. 00 0. 00	0	14. 00 15. 00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and abstracts	В	-51	MEDICAL RECORDS & LIBRARY	16.00	0	18. 00
19. 00	Nursing and allied health		0		0.00	О	19. 00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of	В	-20, 099 0	CAFETERI A	11. 00 0. 00	0	20. 00 21. 00
200	interest, finance or penalty		J		3.00		21100
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)		_				
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
25. 00	limitation (chapter 14) Utilization review -		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
20.00	physicians' compensation		· ·	STIELENTION REVIEW SW	111.00		20.00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	О	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00	Physicians' assistant	4.0.2	0		0.00	0	29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0.00	0	32. 00
33. 00	Depreciation and Interest MISC	В	-85	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00

Provi der CCN: 31-0040 Peri od: Worksheet A-8 From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				'	0 12/31/2023	5/31/2024 12:0	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					·		
					<u> </u>		
	Cost Center Description	Basis/Code (2)		Cost Center		Wkst. A-7 Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
33. 01	CMHC OP YOUTH	В	-1, 140	CLI NI C	90.00		33. 01
33. 02	CCIS TUTOR	В	-475	ADMINISTRATIVE & GENERAL	5. 00		33. 02
33. 03	MAXI MUS	В	-5, 220	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33.04	ROTHMAN ONE	A	-3, 000, 000	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
33.05	ROTHMAN ONE LEASE EQUIP	A	-21, 368	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33.06	LATE FINANCE CHARGE	A	-11, 884	OPERATION OF PLANT	7. 00	0	33. 06
33. 07	PENALTI ES	A	-1, 143	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	COURTESY ADVERTISING	A	-8, 867	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33.09	DONATI ON	A	-300, 000	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	MAPLE HEALTHCARE INTEREST	A	-1, 317, 567	ADMINISTRATIVE & GENERAL	5.00	0	33. 10
33. 11	LOBBYI NG	A	-9, 170	ADMINISTRATIVE & GENERAL	5.00	0	33. 11
33. 12	MPT LEASE	A		CAP REL COSTS-BLDG & FIXT	1.00	9	33. 12
33. 13	OTHER REVENUE	В	-29, 235	ADMINISTRATIVE & GENERAL	5.00	0	33. 13
33. 14	RENTAL INCOME	В		ADMINISTRATIVE & GENERAL	5.00	0	33. 14
50.00	TOTAL (sum of lines 1 thru 49)		-30, 408, 844				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

⁽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

Provi der CCN: 31-0040 | Peri od: From 01/01/2023

Worksheet A-8-1

				To 12/31/2023	Date/Time Pre 5/31/2024 12:		
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount		
			·	Allowable Cost	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	90. 03	CLINIC RYAN WHITE	PHYSCI ANS	0	421, 852	1. 00	
2.00	91.00	EMERGENCY	AMBULANCE	0	1, 176, 621	2. 00	
3.00	22. 00	I&R SERVICES-OTHER PRGM COST	TEACHI NG JHA	1, 234, 809	1, 234, 809	3.00	
4.00	5. 00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES & HO A&G	9, 952, 006	11, 202, 592	4.00	
4.01	90. 03	CLINIC RYAN WHITE	MSO SHARED SALARY	9, 680	9, 680	4. 01	
4.02	90. 03	CLINIC RYAN WHITE	MSO SHARED SALARY	6, 608	6, 608	4. 02	
4.03	90. 01	CLINIC CMHC	MSO SHARED SALARY	3, 630	3, 630	4.03	
4.04	190. 02	FAI TH	MSO SHARED SALARY	9, 494	9, 494	4.04	
4.05	5. 00	ADMINISTRATIVE & GENERAL	JHA SUBS	471, 616	18, 393, 549	4. 05	
5.00	TOTALS (sum of lines 1-4).			11, 687, 843	32, 458, 835	5.00	
	Transfer column 6, line 5 to						
	Worksheet A-8, column 2,						
	line 12.						

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

1105 110	t been posted to norksheet 74,	cordinis r and or 2, the amoun	it arrowabie sii	our a be intareated in cordini	or this part.			
				Related Organization(s) and/or Home Office				
						ľ		
	Symbol (1)	Name	Percentage of	Name	Percentage of			
			Ownershi p		Ownershi p			
	1. 00	2. 00	3.00	4. 00	5. 00			
	B. INTERRELATIONSHIP TO 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.

. or mour oc	smorre under the control				
6.00	В	JHA	100.00 HUMC OPCO	100.00	6. 00
7. 00	В	MCCABE	100.00 HUMC OPCO	100.00	7. 00
8. 00	В	MSO ALL ADMIN	100.00 HUMC OPCO	100.00	8. 00
9. 00			0. 00	0.00	9. 00
10. 00			0. 00	0.00	10. 00
100. 00 G.	Other (financial or				100.00
no	on-financial) specify:				

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

3.00

4.00

4.01

4 02

4.03

4.04

4.05

5.00 -20, 770, 992 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:	
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 7. 00	В	6.00
7.00	В	7.00
8.00	В	8.00
9.00		9.00
8. 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.
- 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 organi zati on.
- 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 provi der

3.00

4.00

4.01

4 02

4.03

4.04

4.05

-1, 250, 586

-17, 921, 933

0

0

0

0

0

0

0

0

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 31-0040

					'	0 12/31/2023	5/31/2024 12:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1. 00		ADULTS & PEDIATRICS	113, 410		113, 410		693	1. 00
2. 00		INTENSIVE CARE UNIT	36, 825					2. 00
3.00	40. 00	SUBPROVIDER - IPF	17, 952	0	17, 952	181, 300	90	3. 00
4.00	50. 00	OPERATING ROOM	165, 891	0	165, 891	246, 400	553	4.00
5.00	54. 00	RADI OLOGY-DI AGNOSTI C	101, 969		101, 969	271, 900	510	5. 00
6.00	60. 00	LABORATORY	9, 975		9, 975	260, 300		6. 00
7.00		EMERGENCY	25, 594	0	25, 594			7. 00
8.00		ADMINISTRATIVE & GENERAL	1, 571, 367	24, 559	1, 546, 808	211, 500	196, 047	8. 00
9. 00		ADULTS & PEDIATRICS	293, 850		0	0	0	9. 00
10.00	43. 00	NURSERY	104, 712		0	0	0	10.00
200.00			2, 441, 545		2, 018, 424		198, 255	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		ldenti fi er	Limit	Unadjusted RCE			of Malpractice	
				Li mi t	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
1 00	1. 00	2.00	8.00	9.00	12. 00	13. 00	14. 00	4 00
1.00		ADULTS & PEDIATRICS	70, 466		0		ı	
2.00		INTENSIVE CARE UNIT	18, 710		0	_	ı	2. 00
3.00		SUBPROVI DER - I PF	7, 845		0	0	0	3. 00
4.00		OPERATING ROOM	65, 509		0	0	0	4. 00
5.00		RADI OLOGY-DI AGNOSTI C	66, 668		0	0	0	
6.00		LABORATORY	6, 257		0	0	0	6. 00
7.00		EMERGENCY	13, 015		0	0	0	7. 00
8.00		ADMINISTRATIVE & GENERAL	19, 934, 587		0	0	0	8. 00
9.00		ADULTS & PEDIATRICS NURSERY	0	0	0	0	Ĭ	9. 00
10. 00 200. 00	43.00	INURSERY	20 102 057	1 000 153	0	0	0	10. 00 200. 00
200.00	Wko+ Alino#	Cost Center/Physician	20, 183, 057 Provi der	1,009,152 Adjusted RCE	RCE	Adiustment	U	200.00
	Wkst. A Line #	I denti fi er	Component	Limit	Di sal I owance	Adjustment		
		rdentifier	Share of col.	LIIIII	Di Sai i Owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	0.00		42, 944			1. 00
2. 00		INTENSIVE CARE UNIT	0	·	18, 115			2. 00
3. 00		SUBPROVIDER - IPF		7, 845	10, 113	10, 113		3. 00
4. 00		OPERATI NG ROOM		65, 509	100, 382			4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	0	66, 668		35, 301		5. 00
6. 00		LABORATORY	1 0	6, 257	3, 718			6. 00
7. 00		EMERGENCY	0	13, 015				7. 00
8. 00		ADMINISTRATIVE & GENERAL	1 0	19, 934, 587	12, 377	24, 559		8. 00
9. 00		ADULTS & PEDIATRICS		17, 734, 307	0	293, 850		9. 00
10. 00		NURSERY		n	0	104, 712		10. 00
200.00	73.00	INDICATION		20, 183, 057	223, 146			200. 00
200.00		I	1	20, 100, 007	220, 140	010, 207	ı	200.00

Provider CCN: 31-0040

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | Date/Time Prepared: | Date/Time Prepared: | Da

Cast Center Rescription					11	0 12/31/2023	Date/lime Pre 5/31/2024 12:	
Part				CAPI TAL REI	LATED COSTS		070172021 12.	DO PIII
Description Control Control Centres Description Contro		Cost Center Description	for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	BENEFI TS	Subtotal	
ERICRAL SERVICE COST CENTERS 1.00 OLTOID CAP REL COSTS CADE & FIXT 7, 564, 463				1. 00	2.00	4. 00	4A	
2.00 00000 QAP RELL COSTSWBILE EQUIP 767, 399 767, 399 2.0 0.0		GENERAL SERVICE COST CENTERS						
6.00 0.600 0.600 0.600 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.	2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	767, 399 13, 873, 001	14, 509	767, 399 1, 472		37 305 841	2. 00 4. 00
9.00 000000 HOUSERFEYEN INS 2,788,7969 40,713 4,130 307,202 3,140,329 9,00 11.00 011000 DEFARM TO 1,247,390 157,227 15,664 15,893 23,302 2,20,202 11.00 01200 MAINTENANCE OF FERSONNEL 1,247,390 157,227 15,950 123,419 1,543,968 11.00 13.00 01300 MAINTENANCE OF FERSONNEL 1,247,390 157,227 15,950 123,419 1,543,968 11.00 13.00 01300 HANTENANCE OF FERSONNEL 1,247,488 130,713 12,90 108,352 1,931,821 14.00 13.00 01300 HANTENANCE OF FERSONNEL 1,247,488 130,713 10,819 108,353 1,931,821 14.00 14.00 01300 HANTENANCE OF FERSONNEL 1,557,488 130,713 10,819 108,353 1,931,821 14.00 14.00 01300 HANTENANCE OF FERSONNEL 1,557,488 130,713 10,819 10,819 10,819 14.00 01300 HANTENANCE OF FERSONNEL 1,557,488 130,713 10,819 10,81	6.00	00600 MAINTENANCE & REPAIRS	0	0	0	O	0	6. 00
11.00 0 011000 (CAFELERIA 1.94) 1,943,986 11,00 0 120 0 120 0 120 0 120 0 120 0 120 0 120 0 130 0 13000 MINISHARCE OF PERSONNEL 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.								1
13. 00 01300 NURSHING ADMINISTRATION 3,546,747 38,492 3,995 704,239 4,287,383 13. 0. 0 15. 00 01300 PHARMARCY 3,004,379 10,657,466 150,713 15,290 10,8194 509,726 3,991,514 15. 00 17. 00 01300 PHARMARCY 3,004,379 10,657,466 126,466 0 10,819 10,8194 509,726 3,991,514 15. 00 17. 00 01700 SOCI AL SERVICE (SPECI FY) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		I I						
15. 00 01500 PHARMACY 3,004,379 106,999 10,814 509,726 3,091,514 15.00 17.00 01700 000 10170 000 01700		1 1	0 3, 540, 747	0 38, 492	0 3, 905	0 704, 239		1
17. 00 01700 SOCIAL SERVICE 0 0 0 0 0 0 17. 00 18. 00 118. 00 11800 011800								
21.00	17. 00 18. 00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS	843, 290 0 0 0	124, 656 0 0 0	12, 646 0 0 0	170, 488 0 0 0		17. 00 18. 00
30.00 03000 ADULTS & PEDI ATRICS 8, 400, 262 946, 382 96, 011 1, 642, 463 11, 085, 118 30, 00 0300 03200	21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-(SPECIFY)	1, 714, 909	0	0	82, 058	1, 796, 967	21. 00 22. 00
32.00 03200 CORONARY CARE UNIT 0 0 0 0 0 0 33.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 33.00 34.00 03400 SUBROI CAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 33.00 41.00 04000 SUBPROVIDER - IPF 7,166,430 628,316 63,741 1,402,588 9,261,075 40.00 41.00 04000 SUBPROVIDER - IPF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00		8, 400, 262	946, 382	96, 011	1, 642, 463	11, 085, 118	30.00
33.0 0 3300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 34.00 34.00 34.00 34.00 SIRGICAL INTENSIVE CARE UNIT 0 0 0 0 0 34.00 34.00 34.00 34.00 SIRGICAL INTENSIVE CARE UNIT 0 0 0 0 0 34.00 34.00 34.00 34.00 SIRGICAL INTENSIVE CARE UNIT 1 0 0 0 0 0 0 34.00 34.00 34.00 34.00 34.00 SIRGICAL INTENSIVE CARE UNIT 1 7, 166, 430 628, 316 63, 741 1, 402, 588 9, 261, 075 40.00 34.00 34.00 SIRGICAL SIRGICAL SUBPROVIDER - IPF 0 0 0 0 0 0 41.00 34.00 34.00 34.00 34.00 SIRGICAL SUBPROVIDER - IRF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			2, 310, 689 0	405, 059 0	41, 092 0	425, 144 0	3, 181, 984 0	1
40.00 04000 SUBPROVI DER - I PF 7, 166, 430 628, 316 63, 741 1, 402, 588 9, 261, 075 40.00 41.00 41100 SUBPROVI DER - I RF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
43.00 04300 NURSERY 2, 681, 125 85, 128 8, 636 534, 785 3, 309, 674 43, 00 44.00 04400 SKILLED NURSING FACILITY 1, 588, 733 216, 150 21, 928 334, 858 2, 161, 669 45, 00 45.00 04500 NURSING FACILITY 1, 588, 733 216, 150 21, 928 334, 858 2, 161, 669 46, 00 46.00 04500 NURSING FACILITY 0 0 0 0 0 0 46.00 04500 NURSING FACILITY 0 0 0 0 0 0 46.00 04500 NURSING FACILITY 0 0 0 0 0 0 46.00 04500 NURSING FACILITY 0 0 0 0 0 0 46.00 04500 NURSING FACILITY 0 0 0 0 0 0 46.00 04500 NURSING FACILITY 0 0 0 0 0 46.00 04500 NURSING FACILITY 0 0 0 0 0 46.00 04500 NURSING FACILITY 0 0 0 0 0 46.00 04500 NURSING FACILITY 0 0 0 0 0 46.00 04500 NURSING FACILITY 0 0 0 0 0 46.00 04500 NURSING FACILITY 0 0 0 0 0 46.00 04500 NURSING FACILITY 0 0 0 0 0 46.00 05000 05000 05000 05000 0	40.00	04000 SUBPROVI DER - I PF	7, 166, 430	628, 316	63, 741	1, 402, 588		40. 00
45. 00 04500 NURSING FACILITY 0 0 0 0 0 0 45. 00 46. 00 04600 OTHER LONG TERM CARE 0 0 0 0 0 0 46. 00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM 1, 166, 056 59, 219 6, 008 193, 861 1, 425, 144 51. 00 51. 00 05100 RECOVERY ROOM 3, 065, 563 83, 499 8, 471 580, 485 3, 738, 018 52. 00 52. 00 05200 DELIVERY ROOM 4, 840 8, 245, 847 580, 485 3, 738, 018 52. 00 53. 00 05300 AMESTHESI OLOGY 0 0 0 0 0 0 0 54. 00 05400 RADIO INCOV-THERAPEUTI C 2, 515, 658 212, 449 21, 553 335, 597 3, 085, 257 54. 00 55. 00 05500 RADIO IOOY-THERAPEUTI C 0 0 0 0 0 0 0 55. 00 05500 RADIO IOOY-THERAPEUTI C 0 0 0 0 0 0 0 55. 00 05500 RADIO IOOY-THERAPEUTI C 0 0 0 0 0 0 0 56. 00 05600 RADIO IOOY-THERAPEUTI C 0 0 0 0 0 0 0 57. 00 05700 CT SCAN 606, 482 49, 300 5, 001 125, 347 786, 130 50. 00 59. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 277, 279 49, 300 5, 001 125, 347 786, 130 50. 00 59. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 277, 279 49, 300 5, 001 57, 282 388, 873 58. 00 60. 00 60000 LABORATORY 4, 844, 154 227, 994 23, 130 403, 115 5, 498, 393 60. 00 60. 00 60000 LABORATORY 4, 844, 154 227, 994 23, 130 403, 115 5, 498, 393 60. 00 61. 00 60500 RADIO IN CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 0 0 62. 00 06500 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 64. 00 64000 MHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 65. 00 06600 PHYSICIAN, PROCESSI NG & TRANS. 481, 866 7, 402 751 0 490, 019 63. 00 66. 00 06600 PHYSICIAN, PROCESSI NG & TRANS. 481, 866 7, 402 751 0 490, 019 63. 00 67. 00 06600 PHYSICIAN, PROCESSI NG & TRANS. 481, 866 7, 254 736 16, 918 103, 507 68. 00 06600 SPECEH PATHOLOGY 78, 599 7, 254 736 16	43.00	04300 NURSERY					3, 309, 674	43. 00
ANCILLARY SERVICE COST CENTERS	45.00	04500 NURSING FACILITY	0	0	21, 928	O	0	45. 00
50.00	46.00] 0	0	0	U	0	46.00
51.00	50.00		6, 653, 693	784. 358	79, 572	728, 224	8, 245, 847	50.00
53.00 05300 AMESTHESI OLOGY 0 0 0 0 0 0 53.00	51.00	05100 RECOVERY ROOM	1, 166, 056	59, 219	6, 008	193, 861	1, 425, 144	51. 00
55.00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 0 55.00	53.00	05300 ANESTHESI OLOGY	0	0	0	O	0	53. 00
57. 00 05700 CT SCAN 606, 482 49, 300 5, 001 125, 347 786, 130 57. 00 58.00 MAGNETIC RESONANCE IMAGING (MRI) 277, 290 49, 300 5, 001 57, 282 388, 873 58. 00 05900 CARDIA C CATHETERI ZATION 0 0 0 0 0 0 0 59.00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	О	0	55. 00
59.00 05900 CARDI AC CATHETERI ZATI ON 0			1				· ·	1
60. 00 06000 LABORATORY 4, 844, 154 227, 994 23, 130 403, 115 5, 498, 393 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0				49, 300 0	5, 001 0		388, 873	58. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 481,866 7,402 751 0 490,019 63. 00 64. 00 64. 00 64. 00 65. 00 65. 00 65. 00 65. 00 65. 00 66. 00 6	60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	4, 844, 154 O O	227, 994 0	23, 130 0	403, 115 0	0	60. 00 60. 01
66. 00 06600 PHYSI CAL THERAPY 666, 133 47, 671 4, 836 142, 748 861, 388 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 278, 054 7, 254 736 59, 851 345, 895 67. 00 68. 00 06800 SPEECH PATHOLOGY 78, 599 7, 254 736 16, 918 103, 507 68. 00 69. 00 06900 ELECTROCARDI OLOGY 564, 056 38, 196 3, 875 116, 375 722, 502 69. 00 07000 ELECTROENCEPHALOGRAPHY 0 7, 254 736 0 7, 990 70. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 5, 396, 934 0 0 0 0 5, 396, 934 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 2, 320, 902 0 0 0 0 2, 320, 902 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 3, 578, 928 0 0 0 0 3, 578, 928 73. 00 74. 00 07400 RENAL DI ALYSI S 824, 511 26, 501 2, 688 0 853, 700 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0	63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0 481, 866 0	0 7, 402 0	0 751 0	0 0 0	-	63. 00
67. 00 06700 OCCUPATIONAL THERAPY 278, 054 7, 254 736 59, 851 345, 895 67. 00 68. 00 06800 SPEECH PATHOLOGY 78, 599 7, 254 736 16, 918 103, 507 68. 00 69. 00 06900 ELECTROCARDI OLOGY 564, 056 38, 196 3, 875 116, 375 722, 502 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 7, 254 736 0 7, 990 70. 00 70. 00 70. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 5, 396, 934 0 0 0 0 5, 396, 934 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 320, 902 0 0 0 2, 320, 902 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 3, 578, 928 0 0 0 3, 578, 928 73. 00 74. 00 07400 RENAL DI ALYSI S 824, 511 26, 501 2, 688 0 853, 700 74. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0								1
69. 00 06900 ELECTROCARDI OLOGY 564, 056 38, 196 3, 875 116, 375 722, 502 69. 00 70.	67. 00	06700 OCCUPATI ONAL THERAPY	278, 054	7, 254	736	59, 851	345, 895	67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 7, 254 736 0 7, 990 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 5, 396, 934 0 0 0 5, 396, 934 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 320, 902 0 0 0 2, 320, 902 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 3, 578, 928 0 0 0 3, 578, 928 73. 00 74. 00 07400 RENAL DIALYSIS 824, 511 26, 501 2, 688 0 853, 700 74. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 78. 00 00TPATIENT SERVICE COST CENTERS								
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 320, 902 0 0 0 2, 320, 902 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 3, 578, 928 0 0 0 3, 578, 928 73. 00 74. 00 07400 RENAL DIALYSIS 824, 511 26, 501 2, 688 0 853, 700 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 75. 00 07500 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0		i i	1			110, 375		
73. 00 07300 DRUGS CHARGED TO PATIENTS 3,578,928 0 0 0 3,578,928 73. 00 74. 00 07400 RENAL DIALYSIS 824,511 26,501 2,688 0 853,700 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 75. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 0		1 1		0	0	o		
74. 00 07400 RENAL DI ALYSI S 824, 511 26, 501 2, 688 0 853, 700 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 75. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0				0	0	0 0		
77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 78. 00 0 78. 00 0 0 78. 00 0 0 78. 00	74.00	07400 RENAL DIALYSIS		26, 501	2, 688	o		74. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78. 00 0 0 78. 00 0 0 0 78. 00			1	0	0	o		
OUTPATIENT SERVICE COST CENTERS		07800 CAR T-CELL IMMUNOTHERAPY	1	0	0			
	00.00	OUTPATIENT SERVICE COST CENTERS						00.00
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89.00	88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90. 00 09000 CLI NI C 984, 265 94, 455 9, 582 192, 942 1, 281, 244 90. 00			984, 265	94, 455	9, 582	192, 942	1, 281, 244	

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-0040 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 12:06 pm CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A 90. 01 09001 CLINIC CMHC 2, 445, 758 489, 278 2, 935, 036 90. 01 09002 CLINIC CHEMO 26, 501 2, 688 90 02 29, 189 90 02 90.03 09003 CLINIC RYAN WHITE 710, 430 132, 424 842, 854 90.03 91.00 09100 EMERGENCY 7, 610, 940 620, 025 62, 900 1, 317, 332 9, 611, 197 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92 00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 94.00 09500 AMBULANCE SERVICES 0 95.00 00000 0 0 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 96 00 Ω 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 98.00 0 99.00 09900 CMHC 0 99.00 0 0 99. 10 |09910 CORF 0 99. 10 0 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 0 0 0 0 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 0 106. 00 0 0 107. 00 10700 LIVER ACQUISITION 0 107. 00 0 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 0 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 C 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 155, 596, 579 7, 170, 349 727, 419 13, 743, 190 155, 016, 703 118. 00 118, 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 21, 198 190. 00 19, 246 1, 952 190. 01 19001 COMMUNTLY MOBILE 0 190. 01 190. 02 19002 FAI TH 733, 315 145, 792 879, 107 190. 02 0 191. 00 19100 RESEARCH 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 181, 983 192. 00 165, 222 16, 761 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 194.00 07950 VACANT SPACE 0 209, 636 21, 267 0 230, 903 194. 00 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 ol 0 194. 01 0 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 201. 00 202.00 TOTAL (sum lines 118 through 201) 156, 329, 894 767, 399 13, 888, 982 156, 329, 894 202. 00 7, 564, 453

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0040

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

5/31/2024 12:06 pm Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS **PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 37, 305, 841 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 3, 133, 756 13, 131, 987 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 171.609 0 103, 049 822, 177 8.00 00900 HOUSEKEEPI NG 4, 211, 406 9.00 984, 246 0 86, 928 9 00 10.00 01000 DI ETARY 811, 837 334, 498 108, 859 10.00 11.00 01100 CAFETERI A 483, 933 335, 700 0 109, 250 11.00 0 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 0 C 0 13.00 01300 NURSING ADMINISTRATION 1, 343, 799 82, 186 26, 747 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 605, 493 321, 791 104, 723 14.00 0 01500 PHARMACY 1, 157, 035 15.00 227, 593 74,068 15.00 01600 MEDICAL RECORDS & LIBRARY 360, 784 16.00 0 266, 157 86, 618 16.00 0 17.00 01700 SOCIAL SERVICE 0 C 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18 00 0 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 0 19.00 0 02000 NURSING PROGRAM 0 20 00 0 C Γ Λ 20 00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 1,088,983 170, 870 21.00 525, 044 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 563, 225 C 22.00 C Ω 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 474, 434 2, 020, 648 320, 013 882, 227 30.00 31.00 03100 INTENSIVE CARE UNIT 997, 332 864.853 54, 103 281, 457 31.00 03200 CORONARY CARE UNIT 32.00 \cap Λ 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 C 0 33.00 0 0 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 34.00 04000 SUBPROVIDER - IPF 0 40.00 2, 902, 708 1.341.534 62.557 436, 176 40.00 04100 SUBPROVI DER - I RF 41.00 Ω 41.00 43.00 04300 NURSERY 1,037,354 181, 758 59, 151 43.00 44.00 04400 SKILLED NURSING FACILITY 677, 534 0 461, 508 73, 018 150, 193 44.00 45 00 04500 NURSING FACILITY Ω 45 00 C 0 04600 OTHER LONG TERM CARE 46.00 0 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 584, 504 0 1, 674, 705 545, 015 50.00 05100 RECOVERY ROOM C 0 51.00 446,684 126, 441 41, 149 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 1, 171, 611 0 178, 281 0 58,020 52.00 0 53.00 05300 ANESTHESI OLOGY 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 967 015 0 453, 605 147, 621 54 00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 C 55.00 05600 RADI OI SOTOPE 66, 271 50, 576 0 16, 459 56.00 56.00 0 57.00 05700 CT SCAN 246, 398 0 105, 262 34, 256 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 121, 885 C 58 00 58 00 105, 262 34, 256 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 60.00 06000 LABORATORY 1, 723, 367 486, 796 0 158, 423 60.00 06001 BLOOD LABORATORY 0 60.01 0 60.01 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 153, 587 15,805 5, 144 63.00 0 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 0 06500 RESPIRATORY THERAPY 65 00 563 444 72 071 23, 455 65 00 06600 PHYSI CAL THERAPY 269, 986 101, 785 o 33, 125 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 108, 414 15, 489 5, 041 67.00 0 06800 SPEECH PATHOLOGY 5, 041 68.00 32, 442 0 15.489 68.00 69.00 06900 ELECTROCARDI OLOGY 226, 455 81, 554 26, 541 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 2,504 15, 489 0 0 5,041 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 691, 566 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 727, 443 0 0 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 121, 747 C C Ω 73.00 74.00 07400 RENAL DIALYSIS 267, 576 0 56, 582 0 18, 414 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0 75.00 0 0 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 Ω 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER C 0 89.00 09000 CLI NI C 0 90.00 401, 582 0 201, 673 65, 632 90.00 90.01 09001 CLINIC CMHC 919, 931 90.01 0 09002 CLINIC CHEMO 90 02 9, 149 C 56, 582 0 18, 414 90.02 90.03 09003 CLINIC RYAN WHITE 264, 177 0 90.03 0 91.00 09100 EMERGENCY 3, 012, 447 1, 323, 832 312, 486 430, 827 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 Provider CCN: 31-0040

			'	0 12/31/2023	5/31/2024 12:	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106. 00
107. 00 10700 LIVER ACQUISITION	0	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 H0SPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	36, 894, 247	0	12, 290, 526	822, 177	4, 162, 213	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 644	0	41, 093	0		190. 00
190. 01 19001 COMMUNTLY MOBILE	0	0	0	0		190. 01
190. 02 19002 FAI TH	275, 539	0	0	0		190. 02
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	57, 039	0	352, 769	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 VACANT SPACE	72, 372	0	447, 599	0		194. 00
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 01
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	37, 305, 841	0	13, 131, 987	822, 177	4, 211, 406	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 31-0040

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/31/2024 | 12: 06 pm

						5/31/2024 12:	06 pm
C	ost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	F NURSING ADMINISTRATION	CENTRAL SERVI CES & SUPPLY	
		10.00	11. 00	12. 00	13. 00	14. 00	
GENERAL	SERVICE COST CENTERS						
1. 00	AP REL COSTS-BLDG & FIXT AP REL COSTS-MVBLE EQUIP MPLOYEE BENEFITS DEPARTMENT DMINISTRATIVE & GENERAL AINTENANCE & REPAIRS PERATION OF PLANT AUNDRY & LINEN SERVICE OUSEKEEPING IETARY AFETERIA AINTENANCE OF PERSONNEL URSING ADMINISTRATION ENTRAL SERVICES & SUPPLY	3, 845, 356 0 0 0 0 0 0 0 0	2, 472, 869 0 113, 541 38, 566 98, 610 48, 706 0 0 0 150, 989 16, 488		5, 853, 656 0 0 0 0 0 0 0 0 0 0 0	3, 002, 396 5, 603 28 0 0 0 0 3, 969	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
	ARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	23. 00
	NT ROUTINE SERVICE COST CENTERS	4 500 04-	240.000		1 440 400	100 071	20.00
	DULTS & PEDIATRICS NTENSIVE CARE UNIT	1, 528, 917 136, 531	348, 888 77, 850		1, 413, 493 420, 598	129, 071 42, 668	1
	ORONARY CARE UNIT	0	0		0 0	0	32.00
	URN INTENSIVE CARE UNIT	0	0		0	0	33.00
1 1	URGICAL INTENSIVE CARE UNIT UBPROVIDER - IPF	1, 514, 030	0 297, 985	1	983, 433	0 10, 626	34. 00 40. 00
	UBPROVI DER - I RF	1, 514, 030	277, 703		0 703, 433	0 0 0 0 0 0	41.00
43. 00 04300 N		224, 813	92, 741		597, 620	3, 728	43. 00
	KILLED NURSING FACILITY	441, 065	75, 614		252, 063	1, 914	
	URSING FACILITY THER LONG TERM CARE	0	0		0 0	0	
	RY SERVICE COST CENTERS	<u> </u>	0	· ·	5 0	0	40.00
50. 00 05000 0	PERATING ROOM ECOVERY ROOM	0	117, 453 27, 467	•	0 445, 291 0 177, 301	231, 399 1, 392	1
	ELIVERY ROOM & LABOR ROOM	o	108, 431	•	532, 406	26, 572	
	NESTHESI OLOGY	0	0		0 0	0	53. 00
1 1	ADI OLOGY-DI AGNOSTI C	0	59, 725	(0	22, 106	
	ADI OLOGY-THERAPEUTI C ADI OI SOTOPE	0	0 4, 272			0 37	55. 00 56. 00
57. 00 05700 C		0	20, 520		0	6, 057	1
	AGNETIC RESONANCE IMAGING (MRI)	o	8, 663		0	2, 868	
	ARDI AC CATHETERI ZATI ON	0	0	(0	0	59. 00
1 1	ABORATORY	0	102, 522	(0	17, 534	
1 1	LOOD LABORATORY BP CLINICAL LAB SERVICES-PRGM ONLY		U	'	3	0	60. 01 61. 00
1 1	HOLE BLOOD & PACKED RED BLOOD CELLS	o	0		0 0	0	62. 00
	LOOD STORING, PROCESSING & TRANS.	0	0	(0	412	
	NTRAVENOUS THERAPY ESPI RATORY THERAPY	0	0 42, 917		0	0 16, 550	64. 00 65. 00
	HYSI CAL THERAPY	0	42, 917 27, 427		0	423	1
1 1	CCUPATI ONAL THERAPY	o	12, 017		0	0	67. 00
	PEECH PATHOLOGY	O	3, 633		0 0	0	68. 00
1 1	LECTROCARDI OLOGY	0	27, 946		32, 105	1, 607	69. 00
1 1	LECTROENCEPHALOGRAPHY EDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0 1, 832, 723	70. 00 71. 00
	MPL. DEV. CHARGED TO PATIENTS	0	0		0	596, 845	
73. 00 07300 DI	RUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
1 1	ENAL DIALYSIS	0	0		0	0	74. 00
	SC (NON-DISTINCT PART) LLOGENEIC HSCT ACQUISITION	0	0		0	0	75. 00 77. 00
1 1	AR T-CELL IMMUNOTHERAPY		0		0	0	78.00
	ENT SERVICE COST CENTERS	91			91		
88. 00 08800 R	URAL HEALTH CLINIC	0	0		0 0	0	1
89. 00 08900 FI	EDERALLY QUALIFIED HEALTH CENTER	0	0 50, 223		0 0 158, 834	0 3, 331	89. 00 90. 00
1 1	LINIC CMHC		129, 909		0 4, 327	3, 331	
	LINIC CHEMO		0		0	0	90. 02
1 1	LINIC RYAN WHITE	0	45, 871		29, 034	394	
91. 00 09100 E	MERGENCY	0	280, 339	<u> </u>	0 807, 151	43, 662	91.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | Part | Part | Prepared: | Part | P Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS HOBOKEN UNIVERSITY MEDICAL CENTER Provider CCN: 31-0040

				10 12/31/2023	5/31/2024 12:	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	F NURSI NG	CENTRAL	Piii
μ			PERSONNEL	ADMINISTRATION	SERVICES &	
					SUPPLY	
	10.00	11. 00	12.00	13.00	14. 00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0)	0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0)	0 0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0)	lo lo	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0)	lo lo	0	98. 00
99. 00 09900 CMHC	O	O)	lo lo	0	99. 00
99. 10 09910 CORF	0	0)	ol o	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	O	0		ol ol	0	100. 00
101.00 10100 HOME HEALTH AGENCY	ol	0)	ol ol	0	101. 00
102.00 10200 OPLOLD TREATMENT PROGRAM	o	0		o	0	102.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0)	0 0	0	105. 00
106.00 10600 HEART ACQUISITION	o	0)	lo lc	0	106. 00
107.00 10700 LIVER ACQUISITION	O	0)	o o	0	107. 00
108.00 10800 LUNG ACQUISITION	o	O)	lo lo	0	108. 00
109. 00 10900 PANCREAS ACQUISITION	O	0)	o o	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	o	0)	ol ol	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	o	0)	ol ol	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	o	0		ol ol	0	115. 00
116. 00 11600 HOSPI CE	o	0		ol ol	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 845, 356	2, 429, 313	3	5, 853, 656	3, 001, 893	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C)	0 C	0	190. 00
190.01 19001 COMMUNTLY MOBILE	0	0		o c	0	190. 01
190. 02 19002 FAI TH	0	43, 556		lo lo	503	190. 02
191. 00 19100 RESEARCH	O	O)	lo lo	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	O	0		ol ol	0	192. 00
193. 00 19300 NONPALD WORKERS	O	0		ol ol	0	193. 00
194. 00 07950 VACANT SPACE	O	0		ol ol	0	194. 00
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS	o	0		lo lo		194. 01
200.00 Cross Foot Adjustments	1					200. 00
201.00 Negative Cost Centers	ol	0		lo lo	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	3, 845, 356	2, 472, 869		5, 853, 656	3, 002, 396	
			•			

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/31/2024 | 12: 06 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-0040

					12/31/2023	5/31/2024 12:	
					OTHER GENERAL SERVI CE		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE		NONPHYSI CI AN	
	'		RECORDS &		,	ANESTHETI STS	
		15.00	LI BRARY	17.00	19.00	10.00	
	GENERAL SERVICE COST CENTERS	15. 00	16. 00	17. 00	18. 00	19. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A			•			11.00
12.00	01200 MAINTENANCE OF PERSONNEL						12. 00
13.00	01300 NURSING ADMINISTRATION						13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	5, 254, 423					14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0, 254, 425	1, 913, 373				16.00
17. 00	01700 SOCIAL SERVICE	0	0				17. 00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0		18.00
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM	0	0	0	0	0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD		0	0	0		21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0		22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	O	237, 797	0	0	0	30. 00
31. 00	03100 NTENSI VE CARE UNIT		26, 342			l .	31.00
32. 00	03200 CORONARY CARE UNIT	o	. 0		0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0		0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	190, 365	0	0	0	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF		170, 303	ő	0	0	41.00
43.00	04300 NURSERY	0	35, 664		0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	64, 873		0	0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE		0			•	45. 00 46. 00
.0.00	ANCILLARY SERVICE COST CENTERS	91					10.00
50.00	05000 OPERATING ROOM	0	74, 908			1	50. 00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	7, 294			0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY		10, 245 0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	187, 353	0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 57. 00	05600	0	6, 055 101, 073	1	0	0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		17, 095		0		1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	_	0	0	
60.00	06000 LABORATORY	0	252, 466		0	0	60.00
60. 01 61. 00	O6001 BLOOD LABORATORY O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	O	0	0	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	O	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	8, 702	0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	11 703	0	0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		11, 703 9, 700		0	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		4, 484		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	1, 018	1	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	34, 193	1	0	0	69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		664 8, 406		0	0	70. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		9, 525		Ö	ő	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	5, 254, 423	55, 289	0	0	0	73. 00
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	563 0		0	0	74. 00 75. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		0	0	0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY		0				78. 00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0			l	1
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC		27, 723	_	0	0	89. 00 90. 00
90. 01	09001 CLINIC CMHC		39, 243	1	0	ő	90. 01
90. 02	09002 CLI NI C CHEMO	l o	1, 006	0	0	0	90. 02

0 190. 02

0 191. 00

0 192. 00

0 193. 00

0 194.00

0 194. 01

0 200.00

0 201. 00

0 202. 00

Health Financial Systems HOBOKEN UNIVERSITY MEDICAL CENTER In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-0040 Peri od: Worksheet B From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/31/2024 12:06 pm OTHER GENERAL SERVI CE NONPHYSI CI AN Cost Center Description **PHARMACY** MEDI CAL SOCIAL SERVICE (SPECIFY) **ANESTHETI STS** RECORDS & LI BRARY 19.00 17.00 18.00 15.00 16.00 90. 03 09003 CLINIC RYAN WHITE 90.03 144 0 09100 EMERGENCY 0 0 o 91.00 91.00 489, 480 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0000000 0 0 0 0 0 0 95.00 09500 AMBULANCE SERVICES 0 95.00 0 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 96.00 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 0 99.00 109900 CMHC 0 99.00 0 99. 10 09910 CORF 99. 10 0 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 0 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 0 0 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105. 00 000000 0 0 0 0 0 106. 00 10600 HEART ACQUISITION 0 0 0 106, 00 0 107.00 10700 LIVER ACQUISITION 0 0 107, 00 108.00 10800 LUNG ACQUISITION 0 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 Ω 111.00 11100 | SLET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 5, 254, 423 1, 913, 373 0 0 118.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 01 19001 COMMUNTLY MOBILE 0 0 0 0 0 0 0 0 0 190. 01 0000

0

0

5, 254, 423

0

0

0

0

0

0

0

0

0

0

1, 913, 373

190. 02 19002 FAI TH

200.00

201.00

202.00

191. 00 19100 RESEARCH

193. 00 19300 NONPALD WORKERS

194.00 07950 VACANT SPACE

192.00 19200 PHYSICIANS' PRIVATE OFFICES

194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/31/2024 | 12: 06 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-0040

					72/31/2023	5/31/2024 12:	
			INTERNS &	RESI DENTS			
	Cost Center Description	NURSI NG	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	
		PROGRAM	Y & FRINGES	PRGM COSTS	PRGM		
	OFNEDAL CERVILOE COCT OFNEEDO	20. 00	21. 00	22. 00	23. 00	24. 00	
1. 00	GENERAL SERVICE COST CENTERS 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 MAI NTENANCE & REPAI RS						6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY						15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCI AL SERVI CE						17. 00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)						18. 00
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM	0					19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD		5, 414, 249				21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD			2, 376, 680			22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)				0		23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1 040 045	000 071		24 000 522	20.00
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T		1, 840, 845 108, 285		0		30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT		0		0	0, 237, 337	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0		34. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0	0	,	1
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY			0	0	0 5, 542, 503	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY		Ö	Ö	0	4, 359, 451	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
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		324, 855	142, 601	0	14, 386, 578	50.00
51. 00	05100 RECOVERY ROOM		0 0		0		1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	812, 137	356, 502	0	6, 992, 223	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	4, 922, 682 0	54. 00 55. 00
56. 00	05600 RADI OLOGI - ITIERAF LUTT C			0	0	355, 108	1
57.00	05700 CT SCAN	0	0	0	0		1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	-	0		1
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY		0	-	0	8, 239, 501 0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				· ·	ő	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	673, 669	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0	0	0	0 2, 527, 806	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY		Ö	ő	0	1, 303, 834	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	491, 340	
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	161, 130	
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	108, 285	47, 534	0	1, 308, 722 31, 688	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0	0	8, 929, 629	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	O	0	3, 654, 715	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	10, 010, 387	
74.00	07400 RENAL DI ALYSI S	0	0	0	0	1, 196, 835	1
75. 00 77. 00	O7500 ASC (NON-DISTINCT PART) O7700 ALLOGENEIC HSCT ACQUISITION			0	0	0 0	75. 00 77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0			0	0	78.00
	OUTPATIENT SERVICE COST CENTERS]
88. 00	08800 RURAL HEALTH CLINIC	0	0		0		88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	2 210 842	0 974 438	0	0 5 384 522	89.00
90.00	09001 CLINIC CMHC		2, 219, 842 0	974, 438 0	0	5, 384, 522 4, 028, 820	90. 00 90. 01
90. 02	09002 CLINIC CHEMO		0	0	0	114, 340	1
90. 03	09003 CLINIC RYAN WHITE	0	0	0	0	1, 182, 474	90. 03

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | Part | Part | Prepared: | Part | P Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-0040

SERVICES-OTHER PROMES PROM COSTS PROM				10	12/31/2023	5/31/2024 12:06 pm
PROGRAM Y & FRINCES PROM COSTS PROM			INTERNS &	RESI DENTS		07 0 17 202 1 121 00 pm
PROGRAM Y & FRINCES PROM COSTS PROM						
1.00 09100 EMERGENCY 0 0 0 0 0 0 0 0 16, 311, 421 91, 00	Cost Center Description					Subtotal
10 09100 09100 EMERGENCY 0 0 0 0 0 16,311,421 91.00						
92.00						
OTHER RELIBBURSABLE COST CENTERS		0	0	0	0	
94. 00 09400 MOWE PROGRAM DI ALYSIS 0 0 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 0 0						92.00
95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUIP-RENTED 0 0 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUIP-SOLD 0 0 0 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 98. 00 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99. 10 99. 10 09910 CORF 0 0 0 0 0 0 0 0 99. 10 100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 101. 00 10100 HOWE HEALTH AGENCY 0 0 0 0 0 0 101. 00 102. 00 102.00 101 TREATMENT PROGRAM 0 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS						
96. 00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 97. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 0 100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 101. 00 10100 HEALTH AGENCY 0 0 0 0 0 0 102. 00 10200 OPI OID TREATMENT PROGRAM 0 0 0 0 0 0 105. 00 10200 OPI OID TREATMENT PROGRAM 0 0 0 0 0 0 106. 00 10600 HEART ACQUI SITI ON 0 0 0 0 0 0 105. 00 106. 00 10600 HEART ACQUI SITI ON 0 0 0 0 0 0 106. 00 107. 00 10700 LIVER ACQUI SITI ON 0 0 0 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SITI ON 0 0 0 0 0 0 0 0 109. 00 10900 PANCREAS ACQUI SITI ON 0 0 0 0 0 0 0 0 110. 00 11000 INTESTI NAL ACQUI SITI ON 0 0 0 0 0 0 0 0 111. 00 11100 INTESTI NAL ACQUI SITI ON 0 0 0 0 0 0 0 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 114.00 11		0	0		0	
97. 00 99700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 97. 00 98. 00 09800 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 100. 00 10000 L8R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 0 106. 00 107. 00 10700 LOVER ACQUI SI TI ON 0 0 0 0 0 0 107. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 109. 00 110. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 111. 00 111. 00 11100 SLEF ACQUI SI TI ON 0 0 0 0 0 0 0 111. 00 111. 00 11100 SLEF ACQUI SI TI ON 0 0 0 0 0 0 0 111. 00 111. 00 11100 SLEF ACQUI SI TI ON 0 0 0 0 0 0 0 111. 00 111. 00 11100 SLEF ACQUI SI TI ON 0 0 0 0 0 0 0 111. 00 111. 00 11100 SUBTOTALS (SUM OF LINES 1 through 117) 0 5,414,249 2,376,680 0 153,670,396 118. 00 190. 01 1900 COMMUNTLY MOBILE 0 0 0 0 0 0 0 0 0 190. 01 1900 COMMUNTLY MOBILE 0 0 0 0 0 0 0 0 191. 00 1900 RESEARCH 0 0 0 0 0 0 0 0 0 191. 00 1900 RESEARCH 0 0 0 0 0 0 0 0 191. 00 1900 07950 VACANT SPACE 0 0 0 0 0 0 0 0 191. 00 1900 07950 VACANT SPACE 0 0 0 0 0 0 0 0 191. 00 1900 07950 VACANT SPACE 0 0 0 0 0 0 0 0 191. 00 1900 07950 VACANT SPACE 0 0 0 0 0 0 0 0 0 191. 00 1900 07950 VACANT SPA		0	0	0	0	
98. 00 9950 OTHER REIMBURSABLE COST CENTERS		0	0	0	0	
99. 10 09900 CMHC 09910 CORF 0 0 0 0 0 0 0 0 0 0 0 99.00 101. 00 10000 SAR SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 0 0 0 0 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 0 0 0 101. 00 102. 00 10200 OPI D TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0 0 0 1010. 00 **SPECI AL PURPOSE COST CENTERS** 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 105. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 1016. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 109. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 109. 00 110. 00 11000 INTESTINAL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 111. 00 111. 00 11100 INTESTINAL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 111. 00 111. 00 11100 INTESTINAL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 111. 00 111. 00 11100 INTESTINAL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 111. 00 111. 00 11100 INTESTINAL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 111. 00 111. 00 11000 INTESTINAL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0	0	
99. 10		0	0	0	0	
100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 100. 00 101. 00 10100 MORE HEALTH AGENCY 0 0 0 0 0 0 0 101. 00 102. 00 10200 OPI OID TREATMENT PROGRAM 0 0 0 0 0 0 0 102. 00 102. 00 SPECIAL PURPOSE COST CENTERS		0	0	0	0	
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0	0	
102. 00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O O O O O O O O O O		0	0	0	0	
SPECIAL PURPOSE COST CENTERS 105.00 105.00 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105.00 106.00 106.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 109.00		0	0	0	0	
105. 00 10500 KIDNEY ACQUISITION 0 0 0 0 0 0 105. 00 106. 00 106.00 106.00 106.00 106.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 109.00		0	0	0	0	0 102. 00
106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 106. 00 107. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 109. 00 1		1				
107. 00		0	0		-1	
108. 00 10800 LUNG ACQUISITION 0 0 0 0 0 108. 00 109. 00		0	0	0	0	
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 109. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 0 0 0		0	0	0	0	
110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 0 0 0 1110.00 1111.00 1111.00 11100 ISLET ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0	0	
111. 00 11100 1 1 1 1 1 1 1		0	0	0	0	•
113.00 11300 INTEREST EXPENSE 113.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 115.00 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 115.00 115.00 116.00 HOSPI CE 0 0 0 0 0 116.00 116.00 116.00 USUBTOTALS (SUM OF LINES 1 through 117) 0 5,414,249 2,376,680 0 153,670,396 118.00 NONREI MBURSABLE COST CENTERS 1800 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190.01 19001 COMMUNTI Y MOBI LE 0 0 0 0 0 0 190.01 190.01 19001 COMMUNTI Y MOBI LE 0 0 0 0 0 1,198,705 190.02 191.00 191.00 191.00 191.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 193.00 193.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 194.00 0750,874 194.00 194.00 07950 VACANT SPACE 0 0 0 0 0 0 0 194.00 194.00 194.00 07950 VACANT SPACE 0 0 0 0 0 0 0 0 0		0	0	0	0	
114. 00 114. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 116. 0		0	0	0	0	
115. 00						
116. 00						
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 5, 414, 249 2, 376, 680 0 153, 670, 396 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 82, 308 190. 00 190. 01 19001 COMMUNTI Y MOBI LE 0 0 0 0 0 0 1, 198, 705 190. 01 190. 02 19002 FAI TH 0 0 0 0 0 0 1, 198, 705 190. 02 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 193. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 194. 00 07950 VACANT SPACE 0 0 0 0 0 0 750, 874 194. 00		0	0	0	0	
NONRE MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 82,308 190.00 190.01 19000 COMMUNTI Y MOBI LE 0 0 0 0 0 190.01 190.02 19002 FAI TH 0 0 0 0 0 1,198,705 190.02 191.00 191.00 RESEARCH 0 0 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 627,611 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 194.00 07950 VACANT SPACE 0 0 0 0 0 750,874 194.00 194.00 195.00		0			- 1	
190. 00		0	5, 414, 249	2, 376, 680	0	<u>153, 670, 396</u> 118. 00
190. 01 19001 COMMUNTI Y MOBI LE 0 0 0 0 0 0 190. 01 190. 01 190. 02 190. 02 190. 02 191. 00 191. 00 191. 00 191. 00 192. 00 192. 00 192. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 00 194. 00 07950 VACANT SPACE 0 0 0 0 0 0 194. 00 0750, 874 194. 00						
190. 02 19002 FAI TH 0 0 0 0 0 1, 198, 705 190. 02 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 193. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 194. 00 07950 VACANT SPACE 0 0 0 0 0 750, 874 194. 00		0	0	0	0	
191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 192. 00 192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 193. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 194. 00 07950 VACANT SPACE 0 0 0 0 0 750, 874 194. 00		0	0	0	0	
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 627, 611 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 194.00 197		0	0	0	0	
193. 00 19300 NONPAI D WORKERS 0 0 0 0 193. 00 194. 00 0750, 874 194. 00		0	0	0	0	
194. 00 07950 VACANT SPACE 0 0 0 750, 874 194. 00		0	0	0	0	
		0	0	0	0	
		0	0	0	0	
	194.01 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194. 01
200.00 Cross Foot Adjustments 0 0 0 0 200.00		0	0	0	0	
201.00 Negative Cost Centers 0 0 0 0 201.00		0	0	0	0	
202.00 TOTAL (sum lines 118 through 201) 0 5,414,249 2,376,680 0 156,329,894 202.00	202.00 TOTAL (sum lines 118 through 201)	0	5, 414, 249	2, 376, 680	이	156, 329, 894 202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | Date/Time Prepared: | Date/Time Prepared: | Da Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 31-0040

				lo 12/31/202	23 Date/lime Prepared: 5/31/2024 12:06 pm
	Cost Center Description	Intern &	Total		07 0 17 E0E 1 121 00 piii
		Residents Cost			
		& Post Stepdown			
		Adjustments			
	JOSUS DAL OS DIVINOS DO CONTESTO	25. 00	26. 00		
1. 00	GENERAL SERVICE COST CENTERS 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 7. 00	00600 MAI NTENANCE & REPAIRS 00700 OPERATION OF PLANT				6. 00
8.00	00800 LAUNDRY & LINEN SERVICE				8.00
9.00	00900 HOUSEKEEPI NG				9. 00
10.00	01000 DI ETARY				10.00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL				11. 00
13. 00	01300 NURSI NG ADMINI STRATI ON				13. 00
14.00					14. 00
15. 00	01500 PHARMACY				15. 00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE				16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)				18.00
19. 00	01900 NONPHYSICIAN ANESTHETISTS				19. 00
20.00	02000 NURSI NG PROGRAM				20. 00
21. 00 22. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD				21. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	1 1	-2, 648, 916	21, 440, 606		30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	-155, 819	6, 083, 718 0		31. 00 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	Ö	Ö		33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	o		34.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	17, 000, 489		40. 00 41. 00
43.00	04300 NURSERY		5, 542, 503		43.00
44. 00	04400 SKILLED NURSING FACILITY	0	4, 359, 451		44. 00
45. 00	04500 NURSING FACILITY	0	0		45. 00
46. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0		46. 00
50. 00	05000 OPERATING ROOM	-467, 456	13, 919, 122		50.00
51. 00	05100 RECOVERY ROOM	0	2, 252, 872		51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	-1, 168, 639	5, 823, 584		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		4, 922, 682		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
56. 00	05600 RADI OI SOTOPE	0	355, 108		56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	1, 299, 696 678, 902		57. 00 58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	070, 702		59. 00
60.00	06000 LABORATORY	0	8, 239, 501		60.00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		61. 00
63. 00	1 1	Ö	673, 669		63. 00
64. 00	1 1	0	o		64. 00
65. 00	· ·	0	2, 527, 806		65. 00
66. 00 67. 00	1 1	0	1, 303, 834 491, 340		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	O	161, 130		68. 00
69. 00	+ I	-155, 819	1, 152, 903		69. 00
70.00	1 1	0	31, 688 8, 929, 629		70.00
71. 00 72. 00	1 1		3, 654, 715		71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	j o	10, 010, 387		73. 00
	07400 RENAL DIALYSIS	0	1, 196, 835		74.00
75. 00 77. 00	O7500 ASC (NON-DISTINCT PART) O7700 ALLOGENEIC HSCT ACQUISITION	0	0		75. 00 77. 00
78. 00	1		0		78.00
	OUTPATIENT SERVICE COST CENTERS				
	08800 RURAL HEALTH CLINIC	0	0		88.00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	-3, 194, 280	0 2, 190, 242		89. 00 90. 00
90. 01	1	0	4, 028, 820		90. 01
90. 02	09002 CLINIC CHEMO	0	114, 340	 	90. 02

In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 31-0040 Peri od: Worksheet B From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/31/2024 12:06 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 26.00 25.00 90. 03 09003 CLINIC RYAN WHITE 1, 182, 474 90.03 09100 EMERGENCY 0 91.00 91.00 16, 311, 421 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0000000 95.00 09500 AMBULANCE SERVICES 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 99. 00 09900 CMHC 0 99.00 99. 10 09910 CORF 99. 10 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101. 00 102.00 10200 OPI OI D TREATMENT PROGRAM 102. 00 0 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105. 00 000000 106. 00 10600 HEART ACQUISITION 0 106. 00 107.00 10700 LIVER ACQUISITION 107. 00 0 108.00 10800 LUNG ACQUISITION 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 110.00 0 111.00 11100 I SLET ACQUISITION 0 C 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115. 00 116. 00 11600 HOSPI CE 116. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) -7, 790, 929 145, 879, 467 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 82.308 0 190. 01 19001 COMMUNTLY MOBILE 190.01 190. 02 19002 FAI TH 1, 198, 705 190.02 191. 00 19100 RESEARCH 00000 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192. 00 627, 611 193. 00 19300 NONPALD WORKERS 193. 00

0

-7, 790, 929

750, 874

148, 538, 965

C

0

194. 00

194. 01

200. 00

201.00

202. 00

194.00 07950 VACANT SPACE

200.00

201.00

202.00

194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 12/31/2023 | Date/Time Prepared: | From 12/31/2024 | Prepa Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0040

				Io	12/31/2023	Date/lime Pre 5/31/2024 12:0	
			CAPI TAL REI	_ATED COSTS			·
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	oost contol possification	Assigned New	5250 a 11711		oub to tu.	BENEFITS	
		Capi tal Rel ated Costs				DEPARTMENT	
		0	1. 00	2.00	2A	4. 00	
	GENERAL SERVI CE COST CENTERS						
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	14, 509	1, 472	15, 981	15, 981	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	o	629, 796		693, 688	1, 021	5. 00
6.00	00600 MAI NTENANCE & REPAI RS	0	0	·	0	0	6. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	769, 702 48, 264		847, 787 53, 160	570 32	7. 00 8. 00
9. 00	00900 HOUSEKEEPING		40, 713		44, 843	354	9. 00
10.00	01000 DI ETARY	o	156, 664		172, 557	235	10.00
11.00	01100 CAFETERIA	0	157, 227 0	1	173, 177 0	142	11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON		38, 492	1	42, 397	0 811	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	o	150, 713		166, 003	125	14. 00
15.00	01500 PHARMACY	0	106, 595		117, 409	656	15. 00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	124, 656 0	1	137, 302 0	196 0	16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)		0	1	o	0	18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	o	0	19. 00
20. 00 21. 00	02000 NURSI NG PROGRAM 02100 L&R SERVI CES-SALARY & FRINGES APPRVD	0	0 245, 908	0 24, 947	0 270, 855	0 640	20. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD		243, 408	24, 747	270, 833	95	22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	O	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 0	04/ 202	0/ 011	1 042 202	1 070	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	946, 382 405, 059		1, 042, 393 446, 151	1, 872 490	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	l o	0	·	0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0 628, 316	63, 741	0 692, 057	0 1, 616	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF		020, 310	03, 741	072,037	0	41. 00
43.00	04300 NURSERY	o	85, 128		93, 764	616	43.00
44. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	216, 150		238, 078	386	44. 00
45. 00 46. 00	04500 NORSTNG FACTETTY 04600 OTHER LONG TERM CARE		0		0	0	45. 00 46. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	784, 358 59, 219		863, 930 65, 227	839 223	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		83, 499		91, 970	669	52.00
53.00	05300 ANESTHESI OLOGY	o	0	0	O	0	53.00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0	212, 449	21, 553	234, 002	387	54. 00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE		23, 688	2, 403	26, 091	0 31	55. 00 56. 00
57. 00	05700 CT SCAN	l o	49, 300		54, 301		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	49, 300	5, 001	54, 301	66	
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 227, 994	23, 130	0 251, 124	0 464	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY		227, 774	23, 130	251, 124	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				o		61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	7, 402	0 751	0 153	0	62. 00 63. 00
63. 00 64. 00	06400 I NTRAVENOUS THERAPY		7, 402	1	8, 153 0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	o	33, 755	3, 424	37, 179	290	65.00
66.00	06600 PHYSI CAL THERAPY	0	47, 671		52, 507	164	66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	7, 254 7, 254		7, 990 7, 990	69 19	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	l o	38, 196		42, 071	134	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	7, 254		7, 990	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0		0	0	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	0	26, 501	2, 688	29, 189	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
77. 00 78. 00	07700 ALLOGENEI C HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	77. 00 78. 00
, 5. 55	OUTPATIENT SERVICE COST CENTERS					0	, 5. 66
88. 00	· ·	0	0		0	0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC		94, 455		0 104, 037	0 222	89. 00 90. 00
	09001 CLINIC CMHC	0	0	1	О		90. 01

Health Financial Systems HOBOKEN UNIVERSITY MEDICAL CENTER In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 31-0040 Peri od: Worksheet B From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/31/2024 12:06 pm CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Directly BLDG & FIXT MVBLE EQUIP Subtotal **BENEFITS** Assigned New DEPARTMENT Capi tal Related Costs 0 1.00 2.00 2A 4.00 90. 02 09002 CLINIC CHEMO 0 26, 501 2, 688 29, 189 90. 02 0 90.03 09003 CLINIC RYAN WHITE 153 90.03 91.00 09100 EMERGENCY 620, 025 62, 900 1, 518 91.00 682, 925 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0000000000 0 0 09500 AMBULANCE SERVICES 0 95.00 0 0 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 0 97.00 0 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 98.00 0 0 99. 00 09900 CMHC 0 0 0 99.00 99. 10 09910 CORF 0 99. 10 0 0 0 0 100. 00 10000 I &R SERVICES-NOT APPRVD PRGM 100.00 Ω 0 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 0 102.00

7, 564, 453

767, 399

8, 331, 852

15, 981 202. 00

202.00

TOTAL (sum lines 118 through 201)

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/31/2024 | 12:06 pm | Prepared | Prepared

Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	5/31/2024 12: HOUSEKEEPI NG	06 pm
	& GENERAL 5.00	REPAI RS 6. 00	PLANT 7. 00	LINEN SERVICE 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 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	694, 709					5. 00
6. 00 00600 MAINTENANCE & REPAIRS	0	0				6.00
7.00 00700 OPERATION OF PLANT	58, 360	0	906, 717			7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	3, 196	0	7, 115			8. 00
9. 00 00900 HOUSEKEEPI NG	18, 330	0	6, 002		69, 529	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	15, 119 9, 012	0	23, 096 23, 179		1, 797 1, 804	10. 00 11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL	9,012	0	23, 1/9	0	0	12.00
13. 00 01300 NURSING ADMINISTRATION	25, 025	0	5, 675	0	442	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	11, 276	0	22, 219	0	1, 729	14. 00
15. 00 01500 PHARMACY	21, 547	0	15, 714	0	1, 223	
16. 00 01600 MEDICAL RECORDS & LIBRARY	6, 719	0	18, 377	0	1, 430	
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
18. 00 01850 OTHER GENERAL SERVICE (SPECIFY) 19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	18. 00 19. 00
20. 00 02000 NURSI NG PROGRAM	0	0		0	0	20.00
21.00 02100 I &R SERVI CES-SALARY & FRI NGES APPRVI	20, 280	0	36, 252	0	2, 821	1
22.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRVI	10, 489	0	0	0	0	22. 00
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	/4 //7		120 521	24.71/	14 5/2	20.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT	64, 667 18, 573	0		24, 716 4, 179		30. 00 31. 00
32. 00 03200 CORONARY CARE UNIT	10, 5/3	0	37,713	4, 1/9	4,047	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0	ĺ	0	0	33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00 04000 SUBPROVI DER - I PF	54, 057	0	92, 628	4, 832	7, 201	
41. 00 04100 SUBPROVI DER - RF	0	0	0	0	0	41.00
43. 00 04300 NURSERY	19, 319	0	12, 550		977	43.00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY	12, 618) 0	31, 865		2, 480 0	44. 00 45. 00
46. 00 04600 OTHER LONG TERM CARE	0	0		_	0	46. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	48, 131	0	115, 632		-,	50. 00
51. 00 05100 RECOVERY ROOM	8, 319	0	8, 730		679	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	21, 819	0	12, 310	0	958	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	18, 009) 0	31, 320	0	0 2, 437	53. 00 54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	01, 320	0	0	55.00
56. 00 05600 RADI OI SOTOPE	1, 234	0	3, 492	0	272	56. 00
57. 00 05700 CT SCAN	4, 589	0	7, 268		566	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 270	0	7, 268	0	566	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	32, 094	0	0 33, 612	0	0 2, 616	59. 00 60. 00
60. 01 06000 LABORATORY	32,094	0	33,612	0	2,616	60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	5 0	0	0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	2, 860	0	1, 091	0	85	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	10, 493	0	4, 976		387	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	5, 028 2, 019) 0	7, 028 1, 069		547 83	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	604	0	1, 069		83	68.00
69. 00 06900 ELECTROCARDI OLOGY	4, 217	0	5, 631	0	438	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	47	0	1, 069	0	83	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	13, 547	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	20, 890	0	2 007	0	0	73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	4, 983) 0	3, 907	0	304 0	75.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	Ö	0		78. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	7 470	0	12.005	0	0	89.00
90. 00 09000 CLI NI C 90. 01 09001 CLI NI C CMHC	7, 479 17, 132	0	13, 925	0	1, 084 0	90. 00 90. 01
90. 01 09001 CELINI C CMIAC 90. 02 09002 CLINI C CHEMO	17, 132	n	3, 907	0	304	90.01
90. 03 09003 CLINIC RYAN WHITE	4, 920	Ö	0	0	0	90. 03
91. 00 09100 EMERGENCY	56, 101	0	91, 406	24, 136	7, 113	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART))					92. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | Part | To 12/31/2023 | Part | I | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS HOBOKEN UNIVERSITY MEDICAL CENTER Provider CCN: 31-0040

			'	0 12/31/2023	5/31/2024 12:	
Cost Center Description	ADMI NI STRATI VE N	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
'	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	C	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	C	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	98. 00
99. 00 09900 CMHC	0	0	C	0	0	99. 00
99. 10 09910 CORF	0	0	C	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	C	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	C	0		101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	C	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	C	0		105. 00
106.00 10600 HEART ACQUISITION	0	0	(0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	(0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	(0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	(0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	(0		110. 00
111.00 11100 ISLET ACQUISITION	0	0	(0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	(0		115. 00
116. 00 11600 HOSPI CE	0	0	(0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	687, 044	0	848, 618	63, 503	68, 717	118. 00
NONRE MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	124	0	2, 837	0		190. 00
190. 01 19001 COMMUNTLY MOBILE	0	0	(0		190. 01
190. 02 19002 FAI TH	5, 131	0	C	0		190. 02
191. 00 19100 RESEARCH	0	0	C	0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 062	0	24, 357	0		192. 00
193. 00 19300 NONPAI D WORKERS	0	0	C	0		193. 00
194.00 07950 VACANT SPACE	1, 348	0	30, 905	0		194. 00
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0	0	194. 01
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0		201. 00
202.00 TOTAL (sum lines 118 through 201)	694, 709	0	906, 717	63, 503	69, 529	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0040

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/31/2024 12:06 pm

						5/31/2024 12:	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	
				PERSONNEL	ADMI NI STRATI ON	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 4. 00	OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAI NTENANCE & REPAI RS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	212, 804					10.00
11. 00	01100 CAFETERI A	0	207, 314	ļ.			11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	C	ή			12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	9, 519	1	83, 869	204 505	13.00
14. 00 15. 00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY	0	3, 233 8, 267	1	0	204, 585 382	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	4, 083	1	0	2	16. 00
17. 00	01700 SOCIAL SERVICE	0	4, 000	1	0	0	17. 00
	01850 OTHER GENERAL SERVICE (SPECIFY)	0	C	o o	0	0	18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	O	C	0	0	0	19. 00
20. 00	02000 NURSI NG PROGRAM	0	C	0	0	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	12, 658	1	0	270	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	1, 382	1	0	0	22. 00
23. 00	O2300 PARAMED ED PRGM-(SPECIFY)	0	C) 0	0	0	23. 00
30. 00	O3000 ADULTS & PEDIATRICS	84, 611	29, 250) 0	20, 253	8, 795	30.00
31. 00	03100 INTENSIVE CARE UNIT	7, 556	6, 527			2, 907	31.00
32. 00	03200 CORONARY CARE UNIT	0	0, 02,	1	0, 020	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	C	o o	0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	C	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	83, 787	24, 982	2 0	14, 090	724	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	C	0	0	0	41. 00
43. 00	04300 NURSERY	12, 441	7, 775	1	8, 562	254	43. 00
44. 00	04400 SKILLED NURSING FACILITY	24, 409	6, 339	1	3, 611	130	1
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	C		0	0	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	l of) 0	<u> </u>	0	40.00
50.00	05000 OPERATI NG ROOM	0	9, 847	0	6, 380	15, 768	50.00
51.00	05100 RECOVERY ROOM	0	2, 303		2, 540	95	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	9, 090	0	7, 628	1, 811	52. 00
53. 00	05300 ANESTHESI OLOGY	0	C	0	0	0	53. 00
54.00	O5400 RADI OLOGY - DI AGNOSTI C	0	5, 007 0	1	0	1, 506	1
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	358	1	0	0	55. 00 56. 00
57. 00	05700 CT SCAN	0	1, 720	1	0	413	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	l o	726	1	o	195	1
59.00	05900 CARDI AC CATHETERI ZATI ON	O	C		0	0	59. 00
60.00	06000 LABORATORY	0	8, 595	0	0	1, 195	60. 00
60. 01	06001 BLOOD LABORATORY	0	C	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_	_	_	_	_	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C	0	0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0			0	28 0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0	3, 598		0	1, 128	ı
66. 00	06600 PHYSI CAL THERAPY	0	2, 299	1	0	29	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 007		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	305		0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	2, 343	0	460	110	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C	0	0	0	70. 00
	1 1	0	C	0	0	124, 883	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C	0	0	40, 669	1
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0			0	0	73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0			0	0	75.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	C		0	0	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	o	C	o o	o	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	C		0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	4 216	1	0	0	89.00
90.00	09000 CLINIC	0	4, 210	1	2, 276	227	90.00
90. 01 90. 02	09001 CLINIC CMHC 09002 CLINIC CHEMO		10, 891		62	25 0	90. 01 90. 02
90. 02	09003 CLINIC CHEMO		3, 846) 0	416	27	90. 02
91. 00	09100 EMERGENCY	0	23, 502	1		2, 975	1
	I I I I I I I I I I I I I I I I I I I	<u> </u>		<u>'</u>	,	_, _,,,,	

190. 02 19002 FAI TH

200.00

201.00

202.00

191. 00 19100 RESEARCH

193. 00 19300 NONPALD WORKERS

194. 00 07950 VACANT SPACE

192.00 19200 PHYSICIANS' PRIVATE OFFICES

194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 31-0040 Peri od: Worksheet B From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/31/2024 12:06 pm Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL PERSONNEL ADMI NI STRATI ON SERVICES & **SUPPLY** 10.00 11.00 12.00 13.00 14.00 92. 00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART)
OTHER REI MBURSABLE COST CENTERS 92.00 94.00 09400 HOME PROGRAM DIALYSIS 94.00 95.00 09500 AMBULANCE SERVICES 000000000 0 0 0 0 0 0 0 0 0 0 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96.00 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 09900 CMHC 0 99.00 99 00 0 0 99. 10 09910 CORF 0 0 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 0 102.00 10200 OPI OID TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0000000 0 105. 00 0 0 0 0 0 0 0 106.00 10600 HEART ACQUISITION 0 0 106. 00 107.00 10700 LIVER ACQUISITION 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 113. 00 11300 | INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 C 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 212, 804 203, 662 83, 869 204, 551 118. 00 118.00 0 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 COMMUNTLY MOBILE 0 190. 00 0

0

3, 652

207, 314

C

0

0

Ω

0

0 0

212, 804

0

0

0

0

0

0

0

0

0

0

0

0

0

83 869

0 190. 01

34 190. 02

0 191.00

0 192. 00

0 193.00

0 194.00

0 194. 01

0 201. 00 204, 585 202. 00

200.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2024 | Date/Time Prepared: | 5/31/2024 | 12: 06 pm |

						5/31/2024 12:	06 pm_
					OTHER GENERAL		
		DUA DUA OV	MEDIONI	COOLAL CEDVIOL	SERVI CE	NONDUNCI OLAN	
	Cost Center Description	PHARMACY		SOCIAL SERVICE	(SPECI FY)	NONPHYSI CI AN	
			RECORDS & LI BRARY			ANESTHETI STS	
		15.00	16.00	17. 00	18. 00	19. 00	
	GENERAL SERVICE COST CENTERS	10.00		171.00	101.00	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAI RS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LI NEN SERVI CE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11. 00
12. 00	1 1						12.00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14.00							14. 00
15. 00	01500 PHARMACY	165, 198					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	168, 109				16. 00
17. 00	1 1	0	0	0			17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	_	18. 00
19. 00	1 1	0	0	0	0	0	
20.00		0	0	0	0		20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0		21. 00 22. 00
23. 00	1 1	0	0		0		23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	·		0	<u> </u>		23.00
30.00		0	20, 872	0	0		30.00
31.00		0	2, 312	1	0		31. 00
32.00	03200 CORONARY CARE UNIT	0	0		0		32. 00
33. 00		0	0	0	0		33. 00
34.00		0	0	0	0		34. 00
40. 00	04000 SUBPROVI DER - I PF	0	16, 709	0	0		40. 00
41.00		0	0	0	0		41.00
43.00	1 1	0	3, 130		0		43. 00
44. 00 45. 00	1 1	0	5, 694 0		0		44. 00 45. 00
46. 00	1 1	0	0		0		46. 00
10. 00	ANCI LLARY SERVI CE COST CENTERS	٥		J	<u> </u>		10.00
50.00		0	6, 575	0	0		50.00
51.00	05100 RECOVERY ROOM	0	640	0	0		51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	899	0	0		52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	16, 445	0	0		54.00
55. 00	1 1	0	0	0	0		55. 00
56. 00 57. 00	05600 RADI OI SOTOPE	O O	531		0		56.00
58. 00		0	8, 872 1, 500		0		57. 00 58. 00
59. 00		0	1, 500	0	0		59. 00
60.00	1 1	o	22, 160	Ö	0		60.00
60. 01	06001 BLOOD LABORATORY	Ö	0	Ō	0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0		62. 00
63. 00	1 1	0	764	0	0		63. 00
64. 00	1 1	0	0	1	0		64. 00
65. 00	1 1	0	1, 027		0		65. 00
66.00	1 1	O O	851 394		0		66. 00 67. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	89		0		68.00
69. 00	1 1	0	3, 001		0		69.00
70. 00	1 1	o o	58		0		70.00
71. 00	1 1	o	738		0		71. 00
72. 00	1 1	O	836		0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	165, 198	4, 853	0	0		73. 00
74.00	1 1	0	49	0	0		74. 00
75. 00		0	0	0	0		75. 00
77. 00	1 1	0	0	0	0		77. 00
78. 00		0	0	0	0		78. 00
go 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	ما	0		0		80 00
88. 00 89. 00	1 1	0	0	-	0		88. 00 89. 00
90.00	1 1	0	2, 433	_	0		90.00
90. 01	09001 CLINIC CMHC	ol	3, 444		0		90. 01
	1 1	ō	88		0		90. 02

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | Part | To 12/31/2023 | Part | I | Part | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS HOBOKEN UNIVERSITY MEDICAL CENTER Provider CCN: 31-0040

			''	0 12/31/2023	5/31/2024 12:	
		_		OTHER GENERAL		J
				SERVI CE		
Cost Center Description	PHARMACY		SOCIAL SERVICE	(SPECI FY)	NONPHYSI CI AN	
		RECORDS &			ANESTHETI STS	
	15. 00	16. 00	17. 00	18. 00	19. 00	
90. 03 09003 CLINIC RYAN WHITE	0	13		0	17.00	90. 03
91. 00 09100 EMERGENCY	O	43, 132	0	o		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	1	0		94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0		97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0		98.00
99. 00 09900 CMHC 99. 10 09910 CORF	0	0	0	0		99.00
99. 10 09910 CORF 100. 00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		99. 10 100. 00
101. 00 10100 HOME HEALTH AGENCY	0	0		0		100.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>			<u> </u>		102.00
105. 00 10500 KIDNEY ACQUISITION	0	0	0	o		105. 00
106. 00 10600 HEART ACQUISITION	0	0	0	O		106.00
107.00 10700 LIVER ACQUISITION	O	0	0	o		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	0	0		111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		0				114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE	0	0	0	0		115. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	165, 198	168, 109		0	^	118.00
NONREI MBURSABLE COST CENTERS	103, 170	100, 107	0	<u> </u>	0	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	ol		190. 00
190. 01 19001 COMMUNTLY MOBILE	0	0		o		190. 01
190. 02 19002 FAI TH	O	0	0	o		190. 02
191. 00 19100 RESEARCH	0	0	0	o		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 VACANT SPACE	0	0	0	0		194. 00
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	_	194. 01
200.00 Cross Foot Adjustments		^	_			200. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	165, 198	168, 109	0	0		201. 00 202. 00
202.00 TOTAL (Suil TITIES TTO THEOUGH 201)	105, 196	100, 109	1	l 의	0	1202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 31-0040

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

5/31/2024 12:06 pm INTERNS & RESIDENTS NURSI NG SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Subtotal Cost Center Description **PROGRAM** Y & FRINGES PRGM COSTS PRGM 24.00 20.00 21.00 22.00 23.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18 00 18 00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING PROGRAM 20.00 20.00 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 343, 776 21.00 11, 966 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22 00 22 00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 1 451 513 30 00 31.00 03100 INTENSIVE CARE UNIT 559, 083 31.00 03200 CORONARY CARE UNIT 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 34 00 0 34 00 40.00 04000 SUBPROVI DER - I PF 992, 683 40.00 04100 SUBPROVI DER - I RF 41.00 0 41.00 43.00 04300 NURSERY 159, 388 43.00 04400 SKILLED NURSING FACILITY 331, 250 44.00 44 00 45.00 04500 NURSING FACILITY 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 1, 076, 100 05000 OPERATING ROOM 50 00 05100 RECOVERY ROOM 88, 756 51.00 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 147, 154 52 00 05300 ANESTHESI OLOGY 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 309, 113 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 56.00 05600 RADI OI SOTOPE 32, 012 56.00 05700 CT SCAN 57.00 77,873 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 66, 892 58.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 06000 LABORATORY 351, 860 60.00 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 12, 981 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 65.00 06500 RESPIRATORY THERAPY 59,078 65.00 06600 PHYSI CAL THERAPY 68, 453 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 12, 631 67.00 68.00 06800 SPEECH PATHOLOGY 10, 159 68.00 06900 ELECTROCARDI OLOGY 69.00 58, 405 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 9, 247 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 157, 123 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 55,052 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 190, 941 73.00 07400 RENAL DIALYSIS 74 00 74 00 38, 432 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 135.893 90.00 09001 CLINIC CMHC 90 01 32, 118 90.01 90.02 09002 CLINIC CHEMO 33, 658 90.02 09003 CLINIC RYAN WHITE 9, 375 90.03

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0040

			To	12/31/2023	Date/Time Pre 5/31/2024 12:	
		I NTFRNS &	RESI DENTS		3/31/2024 12.	oo piii
		1111211110 0	11201321110			
Cost Center Description	NURSI NG	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	
· ·	PROGRAM	Y & FRINGES	PRGM COSTS	PRGM		
	20.00	21. 00	22.00	23. 00	24.00	
91. 00 09100 EMERGENCY					944, 373	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS					0	94.00
95. 00 09500 AMBULANCE SERVICES					0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED					0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD					0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS					0	98. 00
99. 00 09900 CMHC					0	99. 00
99. 10 09910 CORF					0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM					0	100. 00
101.00 10100 HOME HEALTH AGENCY						101. 00
102.00 10200 OPIOID TREATMENT PROGRAM					0	102. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION						105. 00
106. 00 10600 HEART ACQUI SI TI ON						106. 00
107. 00 10700 LI VER ACQUI SI TI ON						107. 00
108.00 10800 LUNG ACQUISITION						108. 00
109.00 10900 PANCREAS ACQUISITION						109. 00
110.00 11000 INTESTINAL ACQUISITION						110. 00
111. 00 11100 I SLET ACQUI SI TI ON					0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)						115. 00
116. 00 11600 H0SPI CE						116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	7, 471, 596	118. 00
NONREI MBURSABLE COST CENTERS		1				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					24, 380	
190. 01 19001 COMMUNTLY MOBILE						190. 01
190. 02 19002 FAI TH						190. 02
191. 00 19100 RESEARCH						191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES					207, 993	
193. 00 19300 NONPALD WORKERS						193. 00
194.00 07950 VACANT SPACE					263, 156	
194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS						194. 01
200.00 Cross Foot Adjustments	0	343, 776	11, 966	0	355, 742	
201.00 Negative Cost Centers	0) 0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	343, 776	11, 966	이	8, 331, 852	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | From 12/31/2023 | Date/Time Prepared: | From 12/31/2024 | Prepa Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 31-0040

					0 12/31/2023	Date/lime Prepared: 5/31/2024 12:06 pm
	Cost Center Description	Intern &	Total		,	1 07 0 17 202 1 12: 00 piii
		Residents Cost				
		& Post Stepdown				
		Adjustments				
		25. 00	26. 00			
1 00	GENERAL SERVICE COST CENTERS					1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1.00
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 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING					8. 00 9. 00
10. 00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL					12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON					13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY					16. 00
17. 00	01700 SOCIAL SERVICE					17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)					18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS					19. 00
20. 00 21. 00	02000 NURSING PROGRAM					20.00
22. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD					21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)					23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	1 1	0	1, 451, 513			30.00
31.00	03100 I NTENSI VE CARE UNI T	0	559, 083			31.00
32. 00 33. 00	03200 CORONARY CARE UNIT		0			32. 00 33. 00
34. 00	03400 SURGI CAL INTENSIVE CARE UNIT		o			34.00
40. 00	04000 SUBPROVI DER - I PF	O	992, 683			40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0			41. 00
43.00	04300 NURSERY	0	159, 388			43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY		331, 250 0			44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	O	o			46. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	1, 076, 100			50. 00
51. 00 52. 00		0	88, 756			51. 00 52. 00
53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY		147, 154			53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	O	309, 113			54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0			55. 00
56. 00	05600 RADI OI SOTOPE	0	32, 012			56. 00
57. 00		0	77, 873			57.00
	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON		66, 892 0			58. 00 59. 00
60. 00	1 1		351, 860			60.00
60. 01	06001 BLOOD LABORATORY	0	0			60. 01
61. 00	· ·					61.00
62.00	1 1	0	12.001			62.00
63. 00 64. 00			12, 981 0			63. 00 64. 00
65. 00	1 1		59, 078			65. 00
66. 00	1 1	O	68, 453			66. 00
67. 00		0	12, 631			67. 00
68. 00	1	0	10, 159			68. 00
69. 00 70. 00	+ I		58, 405 9, 247			69. 00 70. 00
71.00			157, 123			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	55, 052			72. 00
73. 00	1	0	190, 941			73. 00
	07400 RENAL DIALYSIS	0	38, 432			74.00
75. 00	O7500 ASC (NON-DISTINCT PART) O7700 ALLOGENEIC HSCT ACQUISITION	0	0			75. 00 77. 00
77.00	1		o O			77.00
. 5. 55	OUTPATIENT SERVICE COST CENTERS	<u> </u>				75.00
	08800 RURAL HEALTH CLINIC	0	0			88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	125 002			89.00
90. 00 90. 01	1	0	135, 893 32, 118			90. 00 90. 01
	09002 CLINIC CHEMO		33, 658			90.02
	· · · · ·					

202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 31-0040 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/31/2024 12:06 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 26.00 25.00 90. 03 09003 CLINIC RYAN WHITE 9, 375 90.03 09100 EMERGENCY 0 91.00 91.00 944, 373 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 00000000 95.00 09500 AMBULANCE SERVICES 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 0 99. 00 09900 CMHC 99.00 99. 10 09910 CORF 99. 10 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 101. 00 102.00 10200 OPI OI D TREATMENT PROGRAM 102. 00 0 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105. 00 0000000 106. 00 10600 HEART ACQUISITION 0 106. 00 107.00 10700 LIVER ACQUISITION 0 107. 00 108.00 10800 LUNG ACQUISITION 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 110.00 0 111.00 11100 I SLET ACQUISITION C 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115. 00 116. 00 11600 HOSPI CE 0 116. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 7, 471, 596 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 24, 380 00000000000 190. 01 19001 COMMUNTLY MOBILE 190.01 190. 02 19002 FAI TH 8, 985 190.02 191. 00 19100 RESEARCH 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 207, 993 192. 00 193. 00 19300 NONPALD WORKERS 193. 00 194.00 07950 VACANT SPACE 194. 00 263, 156 194. 01 07951 OTHER NONREI MBURSABLE COST CENTERS 194. 01 200.00 Cross Foot Adjustments 355, 742 200. 00 201.00 Negative Cost Centers 201.00

8, 331, 852

202.00

TOTAL (sum lines 118 through 201)

In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 31-0040

				1	o 12/31/2023	Date/Time Pre 5/31/2024 12:	
		CAPI TAL REI	LATED COSTS			0,01,2021 12.	OU PIII
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	 EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	oost conton boson per on		(DOLLAR VALUE)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
	T	1.00	2. 00	4. 00	5A	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	255, 473				1	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	255, 475	255, 473				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	490				110 001 050	4. 00
5. 00 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS	21, 270	21, 270	4, 118, 378	-37, 305, 841	119, 024, 053	5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	25, 995	1	2, 296, 708	8 0	9, 998, 231	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 630				547, 519	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	1, 375 5, 291	1, 375 5, 291	1, 428, 215 946, 482		3, 140, 232 2, 590, 162	9. 00 10. 00
11. 00	01100 CAFETERI A	5, 310				1, 543, 986	1
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	2 271 75	0	0	12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 300 5, 090				4, 287, 383 1, 931, 823	1
15. 00	01500 PHARMACY	3, 600	3, 600	2, 646, 835	0	3, 691, 514	15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	4, 210		792, 053	0	1, 151, 080 0	16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)		1			0	18.00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	C	0	0	19. 00
20. 00 21. 00	02000 NURSING PROGRAM 02100 L&R SERVICES-SALARY & FRINGES APPRVD	8, 305	0 8, 305	2, 581, 985	0	0 3, 474, 394	20. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0, 303	0, 303	381, 227		1	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	(0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	31, 962	31, 962	7, 630, 507	' 0	11, 085, 118	30.00
31. 00	03100 NTENSI VE CARE UNI T	13, 680					31. 00
32. 00	03200 CORONARY CARE UNIT	0	0	(0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	(0	33. 00 34. 00
40. 00	04000 SUBPROVI DER – I PF	21, 220	21, 220	6, 516, 151	Ö	9, 261, 075	40. 00
41.00	04100 SUBPROVI DER - I RF	0 075	0	()	0	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	2, 875 7, 300				3, 309, 674 2, 161, 669	43. 00 44. 00
45. 00	04500 NURSING FACILITY	0	1			0	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0		0	0	46. 00
50. 00	05000 OPERATING ROOM	26, 490	26, 490	3, 383, 186	0	8, 245, 847	50.00
51. 00	05100 RECOVERY ROOM	2, 000				1, 425, 144	1
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	2, 820	2, 820	2, 696, 820	0	3, 738, 018	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	7, 175	7, 175	1, 559, 119		3, 085, 257	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		(0	
56. 00 57. 00	05600 RADI OI SOTOPE 05700 CT SCAN	800 1, 665			0	211, 438 786, 130	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 665				388, 873	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	1 070 700	0	0	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	7, 700	7, 700 0	1, 872, 793		5, 498, 393 0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61. 00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0 250	0 250	(0	0 490, 019	62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	250	250			490,019	64. 00
65. 00	06500 RESPI RATORY THERAPY	1, 140				1, 797, 666	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 610	1	1		861, 388 345, 895	1
68. 00	06800 SPEECH PATHOLOGY	245 245		· ·		103, 507	
69. 00	06900 ELECTROCARDI OLOGY	1, 290		540, 657		722, 502	69. 00
	07000 ELECTROENCEPHALOGRAPHY	245			0	7, 990	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	5, 396, 934 2, 320, 902	71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	O		0	3, 578, 928	73. 00
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	895	895	(853, 700 0	74. 00 75. 00
75.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0			0	75.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0			-	1	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	T 0	0) 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			-	1	
90. 00	09000 CLI NI C	3, 190	3, 190	896, 372	2 0	1, 281, 244	90. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10 Provider CCN: 31-0040

				1	o 12/31/2023	Date/lime Pre 5/31/2024 12:	
		CAPITAL REL	ATED COSTS			3/31/2024 12.	OO piii
	Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	cost denter bescription		(DOLLAR VALUE)	BENEFITS	Reconciliation	& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1.00	2. 00	SALARI ES) 4. 00	5A	5. 00	
90. 01 0900	D1 CLINIC CMHC	0					90. 01
	02 CLINIC CHEMO	895	895		_		
	03 CLINIC RYAN WHITE	0	0				90. 03
	DO EMERGENCY DO OBSERVATION BEDS (NON-DISTINCT PART)	20, 940	20, 940	6, 120, 068	0	9, 611, 197	91. 00 92. 00
	R REIMBURSABLE COST CENTERS						92.00
	OO HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
	00 AMBULANCE SERVICES	0	0				95. 00
	DO DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
	DO DURABLE MEDICAL EQUIP-SOLD DO OTHER REIMBURSABLE COST CENTERS	0	0	_			97. 00 98. 00
	OO CMHC	0	0			-	99.00
99. 10 0991		0	Ö	_	_	-	99. 10
	00 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
	OO HOME HEALTH AGENCY	0	0				101.00
	OO OPLOID TREATMENT PROGRAM CLAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
	DO KIDNEY ACQUISITION	0	0	0	0	0	105. 00
	OO HEART ACQUISITION	0	Ö				106. 00
	DO LIVER ACQUISITION	0	0	· ·	_		107. 00
	DO LUNG ACQUISITION	0	0	· ·	_		108. 00
	DO PANCREAS ACQUISITION DO INTESTINAL ACQUISITION	0	0	0	_		109. 00 110. 00
	DO ISLET ACQUISITION	0) 0	J 0	0		111.00
	00 INTEREST EXPENSE					Ĭ	113. 00
	OO UTILIZATION REVIEW-SNF						114. 00
	OO AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	_	-	115. 00
116. 00 1160 118. 00		0	0	0	_	-	116. 00
	SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	242, 163	242, 163	63, 848, 122	-37, 305, 841	117, 710, 862] 118.00
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	650	650	0	0	21, 198	190. 00
190. 01 1900	O1 COMMUNTIY MOBILE	0	0			0	190. 01
190. 02 1900	•	0	0				
191. 00 1910	DO RESEARCH DO PHYSICIANS' PRIVATE OFFICES	5, 580	0	0		0 181, 983	191. 00
	ON NONPALD WORKERS	5, 580	5, 580 0	0			193. 00
	50 VACANT SPACE	7, 080	7, 080	_	_	230, 903	
	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 01
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	7 5/4 452	7/7 200	12 000 002		27 205 044	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	7, 564, 453	767, 399	13, 888, 982		37, 305, 841	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	29. 609599	3. 003836	0. 215248		0. 313431	203. 00
204.00	Cost to be allocated (per Wkst. B,			15, 981		694, 709	204. 00
205 20	Part II)			0.0000:0		0 005005	005 00
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000248		0. 005837	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: 31-0040

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

5/31/2024 12:06 pm Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY (HOURS OF REPAIRS PLANT LINEN SERVICE (MEALS SERVED) (SQUARE FEET) (SQUARE FEET) (POUNDS OF SERVICE) LAUNDRY) 7.00 6.00 9.00 10.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 233, 713 6.00 00700 OPERATION OF PLANT 25, 995 7.00 207, 718 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 1,630 1,630 516, 451 8.00 9.00 00900 HOUSEKEEPI NG 1, 375 1, 375 204, 692 9.00 01000 DI ETARY 5, 291 5, 291 5, 291 99, 703 10.00 10.00 0 01100 CAFETERI A 5, 310 0 5, 310 11.00 5, 310 Λ 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 0 12.00 13.00 01300 NURSING ADMINISTRATION 1.300 1, 300 1.300 0 13.00 01400 CENTRAL SERVICES & SUPPLY 5,090 5, 090 0 5,090 14.00 14.00 0 01500 PHARMACY 0 15.00 3,600 3, 600 3,600 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 4, 210 4, 210 4, 210 0 16.00 01700 SOCIAL SERVICE 17.00 0 0 0 0 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 18 00 0 0 0 18 00 Ω 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 0 19.00 02000 NURSING PROGRAM 0 20.00 20.00 0 0 0 02100 | &R SERVICES-SALARY & FRINGES APPRVD 21.00 8, 305 0 8, 305 21.00 8, 305 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22 00 22 00 0 0 0 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 31 962 31 962 201, 017 42 880 39 642 30 00 31.00 03100 INTENSIVE CARE UNIT 13,680 13,680 33, 985 13,680 3, 540 31.00 03200 CORONARY CARE UNIT 32.00 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 ol 33.00 C 0 03400 SURGICAL INTENSIVE CARE UNIT 34 00 0 0 0 34 00 04000 SUBPROVIDER - IPF 21, 220 40.00 21, 220 39, 295 21, 200 39, 256 40.00 04100 SUBPROVIDER - IRF 41.00 0 41.00 43.00 04300 NURSERY 2,875 2,875 2, 875 5,829 43.00 04400 SKILLED NURSING FACILITY 44.00 45, 866 7.300 7, 300 7, 300 11, 436 44 00 45.00 04500 NURSING FACILITY 0 45.00 C 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 26, 490 50.00 05000 OPERATING ROOM 26, 490 0 26, 490 0 05100 RECOVERY ROOM 2,000 2,000 0 2,000 0 51.00 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 2,820 2,820 0 2,820 0 52.00 0 05300 ANESTHESI OLOGY 53.00 53.00 0 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 7, 175 7, 175 7, 175 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 56.00 05600 RADI OI SOTOPE 800 800 0 800 0 56.00 0 05700 CT SCAN 1,665 57.00 1,665 1,665 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 1,665 1, 665 1,665 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 7,700 7,700 0 7, 700 60.00 60.00 0 0 60.01 06001 BLOOD LABORATORY 0 r 0 Ω 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 O 0 O 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 250 250 0 250 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 1.140 1, 140 0 1, 140 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 1.610 1,610 1.610 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 245 245 245 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 245 245 245 0 68.00 06900 ELECTROCARDI OLOGY 69.00 1, 290 1, 290 1, 290 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 245 245 245 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 0 71.00 C 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 C 0 0 73.00 07400 RENAL DIALYSIS 0 74 00 895 895 895 0 74 00 07500 ASC (NON-DISTINCT PART) 75.00 0 C 0 0 75.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77.00 77.00 C 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0 0 90.00 09000 CLI NI C 3.190 3, 190 0 3, 190 0 90.00 0 90.01 09001 CLINIC CMHC 90 01 0 0 90.02 09002 CLINIC CHEMO 895 895 895 0 90.02 90.03 09003 CLINIC RYAN WHITE 0 0 90.03

Health Financial Systems HOBOKEN UNIVERSITY MEDICAL CENTER In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 31-0040
Period:
From 01/01/2023
To 12/31/2023 Date/Time Prepared:

			To	12/31/2023	Date/Time Pre 5/31/2024 12:	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	9
	REPAI RS	PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	
	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	SERVICE)		
		7.00	LAUNDRY)	0.00	10.00	
91. 00 09100 EMERGENCY	6. 00	7. 00 20, 940	8. 00 196, 288	9. 00 20, 940	10. 00	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	20, 940	20, 940	190, 200	20, 940	U	91.00
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0		0	0	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	0	-	0		101. 00 102. 00
102.00 10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS		0	l O	U	U	102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	1	0	O	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	-	Ö		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	· ·	Ö		107. 00
108. 00 10800 LUNG ACQUISITION	0	Ö	-	O		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	1 4	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	220, 403	194, 408	516, 451	202, 301	99, 703	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	650	650	0	650	0	190. 00
190. 00 19000 GTFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 COMMUNTLY MOBILE	050	050		050		190. 00
190. 02 19002 FAI TH	0	0	-	0		190. 01
191. 00 19100 RESEARCH	0	0	1	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	5, 580	5, 580	Ö	1, 741		192. 00
193. 00 19300 NONPALD WORKERS	0	0	o	0		193. 00
194. 00 07950 VACANT SPACE	7, 080	7, 080	0	0		194. 00
194.01 07951 OTHER NONREIMBURSABLE COST CENTERS	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)	0	13, 131, 987	822, 177	4, 211, 406	3, 845, 356	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	63. 220265	1. 591975	20. 574356	38. 568107	
204.00 Cost to be allocated (per Wkst. B, Part II)	0	906, 717	63, 503	69, 529	212, 804	204. 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	4. 365134	0. 122960	0. 339676	2. 134379	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

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 31-0040

				To	12/31/2023	Date/Time Pre 5/31/2024 12:	
	Cost Center Description		MAINTENANCE OF		CENTRAL	PHARMACY	
		(MEALS SERVED)	PERSONNEL (NUMBER	ADMINISTRATION	SERVI CES & SUPPLY	(COSTED REQUIS.)	
			HOUSED)	(DIRECT NURS.	(COSTED	REQUIS.)	
		11 00	12.00	HRS.)	REQUIS.)	15.00	
	GENERAL SERVICE COST CENTERS	11.00	12. 00	13. 00	14. 00	15. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A	61, 941					11.00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0				12. 00
13. 00	01300 NURSING ADMINISTRATION	2, 844	0	419, 361			13. 00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	966 2, 470	0	0	11, 675, 150	100	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 220	0	0	21, 786 107	0	1
17. 00	01700 SOCIAL SERVICE	0	0	Ō	0	0	1
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG PROGRAM	0	0	0	0	0	19. 00 20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	3, 782	0	0	15, 434	0	1
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	413	0	Ö	0	0	
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	8. 739	0	101, 264	501, 906	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T	1, 950	0		165, 919	0	1
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	7, 464	0	0 70, 454	0 41, 321	0	34. 00 40. 00
41. 00	04100 SUBPROVI DER – I RF	0	Ö	70, 434	0	0	1
43.00	04300 NURSERY	2, 323	0	42, 814	14, 497	0	
44. 00	04400 SKILLED NURSING FACILITY	1, 894	0	18, 058	7, 444	0	
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0		0	0	45. 00 46. 00
10.00	ANCILLARY SERVICE COST CENTERS	, ,		<u> </u>			10.00
50.00	05000 OPERATING ROOM	2, 942	0		899, 823	0	
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	688 2, 716	0		5, 413 103, 330	0	
53. 00	05300 ANESTHESI OLOGY	2,710	0	0	103, 330	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 496	0	0	85, 960	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	
56. 00 57. 00	05600	107 514	0	0	144 23, 554	0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	217	0	o	11, 154	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	1
60.00		2, 568	0	0	68, 183	0	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		C	٥	U	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	0	0	0	0	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	1, 601	0	
64. 00 65. 00	06400 NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	1, 075	0	0	0 64, 356	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	687	Ö	Ö	1, 643	0	1
67. 00	06700 OCCUPATI ONAL THERAPY	301	0	0	0	0	
68. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	91	0	0	0	0	
69. 00 70. 00	07000 ELECTROENCEPHALOGRAPHY	700	0	2, 300	6, 249 0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	7, 126, 747	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	2, 320, 901	0	
73. 00 74. 00		0	0	0	0	100 0	1
	07500 ASC (NON-DISTINCT PART)		0		0	0	1
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
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	l ol	0	O	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	Ö	Ö	0	89. 00
90.00	09000 CLINIC	1, 258	0	11, 379	12, 953	0	
	09001 CLINIC CMHC 09002 CLINIC CHEMO	3, 254 0	0	310 0	1, 453 0	0	1
	14 44 14 14 14 14 14 14 14 14 14 14 14 1	<u> </u>		, 9	<u>_</u>		1

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS HOBOKEN UNIVERSITY MEDICAL CENTER In Lieu of Form CMS-2552-10 Provider CCN: 31-0040 Peri od: From 01/01/2023 To 12/31/2023 Worksheet B-1 Date/Time Prepared: 5/31/2024 12:06 pm Cost Center Description CAFETERI A MAINTENANCE OF CENTRAL PHARMACY NURSI NG PERSONNEL (MEALS SERVED) ADMI NI STRATI ON SERVICES & (COSTED (NUMBER SUPPLY REQUIS.) HOUSED) (DI RECT NURS. (COSTED

			ŕ	HRS.)	REQUIS.)		
		11.00	12.00	13.00	14. 00	15. 00	
90. 03 09003	CLINIC RYAN WHITE	1, 149	0	2, 080	1, 532	0	90. 03
91.00 09100	EMERGENCY	7, 022	0	57, 825	169, 785	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER	REIMBURSABLE COST CENTERS						1
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
	AMBULANCE SERVICES	ol	0	0	0	0	95.00
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	l ol	o	0	0	0	96.00
97. 00 09700	DURABLE MEDICAL EQUIP-SOLD	l ol	o	0	0	0	97.00
	OTHER REIMBURSABLE COST CENTERS	o	0	0	0	0	98.00
99.00 09900		ol ol	0	0	0	0	
99. 10 09910		أم	0	0	0	0	
	I&R SERVICES-NOT APPRVD PRGM		0	0	0	_	100.00
	HOME HEALTH AGENCY		0	Ö	0		101.00
	OPIOID TREATMENT PROGRAM		0	Ö	0		102.00
	AL PURPOSE COST CENTERS	<u> </u>	9	<u> </u>			1102.00
	KIDNEY ACQUISITION	0	0	0	0	0	105. 00
	HEART ACQUISITION	0	0	0	0		106. 00
	LIVER ACQUISITION	0	0	0	0		107. 00
	LUNG ACQUISITION	0	0	0	0		107.00
		0	0		0		
•	PANCREAS ACQUISITION	0	0	0	0		109.00
	INTESTINAL ACQUISITION	0	0	0	0		110.00
	I SLET ACQUI SI TI ON	0	O	0	0		111.00
	I NTEREST EXPENSE						113.00
•	UTILIZATION REVIEW-SNF	_	_	_	_		114.00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600		0	0	0	0		116. 00
	SUBTOTALS (SUM OF LINES 1 through 117)	60, 850	0	419, 361	11, 673, 195	100	118. 00
	IMBURSABLE COST CENTERS	T		ı			
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	COMMUNTIY MOBILE	0	0	0	0	_	190. 01
190. 02 19002		1, 091	0	0	1, 955		190. 02
191. 00 19100	l i	0	0	0	0		191. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
	NONPALD WORKERS	0	0	0	0		193. 00
	VACANT SPACE	0	0	0	0		194.00
194. 01 07951	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 0°
200.00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	2, 472, 869	0	5, 853, 656	3, 002, 396	5, 254, 423	202.00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	39. 922975	0. 000000	13. 958513	0. 257161	52, 544. 230000	203.00
204. 00	Cost to be allocated (per Wkst. B,	207, 314	0	83, 869	204, 585	165, 198	204.00
	Part II)	·		·	·		
205. 00	Unit cost multiplier (Wkst. B, Part	3. 346959	0. 000000	0. 199992	0. 017523	1, 651. 980000	205. 00
	11)					,	
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)	1	l	J			1
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 31-0040

				1	o 12/31/2023	Date/lime Pre 5/31/2024 12:	
	Cost Center Description	RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE	(TÎME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	NURSI NG PROGRAM (ASSI GNED TI ME)	
	GENERAL SERVICE COST CENTERS	16. 00	17. 00	18. 00	19. 00	20. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT			1			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 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL						11. 00 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 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 999, 295, 612	0				16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	o			18.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	ō			19. 00
20. 00	02000 NURSI NG PROGRAM	0	0	0		0	
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0			21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-	_	_]
30.00	03000 ADULTS & PEDI ATRI CS	248, 481, 922	0				1
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	27, 526, 000	0				
33. 00	03300 BURN INTENSIVE CARE UNIT	0	Ö	ő		Ö	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40.00	04000 SUBPROVIDER - I PF	198, 918, 000	0	0	0	0	
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	37, 266, 109	0	0	0	0	
44. 00	04400 SKILLED NURSING FACILITY	67, 788, 000	0	Ö	_	Ö	•
45. 00	04500 NURSING FACILITY	O	0				1
46. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	46. 00
50. 00	05000 OPERATING ROOM	78, 273, 526	0	0	0	0	50.00
51. 00	05100 RECOVERY ROOM	7, 621, 975	0	О	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	10, 705, 521	0	0	0	0	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	195, 770, 880	0	0	0	0 0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	Ö	0	Ö	55. 00
56. 00	05600 RADI OI SOTOPE	6, 326, 622	0				
	05700 CT SCAN	105, 614, 588	0	0	0	Ĭ	07.00
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	17, 862, 931	0	0	0	0 0	
60. 00	06000 LABORATORY	263, 809, 722	0	ō	0	0	
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	9, 093, 101	Ö	ő	0	Ö	1
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
65. 00	06500 RESPIRATORY THERAPY	12, 229, 077	0	0	0	0	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	10, 135, 980 4, 685, 325	0	0	0	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 063, 529	Ö	ő	0	Ö	1
69. 00	06900 ELECTROCARDI OLOGY	35, 729, 863	0	0	0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	694, 044	0	0	0	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 783, 649 9, 952, 507	0	0	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	57, 773, 475	Ö	Ö	Ö	Ö	1
74. 00	07400 RENAL DI ALYSI S	588, 366	0	0	0	0	
75. 00	07500 ASC (NON-DISTINCT PART) 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	
77. 00 78. 00	07700 ALLOGENETC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY		0	0	_		1
	OUTPATIENT SERVICE COST CENTERS	,				-	1
	08800 RURAL HEALTH CLINIC	0	0				
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	28, 968, 842	0	0		-	1
	09001 CLINIC CMHC	41, 005, 850	Ö	•	_	-	
		'					

Provider CCN: 31-0040

Peri od:

From 01/01/2023

COST ALLOCATION - STATISTICAL BASIS

12/31/2023 Date/Time Prepared: 5/31/2024 12:06 pm OTHER GENERAL SERVI CE Cost Center Description MEDI CAL SOCIAL SERVICE (SPECI FY) NONPHYSI CI AN NURSI NG (TÎME SPENT) PROGRAM RECORDS & **ANESTHETISTS** (TIME SPENT) (ASSI GNED (ASSI GNED LIBRARY (TIME SPENT) TIME) TIME) 16.00 17.00 18.00 19.00 20.00 90. 02 09002 CLINIC CHEMO 1, 051, 240 90. 02 0 90. 03 09003 CLINIC RYAN WHITE 150, 858 0 90.03 0 0 09100 EMERGENCY C 91.00 91.00 511, 424, 130 Λ 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94 00 0 0 09500 AMBULANCE SERVICES 0 0 95.00 0 0 95.00 0 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 97.00 0 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 98.00 0 0 99. 00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 99. 10 0 0 0 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100.00 Ω 0 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 102.00 10200 OPI OID TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 105.00 0 Ω 0 0 106.00 10600 HEART ACQUISITION 0 0 0 0 0 106.00 107.00 10700 LIVER ACQUISITION 0 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 0 108. 00 0 0 109.00 10900 PANCREAS ACQUISITION 0 0 109, 00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 0 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115.00 0 0 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,999,295,612
NONREIMBURSABLE COST CENTERS 118.00 0 0 0 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 190. 01 19001 COMMUNTLY MOBILE 0 190. 01 0 0 0 0 0 190. 02 19002 FAI TH 0 190. 02 0 0 0 191. 00 19100 RESEARCH 0 191.00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 0 193. 00 19300 NONPALD WORKERS 0 193. 00 0 194.00 07950 VACANT SPACE 0 0 0 0 194. 00 194. 01 07951 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 01 200.00 Cross Foot Adjustments 200.00 201. 00 201 00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, 1, 913, 373 0 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000957 0.000000 0.000000 0.000000 0.000000 203.00 Cost to be allocated (per Wkst. B, 0 204. 00 204.00 168, 109 Part II) 0. 000000 205.00 Unit cost multiplier (Wkst. B, Part 0.000084 0.000000 0.000000 0.000000 205.00 II) 206.00 NAHE adjustment amount to be allocated 0 206. 00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 0.000000 207.00 207.00 Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

In Lieu of Form CMS-2552-10
Worksheet B-1

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/31/2024 12:06 pm

			INTERNS &	DESTREMTS		5/31/2024 12:	U6 pili
			TIVILKIVS &	KLSIDLNIS			
		Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED		
			Y & FRINGES	PRGM COSTS	PRGM		
			(ASSI GNED	(ASSI GNED	(ASSI GNED		
			TIME)	TIME)	TIME)		
			21. 00	22. 00	23. 00		
		AL SERVICE COST CENTERS					4
1.00	1	CAP REL COSTS-BLDG & FIXT					1. 00
2.00	1	CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	1	ADMINISTRATIVE & GENERAL					5. 00
6. 00 7. 00	1	MAINTENANCE & REPAIRS OPERATION OF PLANT					6. 00 7. 00
8. 00	1	LAUNDRY & LINEN SERVICE					8. 00
9. 00	1	HOUSEKEEPI NG					9. 00
10. 00	1	DIETARY					10.00
11. 00	1	CAFETERI A					11. 00
12. 00	1	MAINTENANCE OF PERSONNEL					12. 00
13.00	1	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	1	SOCIAL SERVICE					17. 00
18. 00	1	OTHER GENERAL SERVICE (SPECIFY)					18. 00
19. 00		NONPHYSI CI AN ANESTHETI STS					19. 00
20.00	1	NURSI NG PROGRAM					20.00
21. 00		I &R SERVICES-SALARY & FRINGES APPRVD	100	100			21. 00
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRVD		100	1		22. 00
23. 00		PARAMED ED PRGM-(SPECIFY) TENT ROUTINE SERVICE COST CENTERS			0		23. 00
30. 00		ADULTS & PEDIATRICS	34	34	0		30.00
31. 00	1	INTENSIVE CARE UNIT	2	2			31. 00
32. 00	1	CORONARY CARE UNIT	l o	0			32. 00
33. 00	1	BURN INTENSIVE CARE UNIT	0	0	0		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0		34. 00
40.00	04000	SUBPROVIDER - IPF	0	0	0		40.00
41. 00	04100	SUBPROVIDER - IRF	0	0	0		41. 00
43.00		NURSERY	0	0	0		43. 00
44. 00		SKILLED NURSING FACILITY	0	0			44. 00
45. 00	1	NURSING FACILITY	0	0			45. 00
46. 00		OTHER LONG TERM CARE	0	0	0		46. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	6	4	O		50.00
51.00		RECOVERY ROOM	0	6			51.00
52. 00	1	DELIVERY ROOM & LABOR ROOM	15	15			52. 00
53. 00	1	ANESTHESI OLOGY	0	0			53. 00
54.00		RADI OLOGY-DI AGNOSTI C	0	0	0		54.00
55.00	05500	RADI OLOGY-THERAPEUTI C	0	0	0		55. 00
56.00		RADI OI SOTOPE	0	0	0		56. 00
57. 00		CT SCAN	0	0			57. 00
		MAGNETIC RESONANCE IMAGING (MRI)	0	0	l "I		58. 00
59. 00	1	CARDI AC CATHETERI ZATI ON	0	0	0		59.00
60.00		LABORATORY	0	0	0		60.00
60. 01	1	BLOOD LABORATORY	0	0	0		60. 01
61. 00 62. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0		61. 00 62. 00
63. 00	1	BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64. 00	1	I NTRAVENOUS THERAPY	0	0	0		64. 00
65. 00	1	RESPI RATORY THERAPY	l o	0	Ö		65. 00
66.00		PHYSI CAL 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	1	ELECTROCARDI OLOGY	2	2	0		69. 00
70. 00	1	ELECTROENCEPHALOGRAPHY	0	0	0		70. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71. 00
72.00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
	1	DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74. 00 75. 00		RENAL DIALYSIS ASC (NON-DISTINCT PART)		0			74. 00 75. 00
		ASC (NON-DISTINCT PART) ALLOGENEIC HSCT ACQUISITION		0	0		75.00
78.00	1	CAR T-CELL IMMUNOTHERAPY		0			78.00
. 5. 55		TIENT SERVICE COST CENTERS	. 9				1 5. 55
88. 00		RURAL HEALTH CLINIC	O	0	0		88. 00
89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER	o	0	0		89. 00
90. 00		CLINIC	41	41	0		90. 00
90. 01	09001	CLINIC CMHC	0	0	0		90. 01

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 31-0040

				'	5/31/2024	
		INTERNS &	RESI DENTS			
	Cost Center Description		SERVI CES-OTHER			
		Y & FRINGES	PRGM COSTS	PRGM		
		(ASSI GNED	(ASSI GNED	(ASSI GNED		
		TIME)	TIME)	TIME)	-	
90. 02 09002	CLINIC CHEMO	21.00	22.00	23.00		90, 02
	CLINIC CHEMO	0	1	_		90. 02
	EMERGENCY	0		-		91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	U	0		,	92.00
	REIMBURSABLE COST CENTERS		L			72.00
	HOME PROGRAM DI ALYSI S	0	0	С		94. 00
	AMBULANCE SERVICES	0	0			95. 00
	DURABLE MEDICAL EQUIP-RENTED	0	0	_		96. 00
	DURABLE MEDICAL EQUIP-SOLD	0	0	l c		97. 00
98. 00 09850	OTHER REIMBURSABLE COST CENTERS	0	0	C		98. 00
99. 00 09900	СМНС	0	0	C)	99. 00
99. 10 09910	CORF	0	0	C		99. 10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	C)	100.00
	HOME HEALTH AGENCY	0	0	C		101. 00
	OPIOID TREATMENT PROGRAM	0	0	C		102. 00
	AL PURPOSE COST CENTERS		i			
	KIDNEY ACQUISITION	0		-		105. 00
	HEART ACQUISITION	0	0			106. 00
	LIVER ACQUISITION	0	0			107. 00
	LUNG ACQUISITION	0	0	_		108.00
	PANCREAS ACQUISITION	0	0	_		109. 00 110. 00
	INTESTINAL ACQUISITION ISLET ACQUISITION	0	0	[1110.00
	INTEREST EXPENSE	U	0	·	,	113.00
•	UTILIZATION REVIEW-SNF					114. 00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0	d		115. 00
116. 00 11600			Ĭ	ď		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	100	100	-		118. 00
NONRE	I MBURSABLE COST CENTERS	<u>'</u>	•		<u> </u>	
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C		190. 00
190. 01 19001	COMMUNTIY MOBILE	0	0	C		190. 01
190. 02 19002	FAI TH	0	0	C		190. 02
191. 00 19100		0	0	_		191. 00
	PHYSICIANS' PRIVATE OFFICES	0	0	C		192. 00
	NONPALD WORKERS	0	0	C		193. 00
	VACANT SPACE	0	0	C		194. 00
	OTHER NONREIMBURSABLE COST CENTERS	0	0	C)	194. 01
200. 00	Cross Foot Adjustments					200. 00
201. 00	Negative Cost Centers	F 414 240	2 27/ /00			201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	5, 414, 249	2, 376, 680	C	9	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	54 142 490000	23, 766. 800000	0. 000000		203. 00
204. 00	Cost to be allocated (per Wkst. B,	343, 776	l '	0.000000		204. 00
201.00	Part II)	343,770	11, 700			204.00
205. 00	Unit cost multiplier (Wkst. B, Part	3, 437. 760000	119. 660000	0. 000000		205. 00
	II)	,				
206. 00	NAHE adjustment amount to be allocated			C		206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,			0. 000000	0	207. 00
	Parts III and IV)	l	l	I	I	1

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 31-0040

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/31/2024 12:06 pm

					1	0 12/31/2023	5/31/2024 12:	
				Title	XVIII	Hospi tal	PPS	
		Cost Contor Dosorintion	Total Cost	Thorany Limit	Total Costs	Costs RCE	Total Costs	
		Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	Di sal I owance	TOTAL COSTS	
			Part I, col.	/kaj .		Di Sai i Gwarice		
			26)					
	LNDAT	LENT DOUTING CEDIM OF COCT CENTEDS	1.00	2. 00	3. 00	4. 00	5. 00	
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	21, 440, 606		21, 440, 606	42, 944	21, 483, 550	30. 00
31. 00		INTENSIVE CARE UNIT	6, 083, 718		6, 083, 718	18, 115	6, 101, 833	
32. 00		CORONARY CARE UNIT	0		0	0	0	32. 00
33. 00		BURN INTENSIVE CARE UNIT	0		0	0	0	33. 00
34. 00		SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34. 00
40. 00 41. 00		SUBPROVIDER - IPF SUBPROVIDER - IRF	17, 000, 489		17, 000, 489	10, 107	17, 010, 596 0	40. 00 41. 00
43.00		NURSERY	5, 542, 503		5, 542, 503	0	5, 542, 503	43.00
44. 00		SKILLED NURSING FACILITY	4, 359, 451		4, 359, 451	Ö	4, 359, 451	44. 00
45.00	04500	NURSING FACILITY	0		0	0	0	45. 00
46. 00		OTHER LONG TERM CARE	0		0	0	0	46. 00
EO 00		LARY SERVICE COST CENTERS OPERATING ROOM	12 010 122		12 010 122	100 202	14 010 E04	50. 00
50. 00 51. 00		RECOVERY ROOM	13, 919, 122 2, 252, 872	l .	13, 919, 122 2, 252, 872	100, 382 0	14, 019, 504 2, 252, 872	51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	5, 823, 584	l .	5, 823, 584	0	5, 823, 584	52. 00
53.00		ANESTHESI OLOGY	0		0	0	0	53. 00
54.00		RADI OLOGY-DI AGNOSTI C	4, 922, 682		4, 922, 682	35, 301	4, 957, 983	
55. 00		RADI OLOGY-THERAPEUTI C	0		0	0	0	55. 00
56. 00 57. 00	1	RADI OI SOTOPE CT SCAN	355, 108 1, 299, 696		355, 108 1, 299, 696	0	355, 108 1, 299, 696	56. 00 57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	678, 902	l .	678, 902	0	678, 902	58. 00
59. 00	1	CARDI AC CATHETERI ZATI ON	0		0	0	0	59. 00
60.00		LABORATORY	8, 239, 501		8, 239, 501	3, 718	8, 243, 219	
60. 01		BLOOD LABORATORY	0		0	0	0	60. 01
61. 00 62. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	61. 00 62. 00
63. 00		BLOOD STORING, PROCESSING & TRANS.	673, 669		673, 669	0	673, 669	63. 00
64. 00		I NTRAVENOUS THERAPY	0		0	0	0	64. 00
65. 00		RESPI RATORY THERAPY	2, 527, 806	l .	, . ,	0	2, 527, 806	
66.00		PHYSI CAL THERAPY	1, 303, 834	l .	1, 303, 834	0	1, 303, 834	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	491, 340 161, 130	l .	491, 340 161, 130	0	491, 340 161, 130	67. 00 68. 00
69. 00		ELECTROCARDI OLOGY	1, 152, 903	l .	1, 152, 903	0	1, 152, 903	69. 00
70. 00		ELECTROENCEPHALOGRAPHY	31, 688	l .	31, 688	0	31, 688	70. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 929, 629	l .	8, 929, 629	0	8, 929, 629	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	3, 654, 715	l .	3, 654, 715	0	3, 654, 715	72. 00
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	10, 010, 387 1, 196, 835		10, 010, 387 1, 196, 835	0	10, 010, 387 1, 196, 835	
75. 00		ASC (NON-DISTINCT PART)	0		0	0	0	75. 00
77. 00		ALLOGENEIC HSCT ACQUISÍTION	0		0	0	0	77. 00
78. 00		CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78. 00
99 00		TIENT SERVICE COST CENTERS	0		0	O	0	88. 00
88. 00 89. 00		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	
90.00	1	CLINIC	2, 190, 242		2, 190, 242	0	2, 190, 242	90.00
90. 01		CLINIC CMHC	4, 028, 820		4, 028, 820	0	4, 028, 820	
90. 02		CLINIC CHEMO	114, 340		114, 340	0	114, 340	
90. 03	1	CLINIC RYAN WHITE	1, 182, 474		1, 182, 474	12 570	1, 182, 474	
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	16, 311, 421 4, 354, 272	l .	16, 311, 421 4, 354, 272	12, 579	16, 324, 000 4, 354, 272	
72.00		REIMBURSABLE COST CENTERS	4, 334, 272		4, 554, 272		4, 554, 272	72.00
94.00		HOME PROGRAM DIALYSIS	0		0	0	0	94. 00
95.00		AMBULANCE SERVICES	0		0	0	0	95. 00
96.00	1	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
97. 00 98. 00		DURABLE MEDICAL EQUIP-SOLD OTHER REIMBURSABLE COST CENTERS	0		0	0	0	97. 00 98. 00
99. 00	09900		0		0	O	0	99. 00
99. 10			0		0		0	99. 10
		I&R SERVICES-NOT APPRVD PRGM	0		0			100. 00
	1	HOME HEALTH AGENCY	0		0			101.00
102.00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	1	0		0	102. 00
105.00		KIDNEY ACQUISITION	0		0		0	105. 00
		HEART ACQUISITION	0		ő			106. 00
		LIVER ACQUISITION	0		0			107. 00
		LUNG ACQUISITION	0		0			108.00
		PANCREAS ACQUISITION INTESTINAL ACQUISITION			0			109. 00 110. 00
		ISLET ACQUISITION	0		0			110.00
		· · · · · · · · · · · · · · · · · · ·		1	<u>'</u>			

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/31/2024 12:06 pm
	T1.11 \0.0111		DDO

					3/31/2024 12.	uo piii
		Title	: XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
113. 00 11300 NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	O)	0	115. 00
116. 00 11600 HOSPI CE	0)	0	116. 00
200.00 Subtotal (see instructions)	150, 233, 739	0	150, 233, 739	223, 146	150, 456, 885	200.00
201.00 Less Observation Beds	4, 354, 272		4, 354, 272		4, 354, 272	201.00
202.00 Total (see instructions)	145, 879, 467		145, 879, 467	223, 146	146, 102, 613	202. 00

Provider CCN: 31-0040

Peri od:

From 01/01/2023

COMPUTATION OF RATIO OF COSTS TO CHARGES

Part I

Date/Time Prepared: 12/31/2023 5/31/2024 12:06 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 248, 481, 922 248, 481, 922 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 27, 526, 000 27, 526, 000 31.00 03200 CORONARY CARE UNIT 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 34 00 40.00 04000 SUBPROVIDER - IPF 198, 918, 000 198, 918, 000 40.00 41.00 04100 SUBPROVIDER - IRF 41.00 04300 NURSERY 43.00 43.00 37, 266, 109 37, 266, 109 04400 SKILLED NURSING FACILITY 44.00 67, 788, 000 67, 788, 000 44 00 45.00 04500 NURSING FACILITY 45.00 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 0.000000 50.00 05000 OPERATING ROOM 18, 242, 873 60, 030, 653 78, 273, 526 0.177827 50.00 05100 RECOVERY ROOM 1, 895, 260 5, 726, 715 7, 621, 975 0. 295576 0.000000 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 10, 653, 927 51, 594 10, 705, 521 0.543980 0.000000 52.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 38, 341, 244 157, 429, 636 195, 770, 880 0.025145 0.000000 54.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0.000000 55.00 55.00 05600 RADI OI SOTOPE 884, 619 5, 442, 003 0.000000 56.00 6, 326, 622 0.056129 56.00 20, 791, 201 57.00 05700 CT SCAN 84, 823, 387 105, 614, 588 0.012306 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 5, 224, 500 12, 638, 431 17, 862, 931 0.038006 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 151, 034, 135 60 00 06000 LABORATORY 112, 775, 587 263, 809, 722 0.031233 0 000000 60 00 60.01 06001 BLOOD LABORATORY C 0.000000 0.000000 60.01 0 C 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0.000000 0.000000 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0.000000 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.074086 63.00 5, 521, 567 3, 571, 534 9, 093, 101 0.000000 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0.000000 64.00 06500 RESPIRATORY THERAPY 65.00 9, 885, 434 2, 343, 643 12, 229, 077 0.206705 0.000000 65.00 3, 891, 445 66 00 06600 PHYSI CAL THERAPY 6 244 536 10, 135, 981 0 128634 0 000000 66 00 06700 OCCUPATIONAL THERAPY 3, 875, 025 67.00 810, 300 4, 685, 325 0.104868 0.000000 67.00 06800 SPEECH PATHOLOGY 788, 496 275, 013 1, 063, 509 0.151508 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 10, 044, 058 25, 685, 805 35, 729, 863 0.032267 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0.045657 70 00 548.371 145, 672 694.043 0.000000 70 00 0.000000 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 253, 222 5, 530, 427 8, 783, 649 1.016620 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 038, 305 6, 914, 202 9, 952, 507 0.000000 72.00 0.367216 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 28, 425, 980 29, 347, 494 57, 773, 474 0.173270 0.000000 73.00 07400 RENAL DIALYSIS 2.034168 74 00 588, 366 588, 366 0.000000 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 75.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0.000000 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0.000000 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 28, 914, 063 90.00 09000 CLINIC 28, 968, 843 0.075607 54, 780 0.000000 90.00 09001 CLINIC CMHC 90.01 0 41,005,850 41, 005, 850 0.098250 0.000000 90.01 09002 CLINIC CHEMO 1,051,240 1, 051, 240 0.108767 0.000000 90.02 90.02 09003 CLINIC RYAN WHITE 90.03 150, 859 150, 859 7.838273 0.000000 90.03 91.00 09100 FMFRGENCY 55, 104, 494 456, 319, 636 511, 424, 130 0.031894 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 162, 955, 140 355, 886, 821 518, 841, 961 0.008392 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0.000000 0.000000 0 94.00 95.00 09500 AMBULANCE SERVICES C 0 0.000000 0.000000 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0.000000 0.000000 96.00 0 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0.000000 0.000000 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0.000000 0.000000 98.00 99.00 09900 CMHC C 0 99.00 99. 10 09910 CORF 0 0 0 99.10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101 00 0 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 105.00 0 106.00 10600 HEART ACQUISITION 0 C 106.00 107. 00 10700 LIVER ACQUISITION 0 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 109 00 Ω 0 110.00 11000 INTESTINAL ACQUISITION C 0 110.00 111.00 11100 I SLET ACQUISITION 0 111. 00 113.00 11300 INTEREST EXPENSE 113.00

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 31-0040	Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/31/2024 12:06 pm

					3/31/2024 12.	OO piii
		Title	xVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col . 7)	Rati o	I npati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		O		115. 00
116. 00 11600 HOSPI CE	0	0		O		116.00
200.00 Subtotal (see instructions)	1, 079, 117, 016	1, 439, 020, 558	2, 518, 137, 57	4		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	1, 079, 117, 016	1, 439, 020, 558	2, 518, 137, 57	4		202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part | To 12/31/2024 | Date/Time Prepared: | 5/31/2024 | 12:06 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 31-0040

			Title XVIII	Hoeni tal	5/31/2024 12: PPS	06 pm
	Cost Center Description	PPS Inpatient	I tre xviii	Hospi tal	PPS	
	oost denter beschiption	Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	1					30.00
31. 00	1					31.00
32. 00 33. 00						32. 00 33. 00
34. 00						34.00
40. 00						40. 00
41. 00						41. 00
43.00						43. 00
44. 00						44. 00
45. 00						45. 00
46. 00	'					46. 00
FO 00	ANCILLARY SERVICE COST CENTERS	0 170100				 EO OO
50. 00 51. 00		0. 179109 0. 295576				50. 00 51. 00
52. 00	1	0. 543980				52.00
53. 00		0. 000000				53. 00
54.00		0. 025325				54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
56. 00	1 1	0. 056129				56. 00
57. 00	1	0. 012306				57. 00
58. 00		0. 038006				58.00
59. 00 60. 00	· · · · · · · · · · · · · · · · · · ·	0. 000000 0. 031247				59. 00 60. 00
60. 00	06001 BLOOD LABORATORY	0. 000000				60.00
61. 00	1	0. 000000				61.00
62.00		0. 000000				62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 074086				63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000				64. 00
65. 00		0. 206705				65. 00
66. 00		0. 128634				66.00
67. 00		0. 104868				67.00
68. 00 69. 00		0. 151508 0. 032267				68. 00 69. 00
70. 00		0. 032207				70.00
71. 00		1. 016620				71.00
72. 00		0. 367216				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 173270				73. 00
74. 00		2. 034168				74. 00
75. 00		0. 000000				75. 00
77. 00	1	0. 000000				77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0. 000000				78. 00
88. 00						88. 00
89. 00						89. 00
90.00	1 1	0. 075607				90.00
90. 01	09001 CLINIC CMHC	0. 098250				90. 01
	09002 CLINIC CHEMO	0. 108767				90. 02
90. 03		7. 838273				90. 03
91.00	1	0. 031919				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0. 008392				92. 00
94. 00		0. 000000				94.00
95. 00		0. 000000				95.00
96. 00		0. 000000				96. 00
97. 00		0. 000000				97. 00
98. 00		0. 000000				98. 00
99. 00						99. 00
	09910 CORF					99. 10
	0 10000 I &R SERVI CES-NOT APPRVD PRGM					100.00
	0 10100 HOME HEALTH AGENCY					101.00
102.0	0 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS					102. 00
105 0	0 10500 KIDNEY ACQUISITION					105. 00
	0 10600 HEART ACQUISITION					106.00
	0 10700 LIVER ACQUISITION					107. 00
	0 10800 LUNG ACQUISITION					108. 00
	0 10900 PANCREAS ACQUISITION					109. 00
	0 11000 INTESTINAL ACQUISITION					110.00
	0 11100 I SLET ACQUI SI TI ON					111.00
	0 11300 INTEREST EXPENSE					113.00
	0 11400 UTILIZATION REVIEW-SNF 0 11500 AMBULATORY SURGICAL CENTER (D.P.)					114. 00 115. 00
175.0	opinios principal control of the object (D.1.)	<u> </u>				1. 10. 00

Health Financial Systems	HOBOKEN UNIVERSITY N	MEDICAL CENTER	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARG	ES	Provider CCN: 31-0040	Peri od:	Worksheet C	
			From 01/01/2023 To 12/31/2023	Part Date/Time Pre	nared.
			10 12/31/2023	5/31/2024 12:	06 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
116. 00 11600 HOSPI CE					116.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/31/2024 12:06 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 31-0040

						0 12/31/2023	5/31/2024 12:0	
				Titl	e XIX	Hospi tal	TEFRA	
		0 1 0 1 0 1 1	T	 	T	Costs	T	
		Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
			Part I, col.	Auj .		DI Sai i Owance		
			26)					
			1.00	2.00	3.00	4. 00	5. 00	
		IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	21, 440, 606	ł .	21, 440, 606	42, 944	21, 483, 550	
31. 00 32. 00		INTENSIVE CARE UNIT	6, 083, 718		6, 083, 718	18, 115	6, 101, 833	
32.00		CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0		J 0	0	0	32. 00 33. 00
34. 00		SURGICAL INTENSIVE CARE UNIT	0		0	0	Ö	34. 00
40.00		SUBPROVIDER - IPF	17, 000, 489		17, 000, 489	10, 107	17, 010, 596	40.00
41.00	1	SUBPROVI DER - I RF	0		0	0	0	41. 00
43.00		NURSERY	5, 542, 503		5, 542, 503	0	5, 542, 503	43. 00
44. 00		SKILLED NURSING FACILITY	4, 359, 451		4, 359, 451	0	4, 359, 451	44. 00
45. 00 46. 00		NURSING FACILITY OTHER LONG TERM CARE	0		0	0	0	45. 00 46. 00
40.00	ANCLL	LARY SERVICE COST CENTERS	0			<u> </u>	U	40.00
50. 00		OPERATI NG ROOM	13, 919, 122		13, 919, 122	100, 382	14, 019, 504	50. 00
51.00		RECOVERY ROOM	2, 252, 872		2, 252, 872	0	2, 252, 872	51. 00
52.00		DELIVERY ROOM & LABOR ROOM	5, 823, 584		5, 823, 584	0	5, 823, 584	52.00
53. 00	1	ANESTHESI OLOGY	0		0	0	0	53. 00
54. 00 55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	4, 922, 682		4, 922, 682	35, 301	4, 957, 983 0	54. 00 55. 00
56. 00		RADI OLOGI - THERAPEUTI C	355, 108		355, 108	0	355, 108	56. 00
57. 00	1	CT SCAN	1, 299, 696		1, 299, 696	0	1, 299, 696	57. 00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	678, 902		678, 902	0	678, 902	58. 00
59. 00		CARDI AC CATHETERI ZATI ON	0		0	0	0	59. 00
60.00		LABORATORY	8, 239, 501		8, 239, 501	3, 718	8, 243, 219	60.00
60. 01		BLOOD LABORATORY	0		0	0	0	60. 01
61. 00 62. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	61. 00 62. 00
63. 00		BLOOD STORING, PROCESSING & TRANS.	673, 669		673, 669	0	673, 669	63. 00
64. 00		I NTRAVENOUS THERAPY	0		0	0	0	64. 00
65.00	06500	RESPI RATORY THERAPY	2, 527, 806	0	2, 527, 806	0	2, 527, 806	65.00
66. 00		PHYSI CAL THERAPY	1, 303, 834		.,,	0	1, 303, 834	
67.00		OCCUPATIONAL THERAPY	491, 340			0	491, 340	
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	161, 130 1, 152, 903		161, 130 1, 152, 903	0	161, 130 1, 152, 903	68. 00 69. 00
70. 00		ELECTROCARDI GEOGRAPHY	31, 688		31, 688	0	31, 688	70. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 929, 629		8, 929, 629	0	8, 929, 629	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	3, 654, 715		3, 654, 715	0	3, 654, 715	72. 00
73.00		DRUGS CHARGED TO PATIENTS	10, 010, 387		10, 010, 387	0	10, 010, 387	
74. 00 75. 00		RENAL DIALYSIS ASC (NON-DISTINCT PART)	1, 196, 835		1, 196, 835 0	0	1, 196, 835 0	74. 00 75. 00
77. 00		ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
78. 00		CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78. 00
		TIENT SERVICE COST CENTERS		,				
		RURAL HEALTH CLINIC	0		0	0		88. 00
89. 00 90. 00	1	FEDERALLY QUALIFIED HEALTH CENTER CLINIC	2, 190, 242		2, 190, 242	0	0 2, 190, 242	89. 00 90. 00
90. 01		CLINIC CMHC	4, 028, 820		4, 028, 820	0	4, 028, 820	
90. 02		CLINIC CHEMO	114, 340		114, 340	0	114, 340	
90. 03	1	CLINIC RYAN WHITE	1, 182, 474		1, 182, 474	0	1, 182, 474	
91.00		EMERGENCY	16, 311, 421		16, 311, 421	12, 579	16, 324, 000	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS	4, 345, 572		4, 345, 572		4, 345, 572	92. 00
94. 00		HOME PROGRAM DI ALYSIS	0		0	0	0	94. 00
95.00		AMBULANCE SERVICES	0		0	0	0	95. 00
96.00	1	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96. 00
97. 00		DURABLE MEDI CAL EQUI P-SOLD	0		0	0	0	97. 00
98. 00 99. 00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	O	0	98. 00 99. 00
99. 10			0] 0		0	99. 10
		I&R SERVICES-NOT APPRVD PRGM	0		Ö		-	100. 00
101.00	10100	HOME HEALTH AGENCY	0		0			101. 00
102.00		OPIOID TREATMENT PROGRAM	0		0		0	102. 00
105 00		AL PURPOSE COST CENTERS		Ι			0	105. 00
		KIDNEY ACQUISITION HEART ACQUISITION	0		0			105. 00
		LIVER ACQUISITION	0		0			107. 00
108.00	10800	LUNG ACQUISITION	0		0		0	108. 00
		PANCREAS ACQUISITION	0		0			109. 00
		INTESTINAL ACQUISITION	0		0			110.00
111.00	111100	ISLET ACQUISITION	1 0	<u>I</u>	0		0	111. 00

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 31-0040	From 01/01/2023	Worksheet C Part I Date/Time Prepared: 5/31/2024 12:06 pm

					0/01/2021 12.	
		Ti tl	e XIX	Hospi tal	TEFRA	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
113.00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0				0	115. 00
116. 00 11600 HOSPI CE	0				0	116. 00
200.00 Subtotal (see instructions)	150, 225, 039	0	150, 225, 03	223, 146	150, 448, 185	200.00
201.00 Less Observation Beds	4, 345, 572		4, 345, 57	2	4, 345, 572	201.00
202.00 Total (see instructions)	145, 879, 467	O	145, 879, 46	223, 146	146, 102, 613	202. 00

Provider CCN: 31-0040

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

Part I

From 01/01/2023 Date/Time Prepared: 12/31/2023 5/31/2024 12:06 pm Title XIX Hospi tal TEFRA Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 248, 481, 922 248, 481, 922 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 27, 526, 000 27, 526, 000 31.00 03200 CORONARY CARE UNIT 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 34 00 40.00 04000 SUBPROVIDER - IPF 198, 918, 000 198, 918, 000 40.00 41.00 04100 SUBPROVIDER - IRF 41.00 04300 NURSERY 43.00 43.00 37, 266, 109 37, 266, 109 04400 SKILLED NURSING FACILITY 44.00 67, 788, 000 67, 788, 000 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 18, 242, 873 60, 030, 653 78, 273, 526 0.177827 0.177827 50.00 05100 RECOVERY ROOM 1, 895, 260 5, 726, 715 7, 621, 975 0. 295576 0.295576 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 10, 653, 927 51, 594 10, 705, 521 0.543980 0.543980 52.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 38, 341, 244 157, 429, 636 195, 770, 880 0.025145 0.025145 54.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0.000000 55.00 55.00 05600 RADI OI SOTOPE 884, 619 5, 442, 003 0.056129 56.00 6, 326, 622 0.056129 56.00 57.00 05700 CT SCAN 20, 791, 201 84, 823, 387 105, 614, 588 0.012306 0.012306 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 5, 224, 500 12, 638, 431 17, 862, 931 0.038006 0.038006 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 151, 034, 135 60 00 06000 LABORATORY 112, 775, 587 263, 809, 722 0.031233 0.031233 60 00 60.01 06001 BLOOD LABORATORY C C 0.000000 0.000000 60.01 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0.000000 0.000000 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 0.000000 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.074086 63.00 5, 521, 567 3, 571, 534 9, 093, 101 0.074086 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0.000000 64.00 06500 RESPIRATORY THERAPY 65.00 9, 885, 434 2, 343, 643 12, 229, 077 0.206705 0.206705 65.00 3, 891, 445 66 00 06600 PHYSI CAL THERAPY 6 244 536 10, 135, 981 0 128634 0 128634 66 00 06700 OCCUPATIONAL THERAPY 3, 875, 025 67.00 810, 300 4, 685, 325 0.104868 0.104868 67.00 06800 SPEECH PATHOLOGY 788, 496 275, 013 1, 063, 509 0.151508 0.151508 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 10, 044, 058 25, 685, 805 35, 729, 863 0.032267 0.032267 69.00 07000 ELECTROENCEPHALOGRAPHY 0.045657 0.045657 70 00 548.371 145, 672 694.043 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 3, 253, 222 5, 530, 427 8, 783, 649 1.016620 1.016620 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 038, 305 6, 914, 202 9, 952, 507 72.00 0.367216 0.367216 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 28, 425, 980 29, 347, 494 57, 773, 474 0.173270 0.173270 73.00 07400 RENAL DIALYSIS 2.034168 588, 366 2.034168 74 00 588, 366 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0.000000 75.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0.000000 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0.000000 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0.000000 0.000000 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0.000000 89 00 28, 914, 063 90.00 09000 CLINIC 54, 780 28, 968, 843 0.075607 0.075607 90.00 09001 CLINIC CMHC 90.01 0 41,005,850 41, 005, 850 0.098250 0.098250 90.01 09002 CLINIC CHEMO 1,051,240 1, 051, 240 0.108767 0.108767 90.02 90.02 09003 CLINIC RYAN WHITE 90.03 150, 859 150, 859 7.838273 7.838273 90.03 09100 EMERGENCY 55, 104, 494 91.00 456, 319, 636 511, 424, 130 0.031894 0.031894 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 162, 955, 140 355, 886, 821 518, 841, 961 0.008376 0.008376 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0.000000 0.000000 0 94.00 95.00 09500 AMBULANCE SERVICES C 0 0.000000 0.000000 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0.000000 96.00 0 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0.000000 0.000000 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0.000000 0.000000 98.00 99.00 09900 CMHC C 0 99.00 99. 10 09910 CORF 0 0 0 99.10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101 00 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 0 0.000000 0.000000 105.00 106.00 10600 HEART ACQUISITION 0 0 0.000000 106.00 C 0.000000 107. 00 10700 LIVER ACQUISITION 0 0 0 0.000000 0.000000 107.00 0 108.00 10800 LUNG ACQUISITION 0 0.000000 0.000000 108.00 109.00 10900 PANCREAS ACQUISITION Ω 0 0.000000 0.000000 109.00 0 110.00 11000 INTESTINAL ACQUISITION C 0 0.000000 0.000000 110.00 111.00 11100 I SLET ACQUISITION 0.000000 0.000000 111.00 113.00 11300 INTEREST EXPENSE 113.00

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 31-0040	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/31/2024 12:06 pm

					3/31/2024 12.	oo piii
		Ti tl	e XIX	Hospi tal	TEFRA	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col . 7)	Rati o	I npati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		o l		115. 00
116. 00 11600 HOSPI CE	0	0		o		116. 00
200.00 Subtotal (see instructions)	1, 079, 117, 016	1, 439, 020, 558	2, 518, 137, 57	4		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	1, 079, 117, 016	1, 439, 020, 558	2, 518, 137, 57	4		202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | 5/31/2024 | 12:06 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 31-0040

			Title XIX	Hospi tal	5/31/2024 12: 06 p TEFRA	<u>m</u>
Cost Center Description		PPS Inpatient	THE XIX	nospi tai	TETRA	
		Ratio				
INDATI ENT POUTINE CEDVICE CO	CT CENTEDS	11.00				
30. 00 03000 ADULTS & PEDIATRICS	SI CENTERS				30	. 00
31. 00 03100 I NTENSI VE CARE UNI T						. 00
32.00 03200 CORONARY CARE UNIT					32.	. 00
33.00 03300 BURN INTENSIVE CARE UNI						. 00
34. 00 03400 SURGICAL INTENSIVE CARE	UNIT					. 00
40. 00 04000 SUBPROVI DER - 1 PF 41. 00 04100 SUBPROVI DER - 1 RF						. 00
43. 00 04100 SUBPROVIDER - TRP						. 00 . 00
44.00 04400 SKILLED NURSING FACILIT	Υ					. 00
45.00 04500 NURSING FACILITY					l	. 00
46.00 O4600 OTHER LONG TERM CARE					46.	. 00
ANCILLARY SERVICE COST CENTER	RS					
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM		0.000000				. 00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR R	OOM	0. 000000 0. 000000				. 00 . 00
53. 00 05300 ANESTHESI OLOGY	OOW	0. 000000				. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 000000				. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 000000			55.	. 00
56. 00 05600 RADI 0I SOTOPE		0. 000000			1	. 00
57. 00 05700 CT SCAN	LING (MDL)	0.000000				. 00
58. 00 05800 MAGNETI C RESONANCE I MAG 59. 00 05900 CARDI AC CATHETERI ZATI ON	, ,	0. 000000 0. 000000				. 00 . 00
60. 00 06000 LABORATORY		0. 000000				. 00
60. 01 06001 BLOOD LABORATORY		0. 000000			ı	. 01
61. 00 06100 PBP CLINICAL LAB SERVIC	ES-PRGM ONLY	0. 000000				. 00
62.00 06200 WHOLE BLOOD & PACKED RE	D BLOOD CELLS	0. 000000			62.	. 00
63.00 06300 BLOOD STORING, PROCESSI	NG & TRANS.	0. 000000			63.	. 00
64. 00 06400 I NTRAVENOUS THERAPY		0. 000000				. 00
65. 00 06500 RESPIRATORY THERAPY		0. 000000				. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY		0.000000				. 00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY		0. 000000 0. 000000				. 00 . 00
69. 00 06900 ELECTROCARDI OLOGY		0. 000000				. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 000000				. 00
71.00 07100 MEDICAL SUPPLIES CHARGE	D TO PATIENTS	0. 000000			71.	. 00
72.00 07200 IMPL. DEV. CHARGED TO P	ATI ENTS	0. 000000			72.	. 00
73.00 07300 DRUGS CHARGED TO PATIEN	ITS	0. 000000				. 00
74. 00 07400 RENAL DI ALYSI S		0. 000000				. 00
75. 00 07500 ASC (NON-DISTINCT PART) 77. 00 07700 ALLOGENEIC HSCT ACQUISI		0. 000000 0. 000000				. 00 . 00
78. 00 07800 CAR T-CELL IMMUNOTHERAP		0. 000000				. 00
OUTPATIENT SERVICE COST CENTE		0.00000			70.	. 00
88. 00 08800 RURAL HEALTH CLINIC		0. 000000			88.	. 00
89.00 08900 FEDERALLY QUALIFIED HEA	LTH CENTER	0. 000000			1	. 00
90. 00 09000 CLI NI C		0. 000000				. 00
90. 01 09001 CLI NI C CMHC		0.000000			1	. 01
90. 02 09002 CLINIC CHEMO 90. 03 09003 CLINIC RYAN WHITE		0.000000				. 02 . 03
91. 00 09100 EMERGENCY		0. 000000				. 00
92. 00 09200 OBSERVATION BEDS (NON-D	ISTINCT PART)	0. 000000				. 00
OTHER REIMBURSABLE COST CENTE						
94. 00 09400 HOME PROGRAM DI ALYSI S		0. 000000				. 00
95. 00 09500 AMBULANCE SERVICES	NENTED	0.000000			1	. 00
96. 00 09600 DURABLE MEDICAL EQUIP-R 97. 00 09700 DURABLE MEDICAL EQUIP-S		0.000000				. 00 . 00
98. 00 09850 OTHER REIMBURSABLE COST		0. 000000 0. 000000			ı	. 00
99. 00 09900 CMHC	CLIVILICS	0.000000				. 00
99. 10 09910 CORF						. 10
100.00 10000 I &R SERVICES-NOT APPRVD	PRGM				100.	. 00
101.00 10100 HOME HEALTH AGENCY					101.	. 00
102.00 10200 OPI OI D TREATMENT PROGRA	M				102.	. 00
SPECIAL PURPOSE COST CENTERS		0.000000			405	00
105. 00 10500 KIDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION		0.000000			105. 106.	
105.00 10600 HEART ACQUISITION 107.00 10700 LIVER ACQUISITION		0. 000000 0. 000000			106.	
108. 00 10800 LUNG ACQUISITION		0. 000000			107.	
109. 00 10900 PANCREAS ACQUISITION		0. 000000			109.	
110. 00 11000 I NTESTI NAL ACQUI SI TI ON		0. 000000			110.	
111.00 11100 ISLET ACQUISITION		0. 000000			111.	
113.00 11300 INTEREST EXPENSE					113.	
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	TED (D.C.)				114.	
115.00 11500 AMBULATORY SURGICAL CEN	IIER (D. P.)	1			115.	. 00

Health Financial Systems	HOBOKEN UNIVERSITY	HOBOKEN UNIVERSITY MEDICAL CENTER In Li				
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 31-0040	Peri od:	Worksheet C		
			From 01/01/2023 To 12/31/2023	Part Date/Time Prepared:		
			12, 12, 11, 212	5/31/2024 12:06 pm		
		Title XIX	Hospi tal	TEFRA		
Cost Center Description	PPS Inpatient					
	Ratio					
	11.00					
116. 00 11600 HOSPI CE				116. 00		
200.00 Subtotal (see instructions)				200. 00		
201.00 Less Observation Beds				201. 00		
202.00 Total (see instructions)				202. 00		

Health Financial Systems HOBOKEN UNIVERSITY CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Peri od: Worksheet C From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared: 5/31/2024 12:06 pm Provi der CCN: 31-0040 Peri od: REDUCTIONS FOR MEDICALD ONLY

					5/31/2024 12:	06 pm_
			e XIX	Hospi tal	TEFRA	
Cost Center Description	Total Cost		Operating Cost		Operating Cost	
			Net of Capital	Reduction	Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
			col . 2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1	1				
50. 00 05000 OPERATI NG ROOM	13, 919, 122			107, 610	744, 895	
51. 00 05100 RECOVERY ROOM	2, 252, 872		1 ' '	8, 876	125, 519	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	5, 823, 584	147, 154	5, 676, 430	14, 715	329, 233	
53. 00 05300 ANESTHESI OLOGY	0	(0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 922, 682	309, 113	4, 613, 569	30, 911	267, 587	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	(0	0	0	55. 00
56. 00 05600 RADI OI SOTOPE	355, 108			3, 201	18, 740	56. 00
57.00 05700 CT SCAN	1, 299, 696	77, 873	1, 221, 823	7, 787	70, 866	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	678, 902	66, 892	612, 010	6, 689	35, 497	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C	0	0	0	59. 00
60. 00 06000 LABORATORY	8, 239, 501	351, 860	7, 887, 641	35, 186	457, 483	60.00
60. 01 06001 BLOOD LABORATORY	0	C	0	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	(0	0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	673, 669	12, 981	660, 688	1, 298	38, 320	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	C	o	o	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	2, 527, 806	59, 078	2, 468, 728	5, 908	143, 186	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 303, 834			6, 845	71, 652	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	491, 340			1, 263	27, 765	
68. 00 06800 SPEECH PATHOLOGY	161, 130			1, 016	8, 756	
69. 00 06900 ELECTROCARDI OLOGY	1, 152, 903		1	5, 841	63, 481	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	31, 688			925	1, 302	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 929, 629			15, 712	508, 805	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 654, 715			5, 505	208, 780	72.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	10, 010, 387			19, 094	569, 528	73.00
74. 00 07400 RENAL DIALYSIS						
	1, 196, 835	38, 432		3, 843	67, 187	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0			U	0	75. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION			0	O ₀	0	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	1		U	0	78. 00
88. 00 08800 RURAL HEALTH CLINIC	1 0		ol ol	ol	0	88. 00
· · · · · · · · · · · · · · · · · · ·				ol ol	-	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	2 100 242	_	1	12 500	110 152	89. 00
90. 00 09000 CLI NI C	2, 190, 242			13, 589		90.00
90. 01 09001 CLINIC CMHC	4, 028, 820			3, 212	231, 809	90. 01
90. 02 09002 CLINIC CHEMO	114, 340			3, 366	4, 680	
90. 03 09003 CLINIC RYAN WHITE	1, 182, 474			938	68, 040	90. 03
91. 00 09100 EMERGENCY	16, 311, 421			94, 437	891, 289	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	4, 345, 572	294, 191	4, 051, 381	29, 419	234, 980	92. 00
OTHER REIMBURSABLE COST CENTERS				ما	0	04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0			0	0	94. 00
95. 00 09500 AMBULANCE SERVICES				U	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0	0	96. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0			0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98. 00
99. 00 09900 CMHC	0			o		99. 00
99. 10 09910 CORF	0	(0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	(0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	(0	0		101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	(0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS	1	1				
105.00 10500 KIDNEY ACQUISITION	0		1	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	C		0		106. 00
107.00 10700 LIVER ACQUISITION	0	(0	0		107. 00
108. 00 10800 LUNG ACQUISITION	0	(0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	(0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	(0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	(0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE]					113. 00
114.00 11400 UTILIZATION REVIEW-SNF]					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	(C	0	0		115. 00
116. 00 11600 HOSPI CE	0	(C	0	0		116. 00
200.00 Subtotal (sum of lines 50 thru 199)	95, 798, 272			427, 186	5, 308, 532	
201.00 Less Observation Beds	4, 345, 572			29, 419		
202.00 Total (line 200 minus line 201)	91, 452, 700	3, 977, 679	87, 475, 021	397, 767	5, 073, 552	202. 00

Heal th Financial Systems HOBOKEN UNIVERSITY MEDICAL CENTER
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Provider CCN:
REDUCTIONS FOR MEDICAL D ONLY

Provider CCN: 31-0040

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part II | To 12/31/2024 | Date/Time Prepared: | 5/31/2024 | 12:06 pm

		Ti +I	e XIX	Hospi tal	5/31/2024 12: TEFRA	06 pm
Cost Center Description	Cost Net of	Total Charges		nospi tai	ILIKA	
COST CENTER DESCRIPTION			Cost to Charge			
	Operating Cost					
	Reduction	8)	/ col . 7)			
	6. 00	7. 00	8.00			
ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00			
50. 00 O5000 OPERATING ROOM	13, 066, 617	78, 273, 526	0. 166935			50.00
51. 00 05100 RECOVERY ROOM	2, 118, 477	7, 621, 975				51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	5, 479, 636	10, 705, 521	1			52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	1			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 624, 184	195, 770, 880	1			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0. 000000			55. 00
56. 00 05600 RADI 0I SOTOPE	333, 167	6, 326, 622	0. 052661			56. 00
57. 00 05700 CT SCAN	1, 221, 043	105, 614, 588	0. 011561			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	636, 716	17, 862, 931	0. 035645			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.000000			59. 00
60. 00 06000 LABORATORY	7, 746, 832	263, 809, 722	0. 029365			60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0				61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.000000			62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	634, 051	9, 093, 101				63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0. 000000			64. 00
65. 00 06500 RESPI RATORY THERAPY	2, 378, 712	12, 229, 077	•			65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 225, 337	10, 135, 981				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	462, 312	4, 685, 325				67. 00
68. 00 06800 SPEECH PATHOLOGY	151, 358	1, 063, 509				68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 083, 581	35, 729, 863				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	29, 461	694, 043				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 405, 112	8, 783, 649	1			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 440, 430	9, 952, 507				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	9, 421, 765	57, 773, 474	1			73.00
74. 00 07400 RENAL DI ALYSI S	1, 125, 805	588, 366	•			74. 00
75. 00 07500 ASC (NON-DI STI NCT PART)	0	0				75. 00
77. 00 07700 ALLOGENEI C HSCT ACQUISITION 78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0				77. 00 78. 00
78. 00 O780O CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	J U		ıj 0.000000			/8.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.000000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0. 000000			89. 00
90. 00 09000 CLINI C	2, 057, 501	28, 968, 843	1			90.00
90. 01 09001 CLINI C CMHC	3, 793, 799	41, 005, 850	1			90. 01
90. 02 09002 CLI NI C CHEMO	106, 294	1, 051, 240	1			90. 02
90. 03 09003 CLINIC RYAN WHITE	1, 113, 496	150, 859				90. 03
91. 00 09100 EMERGENCY	15, 325, 695	511, 424, 130				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 081, 173	518, 841, 961	0. 007866			92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000			94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0.000000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	1			96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	1			97. 00
98. 00 09850 0THER REIMBURSABLE COST CENTERS	0	0				98. 00
99. 00 09900 CMHC	0	0				99. 00
99. 10 09910 CORF	0	0				99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0				100. 00
101. 00 10100 HOME HEALTH AGENCY	0	0				101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0.000000			102. 00
SPECIAL PURPOSE COST CENTERS			0.00000			105.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0				105.00
106. 00 10600 HEART ACQUISITION	0	0	0.000000			106.00
107.00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION	0	0				107. 00
		0	0.000000			108.00
109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION		0	0. 000000 0. 000000			109. 00 110. 00
111. 00 11100 SLET ACQUISITION		0	0.000000			111.00
113. 00 11300 NTEREST EXPENSE	٩	U	0.000000			113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	1					114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0	0. 000000			115.00
116. 00 11600 HOSPI CE		0	0.000000			116.00
200.00 Subtotal (sum of lines 50 thru 199)	90 062 554	1, 938, 157, 543	1			200.00
201.00 Less Observation Beds	4, 081, 173	., .55, 157, 545	b			201.00
202.00 Total (line 200 minus line 201)		1, 938, 157, 543				202.00
1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2			•	1		

	HOBOKEN UNIVERSIT				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	TAL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		nared:
			'	12/31/2023	5/31/2024 12:	06 pm
		Title	xVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		ı	T			
30. 00 ADULTS & PEDI ATRI CS	1, 451, 513		1, 451, 513			
31. 00 INTENSIVE CARE UNIT	559, 083		559, 083	1, 180		1
32. 00 CORONARY CARE UNIT	0		(0	0.00	
33.00 BURN INTENSIVE CARE UNIT	0		(0	0.00	
34.00 SURGICAL INTENSIVE CARE UNIT	0		(0	0.00	
40. 00 SUBPROVI DER - I PF	992, 683	0	992, 683	11, 216		1
41. 00 SUBPROVI DER - I RF	0	0	(0	0.00	
43. 00 NURSERY	159, 388		159, 388			
44.00 SKILLED NURSING FACILITY	331, 250		331, 250			
45.00 NURSING FACILITY	0		(0	0.00	
200.00 Total (lines 30 through 199)	3, 493, 917		3, 493, 917	34, 724		200. 00
Cost Center Description	Inpatient	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	6, 00	6) 7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	2, 092	183, 217	1			30.00
31.00 INTENSIVE CARE UNIT	395					31.00
32. 00 CORONARY CARE UNIT	393	107, 131				32.00
33.00 BURN INTENSIVE CARE UNIT						33.00
34. 00 SURGI CAL INTENSI VE CARE UNI T						34.00
40 00 SURDPOVIDED _ LDE	1 /62	120 402				40.00

129, 402

644, 893

40.00 41. 00 43.00

44.00 45. 00 200. 00

40. 00 SUBPROVI DER - I PF 41. 00 SUBPROVI DER - I RF 43. 00 NURSERY

44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199)

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 31-0040 Peri od: Worksheet D From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/31/2024 12:06 pm Title XVIII Hospi tal PPS Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent (from Wkst. C. to Charges (column 3 x Related Cost Program (from Wkst. B. column 4) Part I. col. (col. 1 ÷ col Charges Part II, col. 8) 2) 26) 3.00 4.00 5.00 1.00 2.00 ANCILLARY SERVICE COST CENTERS 3, 200, 375 50.00 05000 OPERATING ROOM 1,076,100 0.013748 43.999 50.00 78, 273, 526 51.00 05100 RECOVERY ROOM 88, 756 7, 621, 975 0.011645 268, 691 3, 129 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.013746 52.00 147, 154 10, 705, 521 0 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 195, 770, 880 0.001579 54.00 309, 113 8, 182, 136 12, 920 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55.00 56.00 05600 RADI OI SOTOPE 32,012 6, 326, 622 0.005060 203, 396 1,029 56.00 05700 CT SCAN 105, 614, 588 0.000737 5. 833. 000 4, 299 57 00 77 873 57 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 66, 892 17, 862, 931 0.003745 1, 255, 500 4, 702 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 60.00 06000 LABORATORY 351, 860 263, 809, 722 0.001334 19, 589, 518 26, 132 60.00 06001 BLOOD LABORATORY 0.000000 60 01 60 01 0 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 9, 093, 101 06300 BLOOD STORING, PROCESSING & TRANS. 12, 981 63 00 0.001428 311, 703 445 63 00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 Ω 64.00 06500 RESPI RATORY THERAPY 59,078 12, 229, 077 0.004831 2, 251, 223 10,876 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 68, 453 10, 135, 981 0.006753 1, 325, 725 8, 953 66.00 06700 OCCUPATIONAL THERAPY 4, 685, 325 12, 631 0.002696 67 00 67 00 0 68.00 06800 SPEECH PATHOLOGY 10, 159 1,063,509 0.009552 0 0 68.00 06900 ELECTROCARDI OLOGY 58, 405 35, 729, 863 0.001635 3, 752, 114 69.00 6, 135 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 9, 247 694, 043 0.013323 91, 325 1, 217 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 157, 123 8, 783, 649 0.017888 357 554 71 00 6, 396 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 55,052 9, 952, 507 0.005531 682, 696 3, 776 72.00 07300 DRUGS CHARGED TO PATIENTS 190, 941 57, 773, 474 0.003305 73.00 5, 014, 656 16, 573 73.00 07400 RENAL DIALYSIS 74.00 38, 432 588, 366 0.065320 271, 272 17, 719 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 0.000000 0 0 75.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0.000000 0 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0.000000 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 0.000000 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 89.00 0 0 90.00 09000 CLI NI C 135, 893 28, 968, 843 0.004691 O 90.00 09001 CLINIC CMHC 41, 005, 850 90.01 32, 118 0.000783 0 90.01 0 90.02 09002 CLINIC CHEMO 33.658 1,051,240 0.032017 0 Λ 90.02 90.03 09003 CLINIC RYAN WHITE 9.375 150, 859 0.062144 0 90.03 09100 EMERGENCY 944, 373 511, 424, 130 0.001847 7, 727, 369 14, 272 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 294, 192 518, 841, 961 0.000567 26, 766, 802 15, 177 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 94.00 09500 AMBULANCE SERVICES 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0.000000 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 97.00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 98.00 0 87, 085, 055 Total (lines 50 through 199) 4, 271, 871 1, 938, 157, 543 197, 749 200. 00 200.00

Health Financial Systems HO	OBOKEN UNIVERSIT	Y MEDICAL CENTE	ER	In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER I	PASS THROUGH COS	TS Provider C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part III Date/Time Pre 5/31/2024 12:	
		Title	e XVIII	Hospi tal	PPS	оо р
Cost Center Description	Nursi ng Program Post-Stepdown	Nursi ng Program		Allied Health	All Other Medical Education Cost	
	Adj ustments	1.00			2.22	
	1A	1.00	2A	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			,			
30. 00 03000 ADULTS & PEDIATRICS	0		1	0		
31. 00 03100 INTENSIVE CARE UNIT	0	0		0	0	31. 00
32. 00 03200 CORONARY CARE UNIT	0	0		0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0)	ol o	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0	0		0	0	41.00
43. 00 04300 NURSERY	0	0		0 0	0	43. 00
44. 00 04400 SKILLED NURSING FACILITY		0	1	ol o	Ĭ	44. 00
45. 00 04500 NURSING FACILITY						45. 00
				0 0	_	200. 00
	Cui na Dad	Total Costs		Per Diem (col.		200.00
Cost Center Description	Swing-Bed	(sum of cols.		5 ÷ col. 6)	Inpatient	
	Adjustment		Days	5 ÷ COI. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)	/ 00	7.00	0.00	
INDATI ENT DOUTINE CEDVI CE COCT CENTEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	0		1/ 57	0.00	2 002	20.00
			1			30.00
31. 00 03100 I NTENSI VE CARE UNI T		0	,		1	
32. 00 03200 CORONARY CARE UNIT		0		0.00	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0		0.00	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0		0.00	0	34. 00
40. 00 04000 SUBPROVI DER - I PF	0	0	11, 21		1, 462	
41. 00 04100 SUBPROVI DER - I RF	0	0		0.00	0	41. 00
43. 00 04300 NURSERY		0	1, 94	0.00	0	43.00
44.00 04400 SKILLED NURSING FACILITY		0	3, 81	0.00	1, 670	44.00
45.00 04500 NURSING FACILITY		0		0.00	0	45. 00
200.00 Total (lines 30 through 199)		0	34, 72	4	5, 619	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31. 00
32. 00 03200 CORONARY CARE UNIT	0					32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT						33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T						34. 00
40. 00 04000 SUBPROVI DER - PF						40.00
41. 00 04100 SUBPROVI DER - 1 FF						41. 00
43. 00 04300 NURSERY						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

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2023 | Part IV |
| To 12/31/2023 | Date/Time Prepared: | 5/31/2024 | 12:06 pm
 Heal th Financial
 Systems
 HOBOKEN UNIVERSITY
 MEDICAL CENTER

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 31-0040
 THROUGH COSTS

								5/31/2024 12:	06 pm
				Title	XVIII		Hospi tal	PPS	
	Cost Center Description	Non Physician	Nu	ırsi ng	Nursi ng		Allied Health	Allied Health	
		Anestheti st	Pr	ogram	Program		Post-Stepdown		
		Cost		Stepdown			Adjustments		
			Adj u	stments					
	T	1. 00		2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	-1		_1			_	_	
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 ANESTHESI OLOGY	0		0		0	0	0	53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0		U		0	O O	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		U		0	0	0	55. 00
56.00	05600	0		U		0	0	0	56. 00
57. 00 58. 00		0		0		0	0	0	57. 00 58. 00
59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0		0		0	0	0	59. 00
60.00	06000 LABORATORY	0		0		0	0	0	60.00
60. 00	06001 BL00D LABORATORY	0		0		0	0	0	60. 00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			O I		U	U	U	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0		0	0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0		0	0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0		0		0	0	Ö	64. 00
65. 00	06500 RESPI RATORY THERAPY	0		0		0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0		0		0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0		0		0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0		0		0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		0		0	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		0		0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0		0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	İ	O		0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		O		0	0	0	73. 00
74.00	07400 RENAL DI ALYSI S	0		o		0	0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0		o		0	0	0	75. 00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	O	İ	o		0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		0		0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS								
88. 00	08800 RURAL HEALTH CLINIC	0		0		0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0		0	0	0	89. 00
90.00	09000 CLI NI C	0		0		0	0	0	90.00
90. 01	09001 CLINIC CMHC	0		0		0	0	0	90. 01
90. 02	09002 CLINIC CHEMO	0		0		0	0	0	90. 02
90. 03	09003 CLINIC RYAN WHITE	0		0		0	0	0	90. 03
91. 00	09100 EMERGENCY	0		0		0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0		0	92. 00
	OTHER REIMBURSABLE COST CENTERS	1							
94. 00	09400 HOME PROGRAM DI ALYSI S	0	1	0		0	0	0	94. 00
95.00	09500 AMBULANCE SERVICES	_		_				_	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0		0	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0		0		0	0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0		0		0	0	0	98. 00
200.00	Total (lines 50 through 199)	l ol	1	0		0	0	0	200. 00

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

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE
 OTHER PASS
 Provider CCN: 31-0040 THROUGH COSTS

					Γο 12/31/2023	Date/Time Pre 5/31/2024 12:	
			Title	xVIII	Hospi tal	PPS	оо рііі
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	'	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
					7.00	instructions)	
	ANCILLARY CERVICE COCT CENTERS	4.00	5. 00	6. 00	7. 00	8. 00	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0	1	78, 273, 526	0. 000000	50. 00
51. 00	05100 RECOVERY ROOM	0	0		7, 621, 975	0.000000	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	Ö		10, 705, 521	0. 000000	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0 10, 703, 321	0. 000000	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		195, 770, 880	0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0. 000000	55. 00
56. 00	05600 RADI OI SOTOPE	0	0		6, 326, 622	0. 000000	56. 00
57.00	05700 CT SCAN	0	0		105, 614, 588	0. 000000	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		17, 862, 931	0. 000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0.000000	59. 00
60.00	06000 LABORATORY	0	0		263, 809, 722	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0. 000000	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		9, 093, 101	0. 000000	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0. 000000	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		12, 229, 077	0. 000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		10, 135, 981	0. 000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		4, 685, 325	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	1	1, 063, 509	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		35, 729, 863	0.000000	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		694, 043 8, 783, 649	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	•	8, 783, 649 9, 952, 507	0. 000000 0. 000000	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		57, 773, 474	0.000000	
74.00	07400 RENAL DIALYSIS	0	0		588, 366	0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0 300, 300	0. 000000	75.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	Ö			0. 000000	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	Ö		o o	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS	-	_		-		
88. 00	08800 RURAL HEALTH CLINIC	0	0	(0 0	0.000000	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.000000	89. 00
90.00	09000 CLI NI C	0	0		28, 968, 843	0.000000	90. 00
90. 01	09001 CLINIC CMHC	0	0		41, 005, 850	0. 000000	90. 01
90. 02	09002 CLI NI C CHEMO	0	0		1, 051, 240	0.000000	90. 02
90. 03	09003 CLINIC RYAN WHITE	0	0		150, 859	0.000000	90. 03
91. 00	09100 EMERGENCY	0	0		511, 424, 130	0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		518, 841, 961	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS	1		1	-l		
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	1	0	0. 000000	94. 00
95. 00	09500 AMBULANCE SERVICES		_			0.000000	95.00
96.00	09600 DURABLE MEDICAL EQUI P-RENTED		0	1	0	0.000000	
97. 00 98. 00	09700 DURABLE MEDICAL EQUIP-SOLD 09850 OTHER REIMBURSABLE COST CENTERS		0		0	0. 000000 0. 000000	97. 00 98. 00
98. 00 200. 00	1		0		0 1, 938, 157, 543		98. 00 200. 00
200.00	Trotal (Tries so till ough 177)	١	0	1	5 1,750, 157, 545	I	1200.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2023 | Part IV |
| To 12/31/2023 | Date/Time Prepared: | 5/31/2024 | 12:06 pm
 Heal th Financial
 Systems
 HOBOKEN
 UNIVERSITY
 M

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE
 OTHER PASS
 Provider CCN: 31-0040 THROUGH COSTS

						5/31/2024 12:0	
			Title	: XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11.00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	3, 200, 375		0 2, 897, 010	0	50. 00
51.00	05100 RECOVERY ROOM	0. 000000	268, 691		0 511, 658	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	8, 182, 136		0 8, 017, 348	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	203, 396		0 842, 386	0	56. 00
57.00	05700 CT SCAN	0. 000000	5, 833, 000		0 7, 536, 921	o	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	1, 255, 500		0 1, 350, 000	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60.00	06000 LABORATORY	0. 000000	19, 589, 518		0 7, 605, 559	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0 0	Ö	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_			_	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	О	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	311, 703		0 59, 391	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0 0		0 37,371	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	2, 251, 223		0 186, 227	Ö	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	1, 325, 725		0 185, 639	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 323, 723		0 105, 057	_	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	3, 752, 114		0 4, 791, 381	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	91, 325		0 4, 791, 381	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	357, 554	l .	0 336, 336		70.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	682, 696	1	0 1, 468, 709		71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	5, 014, 656	l .	0 6, 941, 717	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	271, 272		0 0, 941, 717	0	74.00
75. 00		0. 000000	2/1, 2/2	1	0 0	0	75.00
75.00	07500 ASC (NON-DISTINCT PART) 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	75.00
		1	0		0 0		
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0. 000000	0		0 0	U	78. 00
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	I	0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	1	0		0 0		89.00
	09000 CLINIC	0.000000	0			0	90.00
90.00		0.000000	0		0 364, 704	-	
90. 01	09001 CLINIC CMHC	0. 000000	0		0	0	90. 01
90. 02	09002 CLINIC CHEMO	0. 000000	0		0 230, 325		90. 02
90. 03	09003 CLINIC RYAN WHITE	0. 000000	0	l .	0 0	0	90. 03
91. 00	09100 EMERGENCY	0. 000000	7, 727, 369		0 21, 526, 253		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	26, 766, 802		0 51, 546, 496	0	92. 00
	OTHER REIMBURSABLE COST CENTERS				_		
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0	0	94. 00
95. 00	09500 AMBULANCE SERVICES						95. 00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000	0		0	-	96. 00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000	0		0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0	0	98. 00
200.00	Total (lines 50 through 199)		87, 085, 055	l	0 116, 432, 836	0	200. 00

Provider CCN: 31-0040

Peri od:

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Part V

From 01/01/2023 Date/Time Prepared: 12/31/2023 5/31/2024 12:06 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 177827 2, 897, 010 50.00 515, 167 51.00 05100 RECOVERY ROOM 0. 295576 511,658 0 0 51.00 151, 234 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0.543980 r 52 00 0 0 0 53.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 201, 596 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 025145 8, 017, 348 0 54.00 0 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55 00 55 00 0 0 56.00 05600 RADI OI SOTOPE 0.056129 842, 386 47, 282 56.00 57.00 05700 CT SCAN 0.012306 7, 536, 921 0 92, 749 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.038006 1, 350, 000 0 51, 308 58.00 05900 CARDIAC CATHETERIZATION 0 59 00 0.000000 59 00 0 0 60.00 06000 LABORATORY 0.031233 7, 605, 559 237, 544 60.00 06001 BLOOD LABORATORY 0.000000 0 0 60.01 0 60.01 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 0.000000 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.074086 59, 391 0 0 4, 400 63.00 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 64.00 06500 RESPIRATORY THERAPY 0. 206705 0 38, 494 65.00 186, 227 0 65.00 06600 PHYSI CAL THERAPY 0 23, 879 66.00 0.128634 185, 639 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.104868 67.00 06800 SPEECH PATHOLOGY 0 68.00 0.151508 0 68.00 06900 ELECTROCARDI OLOGY 4, 791, 381 69.00 0.0322670 154, 603 69.00 07000 ELECTROENCEPHALOGRAPHY O 70.00 0.045657 34, 776 1, 588 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1.016620 336, 336 0 0 341, 926 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.367216 1, 468, 709 35, 868 0 539, 333 72.00 07300 DRUGS CHARGED TO PATIENTS 0.173270 1, 202, 791 73.00 6, 941, 717 38, 985 73.00 0 74.00 07400 RENAL DIALYSIS 2.034168 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0.000000 0 75.00 o 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0.000000 0 Λ 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 0.075607 364, 704 0 0 27, 574 90.00 90.01 09001 CLINIC CMHC 0.098250 0 0 90.01 0 09002 CLINIC CHEMO 0.108767 230, 325 0 25, 052 90.02 90.02 09003 CLINIC RYAN WHITE 7 838273 0 90.03 90.03 Λ 91.00 09100 EMERGENCY 0.031894 21, 526, 253 0 0 686, 558 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.008392 51, 546, 496 0 432, 578 92.00 OTHER REIMBURSABLE COST CENTERS 0. 000000 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 95.00 09500 AMBULANCE SERVICES 0.000000 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 97.00 97 00 0 0 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 \cap Λ 98.00 200.00 Subtotal (see instructions) 116, 432, 836 35, 868 38, 985 4, 775, 656 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 38.985 4, 775, 656 202. 00 116, 432, 836 35, 868

201.00

202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 31-0040 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/31/2024 12:06 pm Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 51.00 05100 RECOVERY ROOM 00000000000000000000000 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 52 00 53.00 05300 ANESTHESI OLOGY 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 05600 RADI OI SOTOPE 0 56.00 56.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 0 59 00 59 00 60.00 06000 LABORATORY 0 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06400 INTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 13, 171 72.00 07300 DRUGS CHARGED TO PATIENTS 6, 755 73.00 0 73.00 74.00 07400 RENAL DIALYSIS 0 C 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 07700 ALLOGENEIC HSCT ACQUISÍTION 0 77.00 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 Λ 78.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 0 0 90.00 90.01 09001 CLINIC CMHC 0 0 90.01 90. 02 09002 CLINIC CHEMO 0 90.02 90.03 09003 CLINIC RYAN WHITE 0 90.03 0 91.00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 96.00 97 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97 00 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 200.00 Subtotal (see instructions) 13, 171 6, 755 200.00 Less PBP Clinic Lab. Services-Program

13. 171

6, 755

201.00

202.00

Only Charges

Net Charges (line 200 - line 201)

APPOR	FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Component	CN: 31-0040 CCN: 31-S040	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre	nared:
			,	XVIII	Subprovi der -	5/31/2024 12:	06 pm
					I PF		
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B, Part II, col.		(col . 1 ÷ col	. Charges	column 4)	
		26)	8)	2)			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		,	,			
50.00	05000 OPERATI NG ROOM	1, 076, 100		•		0	
51. 00	05100 RECOVERY ROOM	88, 756				0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	147, 154	10, 705, 521			0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0.00000		0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	309, 113	195, 770, 880			1, 029	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000		0	55. 00
56. 00	05600 RADI OI SOTOPE	32, 012		•		0	56. 00
57. 00	05700 CT SCAN	77, 873			•	189	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	66, 892				0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000		0	59.00
60.00	06000 LABORATORY	351, 860	263, 809, 722	•			
60. 01	06001 BLOOD LABORATORY	0	0	0.00000	0	0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0 00000	0		61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	12, 981	9, 093, 101	0. 00000 0. 00142		0 0	62. 00 63. 00
64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	12, 981	9,093,101	0.00142		0	64.00
65. 00	06500 RESPIRATORY THERAPY	59, 078	12, 229, 077			_	65.00
66. 00	06600 PHYSI CAL THERAPY	68, 453					
67. 00	06700 OCCUPATI ONAL THERAPY	12, 631	4, 685, 325	1	•	1, 334	67.00
68. 00	06800 SPEECH PATHOLOGY	10, 159				0	ł
69. 00	06900 ELECTROCARDI OLOGY	58, 405				326	ı
70. 00	07000 ELECTROENCEPHALOGRAPHY	9, 247	694, 043			0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	157, 123				13	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	55, 052		1		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	190, 941	57, 773, 474	1		2, 152	
74. 00	07400 RENAL DIALYSIS	38, 432			•	0	l
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0.00000		0	•
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	l o	•		0	•
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	•		0	
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	00	0	89. 00
90.00	09000 CLI NI C	135, 893	28, 968, 843	0. 00469	0	0	90.00
90. 01	09001 CLINIC CMHC	32, 118	41, 005, 850	0. 00078	33 0	0	90. 01
90. 02	09002 CLINIC CHEMO	33, 658	1, 051, 240	0. 03201	7 0	0	90. 02
90. 03	09003 CLINIC RYAN WHITE	9, 375	150, 859	•		0	90. 03
91. 00	09100 EMERGENCY	944, 373				5, 540	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	518, 841, 961	0.00000	00	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
04 00	00400 HOME DDOCDAM DIALVSIS		1		0	Λ .	

3, 977, 679 1, 938, 157, 543

0.000000

0.000000

0.000000

0.000000

8, 202, 464

94. 00 95. 00

96.00

97.00

0 98.00

15, 006 200. 00

94. 00 | 09400 | HOME PROGRAM DI ALYSI S 95. 00 | 09500 | AMBULANCE SERVI CES

96.00 | 09600 | DURABLE MEDI CAL EQUI P-RENTED | 97.00 | 09700 | DURABLE MEDI CAL EQUI P-SOLD | 98.00 | 09850 | OTHER REIMBURSABLE COST CENTERS | 200.00 | Total (lines 50 through 199)

Health Financial Systems	HOBOKEN UNIVERSITY M	EDICAL CENTER	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVICE OTHER PASS	Provi der CCN: 31-0040	Peri od: From 01/01/2023	Worksheet D
THROUGH COSTS		Component CCN: 31-S040		

			Component	CCN. 31-3040	10 12/31/2023	5/31/2024 12:	
			Ti tl e	e XVIII	Subprovider -	PPS	· · ·
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
	ANCILLARY SERVICE COST SENTERS	1.00	2A	2.00	3A	3. 00	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	C	1	0 0	0	50.00
51. 00	05100 RECOVERY ROOM	0		1	0 0	1	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		1	0 0	0	52.00
53. 00	05300 ANESTHESI OLOGY	o o		1		0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0				0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	o o	Č	á	0 0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	Č		0 0	0	56.00
57. 00	05700 CT SCAN	0	Č		0 0	0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	Č		0 0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ċ		0 0	0	59. 00
60.00	06000 LABORATORY	0	Ċ		o o	0	60.00
60. 01	06001 BLOOD LABORATORY	0	C		0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	ol	0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	C		0 0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	C		0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	C		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	C		0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	C	1	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	C	1	0	0	73. 00
	07400 RENAL DIALYSIS	0	C		0	0	74. 00
	07500 ASC (NON-DISTINCT PART)	0			0	0	75. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	C	1	0	-	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	C	η <u></u>	0 0	0	78. 00
88. 00	08800 RURAL HEALTH CLINIC	0	C		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	ő	Ċ	1	0 0	1	89. 00
90.00	09000 CLINIC	0	Ċ	1	0 0	0	90.00
90. 01	09001 CLINIC CMHC	o o	Č	á	0 0	0	90. 01
90. 02	09002 CLINIC CHEMO	0	Č		0 0	0	90. 02
90. 03	09003 CLINIC RYAN WHITE	0	Ċ		0 0	0	90. 03
91. 00	09100 EMERGENCY	0	Ċ		o o	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	C		0 0	0	94. 00
95. 00	09500 AMBULANCE SERVI CES						95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	C		0	0	98. 00
200.00	Total (lines 50 through 199)	0	C	기	0 0	0	200. 00

	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI SH COSTS	RVICE OTHER PASS	S Provider C	CN: 31-0040	Peri od: From 01/01/2023	Worksheet D Part IV	
TTIKOUC	00010		Component	CCN: 31-S040	To 12/31/2023		pared: 06 pm
			Title	· XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and 4)	Cost (sum of cols. 2, 3,	Part I, col. 8)	(col. 5 ÷ col. 7)	
			4)	and 4)	0)	(see	
				and 1)		instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	1	0 78, 273, 526	0.000000	
51.00	05100 RECOVERY ROOM	0	0	1	0 7, 621, 975	0.000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 10, 705, 521	0.000000	
53.00	05300 ANESTHESI OLOGY	0	0		0 105 770 000	0.000000	
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	0		0 195, 770, 880 0 0	0. 000000 0. 000000	
56. 00	05600 RADI OLOGT - THERAPEUTI C	0	0		0 6, 326, 622	0.00000	
57. 00	05700 CT SCAN	0	0		0 105, 614, 588	0.000000	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 17, 862, 931	0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ö		0 0	0. 000000	
60.00	06000 LABORATORY	0	0		0 263, 809, 722	0.000000	
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0.000000	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0.000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 9, 093, 101	0. 000000	
64.00	06400 NTRAVENOUS THERAPY	0	0		0 0	0.000000	
65. 00 66. 00	06500 RESPIRATORY THERAPY	0	0		0 12, 229, 077 0 10, 135, 981	0. 000000 0. 000000	
67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0		0 10, 135, 981 0 4, 685, 325	0.00000	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 1, 063, 509	0.000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 35, 729, 863	0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	Ö		0 694, 043	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 8, 783, 649	0.000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 9, 952, 507	0.000000	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 57, 773, 474	0.000000	
74. 00	07400 RENAL DIALYSIS	0	0		0 588, 366	0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0.000000	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0.000000	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0.000000	78. 00
88. 00	08800 RURAL HEALTH CLINIC	1 0	0		0 0	0. 000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			l .		0.00000	
90.00	09000 CLINIC	0	0		0 28, 968, 843	0.000000	
90. 01	09001 CLINIC CMHC	0	Ö		0 41, 005, 850	0. 000000	
90. 02	09002 CLINIC CHEMO	0	0		0 1, 051, 240		
90. 03	09003 CLINIC RYAN WHITE	0	0		0 150, 859	0. 000000	90. 03
91. 00	09100 EMERGENCY	0	0		0 511, 424, 130		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 518, 841, 961	0. 000000	92. 00
04.05	OTHER REIMBURSABLE COST CENTERS		-	1	ol -	0.0000	
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0.000000	
95. 00 96. 00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED		,		0 0	0. 000000	95. 00 96. 00
	09700 DURABLE MEDICAL EQUIP-RENTED		0			0.000000	
, i . UU	09850 OTHER REIMBURSABLE COST CENTERS	1	0			1	1 77.00

0 0 0 0 0 0 0 1, 938, 157, 543

98.00 200.00

0.000000

98. 00 09850 OTHER REIMBURSABLE COST CENTERS 200. 00 Total (lines 50 through 199)

	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	VICE OTHER PASS			Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/31/2024 12:	pared: 06 pm
			Title	XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program Pass-Through	Program	Program Pass-Through	
		to Charges (col. 6 ÷ col.	Charges	Costs (col. 8	J	Costs (col. 9	
		7)		x col. 10))	x col . 12)	
		9.00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
50. 00	05000 OPERATI NG 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		o o	0	
53. 00	05300 ANESTHESI OLOGY	0. 000000	0		o o	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	651, 671		0 0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	031, 071		o o	0	55.00
56. 00	05600 RADI OLOGI - THERAI EUTIC	0. 000000	0		0 0	0	56.00
57. 00	05700 CT SCAN	0. 000000	256, 500		0 0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	230, 300		0 0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60.00	06000 LABORATORY	0. 000000	3, 219, 249		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	3, 217, 247 N		0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.00000	Ü	·		Ŭ	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		o	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		o o	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		o o	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	26, 659		o o	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	197, 499		0 0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		o o	Ö	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		o o	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	199, 650		o o	Ö	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		o o	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	732		o o	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		o o	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	651, 261		o o	0	73.00
74. 00	07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		o o	0	75. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		o o	0	1
	OUTPATIENT SERVICE COST CENTERS	1					1
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		o o	0	
90. 00	09000 CLI NI C	0. 000000	0		o o	0	1
90. 01	09001 CLINIC CMHC	0. 000000	0		o o	0	90. 01
90. 02	09002 CLINIC CHEMO	0. 000000	0		o o	0	90. 02
90. 03	09003 CLINIC RYAN WHITE	0. 000000	0		o o	0	90. 03
91. 00	09100 EMERGENCY	0. 000000	2, 999, 243		o o	0	•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		o o	0	
	OTHER REIMBURSABLE COST CENTERS	,					1
0/ 00	09400 HOME PROGRAM DLALYSUS	0.000000	0		0	0	94 00

0. 000000

0. 000000

0.000000

0. 000000

8, 202, 464

0

0 0 0

0

0 0 0 0 94.00 95.00 0 96.00 0 97.00

0 98.00 0 200.00

94.00 09400 HOME PROGRAM DI ALYSI S
95.00 09500 AMBULANCE SERVI CES
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD

98.00 09850 OTHER REIMBURSABLE COST CENTERS 200.00 Total (lines 50 through 199)

Health Financial Systems	HOBOKEN	UNI VERSITY M	EDICAL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCI LLARY SERVI CE	OTHER PASS	Provider CCN: 31-0040	Peri od:	Worksheet D
THROUGH COSTS				From 01/01/2023	Part IV

THROUGH COSTS

			Ti tl e	e XVIII	Skilled Nursin	g PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Facility	n Allied Health	
	cost center bescription	Anesthetist	Program	Program	Post-Stepdow		
		Cost	Post-Stepdown		Adjustments	`	
		0001	Adjustments		/ ray do timor res		
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C		0	0 0	
51.00	05100 RECOVERY ROOM	0	0	1	0	0 0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0	0 0	
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0	0	55.00
56. 00	05600 RADI OI SOTOPE	0	0		0	0	56. 00
57. 00	05700 CT SCAN	0	0	1	0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	
60.00	06000 LABORATORY	0	l ~		0	0 0	60.00
60. 01	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	O	1	0	0 0	60. 01 61. 00
61. 00 62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS					o	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0 0	63.00
64. 00	06400 I NTRAVENOUS THERAPY				0	0 0	64.00
65. 00	06500 RESPIRATORY THERAPY				0		65.00
66. 00	06600 PHYSI CAL THERAPY			1	0		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0			0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0			0	ol o	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	l o	,	o	ol o	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	l o)	0	0 0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l c	,	0	0 0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	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	O		0	0 0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0 0	75. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	1	0	0 0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0 0	78. 00
	OUTPATIENT SERVICE COST CENTERS	_	_	1	_1		
88. 00	08800 RURAL HEALTH CLINIC	0	0	1	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90.00	09000 CLI NI C	0	0		0	0	90.00
90. 01	09001 CLINIC CMHC	0			0	0	90. 01
90. 02	09002 CLINIC CHEMO	0	l ~		0	0 0	90. 02
90. 03 91. 00	O9003 CLINIC RYAN WHITE O9100 EMERGENCY	0	0	1	0	0 0	90. 03 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	·	1	0	0	
92.00	OTHER REIMBURSABLE COST CENTERS				U		92.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0		1	0	ol o	94. 00
95. 00	09500 AMBULANCE SERVICES				آ ا	٦	95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	l o	,	0	0 0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0			0	0 0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0 0	1
200.00	Total (lines 50 through 199)	0	o		0	0 0	200. 00

	BOKEN UNIVERSIT				eu of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS:	Component	CCN: 31-5512	Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 12:	pared: 06 pm
		Ti tl e	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medical	(sum of cols. 1, 2, 3, and	Outpatient Cost (sum of	(from Wkst. C, Part I, col.	to Charges (col. 5 ÷ col.	
	Education Cost	1, 2, 3, and 4)	cols. 2, 3,	8)	7)	
		4)	and 4)	0)	(see	
			and 4)		instructions)	
	4.00	5.00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM	0	C		0 78, 273, 526	0.000000	50.00
51. 00 05100 RECOVERY ROOM	0			0 7, 621, 975		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	d		0 10, 705, 521	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 195, 770, 880	0.000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	0.000000	55. 00
56. 00 05600 RADI OI SOTOPE	0	C		0 6, 326, 622	0.000000	56. 00
57. 00 05700 CT SCAN	0	C)	0 105, 614, 588	0.000000	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C)	0 17, 862, 931	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0	0.000000	59. 00
60. 00 06000 LABORATORY	0	C		0 263, 809, 722	0. 000000	60.00
60. 01 06001 BLOOD LABORATORY	0	C)	0	0. 000000	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		2	0 0	0.000000	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	_		9, 093, 101	0.000000	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0			0 0 12, 229, 077	0. 000000 0. 000000	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY				0 12, 229, 077	0.00000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY				0 4, 685, 325	l .	67.00
68. 00 06800 SPEECH PATHOLOGY				0 1, 063, 509	1	68.00
69. 00 06900 ELECT TATHOLOGY				0 35, 729, 863		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 694, 043		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	_		0 8, 783, 649		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	l c		0 9, 952, 507	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	ď		0 57, 773, 474	l e	73. 00
74. 00 07400 RENAL DI ALYSI S	0	d		0 588, 366	l e	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	c		0 0	0.000000	75. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	C		0 0	0. 000000	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	C)	0 0	0. 000000	78. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0			0		
80 00 08000 FEDERALLY OHALLELED HEALTH CENTER	1		NI .		0 000000	1 89 00

0

0 0 0

0

0

0

0

0

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

0 0 0

0 0 0

0

0

0

28, 968, 843

41, 005, 850

511, 424, 130

518, 841, 961

1, 938, 157, 543

1, 051, 240

150, 859

0

89.00

90.00

90.01

90.02

90.03

91.00

92.00

94. 00 95. 00

96.00

97.00

98. 00

200. 00

89.00

90.00

90.01

90.02

90.03

91.00

92.00

200.00

09000 CLI NI C

09001 CLINIC CMHC

09100 EMERGENCY

09002 CLINIC CHEMO

09003 CLINIC RYAN WHITE

94. 00 O9400 HOME PROGRAM DI ALYSI S 95. 00 O9500 AMBULANCE SERVI CES

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

98.00 09850 OTHER REIMBURSABLE COST CENTERS

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

Health Financial Systems	HOBOKEN UNIVERSITY M	EDI CAL CENTER	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 31-0040 Component CCN: 31-5512		Worksheet D Part IV Date/Time Prepared: 5/31/2024 12:06 pm	

	Skilled Nursing		
Title XVIII		PPS	
Cost Center Description Outpatient Inpatient Inpatient	Facility t Outpatient	Outpati ent	
Ratio of Cost Program Program	Program	Program	
to Charges Charges Pass-Throu		Pass-Through	
(col. 6 ÷ col. Costs (col.		Costs (col. 9	
7) x col. 10 9.00 10.00 11.00	12.00	x col . 12) 13.00	
ANCI LLARY SERVI CE COST CENTERS	12.00	13.00	
50. 00 05000 0PERATI NG ROOM 0. 000000 0	0 0	0	50.00
51. 00 05100 RECOVERY ROOM			51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM			52.00
53. 00 05300 ANESTHESI OLOGY	0 0	0	53.00
54. 00 05400 RADI 0LOGY - DI AGNOSTI C 0. 000000 769, 794	-	0	54.00
55. 00 05500 RADI 0LOGY-THERAPEUTI C 0. 000000 0	0 0	0	55. 00
56. 00 05600 RADI 0I SOTOPE 0. 000000 0	0 0	0	56. 00
57. 00 05700 CT SCAN	0 0	0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0. 000000 13, 500	0 0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 0	0 0	0	59. 00
60. 00 06000 LABORATORY	0 0	0	60.00
60. 01 06001 BL00D LABORATORY 0. 000000 0	0 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0. 000000 0	0 0	0	62. 00
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0. 000000 5, 780	0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 0. 000000 0	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY 0. 000000 552, 000	0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY 0. 000000 2, 838, 708	0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 000000 0	0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 0. 000000 0	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 117, 497	0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 5,080	0 0	0	71. 00
72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 0.000000 3,200	0 0	Ö	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 1, 159, 030	0 0	0	73. 00
74. 00 07400 RENAL DI ALYSIS 0. 000000 0	0 0	Ö	74. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0. 000000 0	0 0	0	75.00
77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0. 000000 0		1	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 0			78.00
OUTPATIENT SERVICE COST CENTERS	0 0		70.00
88. 00 08800 RURAL HEALTH CLINI C 0. 000000 0	0 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0	0 0		89. 00
90. 00 09000 CLI NI C 0. 000000	0 0	0	90.00
90. 01 09001 CLI NI C CMHC	0 0	Ö	90. 01
90. 02 09002 CLI NI C CHEMO	o o	ĺ	90. 02
90. 03 09003 CLI NI C RYAN WHI TE		0	90. 02
91. 00 09100 EMERGENCY 0. 000000 555		0	91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0. 000000 0		1	92.00
OTHER REIMBURSABLE COST CENTERS	0 0	0	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S 0. 000000 0	0 0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES			95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 0	0 0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0. 000000 0	0 0	1	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0. 000000 0		•	98.00
200.00 Total (lines 50 through 199) 9, 200, 634			200.00
1.01di (1.1100 00 till ough 177) 7,200,004	-1		1-00.00

Health Financial Systems HOE	BOKEN UNIVERSIT	Y MEDICAL CENTE	ΞR	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023		
		Ti tI	e XIX	Hospi tal	TEFRA	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 451, 513	C	1, 451, 51	3 16, 573	87. 58	30.00
31.00 INTENSIVE CARE UNIT	559, 083		559, 08	3 1, 180	473.80	31. 00
32. 00 CORONARY CARE UNIT	C)		0	0.00	32.00
33.00 BURN INTENSIVE CARE UNIT	C)		0 0	0.00	33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	C)		0 0	0.00	34. 00
40. 00 SUBPROVI DER - I PF	992, 683	0	992, 68	3 11, 216	88. 51	40. 00
41. 00 SUBPROVI DER - I RF	C	0	1	0	0.00	
43. 00 NURSERY	159, 388	3	159, 38	1, 943	82. 03	43. 00
44.00 SKILLED NURSING FACILITY	331, 250)	331, 25	0 3, 812		
45.00 NURSING FACILITY	C	1		0	0.00	45. 00
200.00 Total (lines 30 through 199)	3, 493, 917		3, 493, 91	7 34, 724		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	-			
LAIDATI FAIT DOUTLAIG CEDAUGE COCT CENTEDO	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS	2/0	22 217				30.00
	369					30.00
31. 00 INTENSIVE CARE UNIT	50	23, 690	1			31.00
32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT			1			32.00
33. 00 BURN INTENSIVE CARE UNIT						33.00

341

258

30, 182

107, 353

34.00

40. 00 41. 00

43.00

44. 00 45. 00 200. 00

34.00 SURGICAL INTENSIVE CARE UNIT

44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199)

40. 00 SUBPROVI DER - I PF 41. 00 SUBPROVI DER - I RF 43. 00 NURSERY APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 31-0040 Peri od: Worksheet D From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/31/2024 12:06 pm Title XIX Hospi tal **TEFRA** Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent (from Wkst. C. to Charges (column 3 x Related Cost Program (from Wkst. B. column 4) Part I. col. (col. 1 ÷ col Charges 2) Part II, col. 8) 26) 2.00 3.00 4.00 5.00 1.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1,076,100 78, 273, 526 0.013748 1, 105, 432 50.00 15, 197 51.00 05100 RECOVERY ROOM 88, 756 7, 621, 975 0.011645 139, 514 1, 625 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.013746 52.00 147, 154 10, 705, 521 667, 359 9, 174 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 195, 770, 880 0.001579 1, 277, 925 54.00 309, 113 2,018 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55.00 56.00 05600 RADI OI SOTOPE 32,012 6, 326, 622 0.005060 61, 512 311 56.00 05700 CT SCAN 105, 614, 588 0.000737 57 00 77 873 883 500 651 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 66, 892 17, 862, 931 0.003745 297, 000 1, 112 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 60.00 06000 LABORATORY 351, 860 263, 809, 722 0.001334 4, 093, 776 5, 461 60.00 06001 BLOOD LABORATORY 0.000000 60 01 60 01 0 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 12, 981 9, 093, 101 63 00 0.001428 60, 770 87 63 00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 59,078 12, 229, 077 0.004831 116, 607 563 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 68, 453 10, 135, 981 0.006753 57, 416 388 66.00 06700 OCCUPATIONAL THERAPY 4, 685, 325 12, 735 12, 631 0.002696 67 00 67 00 34 68.00 06800 SPEECH PATHOLOGY 10, 159 1,063,509 0.009552 167, 743 1,602 68.00 06900 ELECTROCARDI OLOGY 58, 405 35, 729, 863 0.001635 328, 371 69.00 537 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 9, 247 694, 043 0.013323 38, 737 516 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 157, 123 8, 783, 649 0.017888 139, 601 2, 497 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 55,052 9, 952, 507 0.005531 15, 511 86 72.00 07300 DRUGS CHARGED TO PATIENTS 190, 941 57, 773, 474 0.003305 1, 047, 596 3, 462 73.00 73.00 07400 RENAL DIALYSIS 74.00 38.432 588, 366 0.065320 19, 600 1, 280 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 0.000000 0 0 75.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0.000000 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0.000000 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 0.000000 88 00 88.00 08800 RURAL HEALTH CLINIC 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 89.00 0 90.00 09000 CLI NI C 135, 893 28, 968, 843 0.004691 5,029 24 90.00 09001 CLINIC CMHC 41, 005, 850 90.01 32, 118 0.000783 90.01 0 0 90.02 09002 CLINIC CHEMO 33.658 1,051,240 0.032017 0 0 90.02 90.03 09003 CLINIC RYAN WHITE 9.375 150, 859 0.062144 0 90.03 09100 EMERGENCY 944, 373 511, 424, 130 0.001847 1, 818, 330 3, 358 91.00 91.00 294, 191 1, 615 09200 OBSERVATION BEDS (NON-DISTINCT PART) 518, 841, 961 0.000567 2, 848, 739 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 94.00 09500 AMBULANCE SERVICES 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0.000000 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0.000000 0 0 97.00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 98.00 0 4, 271, 870 1, 938, 157, 543 Total (lines 50 through 199) 15, 202, 803 51, 598 200. 00 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUCH COSTS Provider CCR: 31-0000 Period: 12/31/2023 Part Item Propagated Program Program Past Program Program Past Program Program Past Program	Health Financial Systems HO	BOKEN UNIVERSIT	Y MEDICAL CENTI	ER	In Lie	eu of Form CMS-2	2552-10
Nursing Program Post Stepdown All Ited Healt M 10 ther Red Ical Education Cost	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C		From 01/01/2023	Part III Date/Time Pre	
Nursing			Ti tl	e XIX	Hospi tal		оо р
INPATIENT ROUTINE SERVICE COST CENTERS 1,00 2A 2,00 3,00	Cost Center Description	Program	Nursi ng Program	Allied Health Post-Stepdowr	Allied Health	All Other Medical	
INPATI ENT ROUTH NE_SERVICE COST_CENTERS 0 0 0 0 0 0 0 0 0		Adjustments					
30.00		1A	1.00	2A	2. 00	3. 00	
30.00	INPATIENT ROUTINE SERVICE COST CENTERS		•		<u> </u>		
10 10 10 10 10 10 10 10		0) C		0 0	0	30.00
33.00	31.00 03100 INTENSIVE CARE UNIT	0			o o	0	31.00
1.0 0.0	32. 00 03200 CORONARY CARE UNIT	0			o o	0	32.00
1.0 0.0		0			o o	0	1
40.00 04000 SUBPROVI DER - I PF				•			1
1.00 04100 04400						-	1
43.00 04300 NURSERY 0 0 0 0 0 43.00				•		-	
44 .00 04400 SKILLED NURSING FACILITY					-	1	
A5.00 O4500 NURSING FACILITY O O O O O O O O O					-	1	1
Total (Lines 30 through 199)							1
Night Swing Bed Adjustment Amount (see Instructions) Adjustment Amount (see Instructions) Amount (sum (see Instructions) Amount (sum (sum (sum (sum (sum (sum (sum (sum	• • • • • • • • • • • • • • • • • • •				-		1
Adjustment Adj		Swi na_Red	Total Costs	Total Patient	-		200.00
Amount (See Intrough 3	oost ochter beschiptron					•	
INPATI ENT ROUTINE SERVICE COST CENTERS 1.00				Days	3 . coi . o)	110graiii bays	
INPATI ENT ROUTINE SERVICE COST CENTERS		,					
INPATI ENT ROUTINE SERVICE COST CENTERS 0 0 16,573 0.00 369 30.00 31.00 3300 ADULTS & PEDIATRICS 0 0 1,180 0.00 50 31.00 32.				6.00	7 00	8 00	
30.00	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
31.00 03100 INTENSI VE CARE UNI T 0 1,180 0.00 50 31.00 32.00 32.00 03200 CORONARY CARE UNI T 0 0.00 0.32.00 33.00 33.00 3300 BURN INTENSI VE CARE UNI T 0 0.00 0.00 0.32.00 34.00 34.00 34.00 03400 SURGI CAL INTENSI VE CARE UNI T 0 0 0 0.00 0.00 0.34.00 04.00 04.000 SUBPROVI DER - I PF 0 0 0 0.00 0.00 0.00 041.00 04.00 04.000 SUBPROVI DER - I RF 0 0 0 0.00 0.00 041.00 04.00				16 57	3 0.00	369	30.00
32.00 03200 0780NARY CARE UNIT 0 0 0 0 0 0 0 0 0							1
33.00 03300 BURNI INTENSIVE CARE UNIT 0 0 0 0.00 0 33.00			1	1 .,			1
34.00 03400 SURGI CAL INTENSI VE CARE UNIT 0 0 0 0.00 0.34.00				1			1
40. 00 04000 SUBPROVI DER - I PF 0 0 0 11, 216 0. 00 341 40. 00				1			
41.00	· · · · · · · · · · · · · · · · · · ·		1	1			1
43. 00		_	1	11,21			
A4. 00			ή	1 04			1
A5.00	· · · · · · · · · · · · · · · · · · ·		1				1
Total (lines 30 through 199)			1				
Inpatient				•			
Program Pass-Through Cost (col. 7 x col. 8) 9.00		Innationt		1 34, 72	4	1,016	200.00
NPATIENT ROUTINE SERVICE COST CENTERS 9.00 30.00 30.00 30.00 ADULTS & PEDIATRICS 0 31.00 31.00 31.00 32.00 32.00 CORONARY CARE UNIT 0 32.00 33.00 BURN INTENSIVE CARE UNIT 0 33.00 33.00 SURGICAL INTENSIVE CARE UNIT 0 33.00 34.00 34.00 SURGICAL INTENSIVE CARE UNIT 0 34.00 40.00 SUBPROVIDER - IPF 0 40.00 41.00 CONTON ON OUTS CONTON ON OUTS CONTON ON OUTS CONTON O	cost center bescriptron						
Cost (col. 7 x col. 8) 9.00 INPATIENT ROUTINE SERVICE COST CENTERS 9.00 30.00 03000 ADULTS & PEDIATRICS 0 31.00							
INPATIENT ROUTINE SERVICE COST CENTERS 9.00 30.00 3000 ADULTS & PEDIATRICS 0 31.00 31.		9	,				
SOLUTION SUBPROVIDER - IRF SUBPROVIDER -			`				
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 33000 ADULTS & PEDIATRICS 0 31.00 31.00 31.00 INTENSIVE CARE UNIT 0 32.00 32.00 CORONARY CARE UNIT 0 32.00 33.00 3300 BURN INTENSIVE CARE UNIT 0 33.00 3300 BURN INTENSIVE CARE UNIT 0 33.00 34.00 SURGICAL INTENSIVE CARE UNIT 0 34.00 40.00 SUBPROVIDER - IPF 0 40.00 41.00 5UBPROVIDER - IRF 0 41.00 43.00 5UBPROVIDER - IRF 0 43.00 44.00 04400 SKILLED NURSING FACILITY 0 44.00 45.00 04500 NURSING FACILITY 0 45.00 45.00 45.00 04500 NURSING FACILITY 0 45.00			-				
30. 00 03000 ADULTS & PEDIATRICS 0 30. 00 31. 00 03100 INTENSI VE CARE UNIT 0 31. 00 32. 00 03200 CORONARY CARE UNIT 0 32. 00 33. 00 03300 BURN I INTENSI VE CARE UNIT 0 33. 00 34. 00 03400 SURGI CAL I INTENSI VE CARE UNIT 0 34. 00 04000 SUBPROVI DER - I PF 0 04. 00 04100 SUBPROVI DER - I RF 0 04. 00 04300 NURSERY 0 044. 00 04400 SKI LLED NURSI NG FACI LI TY 0 045. 00 04500 NURSI NG FACI LI TY 0 045. 00 04500 NURSI NG FACI LI TY 0 045. 00 04500 NURSI NG FACI LI TY 0 045. 00 04500 NURSI NG FACI LI TY 0 045. 00 04500 NURSI NG FACI LI TY 0 045. 00 04500 NURSI NG FACI LI TY 0 045. 00 04500 NURSI NG FACI LI TY 0 045. 00 04500 NURSI NG FACI LI TY 0 045. 00 04500 NURSI NG FACI LI TY 0 045. 00 04500 NURSI NG FACI LI TY 0 045. 00 04500 NURSI NG FACI LI TY 0 045. 00 04500 NURSI NG FACI LI TY 0 045. 00 04500 NURSI NG FACI LI TY 0 045. 00 04500	INPATIENT POLITINE SERVICE COST CENTERS	7.00					
31. 00							30 00
32. 00							1
33. 00		_	1				1
34. 00			•				
40. 00		_	1				
41. 00							1
43. 00							
44. 00 04400 SKILLED NURSING FACILITY 0 44. 00 45. 00 04500 NURSING FACILITY 0 45. 00							
45. 00 04500 NURSING FACILITY 0 45. 00	· · · · · · · · · · · · · · · · · · ·	_	1				1
							1
200.00 Total (Tines 30 through 199) 0 200.00							
	200.00 Total (Times 30 through 199)	1	η				J200. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | From 12/31/2023 | Date/Time Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepa
 Heal th Financial
 Systems
 HOBOKEN
 UNIVERSITY
 M

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE
 OTHER PASS
 Provider CCN: 31-0040 THROUGH COSTS

					110	J 12/31/2023	5/31/2024 12:	
			Ti	tle XIX		Hospi tal	TEFRA	00 p
	Cost Center Description	Non Physician	Nursi ng	Nursi ng			Allied Health	
	'	Anestheti st	Program	Program		Post-Stepdown		
		Cost	Post-Stepdow	n		Adjustments		
			Adjustments					
		1.00	2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATI NG ROOM	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 ANESTHESI OLOGY	0		0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0	0	0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	0	55. 00
56. 00	05600 RADI 0I SOTOPE	0		0	0	0	0	56. 00
57. 00	05700 CT SCAN	0		0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0	0	0	1	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	0	59. 00
60. 00	06000 LABORATORY	0		0	0	0	1	60. 00
60. 01	06001 BLOOD LABORATORY	0		0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0		0	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0		0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0		0	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0		0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0		0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		0	0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	0	71. 00
72. 00	07200 I MPL. 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
75. 00	07500 ASC (NON-DISTINCT PART)	0		0	0	0	0	75. 00
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							
88. 00	08800 RURAL HEALTH CLINIC	0		0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	0	89. 00
90.00	09000 CLI NI C	0		0	0	0	0	90. 00
90. 01	09001 CLINIC CMHC	0		0	0	0	0	90. 01
90. 02	09002 CLI NI C CHEMO	0		0	0	0	0	90. 02
90. 03	09003 CLINIC RYAN WHITE	0		0	0	0	0	90. 03
91. 00	09100 EMERGENCY	0		0	0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0	92. 00
	OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0	0	0	94. 00
95.00	09500 AMBULANCE SERVI CES							95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	1	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0		98. 00
200.00	Total (lines 50 through 199)	0		0	0	0	0	200. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | From 12/31/2023 | Date/Time Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepa
 Heal th Financial
 Systems
 HOBOKEN UNIVERSITY
 MEDICAL CENTER

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CCN: 31-0040
 THROUGH COSTS

			'	0 12/31/2023	5/31/2024 12:0		
			Ti tl	e XIX	Hospi tal	TEFRA	<u> </u>
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	'	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0			0. 000000	
51.00	05100 RECOVERY ROOM	0	0	C	7, 621, 975	0. 000000	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	10, 705, 521	0. 000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0. 000000	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	C	195, 770, 880	0.000000	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0. 000000	55. 00
56.00	05600 RADI OI SOTOPE	0	0	C	6, 326, 622	0.000000	56. 00
57.00	05700 CT SCAN	0	0	C	105, 614, 588	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	17, 862, 931	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0.000000	59. 00
60.00	06000 LABORATORY	0	0	C	263, 809, 722	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0	C	0	0.000000	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0	0.000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	9, 093, 101	0.000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	C	0	0.000000	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	C	12, 229, 077	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	C	10, 135, 981	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	4, 685, 325	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	C	1, 063, 509	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	35, 729, 863	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	694, 043	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	8, 783, 649	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	9, 952, 507	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	57, 773, 474	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0	C	588, 366	0.000000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	C	0	0.000000	75. 00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	C	0	0.000000	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	C	0	0.000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	0.000000	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0	0.000000	89. 00
90.00	09000 CLI NI C	0	0	C	28, 968, 843	0.000000	90. 00
90. 01	09001 CLINIC CMHC	0	0	C	41, 005, 850	0.000000	90. 01
90. 02	09002 CLINIC CHEMO	0	0	C	1, 051, 240	0.000000	90. 02
90. 03	09003 CLINIC RYAN WHITE	0	0	C	150, 859	0.000000	90. 03
91.00	09100 EMERGENCY	0	0	l c	511, 424, 130	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	l c	518, 841, 961	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	C	0	0.000000	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0	0.000000	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C	0	0.000000	97. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0. 000000	98. 00
200.00	Total (lines 50 through 199)	0	0	l c	1, 938, 157, 543		200. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | From 12/31/2023 | Date/Time Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepared: | From 12/31/2024 | Prepa
 Heal th Financial
 Systems
 HOBOKEN
 UNIVERSITY
 M

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE
 OTHER PASS
 Provider CCN: 31-0040 THROUGH COSTS

					10 12/31/2023	5/31/2024 12:	
			Title XIX		Hospi tal	Hospi tal TEFRA	
Cost Center Description		Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	n Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATI NG ROOM	0. 000000	1, 105, 432		0		50. 00
51.00	05100 RECOVERY ROOM	0. 000000	139, 514		0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	667, 359		0	_	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	_	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 277, 925		0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	_	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	61, 512		0	_	56. 00
57. 00	05700 CT SCAN	0. 000000	883, 500		0	_	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	297, 000		0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	_	59. 00
60.00	06000 LABORATORY	0. 000000	4, 093, 776		0	_	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	_	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	60, 770	1	0	_	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	_	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	116, 607		0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	57, 416		0	_	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	12, 735		0	_	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	167, 743		0	_	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	328, 371		0	_	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	38, 737		0	_	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	139, 601		0 0		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	15, 511		0 0	_	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 047, 596		0 0	_	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	19, 600		0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0. 000000	0	Ι	0 0	0	1 00 00
88. 00 89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0		88. 00 89. 00
90.00	09000 CLINIC	0. 000000	5, 029		0 0		90.00
90.00	09001 CLINIC CMHC	0. 000000	5, 029	•	0 0	_	90.00
90.01	09001 CLINIC CHEMO	0. 000000	0		0 0	0	90.01
90. 02	09003 CLINIC CHEMO	0. 000000	0		0 0	_	90.02
91.00	09100 EMERGENCY	1	1 010 220		0 0	_	91.00
91.00	1 1	0. 000000 0. 000000	1, 818, 330 2, 848, 739		0 0		91.00
92.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0.000000	2, 040, 739		0 0	U	92.00
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0 0	0	94. 00
95. 00	09500 AMBULANCE SERVICES	0.000000	0		0	U	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	•	0 0	_	97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	_	98.00
200.00	+ I	3. 000000	15, 202, 803		0 0		200.00
200.00	Trotal (Tries 50 till ough 177)	1	10, 202, 003	I	٥		1200.00

Provider CCN: 31-0040

Peri od:

From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/31/2024 12:06 pm Title XIX Hospi tal TEFRA Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 166935 125, 353 0 50.00 51.00 05100 RECOVERY ROOM 0. 277943 0 0 16, 247 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0.511851 0 10, 100 52 00 0 0 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.023620 5, 906, 569 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 55.00 0 05600 RADI OI SOTOPE 0 56.00 0.052661 0 13, 536 0 56.00 57.00 05700 CT SCAN 0.011561 779,000 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0.035645 0 0 94, 500 0 58.00 05900 CARDIAC CATHETERIZATION 0 0.000000 59 00 59 00 Ω 0 60.00 06000 LABORATORY 0.029365 0 14, 420 0 60.00 06001 BLOOD LABORATORY 0.000000 0 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61.00 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62.00 62 00 0.000000 Ω 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.069729 0 0 4, 955 0 63.00 06400 INTRAVENOUS THERAPY 0.000000 64.00 64.00 65.00 06500 RESPI RATORY THERAPY 0. 194513 0 0 1,006 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 0.120890 0 37, 300 0 66.00 8, 213 67.00 06700 OCCUPATIONAL THERAPY 0.098672 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 0.142319 203 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0.030327 236, 417 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0.042448 5.322 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.956904 0 67, 477 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0. 345685 23, 708 72.00 07300 DRUGS CHARGED TO PATIENTS 0.163081 0 0 73.00 632, 569 73.00 0 0 74.00 07400 RENAL DIALYSIS 1. 913443 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 75.00 0 75.00 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 78.00 0 Λ 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 0.071025 0 0 167, 825 0 90.00 90.01 09001 CLINIC CMHC 0.092518 0 90.01 90.02 09002 CLINIC CHEMO 0. 101113 0 0 0 90.02 0 09003 CLINIC RYAN WHITE 7 381038 0 90.03 90.03 Λ 0 91.00 09100 EMERGENCY 0.029967 C 8, 088, 848 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.007866 0 5, 370, 123 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 94.00 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0.000000 0 0 0 96.00 0 97 00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 97.00 0 O 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0 0 98.00 200.00 Subtotal (see instructions) 0 21, 603, 691 0 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 0 21, 603, 691 0 202, 00

202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 31-0040 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/31/2024 12:06 pm Title XIX Hospi tal TEFRA Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 20, 926 50.00 51.00 05100 RECOVERY ROOM 0 0 0 4, 516 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 5, 170 52 00 53.00 05300 ANESTHESI OLOGY 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 139, 513 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0000000000000000000000000 55.00 C 05600 RADI OI SOTOPE 56.00 713 56.00 57.00 05700 CT SCAN 9,006 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 3, 368 58.00 05900 CARDIAC CATHETERIZATION 59 00 59 00 Ω 60.00 06000 LABORATORY 423 60.00 06001 BLOOD LABORATORY 60.01 60.01 C 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62 00 C 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 346 63.00 06400 INTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 196 65.00 06600 PHYSI CAL THERAPY 66.00 4,509 66.00 67.00 06700 OCCUPATIONAL THERAPY 810 67.00 06800 SPEECH PATHOLOGY 29 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 7, 170 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 226 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 64, 569 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 8, 195 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 103, 160 73.00 74.00 07400 RENAL DIALYSIS C 74.00 75.00 07500 ASC (NON-DISTINCT PART) 75.00 07700 ALLOGENEIC HSCT ACQUISÍTION 77.00 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 Ω 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 0 11, 920 90.00 90.01 09001 CLINIC CMHC 0 90.01 90. 02 09002 CLINIC CHEMO 90.02 90.03 09003 CLINIC RYAN WHITE 90.03 0 91.00 09100 EMERGENCY 242, 399 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 42, 241 92.00 OTHER REIMBURSABLE COST CENTERS 0 94.00 09400 HOME PROGRAM DIALYSIS 94.00 95.00 09500 AMBULANCE SERVICES 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 00000 96.00 0 96.00 97 00 09700 DURABLE MEDICAL EQUIP-SOLD 97 00 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 200.00 Subtotal (see instructions) 669, 405 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

669, 405

202.00

Net Charges (line 200 - line 201)

APP0R1	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Period: From 01/01/2023	Worksheet D Part II	
			Component	CCN: 31-S040	To 12/31/2023	Date/Time Pre 5/31/2024 12:	
			Ti tl	e XIX	Subprovi der - I PF	TEFRA	оо рііі
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost		Capital Costs	
			(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	ANOULL ABY CERVI OF COCT OFNITERS	1.00	2. 00	3. 00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	4 07/ 400	70.070.50/	0.04074			F0 00
50.00	05000 OPERATING ROOM	1, 076, 100				0	
51.00	05100 RECOVERY ROOM	88, 756				0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	147, 154		0.01374		0	52.00
53.00	05300 ANESTHESI OLOGY	0	_	0.00000		0	53.00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	309, 113			·	127	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	_	0.00000		0	55. 00
56.00	05600 RADI 0I SOTOPE 05700 CT SCAN	32, 012 77, 873		0. 00506 0. 00073		0	56.00
57. 00 58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	66, 892		0.00073	·	21 0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	00, 892	17, 862, 931	0.00374		0	59.00
60.00	06000 LABORATORY	351, 860	263, 809, 722	•		943	60.00
60. 00	06001 BL00D LABORATORY	331, 860	203, 609, 722	0.00133	·	943	60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0.00000	٩	Ü	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0. 00000	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	12. 981	9, 093, 101	0.00000		0	63.00
64. 00	06400 NTRAVENOUS THERAPY	12, 701	7,073,101	0.00000		0	64. 00
65. 00	06500 RESPI RATORY THERAPY	59, 078	12, 229, 077	0. 00483		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	68, 453		0.00403		21	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	12, 631		0. 00269	· ·	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	10, 159				0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	58, 405		•		37	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	9, 247		0. 01332	· ·	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	157, 123				1	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	55, 052		0. 00553		0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	190, 941		0.00330		228	73. 00
74.00	07400 RENAL DIALYSIS	38, 432				0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0.00000		0	75. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	O			0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0			0	78. 00
	OUTPATIENT SERVICE COST CENTERS	•					
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000	o	0	89. 00
90.00	09000 CLI NI C	135, 893	28, 968, 843	0.00469	1 529	2	90. 00
90. 01	09001 CLINIC CMHC	32, 118	41, 005, 850	0. 00078	3 0	0	90. 01
90. 02	09002 CLI NI C CHEMO	33, 658	1, 051, 240	0. 03201	7 0	0	90. 02
90. 03	09003 CLINIC RYAN WHITE	9, 375	150, 859	0. 06214	4 0	0	90. 03
91.00	09100 EMERGENCY	944, 373	511, 424, 130	0. 00184	7 518, 106	957	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	518, 841, 961	0.00000	0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0. 00000	0 0	0	94. 00
95. 00							95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.00000	이	0	96. 00

0

3, 977, 679 1, 938, 157, 543

0.000000

0.000000

1, 428, 956

97. 00

98.00

2, 337 200. 00

96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD

200.00

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

Health Financial Systems	HOBOKEN	UNIVERSITY N	IEDI CAL CENTER	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE	OTHER PASS	Provider CCN: 31-0040	Peri od:	Worksheet D
TUDOUCU COSTS				From 01/01/2023	Part IV

THROUGH COSTS Component CCN: 31-SO40 To 12/31/2023 Date/Time Prepared: 5/31/2024 12:06 pm Title XIX Subprovi der **TEFRA** I PF Non Physician Nursi ng Cost Center Description Nursi ng Allied Health Allied Health Anestheti st Post-Stepdown Program Program Post-Stepdown Cost Adjustments Adjustments 1.00 2A 2.00 ЗА 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 00000000000 0 0 05100 RECOVERY ROOM 0 51.00 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 0 0 0 0 0 0 0 53.00 05300 ANESTHESI OLOGY 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54 00 54 00 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 0 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 0 57.00 05700 CT SCAN 0 57.00 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 60.00 06000 LABORATORY 0 0 60.00 06001 BLOOD LABORATORY 0 60 01 60 01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62.00 0000000000000000 0 0 0 0 0 0 0 0 0 0 0 0 0 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 63.00 0 64.00 06400 INTRAVENOUS THERAPY 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 65.00 06600 PHYSI CAL THERAPY 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 67.00 0 0 06800 SPEECH PATHOLOGY 0 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 0 0 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER C 0 89.00 09000 CLI NI C 0 90.00 0000 0 0 0 0 90.00 09001 CLINIC CMHC 0 90.01 90.01 0 0 90.02 09002 CLINIC CHEMO 0 0 90.02 0 90.03 09003 CLINIC RYAN WHITE 0 0 90.03 91.00 09100 EMERGENCY 0 0 91.00 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 09500 AMBULANCE SERVICES 95.00 95.00 0 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 96. 00 96.00 0 0 0 0 0 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 98.00 0

0

0 200.00

200 00

Total (lines 50 through 199)

Heal th	Financial Systems HOE	BOKEN UNIVERSIT	Y MEDICAL CENTI	ER .	In Lie	eu of Form CMS-:	2552-10
APPOR1	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA CH COSTS		S Provider C	CN: 31-0040 F	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV	pared:
			Ti tl	e XIX	Subprovi der -	TEFRA	00 piii
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medical	(sum of cols.	Outpatient	(from Wkst. C,	to Charges (col. 5 ÷ col.	
		Education Cost	1, 2, 3, and 4)	Cost (sum of cols. 2, 3,	Part I, col. 8)	7)	
			.,	and 4)		(see	
						instructions)	
	ANOULL ADV. CEDVLOE COCT CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0			78, 273, 526	0. 000000	50.00
51.00	05100 RECOVERY ROOM	0					
52. 00	05200 DELIVERY ROOM & LABOR ROOM	o o		•		0. 000000	
53.00	05300 ANESTHESI OLOGY	0	C			0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C			•	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	(0. 000000	1
56.00	05600 RADI OI SOTOPE	0	0				
57. 00 58. 00	05700 CT SCAN	0	0	(0. 000000 0. 000000	
59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0				0.00000	
60.00	06000 LABORATORY	0					1
60. 01	06001 BLOOD LABORATORY	0	C		0	0.000000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(1	0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		.,,	0.000000	1
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0	(-	0. 000000 0. 000000	1
66. 00	06600 PHYSI CAL THERAPY	0				0.00000	1
67. 00	06700 OCCUPATI ONAL THERAPY	o o					1
68. 00	06800 SPEECH PATHOLOGY	0	C	(1
69.00	06900 ELECTROCARDI OLOGY	0	0	(35, 729, 863	0. 000000	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	(1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		-,		1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	(0. 000000 0. 000000	1
74.00	07400 RENAL DIALYSIS	0					1
75. 00	07500 ASC (NON-DISTINCT PART)	o o				0. 000000	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	O	(0	l .	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS		T	ı	1	T	
88. 00	08800 RURAL HEALTH CLINIC	0					1
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	•		0. 000000 0. 000000	1
90. 00	09001 CLINIC CMHC	0					1
90. 02	09002 CLINIC CHEMO	Ö					1
90. 03	09003 CLINIC RYAN WHITE	0	0	(1
91. 00	09100 EMERGENCY	0	O				1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(518, 841, 961	0. 000000	92. 00
04.00	OTHER REIMBURSABLE COST CENTERS	T 0	Ι ο			0.000000	04.00
94. 00 95. 00	09400 HOME PROGRAM DI ALYSIS 09500 AMBULANCE SERVICES			1	ا ا	0. 000000	94. 00 95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		o	0. 000000	1
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0					1
	09850 OTHER REIMBURSABLE COST CENTERS	0	C	(o		

200. 00

1, 938, 157, 543

0 0 0

98. 00 09850 OTHER REIMBURSABLE COST CENTERS 200. 00 Total (lines 50 through 199)

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PASS	Provider Component		Period: From 01/01/2023 To 12/31/2023		pared: 06 pm
			Ti tl	e 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 OPERATI NG ROOM	0. 000000	0		0	0	
51. 00	05100 RECOVERY ROOM	0. 000000	0		0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0. 000000	80, 244		0	0	54.00
55. 00	O5500 RADI OLOGY-THERAPEUTI C	0.000000	0		0 0	0	55. 00
56. 00 57. 00	05600	0. 000000 0. 000000	28, 500		0 0	0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	26, 500		0 0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60.00	06000 LABORATORY	0. 000000	706, 856		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	700, 030		0 0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.00000	O			Ŭ	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	3, 128		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	22, 550		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	69 0		0 0	0	71.00
73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0. 000000 0. 000000	68, 974		0 0	0	72. 00 73. 00
74. 00	07400 RENAL DI ALYSI S	0. 000000	00, 9/4		0 0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
70.00	OUTPATIENT SERVICE COST CENTERS	0.00000			<u> </u>	<u> </u>	70.00
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	1
90.00	09000 CLI NI C	0. 000000	529		0	0	90.00
90. 01	09001 CLINIC CMHC	0. 000000	0		0 0	0	90. 01
90. 02	09002 CLINIC CHEMO	0. 000000	0		0	0	90. 02
90. 03	09003 CLINIC RYAN WHITE	0. 000000	0		0	0	90. 03
91. 00	09100 EMERGENCY	0. 000000	518, 106		0	0	
02 00	OCCOO ODCEDVATION DEDC (NON DICTINGT DADT)	0 000000	^		Λ Λ	^	02 00

0.000000 0. 000000 0. 000000

0. 000000

0.000000

0. 000000

0. 000000

1, 428, 956

0

0

0 0 0

0

0

0

92.00

94.00 95.00 96. 00 97. 00

0 98.00 0 200.00

92.00

09200 OBSERVATION BEDS (NON-DISTINCT PART)

OTHER REIMBURSABLE COST CENTERS

98.00 09850 OTHER REIMBURSABLE COST CENTERS 200.00 Total (lines 50 through 199)

94.00 09400 HOME PROGRAM DI ALYSI S
95.00 09500 AMBULANCE SERVI CES
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD

Health Financial Systems	u of Form CMS-2	2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 31-0040	Peri od: From 01/01/2023	Worksheet D-1	
		To 12/31/2023	Date/Time Prep 5/31/2024 12:0	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				
			1. 00	

		Title XVIII	Hospi tal	PPS	оо рііі	
	Cost Center Description			'		
	DADT I ALL DOOM DED COMPONIENTS			1. 00		
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		16, 573	1.00	
2.00	Inpatient days (including private room days, excluding swing-b	ped and newborn days)		16, 573	2. 00	
3.00						
4. 00	do not complete this line.	od days)		13, 214	4. 00	
5.00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		31 of the cost	13, 214	5.00	
	reporting period			_		
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00	
7.00	reporting period (if calendar year, enter 0 on this line)		21 -6	0	7.00	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through becember	31 of the cost	0	7. 00	
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)	,				
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	2, 092	9. 00	
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	oly (including private re	nom dave)	0	10. 00	
10.00	through December 31 of the cost reporting period (see instructions)	ing (frictualing private re inns)	olli days)	O	10.00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00	
	December 31 of the cost reporting period (if calendar year, er			_		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	room days)	0	12. 00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	room days)	0	13. 00	
	after December 31 of the cost reporting period (if calendar ye			· ·	10.00	
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	lays)	0	14. 00	
15. 00	Total nursery days (title V or XIX only)			0	15.00	
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00	
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00	
	reporting period					
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00	
10.00	reporting period	through Docombox 21 of	+ha aca+	0.00	19. 00	
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through becember 31 of	the cost	0.00	19.00	
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00	
	reporting period					
21. 00	Total general inpatient routine service cost (see instructions		na noried (line	21, 483, 550		
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporti	ng period (iine	0	22. 00	
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00	
	x line 18)					
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reportir	ng period (line	0	24. 00	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00	
	x line 20)					
	Total swing-bed cost (see instructions)			0		
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		21, 483, 550	27. 00	
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation hed cha	rnes)	0	28. 00	
29. 00	Pri vate room charges (excluding swing-bed charges)	and observation bed one	gc3)	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	1	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	ions)	0. 00 0. 00	1	
35. 00	Average per diem private room cost differential (line 34 x lin		.1 0113)	0.00	1	
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	21, 483, 550	37. 00	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS				
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 296. 30	38. 00	
39. 00	Program general inpatient routine service cost (line 9 x line	38)		2, 711, 860	39. 00	
40.00	Medically necessary private room cost applicable to the Progra	,		0	•	
41.00	Total Program general inpatient routine service cost (line 39	+ IIne 40)	l	2, 711, 860	41.00	

Cost Center Description			OKEN UNIVERSITY		21 2212 2		u of Form CMS-2	
Cost Center Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN	Fi	om 01/01/2023		pared:
Program inpatient cost (Marchael Loys) 1.00 2.00 3.00 4.00 5.00 4		Cost Center Description	Total				PPS	
		cost center bescription			em (col. 1 ÷	Frogram bays	(col. 3 x col.	
MASSERY (TITLE V & XIX only)			1, 00	2.00		4. 00		
43.00	42. 00							42. 00
44.00 CoROMARY CARE UNIT 0 0 0 0 0 0 0 0 0	43. 00		6, 101, 833	1, 180	5, 171. 04	395	2, 042, 561	43.00
46.00 SURCICAL INTESTIVE CARE UNIT 0 0 0.00 0 0.00 0 0.00 0			0	0	0. 00	0	0	44. 00
Cost Center Description 1,00							_	1
1.00		OTHER SPECIAL CARE (SPECIFY)				_		47. 00
48.01 Program inpati ent cell ular therapy acquisition cast (Worksheet D-6, Part III, Ilne 10, column 1)		Cost Center Description					1. 00	
10 Total Program Inpatient costs (suin of Lines 4.1 through 48.01)(see Instructions)					1 1: 10	1 1)		
111 117, 749 51.00 23st through costs applicable to Program Inpatient ancillary services (from West, D, sum of Parts II 197, 749 51.00 24 and IV 25.00		Total Program inpatient costs (sum of lines				corumn 1)	_	
		[111)		•				
Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 9,079,557 53,05 medical education costs (Line 49 eluns Line 52)		and IV)	,	services (from	ı Wkst. D, sur	n of Parts II		
TARCET MADURT AND LIMIT COMPUTATION 55.00 Parget amount per discharge 0.00 55.00 Personand sixcharge 0.00 55.01 Personand adjustment amount per discharge 0.00 55.01 Personand adjustment amount per discharge (contractor use only) 0.00 55.01 55.01 Personand adjustment amount per discharge (contractor use only) 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 0.00 55.00 0.00		Total Program inpatient operating cost exclude	ding capital rel	ated, non-physi	cian anesthe	tist, and		
55.00 Target amount per discharge 0.00 55.00 55.01 Perinament adjustment amount per discharge 0.00 55.01 55.02 Adjustment amount per discharge (contractor use only) 0.00 55.01 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 55.00 56.0	E4 00	TARGET AMOUNT AND LIMIT COMPUTATION	,					F4 00
Permanent adjustment amount per discharge 0.00 55.07 Adjustment amount per discharge (contractor use only) 0.00 55.02 Adjustment amount (line 54 x sum of lines 55, 55.01, and 55.02) 0.00 55.02 0.00 55.02 0.00 55.00 0.00 0.00 55.00 0.								
56.00 Target amount (line 54 x sum of lines 55, 5.01, and 55.02) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Danus payment (see instructions) 59.00 Trended costs (lesser of line 54 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 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) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incertive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (litic XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CM and SNF inpatient proutine costs (line 64 plus line 65) (title XVIII only): for CM and SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CM and SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CM instructions) (title XVIII only): for CM instructions) 69.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only): for CM instructions) 69.00 Total fine 12 x line 19		Permanent adjustment amount per discharge						
98.00 Bonus payment (see instructions) 90.00 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) 90.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 90.00 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) 90.00 Relicef payment (see instructions) 90.01 Relicef payment (see instructions) 90.02 Relicef payment (see instructions) 90.03 Coll Allowable inpatient cost plus incertive payment (see instructions) 90.04 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (line XVIII only) 90.05 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 90.07 Coll Allowable inpatient payment (see instructions) (line XVIII only); for 90.07 Coll Allowable SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 90.07 Coll Allowable SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 90.07 Coll Allowable SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 90.07 Coll Allowable SNF inpatient routine costs (line 67 * line 68) 90.07 Coll Allowable SNF inpatient routine costs (line 67 * line 68) 90.07 Coll Allowable SNF inpatient routine costs (line 67 * line 68) 90.07 Coll Allowable SNF inpatient routine service cost (line 70 * line 23) 90.07 Coll Allowable SNF inpatient routine service cost (line 70 * line 73) 90.07 Coll Allowable SNF inpatient routine service cost (line 70 * line 73) 90.07 Coll Allowable SNF inpatient routine service costs (line 70 * line 73) 90.07 Coll Allowable SNF inpatient routine service costs (line 70 * line 73) 90.0								1
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) 60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket) 61.00 Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55, or line 65 or 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) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 66.00 Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (CAH, see Instructions) 67.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (CAH, see Instructions) 68.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled ours in gradiility/off-rours in gradiility/off-rours of speciality/off-rours of speciality of sp		1	ng cost and tar	get amount (lin	ie 56 minus li	ne 53)	_	57. 00
60.00 Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the narket basket) 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) 62.00 Relief payment (see instructions) 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see Instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for 66.00 Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 v Iline 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 v Iline 19) 69.00 Total Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Skilled ours in gacility/other nursing facility/other nursing fa								
market basket) 6.00 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) 6.2.00 Relief payment (see instructions) 6.3.00 Allowable Inpatient cost plus incentive payment (see instructions) 6.3.00 Allowable Inpatient cost plus incentive payment (see instructions) 6.4.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (tilt e XVIII only) 6.5.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (tilt e XVIII only) 6.6.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions 6.7.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (CAH, see instructions) 6.7.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (CAH, see instructions) 6.7.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 6.7.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 6.7.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 6.7.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 6.7.00 Total title V or XIX swing-bed NF inpatient routine service cost (line 37) 6.7.00 Program routine service cost (line 9 x line 71) 6.7.00 Program routine service cost (line 9 x line 71) 6.7.00 Program routine service cost (line 9 x line 71) 6.7.00 Program routine service cost (line 9 x line 71) 6.7.00 Program routine service cost (line 9 x line 71) 6.7.00 Program routine service cost (line 9 x line 77) 6.7.00 Program routine service cost per diem (line 70 + line 20) 6.7.00 Program routine service	60. 00	updated and compounded by the market basket)						
53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions) 62.00 Relief payment (see instructions) 63.00 All owable inpatient cost plus incentive payment (see instructions) 64.00 Mountain the patient cost plus incentive payment (see instructions) 65.00 All owable inpatient cost plus incentive payment (see instructions) 65.00 Mountain the patient per set instructions) (it le XVIII only) 65.00 Mountain the patient patient routine costs through December 31 of the cost reporting period (See instructions) (it le XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (it le XVIII only): for CAH, see instructions 67.00 All see instructions 67.00 All see instructions 68.00 (line 12 x line 19) 68.00 (line 12 x line 19) 68.00 (line 3 x line 20) 69.00 (line 3 x line 20) 70		market basket) Continuous improvement bonus payment (if line						
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions) (title XVIII only) 67.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 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) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) O 69.00 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) 71.00 71.00 71.00 71.00 72.		53) are less than expected costs (lines 54 x						
PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 [Instructions) (title XVIII only) 65.00 [Instructions) (title XVIII only) 66.00 [Instructions) (title XVIII only) 67.00 [Instructions) (title XVIII only) 68.00 [Instructions) (title XVIII only) 68.00 [Instructions) (title XVIII only) 69.00 [Instructions) (title XVIII only) 69.00 [Instructions] 69.00 [Instru	62.00 Relief payment (see instructions)							
instructions) (title XVIII only) 65.00 Micliare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 70.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions 70.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 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) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 70.00 Skilled nursing facility/other nursing fa	PROGRAM INPATIENT ROUTINE SWING BED COST							
instructions) (title XVIII only) 66.00 67.00 66.00 67.		instructions)(title XVIII only)					0	64.00
CAH, see instructions 7. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 8. 00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total sylvary or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9. 00 Total sylvary or XIX swing-bed NF inpatient routine costs (line 67 + line 20) 9. 00 Adjusted general inpatient routine service cost (line 70 + line 2) 9. 00 Adjusted general inpatient routine service costs (line 70 + line 2) 9. 01 Total Program general inpatient routine service costs (line 72 + line 73) 9. 02 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 9. 02 Per diem capital-related costs (line 75 + line 2) 9. 03 Aggregate charges to beneficiaries for excess costs (from provider records) 9. 04 Aggregate charges to beneficiaries for excess costs (from provider records) 9. 05 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 9. 01 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 9. 01 Inpatient routine service cost sock (see instructions) 9. 02 Inpatient routine service cost (see instructions) 9. 03 Inpatient routine service cost (see instructions) 9. 04 Ordal Program inpatient ancillary services (see instructions) 9. 05 Ordal Program inpatient operating costs (sum of lines 83 through	65. 00		ts after Decembe	r 31 of the cos	t reporting p	period (See	0	65. 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) 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) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) OFFICIAL PRINTING AND INTERPRETARY OF A STATE OF	66. 00		ne costs (line 6	4 plus line 65)	(title XVIII	only); for	0	66. 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) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 70.00 Skilled nursing Facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 + line 2) 77.00 Program capital-related costs (line 75 + line 2) 77.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient ancillary service see instructions) 84.00 Program inpatient ancillary service (see instructions) 85.00 Unipatient routine service cost (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 77.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine costs per diem (line 27 + line 2) 78.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	67. 00	7.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period						
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) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 8.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	cember 31 of th	e cost repor	ting period	0	68. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID ON	LY		0	
72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient operating costs (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1, 296.30 88.00								70.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 ÷ line 2) 77.00 Program capital -related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 70.10 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Total Program routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Total Program inpatient operating costs (sum of lines 27 ÷ line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 89.00 Total Program inpatient operating costs (sum of lines 27 ÷ line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	72. 00	Program routine service cost (line 9 x line	71)	·				72. 00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 76.00 Program capital-related costs (line 9 x line 76) 77.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Program inpatient ancillary services (see instructions) 84.00 Total Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		, , , , , , , , , , , , , , , , , , , ,		•	: 35)			73.00
77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87. 00 Total Program inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Adjusted general inpatient routine cost set limitation (line 78 minus line 79) 89. 00 Read in a fine 75 minus line 79 89. 00 Read in a fine 75 min		Capital-related cost allocated to inpatient			ksheet B, Pai	t II, column		75. 00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 1, 296.30 88.00		1						76.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 89.00 Reasonable inpatient routine cost per diem (line 27 + line 2) 89.00 Reasonable inpatient routine cost per diem (line 27 + line 2) 89.00 Reasonable inpatient routine cost per diem (line 27 + line 2)								78.00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Reasonable inpatient routine service cost (see instructions) 89.00 Reasonable inpatient routine service cost		Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 84.00 84.00 85.00 86.00 87.00 87.00 88.00 88.00		,		SCITHII LALIUH (iine /o minus	5 TING 19)		81.00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Representation of the control of the cost per diem (line 27 + line 2) 88.00 Representation of the cost per diem (line 27 + line 2) 88.00 Representation of the cost per diem (line 27 + line 2) 88.00 Representation of the cost per diem (line 27 + line 2) 88.00 Representation of the cost per diem (line 27 + line 2) 88.00 Representation of the cost per diem (line 27 + line 2) 88.00 Representation of the cost per diem (line 27 + line 2)		1 .						82.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)								83.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 1,296.30 88.00		.00 Utilization review - physician compensation (see instructions)						
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,296.30 88.00		PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	ough 00)				
				line 2)				1
				- - /				1

Health Financial Systems HC	BOKEN UNIVERSITY MEDICAL CENTER In Lieu of Form CMS-2			2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Period: From 01/01/2023	Worksheet D-1	
				Γο 12/31/2023	Date/Time Prep 5/31/2024 12:0	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	1, 451, 513	21, 483, 550	0. 06756	4, 354, 272	294, 192	90.00
91.00 Nursing Program cost	0	21, 483, 550	0. 000000	4, 354, 272	0	91.00
92.00 Allied health cost	0	21, 483, 550	0. 000000	4, 354, 272	0	92.00
93.00 All other Medical Education	0	21, 483, 550	0. 00000	4, 354, 272	0	93. 00

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-0040		Worksheet D-1
	Component CCN: 31-S040	From 01/01/2023 To 12/31/2023	
	Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I PF	PPS		
	Cost Center Description			1.00		
	PART I - ALL PROVIDER COMPONENTS			1. 00		
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days and swing-bed day			11, 216	1. 00	
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		ivata room dave	11, 216 0	2. 00 3. 00	
3.00	do not complete this line.	ys). IT you have only pr	I vate Toolii days,	U	3.00	
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		11, 216	4. 00	
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5. 00	
	reporting period					
6. 00	Total swing-bed SNF type inpatient days (including private rolling period (if calendar year, enter 0 on this line)	om days) after December	31 or the cost	0	6. 00	
7.00	Total swing-bed NF type inpatient days (including private room	m davs) through December	31 of the cost	0	7. 00	
	reporting period					
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00	
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Drogram (evaluding	swing had and	1, 462	9. 00	
9.00	newborn days) (see instructions)	o the Frogram (excruding	swifig-bed and	1, 402	7.00	
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days)	0	10. 00	
	through December 31 of the cost reporting period (see instruc					
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e	nly (including private r	oom days) after	0	11. 00	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI.		e room days)	0	12. 00	
12.00	through December 31 of the cost reporting period	x only (mer daring private	e room days)	G	12.00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	3 (3)	<i>y</i> ,	0	13. 00	
14.00	after December 31 of the cost reporting period (if calendar y			0	14.00	
14. 00 15. 00	Medically necessary private room days applicable to the Progr. Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00	
16. 00	Nursery days (title V or XIX only)			0		
	SWI NG BED ADJUSTMENT		l			
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost	0.00	17. 00	
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	os after December 21 of	the cost	0.00	18. 00	
10.00	reporting period	es al tel December 31 01	the cost	0.00	10.00	
19. 00	Medicaid rate for swing-bed NF services applicable to service	0.00	19. 00			
	reporting period					
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	0. 00	20. 00			
21. 00	Total general inpatient routine service cost (see instruction	17, 010, 596	21. 00			
22. 00	Swing-bed cost applicable to SNF type services through Decemb	0	22. 00			
	5 x line 17)			_		
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ig period (line 6	0	23. 00	
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	na period (line	0	24. 00	
	7 x line 19)	·				
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00	
26. 00	x line 20) 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)		17, 010, 596		
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT					
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)		28. 00	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00	
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000		
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00		
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00		
34. 00	Average per diem private room charge differential (line 32 mi	, ,	tions)	0.00		
35. 00 36. 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0. 00	35. 00 36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	17, 010, 596		
200	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY					
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 51/ //	20.00	
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 516. 64 2, 217, 328		
40. 00	Medically necessary private room cost applicable to the Programme			2, 217, 320	40. 00	
	Total Program general inpatient routine service cost (line 39	,		2, 217, 328		

0 17	ATION OF INPATIENT OPERATING COST		Provi der C	CN: 31-0040	Peri od:	Worksheet D-1	
			Component	CCN: 31-S040	From 01/01/2023 To 12/31/2023		par
			Title	e XVIII	Subprovi der -	5/31/2024 12: PPS	06
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	4:
	Intensive Care Type Inpatient Hospital Units						
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	(1		0	
00	BURN INTENSIVE CARE UNIT	O	C	0.0	00	0	4
	SURGICAL INTENSIVE CARE UNIT	0	C	0. (00 0	0	Ι.
00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						4
	<u> </u>					1. 00	
	Program inpatient ancillary service cost (Wk			III line 10	column 1)	366, 931	
	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				corumn 1)	0 2, 584, 259	
	PASS THROUGH COST ADJUSTMENTS	THE CHIEGGE TO C	1) (000 111011 40	, tr 0110)		27 00 17 20 7	
00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sur	n of Parts I and	129, 402	5
00	<pre>III) Pass through costs applicable to Program inp</pre>	atient ancillar	v services (fr	om Wkst D s	sum of Parts II	15, 006	5
	and IV)		,				
	Total Program excludable cost (sum of lines		lated non nt	sicion coccti	notist and	144, 408	
00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		rateu, non-phy	ysıcıdı anesti	ictiSt, and	2, 439, 851	5
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0 0. 00	1 -
	Permanent adjustment amount per discharge					0.00	
02	Adjustment amount per discharge (contractor					0.00	
	Target amount (line 54 x sum of lines 55, 55		ract emount (ino E/ minuo	line E2)	0	
	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) Bonus payment (see instructions)						
00	updated and compounded by the market basket)						
00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						
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)						6
00	Relief payment (see instructions)					0	6
00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	na period (See	0	6
	instructions)(title XVIII only)	-		•			
00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the d	cost reportino	g period (See	0	6
00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	55)(title XVII	I only); for	0	6
00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 d	of the cost re	eporting period	0	6
00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	orting period	0	6
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	e 68)		0	6
	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil	URSING FACILITY	, AND ICF/IID	ONLY	\		7
	Adjusted general inpatient routine service c				′		7
00	Program routine service cost (line 9 x line	71)		ŕ			7
	Medically necessary private room cost applic Total Program general inpatient routine serv		•				7
	Capital -related cost allocated to inpatient				Part II, column		7
	26, line 45)		-	-			
	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						7
	Inpatient routine service cost (line 74 minu						7
	Aggregate charges to beneficiaries for exces			•	nuo 11 = 70)		7
	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitation	ı (IINe /8 mir	nus IINe /9)		8
	Inpatient routine service cost per drem rimi)				8
00	Reasonable inpatient routine service costs (see instruction	•				8
	Program inpatient ancillary services (see in Utilization review - physician compensation		ns)				8
	Total Program inpatient operating costs (sum						8
00	Total Trogram Impatront operating costs (same	01 111100 00 111					

Health Financial Systems HOBOKEN UNIVERSITY MEDICAL CENTER In Lieu						2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Title	XVIII	Subprovi der - PPS I PF		
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (OST					
90.00 Capital -related cost	992, 683	17, 010, 596	0. 05835	7 0	0	90.00
91.00 Nursing Program cost	0	17, 010, 596	0.00000	0	0	91. 00
92.00 Allied health cost	0	17, 010, 596	0.00000	0	0	92. 00
93.00 All other Medical Education	0	17, 010, 596	0. 00000	0 0	0	93. 00

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 31-0040	Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 31-5512	To 12/31/2023	Date/Time Prepared: 5/31/2024 12:06 pm
	Title XVIII	Skilled Nursing	PPS
		Facility	

		litle XVIII	Facility	PPS	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 812	1. 00
2.00	Inpatient days (including private room days, excluding swing-	<i>3 1</i>	ivata maam daya	3, 812 0	2.00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). It you have only pr	ivate room days,	U	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 812	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becomber	or the cost	O	0.00
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ii days) arter becember 3	i or the cost	O	0.00
9. 00	Total inpatient days including private room days applicable to	o the Program (excluding	swi ng-bed and	1, 670	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	nly (including privato r	oom dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		oon days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		o room days)	0	12. 00
12.00	through December 31 of the cost reporting period	A only (Therdaing privat	e room days)	O	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	alli (exci during Swirig-bed	uays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17.00	SWING BED ADJUSTMENT	+b	e +1 I	0.00	17.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	r the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period	a through Dagambar 21 of	the cost	0.00	19. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through becember 31 or	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		4, 359, 451	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportin	a ported (line 6	0	23. 00
23.00	x line 18)	31 of the cost reportin	g perrou (Trile o	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December :	31 of the cost reporting	period (line 8	0	25. 00
27, 00	x line 20)			0	27.00
26.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 4, 359, 451	26. 00 27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			.,,	
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus lino 22)/soo instrus	tions)	0. 00 0. 00	33. 00 34. 00
35. 00	Average per diem private room cost differential (line 34 x li		trons)	0.00	•
36. 00	Private room cost differential adjustment (line 3 x line 35)	ŕ		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	4, 359, 451	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see				38.00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program				39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	,			41. 00

lool +h	Financial Systems	DOVEN UNIVERSIT	V MEDICAL CENT	ren	In lie	of Form CMS	2552 1
	Financial Systems HC ATION OF INPATIENT OPERATING COST)BOKEN UNIVERSIT		CCN: 31-0040	Peri od:	worksheet D-1	
			Component	CCN: 31-5512	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 12:	
			Ti tl	e XVIII	Skilled Nursing		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day	Average Per sDiem (col. 1		Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)		2.00	3.00	4.00	3.00	42.00
43. 00	Intensive Care Type Inpatient Hospital Unit INTENSIVE CARE UNIT	S				I	43.00
	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description		1				47. 00
10.00			2 1: 000)			1.00	10.00
	Program inpatient ancillary service cost (W Program inpatient cellular therapy acquisit			III line 10	column 1)		48. 00 48. 0°
	Total Program inpatient costs (sum of lines				corumir 1)		49.00
EO 00	PASS THROUGH COST ADJUSTMENTS	notiont -: !!	00mH (C	m Wko+ D	of Desta !		F
50. 00	Pass through costs applicable to Program in III)	ipatient routine	services (fro	ını WKSı. D, SUN	i oi Paits I and		50.00
51. 00	Pass through costs applicable to Program in	patient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II		51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)					52. 00
53. 00	Total Program inpatient operating cost excl medical education costs (line 49 minus line	uding capital re	elated, non-ph	ysician anesth	netist, and		53. 00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION					I	1 54 00
	Program discharges Target amount per discharge						54. 00 55. 00
	Permanent adjustment amount per discharge						55. 0
	Adjustment amount per discharge (contractor						55. 0
	Target amount (line 54 x sum of lines 55, 5 Difference between adjusted inpatient opera			line 56 minus	line 53)		56. 00 57. 00
58. 00	Bonus payment (see instructions)	iting ooot and th	ar got amount (58. 0
59. 00	Trended costs (lesser of line 53 ÷ line 54,		m the cost rep	orting period	endi ng 1996,		59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						60.00
61. 00							61.00
62. 00	Relief payment (see instructions)						62. 00
63. 00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instr	uctions)				63.00
64. 00	Medicare swing-bed SNF inpatient routine co	sts through Dec	ember 31 of th	e cost reporti	ng period (See		64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	sts after Decemb	per 31 of the	cost reportino	period (See		65. 0
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout CAH, see instructions</pre>	ine costs (line	64 plus line	65)(title XVII	I only); for		66. 0
67. 00	Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs through	n December 31	of the cost re	eporting period		67. 0
68. 00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after I	December 31 of	the cost repo	orting period		68. 0
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER		•				69. 00
	Skilled nursing facility/other nursing faci	-				4, 359, 451	1
	Adjusted general inpatient routine service Program routine service cost (line 9 x line		THE /U ÷ IIN6	: ∠)		1, 143. 61 1, 909, 829	
73. 00	Medically necessary private room cost appli	cabĺe to Progra	•	,		0	73.00
74.00	Total Program general inpatient routine ser			•	Part II column	1, 909, 829	
75. 00 76. 00	Capital-related cost allocated to inpatient 26, line 45) Per diem capital-related costs (line 75 ÷ 1		= COSIS (ILOW	worksneet B, F	art II, COLUMN	0.00	75. 00 76. 00
77. 00	Program capital-related costs (line 9 x lin	ie 76)				0	77.00
	Inpatient routine service cost (line 74 min		anovi dan :	ode)		0	
79. 00 80. 00	Aggregate charges to beneficiaries for exce Total Program routine service costs for com				nus line 79)	0 0	1
	Inpatient routine service cost per diem lim	•		(81. 0
	Inpatient routine service cost limitation (,			0	
83. 00 84. 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see i	•	18)			1, 909, 829 825, 947	1
	Utilization review - physician compensation		ons)			025, 947	1
	Total Program inpatient operating costs (su	m of lines 83 t				2, 735, 776	1
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PA Total observation bed days (see instruction					0	87. 0
	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	- /					1

Health Financial Systems HOBOKEN UNIVERSITY MEDICAL CENTER In Lieu					u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST Provide				Peri od:	Worksheet D-1	
		Component (CCN: 31-5512	From 01/01/2023 To 12/31/2023		
		Title	XVIII	Skilled Nursing	PPS	
				Facility		
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	0	0	0.00000	0 0	0	90. 00
91.00 Nursing Program cost	0	0	0.00000	0 0	0	91.00
92.00 Allied health cost	0	0	0. 00000	0	0	92.00
93.00 All other Medical Education	0	o	0. 00000	0	0	93. 00

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL CENTER	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 31-0040	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre 5/31/2024 12:	
	Title XIX	Hospi tal	TEFRA	
Cost Center Description				
·			1.00	
DADT I ALL DDOVIDED COMPONENTS				

		Title XIX	Hospi tal	TEFRA	00 piii
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		16, 573	1.00
2. 00	Inpatient days (including private room days and swring bed days	,		16, 573	2. 00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	s). If you have only pri	vate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation be	ed days)		13, 214	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period		31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swi ng-bed and	369	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (including private ro	oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period		e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			1, 943 258	1
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	<u> </u>		0.00	
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services			0.00	
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	G		0.00	
21. 00	reporting period		ie cost		
22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December 17)		ng period (line	21, 440, 606 0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 imes 1 line 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		21, 440, 606	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 =	line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	1111e 20)		0.00000	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mir		tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	1
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 21, 440, 606	36. 00 37. 00
37.00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	ina private room cost ur	Torontrar (Title	21, 440, 000	37.00
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 293. 71	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			477, 379	1
40.00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (Line 20)	•		0 477, 379	40.00
41.00	Total Program general inpatient routine service cost (line 39)	+ IIIIE 40)	ı	4/1, 3/9	41.00

		OKEN UNIVERSITY				eu of Form CMS-2	<u> 2552-10</u>
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CC		eriod: rom 01/01/2023 o 12/31/2023	Worksheet D-1 Date/Time Pre 5/31/2024 12:	
	Cost Center Description	Total	Ti tl	e XIX Average Per	Hospital Program Days	TEFRA Program Cost	<u> </u>
	cost center bescription	Inpatient Cost				(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	5, 542, 503	1, 943	2, 852. 55			42. 00
	Intensive Care Type Inpatient Hospital Units			- 1 (0			
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	6, 083, 718	1, 180 0	5, 155. 69 0. 00		257, 785 0	•
45. 00	BURN INTENSIVE CARE UNIT	o	o	0.00			1
46. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0. 00	0	0	46.00
47.00	OST Center Description						47. 00
48. 00	Program inpatient ancillary service cost (Wk:	st D-3 col 3	line 200)			1. 00 1, 312, 794	48. 00
48. 01	Program inpatient cellular therapy acquisition			III, line 10,	column 1)	0	•
49. 00	Total Program inpatient costs (sum of lines	41 through 48.0	1)(see instruc	tions)		2, 783, 916	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program input	atient routine :	services (from	Wkst. D, sum	of Parts I and	77, 171	50.00
51. 00	Pass through costs applicable to Program inp		•			51, 598	51 00
	and IV)	•	y services (iii	om wkst. D, su	01 14113 11		
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		lated non-phy	sician anesthe	tist and	128, 769 2, 655, 147	1
00.00	medical education costs (line 49 minus line				er st, and	2, 000, 117	00.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					228	54.00
55. 00	Target amount per discharge					4, 988. 61	55. 00
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor)	uso only)				0. 00 0. 00	55. 01 55. 02
56. 00	Target amount (line 54 x sum of lines 55, 55					1, 137, 403	•
57. 00	Difference between adjusted inpatient operat		rget amount (I	ine 56 minus I	ine 53)	-1, 517, 744	57. 00
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost reno	rting period e	ndi na 1006	0 00	58. 00 59. 00
37.00	updated and compounded by the market basket)	or title 55 from	the cost repo	iting period e	laring 1770,	0.00	37.00
60. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	m prior year c	ost report, up	dated by the	0.00	60.00
61. 00	Continuous improvement bonus payment (if lin- 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x	ser of 50% of tl	he amount by w	hich operating	costs (line	0	61.00
	enter zero. (see instructions)	00), 0 0.	the target am	(11110 00)	, other in oc		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			113, 740 1, 379, 912	
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos			cost roportin	g port od (Soo	Ι ο	64. 00
	instructions)(title XVIII only)						
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH, see instructions	ne costs (line	64 plus line 6	5)(title XVIII	only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 o	f the cost rep	orting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repor	ting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. 00
71. 00	Adjusted general inpatient routine service co	ost per diem (li					71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		(line 14 x li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv		•	110 33)			74. 00
75. 00	Capital -related cost allocated to inpatient	routine service	costs (from W	orksheet B, Pa	rt II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for exces:		rovi den inecond	s)			78. 00 79. 00
80.00	Total Program routine service costs for compa	arison to the c		•	s line 79)		80. 00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		`				81. 00 82. 00
82. 00 83. 00	Reasonable inpatient routine service cost ilmitation (82.00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS		. ougii 00 <i>)</i>				55.00
87.00	Total observation bed days (see instructions					3, 359	
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see		1111e 2)			1, 293. 71 4, 345, 572	
	,						

Health Financial Systems HOE	BOKEN UNIVERSIT	MEDICAL CENTE	IR .	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/31/2024 12:0	
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	1, 451, 513	21, 440, 606	0. 067699	4, 345, 572	294, 191	90.00
91.00 Nursing Program cost	0	21, 440, 606	0.000000	4, 345, 572	0	91.00
92.00 Allied health cost	0	21, 440, 606	0. 000000	4, 345, 572	0	92.00
93.00 All other Medical Education	0	21, 440, 606	0. 000000	4, 345, 572	0	93. 00

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 31-0040		Worksheet D-1
	Component CCN: 31-S040	From 01/01/2023 To 12/31/2023	
	Title XIX	Subprovi der -	TEFRA

		litle XIX	Subprovider - IPF	TEFRA			
	Cost Center Description						
	PART I - ALL PROVIDER COMPONENTS			1. 00			
	I NPATI ENT DAYS						
1.00	Inpatient days (including private room days and swing-bed days			11, 216	1. 00		
2.00	Inpatient days (including private room days, excluding swing-l			11, 216	2. 00 3. 00		
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.						
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		11, 216	4. 00		
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00		
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	21 of the cost	0	6. 00		
0.00	reporting period (if calendar year, enter 0 on this line)	on days) at tel becember	or or the cost	O	0.00		
7.00	Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7. 00		
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	m days) after December 2	1 of the cost	0	8. 00		
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceiibei 3	i or the cost	U	0.00		
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	341	9. 00		
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv. (i naludi na privata r	nom days)	0	10. 00		
10.00	through December 31 of the cost reporting period (see instructions)		Juli days)	U	10.00		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00		
12 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		a room days)	0	12. 00		
12. 00	through December 31 of the cost reporting period	t only (flictually private	e room days)	U	12.00		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00		
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00		
15. 00	Total nursery days (title V or XIX only)	diii (exci during swring-bed i	uays)	1, 943			
16. 00	Nursery days (title V or XIX only)				16. 00		
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	as through December 21 as	f the cost	0.00	17. 00		
17. 00	reporting period	es through becember 31 o	the cost	0.00	17.00		
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00		
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00		
17.00	reporting period	3 through becember 31 or	the cost	0.00	19.00		
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0. 00	20. 00		
21. 00	reporting period Total general inpatient routine service cost (see instructions	5)		17, 000, 489	21. 00		
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00		
23. 00	5 x line 17)	21 of the cost reporting	a ported (line 4	0	23. 00		
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g perrou (Title 6	U	23.00		
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00		
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	neriod (line 8	0	25. 00		
23.00	x line 20)	or the cost reporting	perrod (Trie o	O	25.00		
	Total swing-bed cost (see instructions)	(1: 04 : 1: 0/)		0	26. 00		
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(IINE 21 MINUS IINE 26)		17, 000, 489	27.00		
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00		
29. 00				0			
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	30. 00 31. 00		
32. 00	Average private room per diem charge (line 29 ÷ line 3)	- Title 20)		0.00000	32.00		
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00		
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	•		
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00		
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	17, 000, 489			
	27 minus line 36)						
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS					
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 515. 74	38. 00		
39. 00	Program general inpatient routine service cost (line 9 x line			516, 867			
40.00	Medically necessary private room cost applicable to the Progra	,		0			
41.00	Total Program general inpatient routine service cost (line 39	+ IINE 4U)	l	516, 867	41.00		

COMPUT	ATION OF INPATIENT OPERATING COST		Component	CN: 31-0040 CCN: 31-S040 e XIX	Peri od: From 01/01/2023 To 12/31/2023 Subprovi der -	Worksheet D-1 Date/Time Pre 5/31/2024 12: TEFRA	pared:
	Cost Center Description	Total Inpatient Cost		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	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	Το	0	0. (00 0	0	43. 00
44. 00	CORONARY CARE UNIT	0	0	0. (00	0	44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0	1		0	
47. 00	OTHER SPECIAL CARE (SPECIFY)			1	3		47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					54, 161	
48. 01 49. 00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				column 1)	0 571, 028	
47.00	PASS THROUGH COST ADJUSTMENTS		, <u> </u>	· ·		371,020	47.00
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, sum	n of Parts I and	30, 182	50.00
51. 00	III) Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	2, 337	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				32, 519	52.00
53. 00	Total Program inpatient operating cost exclu	ding capital re	lated, non-phy	sician anesth	netist, and	538, 509	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54. 00	Program discharges					44	54. 00
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					32, 584. 46 0. 00	
55. 02	Adjustment amount per discharge (contractor	use only)				0.00	
56.00	Target amount (line 54 x sum of lines 55, 55			ino E/ minuo	Line E2)	1, 433, 716	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	895, 207 28, 674					
59. 00	Trended costs (lesser of line 53 ÷ line 54,		the cost repo	orting period	endi ng 1996,	0.00	59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, 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						61.00
62. 00	enter zero. (see instructions) Relief payment (see instructions)					0	1
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			599, 702	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the c	cost reporting	period (See	0	65. 00
·	instructions)(title XVIII only)	(1:	/			0	// 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (Tine	o4 prus rine d	os)(title xvii	i only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12×1 line 19)	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY		0	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	•					70.00
	Program routine service cost (line 9 x line	71)		ŕ			72. 00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv		•				73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service			Part II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				us lino 70)		79. 00 80. 00
81. 00	Inpatient routine service costs for comp		ost iimi tati on	. (11116 10 HHI	143 TINC /7)		80.00
82.00	Inpatient routine service cost limitation (I		* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		15)				83. 00 84. 00
85. 00	Utilization review - physician compensation	(see instruction					85. 00
86. 00	Total Program inpatient operating costs (sum	or lines 83 th	rougn 85)				86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST					

Health Financial Systems HOBOKEN UNIVERSITY MEDICAL CENTER In Lieu						2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component C	CCN: 31-S040	From 01/01/2023 To 12/31/2023		
		Title	e XIX	Subprovi der - I PF	TEFRA	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				0	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (
90.00 Capital-related cost	992, 683	17, 000, 489	0. 05839	1 0	0	90.00
91.00 Nursing Program cost	0	17, 000, 489	0.00000	0	0	91.00
92.00 Allied health cost	0	17, 000, 489	0.00000	0	0	92. 00
93.00 All other Medical Education	0	17, 000, 489	0. 00000	0 0	0	93. 00

Health Financial Systems HOBOKEN UNIVERSITY M	IEDI CAL CENT	ER	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 31-0040	Peri od:	Worksheet D-3	
			From 01/01/2023	Data /Tima Daa	nanad.
			To 12/31/2023	Date/Time Pre 5/31/2024 12:	
	Ti tl e	e XVIII	Hospi tal	PPS	оо рііі
Cost Center Description		Ratio of Cos		Inpati ent	
2001 2000 1 2000 1		To Charges	Program	Program Costs	
		l onar goo	Charges	(col. 1 x col.	
			3	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			37, 778, 000		30. 00
31. 00 03100 INTENSIVE CARE UNIT			7, 900, 000		31.00
32. 00 03200 CORONARY CARE UNIT			0		32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT			0		34.00
40. 00 04000 SUBPROVI DER - 1 PF			0		40.00
41. 00 04100 SUBPROVI DER - RF			0		41.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 17910	3, 200, 375		50.00
51. 00 05100 RECOVERY ROOM		0. 2955	268, 691	79, 419	51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 54398	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 00000	00	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 02532	8, 182, 136	207, 213	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000	0 0	0	55. 00
56. 00 05600 RADI 0I SOTOPE		0. 05612	29 203, 396	11, 416	56. 00
57. 00 05700 CT SCAN		0. 01230	5, 833, 000	71, 781	57.00
58. OO 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 03800	1, 255, 500	47, 717	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000	00	0	59. 00
60. 00 06000 LABORATORY		0. 03124	19, 589, 518	612, 114	60.00
60. 01 06001 BL00D LABORATORY		0.00000	00	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000	00	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000	0 0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 07408	311, 703	23, 093	63.00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000	00	0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 20670	2, 251, 223	465, 339	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 12863	1, 325, 725	170, 533	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 10486		0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 15150		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 03220		121, 069	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 0456		4, 170	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 01662		363, 497	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3672		l	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 1732		1	73. 00
74. 00 07400 RENAL DI ALYSI S		2. 03410		551, 813	74.00
75. 00 07500 ASC (NON-DI STINCT PART)		0.00000		0	75. 00
77. 00 07700 ALLOGENEI C HSCT ACQUISITION		0.00000		0	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS		0.00000	0	0	78. 00
88. 00 08800 RURAL HEALTH CLINIC		0.00000	10	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90. 00 09000 CLINIC		0. 00000		0	90.00
90. 01 09001 CLI NI C CMHC		0.07300		0	90.00
90. 02 09002 CLI NI C CHEMO		0. 10876		0	90. 02
90. 03 09003 CLINIC RYAN WHITE		7. 8382		0	90. 02
91. 00 09100 EMERGENCY		0. 0319			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)		0.00839		1	92.00
OTHER REIMBURSABLE COST CENTERS		0.0003	20, 100, 002	224, 027	, ,2.00
94. 00 O9400 HOME PROGRAM DIALYSIS		0.00000	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES		0.0000	,0	Ĭ	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0.00000	00	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.00000		o o	97. 00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS		0.00000		o o	98. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			87, 085, 055		1
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)	,		87, 085, 055		202. 00
· · · · · · · · · · · · · · · · · · ·		•	•	-	

Health Financial Systems HOBOKEN L INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	JNI VERSITY MEDICAL CENTI Provider C	CN: 31-0040	Peri od:	worksheet D-3	
	Component		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 12:	
	Ti tl e	e XVIII	Subprovi der - I PF	PPS	оо рііі
Cost Center Description		Ratio of Cost	Inpati ent	Inpati ent	
		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS		I			30.00
31. 00 03100 NTENSI VE CARE UNIT					31.00
32. 00 03200 CORONARY CARE UNIT					32.00
33.00 03300 BURN INTENSIVE CARE UNIT					33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
40. 00 04000 SUBPROVI DER - 1 PF			26, 316, 000		40.00
41. 00 04100 SUBPROVI DER - I RF					41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 O5000 OPERATI NG ROOM		0. 17910	9 0	0	50.00
51.00 05100 RECOVERY ROOM		0. 29557		0	1
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 54398	0 0	0	52. 00
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 02532		16, 504	1
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE		0. 00000 0. 05612		0	55. 00 56. 00
57. 00 05700 CT SCAN		0.03012		3, 156	1
58.00 05800 MAGNETIC RESONANCE MAGING (MRI)		0. 03800		0,100	1
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	1
60. 00 06000 LABORATORY		0. 03124		100, 592	1
60. 01 06001 BLOOD LABORATORY		0.00000		0	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000 0. 07408		0	
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	1
65. 00 06500 RESPI RATORY THERAPY		0. 20670		5, 511	1
66. 00 06600 PHYSI CAL THERAPY		0. 12863	4 197, 499	25, 405	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 10486		0	
68. 00 06800 SPEECH PATHOLOGY		0. 15150		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 03226 0. 04565		6, 442 0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 01662		744	70.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 36721		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 17327		112, 844	1
74. 00 07400 RENAL DI ALYSI S		2. 03416	8 0	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)		0. 00000		0	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000		0	1
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS		0.00000	0 0	0	78. 00
88. 00 08800 RURAL HEALTH CLINIC		0.00000	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		Ö	
90. 00 09000 CLI NI C		0. 07560	7 0	0	90.00
90. 01 09001 CLI NI C CMHC		0. 09825		0	
90. 02 09002 CLINIC CHEMO		0. 10876		0	
90. 03 09003 CLINIC RYAN WHITE 91. 00 09100 EMERGENCY		7. 83827		0 05 722	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 03191 0. 00839		95, 733 0	1
OTHER REIMBURSABLE COST CENTERS		0.00039	۷ ا	<u> </u>	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S		0.00000	0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES					95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.00000	0	0	96.00

0.000000

0.000000

8, 202, 464

8, 202, 464

97.00 0

98. 00

201. 00 202. 00

0

366, 931 200. 00

97.00

200.00

201.00

202.00

09700 DURABLE MEDICAL EQUIP-SOLD

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

Net charges (line 200 minus line 201)

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

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

Health Financial Systems	HOBOKEN UNIVERSITY ME	DICAL CENT	ER	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C		Peri od:	Worksheet D-3	
		Component		From 01/01/2023 To 12/31/2023		pared: 06 pm
		Ti tl e	e XVIII	Skilled Nursing Facility	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
			To Charges		Program Costs (col. 1 x col.	
				Charges	2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			_			
00 00 00000 1000 0 0000 17000					1 '	

	Cost Center Description	Ratio of Cost	Inpati ent	Inpatient	
		To Charges	Program Charges	Program Costs (col. 1 x col.	
			charges	2)	
		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDI ATRI CS				30. 00
31. 00	03100 I NTENSI VE CARE UNI T				31.00
32. 00					32. 00
33. 00					33.00
34. 00					34. 00
40.00	04000 SUBPROVI DER - I PF				40.00
41. 00	04100 SUBPROVI DER - I RF				41. 00
43. 00	04300 NURSERY				43. 00
EO 00	ANCILLARY SERVICE COST CENTERS	0 170100	0	0	EO 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0. 179109 0. 295576	0	1	50. 00 51. 00
52. 00		0. 543980	0	1	52.00
53. 00	05300 ANESTHESI OLOGY	0.000000	0	0	53. 00
54. 00		0. 025325	769, 794	1	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	707, 774	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 056129	0	Ö	56. 00
57. 00	05700 CT SCAN	0. 012306	76, 000	1	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 038006	13, 500	513	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0,000	0	59. 00
60.00	06000 LABORATORY	0. 031247	3, 659, 490	-	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0, 221, 112	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	0	0	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 074086	5, 780	428	63.00
64.00	06400 I NTRAVENOUS THERAPY	0.000000	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 206705	552, 000	114, 101	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 128634	2, 838, 708	365, 154	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 104868	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 151508	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 032267	117, 497	3, 791	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 045657	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 016620	5, 080	5, 164	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 367216	3, 200	1, 175	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 173270	1, 159, 030	200, 825	73. 00
74.00	07400 RENAL DI ALYSI S	2. 034168	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0	0	77. 00
78. 00		0.000000	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS			_	
88. 00	08800 RURAL HEALTH CLINIC	0.000000		0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	•	0	89. 00
90.00	09000 CLINIC	0. 075607	0	1	90.00
90. 01	09001 CLINIC CMHC	0.098250	0	0	90. 01
90. 02		0. 108767	0	0	90. 02
90. 03	09003 CLINIC RYAN WHITE	7. 838273	0	0	90. 03
91.00		0. 031919	555	1 _	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.008392	0	0	92.00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94. 00
95. 00		0.000000	Ü	0	95.00
96. 00		0. 000000	0	0	96.00
97. 00		0.000000	0	1	97. 00
98. 00		0.000000	0	0	98. 00
200. 0		0.00000	9, 200, 634	1	
201. 0			0, 200, 301	525, 717	201. 00
202. 0			9, 200, 634		202. 00
				•	

Health Financial Systems HOBOKEN UNIVERSITY N	EDICAL CENTER	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 31-0040	Peri od:	Worksheet D-3	
		From 01/01/2023		
		Γo 12/31/2023	Date/Time Pre	
			5/31/2024 12:0	06 pm_
	Title XIX	Hospi tal	TEFRA	
Cost Center Description	Ratio of Cost	Inpati ent	Inpati ent	
·	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
		criai ges	2)	
	1.00	0.00		
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		9, 066, 000		30. 00
31.00 O3100 INTENSIVE CARE UNIT		1, 000, 000		31.00
32. 00 03200 CORONARY CARE UNIT		0		32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0		33. 00
		0		
		0		34.00
40. 00 04000 SUBPROVI DER - 1 PF		0		40. 00
41. 00 04100 SUBPROVI DER - I RF		0		41. 00
43. 00 04300 NURSERY		4, 644, 000		43.00
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 17782	7 1, 105, 432	196, 576	50.00
51. 00 05100 RECOVERY ROOM	0. 29557		41, 237	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 54398		363, 030	52. 00
53. 00 05300 ANESTHESI OLOGY	0.00000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 02514	1, 277, 925	32, 133	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.00000	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 05612	61, 512	3, 453	56. 00
57. 00 05700 CT SCAN	0. 01230		10, 872	57. 00
				58. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 03800		11, 288	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.00000	1	0	59. 00
60. 00 06000 LABORATORY	0. 03123	4, 093, 776	127, 861	60.00
60. 01 06001 BLOOD LABORATORY	0.00000	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.00000		0	61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 00000		0	62. 00
		1		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 07408		4, 502	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0.00000	1	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 20670	5 116, 607	24, 103	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 12863	4 57, 416	7, 386	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 10486	12, 735	1, 335	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 15150		25, 414	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 03226		10, 596	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 04565		1, 769	70.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 01662		141, 921	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 36721	5 15, 511	5, 696	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 17327	1, 047, 596	181, 517	73.00
74. 00 07400 RENAL DI ALYSI S	2. 03416		39, 870	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 00000		0	75. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 00000		0	77. 00
			0	78. 00
	0.00000	0	U	78.00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0.00000	1	-	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 00000	0	0	89. 00
90. 00 09000 CLINI C	0. 07560		380	90.00
90. 01 09001 CLI NI C CMHC	0. 09825	ol ol	0	90. 01
90. 02 09002 CLINIC CHEMO	0. 10876	7 0	0	90. 02
90. 03 09003 CLINIC RYAN WHITE	7. 83827		0	90. 03
91. 00 09100 EMERGENCY	0. 03189		57, 994	91. 00
92. 00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 00837	2, 848, 739	23, 861	92. 00
OTHER REIMBURSABLE COST CENTERS			_	
94.00 O9400 HOME PROGRAM DIALYSIS	0.00000	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES				95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0.00000	o o	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0.00000	ol ol	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0.00000		0	98. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)	3. 20000	15, 202, 803	1, 312, 794	
201. 00 Less PBP Clinic Laboratory Services-Program only charges	: (line 61)	10, 202, 003	1, 512, 174	201. 00
202.00 Net charges (line 200 minus line 201)	, (1116-01)	15, 202, 803		201.00
202.00 Net Charges (True 200 IIII has True 201)	I	13, 202, 003		202.00

Health Financial Systems INPATIENT ANCILLARY SERVICE	COST APPORTI ONMENT	Provider C		Peri od:	Worksheet D-3	
		Component		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/31/2024 12:	
		Ti ti	e XIX	Subprovi der - I PF	TEFRA	00 piii
Cost Center Des	cri pti on		Ratio of Cost	Inpati ent	Inpati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIAT			T			30.00
31. 00 03100 NTENSI VE CARE						31.00
32. 00 03200 CORONARY CARE U						32.00
33.00 03300 BURN INTENSIVE						33. 00
34. 00 03400 SURGI CAL INTENS	IVE CARE UNIT					34.00
40. 00 04000 SUBPROVI DER - I				6, 138, 000		40.00
41. 00 04100 SUBPROVI DER - I	RF					41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COS	T CENTERS					43.00
50. 00 05000 OPERATING ROOM	OF CENTERS		0. 17782	7 0	0	50.00
51.00 05100 RECOVERY ROOM			0. 29557		0	
52.00 05200 DELIVERY ROOM &	LABOR ROOM		0. 543980	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY			0. 000000		0	53. 00
54. 00 05400 RADI OLOGY - DI AGN			0. 02514		2, 018	1
55. 00 05500 RADI OLOGY-THERA	PEUTIC		0.000000		0	55.00
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN			0. 05612 0. 01230		0 351	56. 00 57. 00
58. 00 05800 MAGNETI C RESONA	NCE IMAGING (MRI)		0.03800		0	1
59. 00 05900 CARDI AC CATHETE			0. 000000		0	1
60. 00 06000 LABORATORY			0. 03123		22, 077	60.00
60. 01 06001 BLOOD LABORATOR			0. 000000	0 0	0	60. 01
61. 00 06100 PBP CLINICAL LA			0. 000000		0	61.00
62. 00 06200 WHOLE BLOOD & P.			0. 000000		0	
63. 00 06300 BLOOD STORING,			0. 07408		0	
64. 00 06400 I NTRAVENOUS THE 65. 00 06500 RESPIRATORY THE			0. 000000 0. 20670		0	
66. 00 06600 PHYSI CAL THERAP			0. 12863		402	1
67. 00 06700 OCCUPATI ONAL TH			0. 10486		0	1
68.00 06800 SPEECH PATHOLOG	Υ		0. 15150	8 0	0	68. 00
69. 00 06900 ELECTROCARDI OLO			0. 03226		728	1
70. 00 07000 ELECTROENCEPHAL			0. 04565		0	
71. 00 07100 MEDI CAL SUPPLI E			1. 016620		70	1
72.00 07200 I MPL. DEV. CHAR 73.00 07300 DRUGS CHARGED T			0. 36721 0. 173270		0 11, 951	72.00
74. 00 07400 RENAL DIALYSIS	O TATIENTS		2. 03416		0	1
75. 00 07500 ASC (NON-DISTIN	CT PART)		0. 000000		0	1
77.00 07700 ALLOGENEIC HSCT	ACQUI SÍ TI ON		0.00000		0	77. 00
78. 00 07800 CAR T-CELL I MMU			0. 000000	0 0	0	78. 00
OUTPATIENT SERVICE CO				-		
88. 00 08800 RURAL HEALTH CL 89. 00 08900 FEDERALLY QUALI			0.000000		0	
89. 00 08900 FEDERALLY QUALI 90. 00 09000 CLI NI C	FIED HEALTH CENTER		0. 000000 0. 07560		40	
90. 01 09001 CLINI C CMHC			0.07300		0	1
90. 02 09002 CLINIC CHEMO			0. 10876		0	1
90.03 09003 CLINIC RYAN WHI	TE		7. 83827		0	1
91.00 09100 EMERGENCY			0. 03189	· ·	16, 524	
92. 00 09200 OBSERVATI ON BED	,		0. 00837	6 0	0	92. 00
OTHER REIMBURSABLE CO			0.00000		^	04.00
94. 00 09400 HOME PROGRAM DI			0. 000000	0	0	
95. 00 09500 AMBULANCE SERVI	CES					95.00

0.000000

0.000000

1, 428, 956

1, 428, 956

97.00 0

98. 00 0

201. 00 202. 00

54, 161 200. 00

97.00

200.00

201.00

202.00

09700 DURABLE MEDICAL EQUIP-SOLD

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

Net charges (line 200 minus line 201)

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

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-00	From 01/01/2023	Worksheet E Part A Date/Time Prepared: 5/31/2024 12:06 pm
	T1.11 \0.01.11		550

	Title XVIII Hospital	PPS	50 piii
	DADT A LINDATIENT HOSDITAL SEDVICES HINDED LDDS	1. 00	
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	4, 193, 410	1. 01
1 00	instructions)	1 000 2/2	1 00
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	1, 088, 363	1. 02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October	0	1. 03
1. 04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after	0	1. 04
1.04	October 1 (see instructions)	O	1.04
2.00	Outlier payments for discharges. (see instructions)		2. 00
2. 01	Outlier reconciliation amount	0	2. 01
2. 02 2. 03	Outlier payment for discharges for Model 4 BPCI (see instructions)	64, 017	2. 02 2. 03
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)	30, 475	2. 03
3.00	Managed Care Simulated Payments	5, 367, 372	3. 00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	104. 67	4. 00
F 00	Indirect Medical Education Adjustment	04.40	F 00
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)	21. 40	5. 00
5. 01	FTE cap adjustment for qualifing 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	0.00	6. 00
/ 2/	new programs in accordance with 42 CFR 413.79(e)	0.00	/ 2/
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)	0.00	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	0.00	7. 01
7.00	cost report straddles July 1, 2011 then see instructions.		7 00
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural	0.00	7. 02
	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)		
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0.00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12,		
0.04	1998), and 67 FR 50069 (August 1, 2002).	0.00	0.01
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	0.00	8. 02
	under § 5506 of ACA. (see instructions)		
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	21. 40	9. 00
	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)		
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	26. 07	
11.00	FTE count for residents in dental and podiatric programs.		11. 00 12. 00
12. 00 13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.	32. 40 32. 84	
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,	31. 96	
	otherwise enter zero.		
	Sum of lines 12 through 14 divided by 3.		15. 00
	Adjustment for residents in initial years of the program (see instructions)		16.00
17. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count	32. 40	17. 00 18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).	0. 309544	
20.00	Prior year resident to bed ratio (see instructions)	0. 312789	20.00
	Enter the lesser of lines 19 or 20 (see instructions)	0. 309544	
22. 00	IME payment adjustment (see instructions)	822, 906	
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA	836, 242	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105	0.00	23. 00
	(f)(1)(iv)(C).		
24. 00	IME FTE Resident Count Over Cap (see instructions)	4. 67	
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	0.00	25. 00
26. 00	Instructions) Resident to bed ratio (divide line 25 by line 4)	0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)	0. 000000	
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 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	822, 906 836, 242	29. 00 29. 01
∠ 9 . U1	Disproportionate Share Adjustment	030, 242	29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	18. 67	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)	28. 56	31.00
32. 00	Sum of lines 30 and 31	47. 23	
33.00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)	28. 18 372, 101	33.00
J4. UU	prisprisportronate share adjustilient (see thistructions)	372, 101	34.00

Heal th	Financial Systems HOBOKEN UNIVERSITY M	EDICAL CENTER	Inlie	u of Form CMS-2	552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0040	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Prep 5/31/2024 12:0	pared:
		Title XVIII	Hospi tal	973172024 12. C	о рііі
		II the XVIII	Prior to 10/1		
			1. 00	2. 00	
	Uncompensated Care Payment Adjustment				
35. 00	Total uncompensated care amount (see instructions)		0	0	35. 00
35. 01	Factor 3 (see instructions)		0. 000000000	0. 000000000	35. 01
35. 02	Hospital UCP, including supplemental UCP (see instructions) Pro rata share of the hospital UCP, including supplemental UCP) (!++!)	3, 441, 069	2, 645, 975	35. 02
35. 03 36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	(see instructions)	2, 573, 730 3, 238, 838	665, 108	35. 03 36. 00
30.00	Additional payment for high percentage of ESRD beneficiary dis	scharges (lines 40 through			30.00
40. 00	Total Medicare discharges (see instructions)	senarges (Times to times	0		40. 00
41.00	Total ESRD Medicare discharges (see instructions)		o		41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructi	ons)	0		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualif	fy for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided blays)	by line 41 divided by 7	0. 000000		44. 00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00		45.00
46. 00	Total additional payment (line 45 times line 44 times line 41.	01)	0		46. 00
47. 00	Subtotal (see instructions)		9, 810, 110		47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, sm only. (see instructions)	nall rural hospitals	0		48. 00
	John y. (See Tristractions)			Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instructions))			49. 00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and	d Pt. II, as applicable)		1. 00 10, 646, 352 535, 628	50.00
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt.	d Pt. II, as applicable) III, see instructions)		1. 00 10, 646, 352 535, 628 0	50. 00 51. 00
50. 00 51. 00 52. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, lir	d Pt. II, as applicable) III, see instructions)		1. 00 10, 646, 352 535, 628 0 1, 378, 615	50. 00 51. 00 52. 00
50. 00 51. 00 52. 00 53. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, lir Nursing and Allied Health Managed Care payment	d Pt. II, as applicable) III, see instructions)		1. 00 10, 646, 352 535, 628 0 1, 378, 615	50. 00 51. 00 52. 00 53. 00
50. 00 51. 00 52. 00 53. 00 54. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, lir Nursing and Allied Health Managed Care payment Special add-on payments for new technologies	d Pt. II, as applicable) III, see instructions)		1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094	50. 00 51. 00 52. 00 53. 00 54. 00
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, lin Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment	d Pt. II, as applicable) III, see instructions) ne 49 see instructions).		1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, lin Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	d Pt. II, as applicable) III, see instructions) ne 49 see instructions).		1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094	50. 00 51. 00 52. 00 53. 00 54. 00
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, lin Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment	H Pt. II, as applicable) III, see instructions) ne 49 see instructions). P)		1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 55. 01	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, lin Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cellular therapy acquisition cost (see instructions)	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). 2) uctions)	hrough 35).	1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094 0	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 55. 01
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, lin Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intru	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). P) uctions) I, column 9, lines 30 t	hrough 35).	1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094 0 0	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00
50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, lin Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58)	d Pt. II, as applicable) III, see instructions) ne 49 see instructions). P) uctions) I, column 9, lines 30 t	hrough 35).	1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094 0 0 0 0 0 12, 568, 689	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00
50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Iir Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 69 Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments	Pt. II, as applicable) III, see instructions) ne 49 see instructions). P) uctions) I, column 9, lines 30 t V, col. 11 line 200)	hrough 35).	1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094 0 0 0 0 0 0 12, 568, 689	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00
50. 00 51. 00 52. 00 53. 00 54. 00 55. 01 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Iir Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 69 Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments	Pt. II, as applicable) III, see instructions) ne 49 see instructions). P) uctions) I, column 9, lines 30 t V, col. 11 line 200)	hrough 35).	1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094 0 0 0 0 12, 568, 689 0 12, 568, 689	50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00
50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Iir Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 69 Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intructions service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. IT Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	Pt. II, as applicable) III, see instructions) ne 49 see instructions). P) uctions) I, column 9, lines 30 t V, col. 11 line 200)	hrough 35).	1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094 0 0 0 12, 568, 689 396, 492	50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00
50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Iir Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 69 Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intra Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	Pt. II, as applicable) III, see instructions) ne 49 see instructions). P) uctions) I, column 9, lines 30 t V, col. 11 line 200)	hrough 35).	1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094 0 0 0 12, 568, 689 396, 492 94, 400	50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
50. 00 51. 00 52. 00 53. 00 54. 01 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 64. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Iir Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 69 Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intru Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	Pt. II, as applicable) III, see instructions) ne 49 see instructions). P) uctions) I, column 9, lines 30 t V, col. 11 line 200)	hrough 35).	1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094 0 0 0 12, 568, 689 0 12, 568, 689 396, 492 94, 400 0	50. 00 51. 00 52. 00 53. 00 54. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Iir Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 69 Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intra Routine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	Pt. II, as applicable) III, see instructions) ne 49 see instructions). P) uctions) I, column 9, lines 30 t V, col. 11 line 200) line 60)	hrough 35).	1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094 0 0 0 12, 568, 689 396, 492 94, 400	50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
50. 00 51. 00 52. 00 53. 00 54. 00 55. 01 55. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 64. 00 65. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Iir Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intruction foutine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	Pt. II, as applicable) III, see instructions) ne 49 see instructions). P) uctions) I, column 9, lines 30 t V, col. 11 line 200) line 60)	hrough 35).	1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094 0 0 0 12, 568, 689 0 12, 568, 689 396, 492 94, 400 0 0	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00
50. 00 51. 00 52. 00 53. 00 54. 00 55. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 64. 00 65. 00 66. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Iir Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 69 Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introcutine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs (from Wkst. D, Pt. II Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a	Pt. II, as applicable) III, see instructions) ne 49 see instructions). P) Juctions) I, column 9, lines 30 t V, col. 11 line 200) Tine 60) Tuctions) applicable to MS-DRGs (s	ee instructions)	1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094 0 0 0 12, 568, 689 396, 492 94, 400 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00
50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Iir Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 65 Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introcost of physicians' services in a teaching hospital (see introcoutine service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs from Wkst. D, Pt. II Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96).	Pt. II, as applicable) III, see instructions) ne 49 see instructions). P) Juctions) I, column 9, lines 30 t V, col. 11 line 200) Tine 60) Tuctions) applicable to MS-DRGs (s	ee instructions)	1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094 0 0 0 12, 568, 689 0 12, 568, 689 396, 492 94, 400 0 0 12, 077, 797 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 61. 00 62. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Iir Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 69 Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introgram to service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs (from Wkst. D, Pt. II Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	Pt. II, as applicable) III, see instructions) ne 49 see instructions). P) uctions) I, column 9, lines 30 t V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions) s)	1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094 0 0 0 12, 568, 689 0 12, 568, 689 396, 492 94, 400 0 0 12, 077, 797 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00
50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Iir Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69 Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see intrough cost of physicians' services in a teaching hospital (see intrough cost of physicians' services in a teaching hospital (see intrough cost of physicians' services in a teaching hospital (see intrough cost of physicians' services in a teaching hospital (see intrough cost of physicians) Ancillary service other pass through costs from Wkst. D, Pt. II Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a coutlier payments reconciliation (sum of lines 93, 95 and 96). (OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonstration)	Pt. II, as applicable) III, see instructions) ne 49 see instructions). P) uctions) I, column 9, lines 30 t V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions) s)	1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094 0 0 12, 568, 689 0 12, 568, 689 396, 492 94, 400 0 0 12, 077, 797 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50
50. 00 51. 00 52. 00 53. 00 54. 01 55. 00 55. 01 56. 00 57. 00 58. 00 61. 00 62. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Iir Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, Iine 69 Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see introgram to service other pass through costs (from Wkst. D, Pt. II Ancillary service other pass through costs (from Wkst. D, Pt. II Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructions) Credits received from manufacturers for replaced devices for a Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	Pt. II, as applicable) III, see instructions) ne 49 see instructions). P) uctions) I, column 9, lines 30 t V, col. 11 line 200) line 60) ructions) applicable to MS-DRGs (s (For SCH see instruction	ee instructions) s)	1. 00 10, 646, 352 535, 628 0 1, 378, 615 0 8, 094 0 0 0 12, 568, 689 0 12, 568, 689 396, 492 94, 400 0 0 12, 077, 797 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 00 55. 01 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00

70. 88 70. 89

0 70. 90 0 70. 91 0 70. 92

70. 94

-12, 170 70. 93

-28, 786

70.88 SCH or MDH volume decrease adjustment (contractor use only)
70.89 Pioneer ACO demonstration payment adjustment amount (see instructions)

70.90
HSP bonus payment HVBP adjustment amount (see instructions)
HSP bonus payment HRR adjustment amount (see instructions)
Bundled Model 1 discount amount (see instructions)

70.93 | HVBP payment adjustment amount (see instructions)

70.94 HRR adjustment amount (see instructions)

70.95 Recovery of accelerated depreciation

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0040	Peri od:	Worksheet E

From 01/01/2023 To 12/31/2023 Part A Date/Time Prepared: 5/31/2024 12:06 pm Title XVIII Hospi tal PPS FFY (yyyy) Amount 1.00 0 70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 0 70.96 the corresponding federal year for the period prior to 10/1) 70. 97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 0 70.97 the corresponding federal year for the period ending on or after 10/1) 70.98 0 Low Volume Payment-3 70.98 0 70 99 HAC adjustment amount (see instructions) 18, 360 70 99 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70) 12, 018, 481 71.00 71.00 71. 01 Sequestration adjustment (see instructions) 240, 370 71.01 Demonstration payment adjustment amount after sequestration 71. 02 71. 02 71. 03 Sequestration adjustment-PARHM pass-throughs 71.03 72.00 Interim payments 10, 763, 778 72.00 72. 01 Interim payments-PARHM 72.01 73.00 Tentative settlement (for contractor use only) Ω 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 1, 014, 333 74.00 73) Balance due provider/program-PARHM (see instructions) 74 01 74 01 75.00 Protested amounts (nonallowable cost report items) in accordance with 225, 358 75.00 CMS Pub. 15-2, chapter 1, §115.2 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 0 90.00 plus 2.04 (see instructions) Capital outlier from Wkst. L, Pt. I, line 2 91.00 Ω 91.00 92.00 Operating outlier reconciliation adjustment amount (see instructions) 0 92.00 93.00 Capital outlier reconciliation adjustment amount (see instructions) 93.00 0 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) 96.00 0 Prior to 10/1 On/After 10/1 2 00 1 00 HSP Bonus Payment Amount 0 100. 00 100.00 HSP bonus amount (see instructions) 0 HVBP Adjustment for HSP Bonus Payment 0.0000000000101.00 101.00 HVBP adjustment factor (see instructions) 0.0000000000 102.00 HVBP adjustment amount for HSP bonus payment (see instructions) 0 102.00 HRR Adjustment for HSP Bonus Payment 0.0000 103.00 103.00 HRR adjustment factor (see instructions) 0.0000 104.00 HRR adjustment amount for HSP bonus payment (see instructions) 0 104, 00 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 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. 00 203.00 203.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration peri od) 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 Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line 211) 212.00 213. 00 218. 00 213.00 Low-volume adjustment (see instructions) 218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL	CENTER	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi		rom 01/01/2023 o 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/31/2024 12:06 pm

		Title XVIII	Hospi tal	5/31/2024 12: PPS	06 pm
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			19, 926	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		4, 775, 656	2.00
3. 00 4. 00	OPPS or REH payments Outlier payment (see instructions)			3, 151, 621 521, 942	3. 00 4. 00
4. 01					4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	5. 00
6.00	Line 2 times line 5			0	6.00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	7. 00 8. 00
9. 00	Ancillary service other pass through costs including REH direct	graduate medical educa	ition costs from	0	9. 00
	Wkst. D, Pt. IV, col. 13, line 200				
10. 00 11. 00	Organ acquisitions Total cost (sum of Lines 1 and 10) (see instructions)			0 19, 926	10. 00 11. 00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			19, 920	11.00
	Reasonabl e charges				
12.00	Ancillary service charges	(0)		74, 853	
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Iir Total reasonable charges (sum of lines 12 and 13)	ne 69)		0 74, 853	13. 00 14. 00
14.00	Customary charges			74, 033	14.00
15. 00	Aggregate amount actually collected from patients liable for pa	9	J	0	15. 00
16. 00	Amounts that would have been realized from patients liable for		a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			74, 853	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lin	ie 11) (see	54, 927	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete only</pre>	if line 11 eyecode lin	10) (600	0	20. 00
20.00	instructions)	I I IIIIe II exceeds III	le 10) (See	O	20.00
21. 00	Lesser of cost or charges (see instructions)			19, 926	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instru Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ictions)		0 3, 673, 563	23. 00 24. 00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			3, 073, 303	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line			612, 785	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plinstructions)	us the sum of lines 22	and 23] (see	3, 080, 704	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lir	ne 50)		423, 472	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 31. 00	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments			3, 504, 176 0	30. 00 31. 00
32. 00	Subtotal (line 30 minus line 31)			3, 504, 176	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	33. 00 34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
36. 00	1 -	ıctions)		0	36. 00
37. 00	Subtotal (see instructions)			3, 504, 176	
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			O	39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration	ud daylage (' ' '	d ana)	0	39. 97
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	ed devices (see instruct	ions)	0	39. 98 39. 99
40. 00	Subtotal (see instructions)			3, 504, 176	40.00
40. 01	Sequestration adjustment (see instructions)			70, 084	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			2, 999, 558	40. 03 41. 00
41. 01	Interim payments-PARHM			2, 777, 550	41. 01
42. 00	Tentative settlement (for contractors use only)			0	42. 00
42. 01	Tentative settlement-PARHM (for contractor use only)			404 504	42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			434, 534	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2. c	hapter 1,	0	44. 00
	§115. 2		· · ·		
00.00	TO BE COMPLETED BY CONTRACTOR			^	00.00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 91. 00
	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0	93. 00

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL CENTER	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-0040	Peri od:	Worksheet E	
		From 01/01/2023		
		To 12/31/2023	Date/Time Pre	
			5/31/2024 12:	06 pm_
	Title XVIII	Hospi tal	PPS	
			1. 00	
94.00 Total (sum of lines 91 and 93)			0	94. 00
			1. 00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems HOBOKEN UNIVERSITY MEDICAL CENTER ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 31-0040 Peri od: Worksheet E-1 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/31/2024 12:06 pm Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 10, 668, 241 2, 999, 558 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 08/23/2023 95, 537 0 3.01 3.02 0 3.02 3.03 3.03 0 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 3.51 0 3.51 0 0 3.52 3.52 0 3.53 3.53 0 3.54 0 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 95, 537 Ω 3.99 3.50-3.98) 2, 999, 558 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 10, 763, 778 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.01 TENTATIVE TO PROVIDER 0 0 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 1, 014, 333 434, 534 6.01

11, 778, 111

0

Contractor

Number

1 00

6.02

7.00

8.00

3, 434, 092

NPR Date (Mo/Day/Yr)

2 00

6 02

7.00

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Total Medicare program liability (see instructions)

Component CCN: 31-S040

		Title	XVIII	Subprovi der – I PF	PPS	•
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 751, 82		0	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for			0	U U	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3. 03
3. 04				0	0	3. 04
3. 05	Dravidar to Dragger			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			ol	0	3. 50
3. 51	ADJUSTIMENTS TO TROOKINI			0	0	3. 51
3. 52				Ö	o	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			0	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		1, 751, 82	0	0	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		1, 751, 62	7	١	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			o	0	5. 01
5.02				O	0	5. 02
5.03				0	0	5. 03
	Provi der to Program					
5. 50 5. 51	TENTATI VE TO PROGRAM			0	0	5. 50 5. 51
5. 51				0		5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
0. , ,	5. 50-5. 98)					0. , ,
6.00	Determined net settlement amount (balance due) based on					6. 00
,	the cost report. (1)				_	,
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			0	0	6. 01 6. 02
6. 02 7. 00	Total Medicare program liability (see instructions)		1, 751, 82			7. 00
7.00	Total medical e program Habitity (See Histraettons)		1, 751, 02	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Provider CCN: 31-0040 Component CCN: 31-5512 Title XVIII Skilled Nursing

				killed Nursing Facility	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider 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		1, 387, 149 0		0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER		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) TO BE COMPLETED BY CONTRACTOR		1, 387, 149		0	4. 00
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) Program to Provider					5. 00
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENTITIVE TO TROVIDER		Ö		0	5. 02
5. 03			Ö		0	5. 03
	Provider to Program					
5.50	TENTATI VE 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, 387, 149		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
0.00		()	1. 00	2. 00	0.00
8. 00	Name of Contractor			I		8. 00

Heal th	Health Financial Systems HOBOKEN UNIVERSITY MEDICAL CENTER In Lieu				
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 31-0040	Peri od:	Worksheet E-1	i
			From 01/01/2023		
			To 12/31/2023		
		T: +1 - W/// 1	11: 4-1	5/31/2024 12:	<u>06 pm</u>
		Title XVIII	Hospi tal	PPS	
				1.00	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14	I	1. 00
2.00	Medicare days (see instructions)			I	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			I	3. 00
4.00	Total inpatient days (see instructions)			I	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			I	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20		I	6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I	I	7. 00
	line 168	03		I	
8.00	Calculation of the HIT incentive payment (see instructions)			I	8. 00
9.00	Sequestration adjustment amount (see instructions)			I	9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		I	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	(,			1
30. 00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)			I	31. 00
22.00	1 3/	ing 21) (coo inctruction	٥)	ı	22.00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL CENTER	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 31-0040	Peri od: From 01/01/2023	Worksheet E-3
	Component CCN: 31-S040		
	Title XVIII	Subprovi der -	PPS
		I PF	

	IPF		
		1. 00	
PART II - MEDICARE PART A SERVICES - IPF PPS			
Net Federal IPF PPS Payments (excluding outlier, ECT, and medi	cal education payments)	1, 942, 975	
Net IPF PPS Outlier Payments		11, 718	
Net IPF PPS ECT Payments	not managet filled on on before Nevember	0	3
Unweighted intern and resident FTE count in the most recent count in the most recent count in the most recent count in the most recent count in the most recent count in the most recent countries.	ost report filed on or before November	0. 00	4
15, 2004. (see firstructions) Cap increases for the unweighted intern and resident FTE count	t for residents that were displaced by	0. 00	4
program or hospital closure, that would not be counted without		0.00	
CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	t a temperary sup augustment under 12		
New Teaching program adjustment. (see instructions)		0.00	5
OO Current year's unweighted FTE count of I&R excluding FTEs in t	the new program growth period of a "new	0.00	6
teaching program" (see instuctions)			
OD Current year's unweighted I&R FTE count for residents within	the new program growth period of a "new	0. 00	7
teaching program" (see instuctions)			_
Intern and resident count for IPF PPS medical education adjust	tment (see instructions)	0.00	
NO Average Daily Census (see instructions) OD Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	the newer of E1EO 1)	30. 728767 0. 000000	
00 Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to 1 00 Teaching Adjustment (line 1 multiplied by line 10).	the power or .5150 -1}.	0.000000	
00 Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		1, 954, 693	
00 Nursing and Allied Health Managed Care payment (see instruction	an)	1, 734, 073	13
00 Organ acquisition (DO NOT USE THIS LINE)	511)	O	12
00 Cost of physicians' services in a teaching hospital (see insti	ructions)	0	15
00 Subtotal (see instructions)	dott ons)	1, 954, 693	
OO Primary payer payments		0	1
00 Subtotal (line 16 less line 17).		1, 954, 693	
00 Deductibles		94, 312	
00 Subtotal (line 18 minus line 19)		1, 860, 381	20
00 Coi nsurance		72, 800	2
00 Subtotal (line 20 minus line 21)		1, 787, 581	22
00 Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)	0	23
00 Adjusted reimbursable bad debts (see instructions)		0	
00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	
00 Subtotal (sum of lines 22 and 24)		1, 787, 581	
OD Direct graduate medical education payments (see instructions)		0	27
00 Other pass through costs (see instructions)		0	
00 Outlier payments reconciliation		0	
OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`	0	
Pioneer ACO demonstration payment adjustment (see instructions	5)	0	
98 Recovery of accelerated depreciation. 99 Demonstration payment adjustment amount before sequestration		0	
79 Demonstration payment adjustment amount before sequestration of Total amount payable to the provider (see instructions)		1, 787, 581	
Of Sequestration adjustment (see instructions)		35, 752	
02 Demonstration payment adjustment amount after sequestration		33, 732	3
00 Interim payments		1, 751, 829	
00 Tentative settlement (for contractor use only)		0	33
00 Balance due provider/program (line 31 minus lines 31.01, 31.02	2. 32 and 33)	0	
On Protested amounts (nonallowable cost report items) in accordance	· ·	0	35
§115. 2	, and the second second		
TO BE COMPLETED BY CONTRACTOR			
OO Original outlier amount from Worksheet E-3, Part II, line 2		11, 718	
OUTLIER reconciliation adjustment amount (see instructions)		0	51
OD The rate used to calculate the Time Value of Money		0.00	
00 Time Value of Money (see instructions)		0	53
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND	BEGINNING ON OR BEFORE MAY 11, 2023 (THE	END OF	
THE COVID-19 PHE)	diataly proceding Faking 20 2022	0.000000	
00 Teaching Adjustment Factor for the cost reporting period immed	3.	0. 000000 0. 000000	
01 Calculated Teaching Adjustment Factor for the current year. (see Thati uctions)	0.000000	ا م

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-0040	Peri od:	Worksheet E-3	
		Component CCN: 31-5512	From 01/01/2023 To 12/31/2023	Part VI Date/Time Prep 5/31/2024 12:0	
		Title XVIII	Skilled Nursing Facility	PPS	
				1. 00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL O	THER HEALTH SERVICES FOR T	TITLE XVIII PART A		
	SERVI CES				1
00	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			4 470 040	1
. 00 . 00	Resource Utilization Group Payment (RUGS)			1, 470, 242	
. 00	Routine service other pass through costs Ancillary service other pass through costs			0	3.0
. 00	Subtotal (sum of lines 1 through 3)			1, 470, 242	
. 00	COMPUTATION OF NET COST OF COVERED SERVICES			1, 470, 242	4.0
. 00	Medical and other services (Do not use this line as vaccine	costs are included in lir	ne 1 of W/S E.		5.0
	Part B. This line is now shaded.)				
. 00	Deducti bl e			0	6.0
. 00	Coi nsurance			54, 784	7.0
. 00	Allowable bad debts (see instructions)			0	8. 0
. 00	Reimbursable bad debts for dual eligible beneficiaries (see	instructions)		0	1
0. 00	Adjusted reimbursable bad debts (see instructions)			0	
1. 00	Utilization review			0	•
2. 00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines	10 and 11)(see instruction	ons)	1, 415, 458	
	Inpatient primary payer payments				13. 0
4. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	
4. 50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		-	14. 5 14. 9
4. 98 4. 99	Recovery of accelerated depreciation. Demonstration payment adjustment amount before sequestration	2		0	1
5. 00	Subtotal (see instructions	1		1, 415, 458	
5. 01	Sequestration adjustment (see instructions)			28, 309	
	Demonstration payment adjustment amount after sequestration			20, 307	1
	Sequestration for non-claims based amounts (see instructions	5)		0	
	Interim payments	-,		1, 387, 149	
	Tentative settlement (for contractor use only)			0	1
	Balance due provider/program (line 15 minus lines 15.01, 15.	02, 15.75, 16, and 17)		0	
	Protested amounts (nonallowable cost report items) in accord		2. chapter 1.	0	

0

16.00 Interim payments
17.00 Tentative settlement (for contractor use only)
18.00 Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)
19.00 Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1,

Health Financial Systems	HOBOKEN UNIVERSITY M	EDICAL CENTER	In Lieu of Form CMS-2		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 31-0040	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/31/2024 12:06 pm	
•					

			o 12/31/2023	Date/lime Pre 5/31/2024 12:	
		Title XIX	Hospi tal	TEFRA	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	TOTOLO FOR TITLES V OR XIX	OLIVI OLO		
1.00	Inpatient hospital/SNF/NF services		1, 379, 912		1.00
2. 00	Medical and other services		1,0,7,712	669, 405	2.00
3.00	Organ acquisition (certified transplant programs only)		٥	007, 100	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		1, 379, 912	669, 405	4.00
5. 00	Inpatient primary payer payments		1, 3, 7, 7, 2	007, 100	5.00
6.00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		1, 379, 912	669, 405	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		., .,	2217 122	
	Reasonabl e Charges				İ
8. 00	Routine service charges		14, 710, 000		8.00
9.00	Ancillary service charges		15, 202, 803	21, 603, 691	9. 00
10.00	Organ acquisition charges, net of revenue		o	, ,	10.00
11. 00	Incentive from target amount computation		o		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		29, 912, 803	21, 603, 691	12.00
	CUSTOMARY CHARGES				1
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis				
14.00	Amounts that would have been realized from patients liable for		0	0	14. 00
	a charge basis had such payment been made in accordance with 4	12 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		29, 912, 803	21, 603, 691	
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	28, 532, 891	20, 934, 286	17. 00
40.00	line 4) (see instructions)	. 6 1			40.00
18. 00	Excess of reasonable cost over customary charges (complete onl	y IT line 4 exceeds line	0	0	18. 00
19. 00	16) (see instructions) Interns and Residents (see instructions)			0	19. 00
20. 00	Cost of physicians' services in a teaching hospital (see instr	custions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1	,	1, 379, 912	669, 405	21.00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			009, 403	21.00
22. 00	Other than outlier payments	compreted for FF3 provide	0	0	22. 00
23. 00	Outlier payments			0	23. 00
24. 00	Program capital payments			O	24.00
25. 00	Capital exception payments (see instructions)				25.00
26. 00	Routine and Ancillary service other pass through costs			0	26.00
27. 00	Subtotal (sum of lines 22 through 26)			0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		o	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		1, 379, 912	669, 405	
	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)	l	1, 379, 912	669, 405	31.00
32.00	Deducti bl es		o	0	32.00
33.00	Coi nsurance		o	0	33. 00
34.00	Allowable bad debts (see instructions)		o	0	34.00
35.00	Utilization review		o		35. 00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	1, 379, 912	669, 405	36. 00
37.00			0	0	37. 00
38. 00	, , , ,		1, 379, 912	669, 405	38. 00
39. 00	, ,		0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		1, 379, 912	669, 405	
41.00	Interim payments		1, 291, 625	682, 561	41.00
42.00	Balance due provider/program (line 40 minus line 41)		88, 287	-13, 156	
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				

Health Financial Systems	HOBOKEN UNIVERSITY MEDICAL CENTER	In Li€	eu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-0040	Peri od: From 01/01/2023	Worksheet E-3 Part VII
	Component CCN: 31-S04		
	Title XIX	Subprovi der -	TEFRA

		II ti e Xi X	IPF	121101	
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES	FOR TITLES V OR XI)	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		599, 702		1. 00
2.00	Medi cal 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)		599, 702	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)		599, 702	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		6, 138, 000		8. 00
9.00	Ancillary service charges		1, 428, 956	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		28, 674		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		7, 595, 630	0	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for serv	vices on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for paym		0	0	14. 00
	a charge basis had such payment been made in accordance with 42 CFR	R §413. 13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		7, 595, 630	0	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only if	line 16 exceeds	6, 995, 928	0	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only if	line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)			0	40.00
19.00	Interns and Residents (see instructions)	>	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruction	ons)	500 700	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	-t 6 DDC	599, 702	0	21. 00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completely then subline payments	eted for PPS provide	ers.	0	22.00
22. 00	Other than outlier payments		0	0	22. 00 23. 00
23. 00 24. 00	Outlier payments Program capital payments		0	Ü	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)		599, 702	0	29.00
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		377, 702	0	29.00
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)		599, 702	0	31.00
32. 00	Deductibles		377, 702	0	32.00
33. 00	Coinsurance			0	33. 00
34. 00	Allowable bad debts (see instructions)			0	34.00
35. 00	Utilization review			O	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		599, 702	0	36.00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0,7,7,02	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		599, 702	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0,7,7,02	Ü	39.00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		599, 702	0	40.00
41. 00	Interim payments		609, 026	0	41.00
42. 00	Balance due provider/program (line 40 minus line 41)		-9, 324	0	42. 00
43. 00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2	,			
					•

	Financial Systems HOBOKEN UNIVERSITY M				u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider CO	CN: 31-0040	Peri od: From 01/01/2023	Worksheet E-4	
WEDI OF	LEDUCATION COSTS			To 12/31/2023	Date/Time Prep 5/31/2024 12:0	
		Title	XVIII	Hospi tal	PPS	36 piii
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	orograms for	cost reporti	ng periods	21. 40	1. 00
1. 01	FTE cap adjustment under §131 of the CAA 2021 (see instruction	ns)			0. 00	1. 01
2.00	Unweighted FTE resident cap add-on for new programs per 42 CF				0.00	2.00
2. 26	Rural track program FTE cap limitation adjustment after the cap the CAA 2021 (see instructions)	ap-building	window closed	under §127 of	0. 00	2. 26
3.00	Amount of reduction to Direct GME cap under section 422 of MM.				1. 92	3. 00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)	with 42 CFR	§413.79 (m).	(see	0. 00	3. 01
3. 02	Adjustment (increase or decrease) to the hospital's rural trace programs with a rural track Medicare GME affiliation agreemen				0. 00	3. 02
4. 00	49075 (August 10, 2022) (see instructions) Adjustment (plus or minus) to the FTE cap for allopathic and (CMT offiliation personne) (AC CFD 8412 75(b) and 8 412 70 (f))		programs due	to a Medicare	0.00	4. 00
4. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see instistraddling 7/1/2011)		cost reporti	ng periods	0. 00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slot: periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0. 00	4. 02
4. 21	The amount of increase if the hospital was awarded FTE cap slinstructions)	ots under §1	26 of the CAA	A 2021 (see	0. 00	4. 21
5. 00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus line 3.01, plus or minus line 3.02, plus or minus line 4, plus line			nus lines 3 and	19. 48	5. 00
6.00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)			year from your	26. 07	6. 00
7. 00	Enter the lesser of line 5 or line 6				19. 48	7. 00
			Primary Care	0ther 2.00	Total 3.00	
8. 00	Weighted FTE count for physicians in an allopathic and osteop	athi c	21. 5		25. 81	8. 00
9. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw		16. 2	3. 20	19. 48	9. 00
	multiply line 8 times the result of line 5 divided by the amount of the cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions.					
10.00		ent year		11.00		10.00
10. 01	Unweighted dental and podiatric resident FTE count for the cu	rrent year		11.00		10. 01
11. 00 12. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reporting	n vear (see	16. 2 17. 2			11. 00 12. 00
	instructions)					
13. 00	Total weighted resident FTE count for the penultimate cost relyear (see instructions)	porting	17. 2	27 14. 24		13. 00
14. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	16. 9			14. 00
15. 00	Adjustment for residents in initial years of new programs		0.0			15. 00
15. 01 16. 00	Unweighted adjustment for residents in initial years of new placed by program or hospital close		0. (0. (15. 01 16. 00
	Unweighted adjustment for residents displaced by program or held osure		0. 0			16. 01
17. 00			16. 9			17. 00
18. 00 18. 01			195, 619. 2			18.00
	Per resident amount under §131 of the CAA 2021 Approved amount for resident costs		0. 0 3, 313, 79		5, 912, 627	18. 01 19. 00
				·	1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots red	cei ved under 42		20. 00
21. 00	Direct GME FTE unweighted resident count over cap (see instru	ctions)			6. 59	21. 00
22. 00	Allowable additional direct GME FTE Resident Count (see instr					22. 00
23. 00	Enter the locality adjustment national average per resident and Multiply line 22 time line 23	mount (see i	nstructions)			23. 00
	Total direct GME amount (sum of lines 19 and 24)				5, 912, 627	24. 00 25. 00

Heal th	Financial Systems HOBOKEN UNIVERSITY M	IEDI CAL CENTI	ER	In Lie	u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT		CN: 31-0040	Peri od:	Worksheet E-4	
MEDI CAI	L EDUCATION COSTS			From 01/01/2023 To 12/31/2023	Date/Time Pre	aanad.
				To 12/31/2023	5/31/2024 12:0	
		Title	· XVIII	Hospi tal	PPS	
			Inpatient Par	t Managed Care	Total	
			A			
	COMPUTATION OF PROCESM DATIENT LOAD		1.00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD Inpatient Days (see instructions) (Title XIX - see S-2 Part I)	Y line	3, 94	19 4, 228		26. 00
20.00	3.02, column 2)	X, TITIE	3, 7	4, 220		20.00
27. 00	Total Inpatient Days (see instructions)		26, 37	26, 375		27. 00
28. 00	Ratio of inpatient days to total inpatient days		0. 14972	0. 160303		28. 00
29. 00	Program direct GME amount		885, 20	947, 812	1, 833, 080	29. 00
29. 01	Percent reduction for MA DGME			3. 27		29. 01
	Reduction for direct GME payments for Medicare Advantage			30, 993	30, 993	
31. 00	Net Program direct GME amount				1, 802, 087	31. 00
					1 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE	E VIIII ONLV	/ (NUIDCLNC DD)	CDAM AND DADAMER	1. 00	
	EDUCATION COSTS)	E AVIII UNLT	(NUKSING PKC	GRAW AND PARAWEL	JI CAL	
32. 00	Renal dialysis direct medical education costs (from Wkst. B, I	Pt. I, sum c	of col. 20 and	l 23, lines 74	0	32. 00
33. 00	and 94) Renal dialysis and home dialysis total charges (Wkst. C, Pt.		um of lines :	(4 and 04)	E00 244	33. 00
	Ratio of direct medical education costs to total charges (line			4 and 94)	588, 366 0. 000000	
35. 00	Medicare outpatient ESRD charges (see instructions)	e 32 - 1111e	33)		0.000000	35. 00
	Medicare outpatient ESRD direct medical education costs (line	34 x line 3	35)		0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII				-	
ĺ	Part A Reasonable Cost					
	Reasonable cost (see instructions)				15, 612, 004	37. 00
	Organ acquisition and HSCT acquisition costs (see instructions				0	38. 00
	Cost of physicians' services in a teaching hospital (see inst	ructions)			0	
	Primary payer payments (see instructions)				0	40. 00
	Total Part A reasonable cost (sum of lines 37 through 39 minus	s line 40)			15, 612, 004	41. 00
	Part B Reasonable Cost Reasonable cost (see instructions)				4, 795, 582	42. 00
	Primary payer payments (see instructions)				4, 795, 562	42.00
	Total Part B reasonable cost (line 42 minus line 43)				4, 795, 582	
	Total reasonable cost (sum of lines 41 and 44)				20, 407, 586	
	Ratio of Part A reasonable cost to total reasonable cost (line	e 41 ÷ line	45)		0. 765010	
	Ratio of Part B reasonable cost to total reasonable cost (line				0. 234990	
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	RT B				
	Total program GME payment (line 31)				1, 802, 087	
	Part A Medicare GME payment (line 46 x 48) (title XVIII only)				1, 378, 615	
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instru	ictions)		423, 472	50.00

Heal th	Health Financial Systems HOBOKEN UNIVERSITY MEDICAL CENTER In Lieu		u of Form CMS-2	552-10	
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 31-0040	Peri od:	Worksheet E-5	
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/31/2024 12:0	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instr	uctions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instruc	tions)		О	4.00
5.00	The rate used to calculate the time value of money (see instr	uctions)		0.00	5.00
6.00	Time value of money for operating expenses (see instructions)			O	6.00
7. 00	Time value of money for capital related expenses (see instruc	tions)		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: 31-0040

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

5/31/2024 12:06 pm Speci fi c Endowment Fund General Fund Plant Fund Purpose Fund 1.00 3.00 4.00 2.00 CURRENT ASSETS 1.00 1.00 Cash on hand in banks 998,000 0 0 0 0 0 2.00 Temporary investments 0 2.00 0 3.00 Notes receivable 0 0 3.00 45, 587, 000 0 4 00 4 00 Accounts receivable 0 0 5.00 Other receivable 214,000 0 0 5.00 6.00 Allowances for uncollectible notes and accounts receivable 6.00 0 7.00 Inventory 2, 934, 000 0 0 7.00 0 8.00 Prepaid expenses 1, 212, 000 0 8.00 0 9.00 Other current assets 38, 156, 000 0 9.00 10 00 Due from other funds 0 0 0 10 00 Total current assets (sum of lines 1-10) 89, 101, 000 0 0 11.00 0 11 00 FIXED ASSETS 12.00 Land 0 0 0 12.00 Land improvements 0 13.00 0 0 0 0 0 0 0 0 0 0 0 0 0 13.00 οl Accumulated depreciation 14.00 0 14.00 15.00 Bui I di ngs 58, 147, 262 0 0 15.00 16.00 Accumulated depreciation -51, 716, 879 0 16.00 0 17.00 Leasehold improvements 17.00 0 0 18 00 Accumulated depreciation C Λ 18 00 Fi xed equipment 19.00 19.00 0 20.00 Accumulated depreciation 0 20.00 0 21.00 Automobiles and trucks C 0 21.00 22.00 Accumulated depreciation 0 22.00 23.00 Major movable equipment 36, 688, 057 0 23.00 Accumulated depreciation -32, 538, 440 24.00 24.00 0 25.00 Mi nor equi pment depreci able Λ 25, 00 26.00 Accumulated depreciation 0 0 26.00 C 27.00 HIT designated Assets 0 0 0 27.00 0 28.00 Accumulated depreciation 0 0 28.00 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 30.00 Total fixed assets (sum of lines 12-29) 10, 580, 000 0 30.00 OTHER ASSETS 31 00 Investments O 0 0 31 00 0 0 32.00 Deposits on Leases C 0 32.00 Due from owners/officers 0 0 0 33.00 33.00 0 34.00 Other assets 28, 567, 000 0 0 34.00 0 Total other assets (sum of lines 31-34) 35.00 28, 567, 000 0 35, 00 36.00 Total assets (sum of lines 11, 30, and 35) 128, 248, 000 0 0 0 36.00 CURRENT LIABILITIES 37 00 39 202 000 O 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 7, 100, 000 0 38.00 0 Payroll taxes payable 39.00 39.00 0 0 Notes and Loans payable (short term) 32, 045, 000 0 40.00 40.00 0 5, 488, 000 0 Deferred income 41 00 41 00 0 42.00 Accelerated payments 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities 0 0 44.00 13, 331, 000 0 44.00 Total current liabilities (sum of lines 37 thru 44) 0 0 45.00 97, 166, 000 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 11, 453, 000 0 46.00 0 0 Notes payable 0 47.00 47.00 48 00 Unsecured Loans 0 0 0 48 00 Other long term liabilities 6, 715, 000 0 0 49.00 49.00 0 50 00 Total long term liabilities (sum of lines 46 thru 49) 18, 168, 000 0 0 0 50.00 Total liabilities (sum of lines 45 and 50) 51.00 115, 334, 000 0 0 0 51.00 CAPITAL ACCOUNTS General fund balance 12, 914, 000 52.00 52.00 53.00 Specific purpose fund 0 53.00 Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted 54.00 0 54.00 55.00 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 57.00 0 58.00 0 58.00 replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 12, 914, 000 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 128, 248, 000 0 0 0 60.00

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10 Provider CCN: 31-0040

					То	12/31/2023	Date/Time Prep 5/31/2024 12:0	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	ус р
				·				
	I 	1.00	2.00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		26, 648, 000			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-13, 734, 000					2.00
3.00	Total (sum of line 1 and line 2)		12, 914, 000			0	0	3. 00
4. 00 5. 00	Additions (credit adjustments) (specify)	0			0		0	4. 00 5. 00
6.00		0			0		0	6. 00
7. 00					0		0	7. 00
8. 00					0		0	8. 00
9. 00					0		0	9. 00
10. 00	Total additions (sum of line 4-9)		0			0	Ĭ	10. 00
11. 00	Subtotal (line 3 plus line 10)		12, 914, 000			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	0	12, 7.1, 000		0	, and a	0	12. 00
13. 00	, (, (, (, /, /, /, /	o			Ō		ol	13. 00
14. 00		o			Ō		ol	14. 00
15.00		O			0		o	15.00
16.00		O			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		12, 914, 000			0		19.00
	sheet (line 11 minus line 18)		51	L				
		Endowment Fund	PI ant	Funa				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0.00	7.00	0.00	0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)				Ī			2. 00
3.00	Total (sum of line 1 and line 2)	o			0			3. 00
4.00	Additions (credit adjustments) (specify)		0					4.00
5.00			0					5.00
6.00			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 17. 00			0					16. 00 17. 00
18.00	Total deductions (sum of lines 12-17)		U		0			17.00
19. 00	Fund balance at end of period per balance				0			19. 00
17.00	sheet (line 11 minus line 18)				٥			17.00
	12	1	'	!	,		'	

			') 12/31/2023	5/31/2024 12:0	
	Cost Center Description	Inpa	ti ent	Outpati ent	Total	<u> Б.ш.</u>
	Social Social Person		. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	285	, 748, 031		285, 748, 031	1.00
2.00	SUBPROVI DER - I PF	198	, 918, 000		198, 918, 000	2.00
3.00	SUBPROVI DER - I RF		0		0	3.00
4.00	SUBPROVI DER					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	67	, 788, 000		67, 788, 000	7.00
8.00	NURSING FACILITY		0		0	8.00
9.00	OTHER LONG TERM CARE		0		0	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	552	, 454, 031		552, 454, 031	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT	27	, 526, 000		27, 526, 000	
12. 00	CORONARY CARE UNIT		0		0	12. 00
13. 00	BURN INTENSIVE CARE UNIT		0		0	13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT		0		0	14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	lines 27	, 526, 000		27, 526, 000	16. 00
17 00	11-15)	F70	000 001		F70 000 001	17.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		, 980, 031	FFF (02 000	579, 980, 031	17. 00
18.00	Ancillary services	499	, 136, 985	555, 692, 089		18.00
19.00	Outpatient services		0	883, 328, 469	883, 328, 469 0	19. 00
20. 00 21. 00	RURAL HEALTH CLINIC		0	0	0	20. 00 21. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY		U	0	0	21.00
23. 00	AMBULANCE SERVICES		0	0	0	23. 00
24. 00	CMHC		U	0	0	24. 00
24. 00	CORF		0	0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		0	0	0	25. 00
26. 00	HOSPI CE		0	0	0	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 1 079	117 016	1 439 020 558	2, 518, 137, 574	
20.00	G-3, line 1)	1,077	, 117, 010	1, 107, 020, 000	2,010,107,071	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			186, 738, 738		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		186, 738, 738		43.00
	to Wkst. G-3, line 4)					

	<i></i>	ITY MEDICAL CENTER		u of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 31-0040	Peri od: From 01/01/2023	Worksheet G-3	
			To 12/31/2023	Date/Time Pre 5/31/2024 12:	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,	line 28)		2, 518, 137, 574	1. 00
2.00	Less contractual allowances and discounts on patients' ac	ccounts		2, 384, 731, 836	2. 00
3.00	Net patient revenues (line 1 minus line 2)			133, 405, 738	
4.00	Less total operating expenses (from Wkst. G-2, Part II, I			186, 738, 738	
5.00	Net income from service to patients (line 3 minus line 4)	<u> </u>		-53, 333, 000	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communica	ation services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
11. 00	Rebates and refunds of expenses			0	
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 oth	ner than patients		0	
17. 00	Revenue from sale of drugs to other than patients			0	
18. 00	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER REVENUE			6, 338, 658	24. 00
24. 01	STATE SUSIDIES			21, 526, 396	
24. 02	COVI D PHE FUNDI NG			11, 733, 946	
24. 50	COVI D-19 PHE Fundi ng			0	
	Total other income (sum of lines 6-24)			39, 599, 000	
26. 00	Total (line 5 plus line 25)			-13, 734, 000	
27. 00	OTHER EXPENSES (SPECIFY)			0	
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

0 28. 00

-13, 734, 000 29. 00

		RSITY MEDICAL CENTER		u of Form CMS-2	2552-1
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 31-0040	Peri od: From 01/01/2023	Worksheet L Parts I-III	
			To 12/31/2023		pared:
				5/31/2024 12:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				1
. 00	Capital DRG other than outlier			397, 189	1.0
. 01	Model 4 BPCI Capital DRG other than outlier			0	
. 00	Capital DRG outlier payments			773	2.0
. 01	Model 4 BPCI Capital DRG outlier payments			0	2.0
00	Total inpatient days divided by number of days in the c	ost reporting period (see inst	ructions)	41. 53	3.0
. 00	Number of interns & residents (see instructions)		·	32. 40	4. (
. 00	Indirect medical education percentage (see instructions			24. 63	5. (
. 00	Indirect medical education adjustment (multiply line 5 1.01)(see instructions)	by the sum of lines 1 and 1.01	, columns 1 and	97, 828	6. (
. 00	Percentage of SSI recipient patient days to Medicare Pa	rt A patient days (Worksheet E	E, part A line	18. 67	7. (
. 00	30) (see instructions) Percentage of Medicaid patient days to total days (see	instructions)		28. 56	8. (
. 00				47. 23	
0. 00	Allowable disproportionate share percentage (see instru	actions)		10. 03	
1. 00	Disproportionate share adjustment (see instructions)	10113)		39, 838	
2. 00	Total prospective capital payments (see instructions)			535, 628	1
				,	
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				١
. 00	Program inpatient routine capital cost (see instruction			0	1
. 00	Program inpatient ancillary capital cost (see instructi			0	1
. 00	Total inpatient program capital cost (line 1 plus line	2)		0	
. 00	Capital cost payment factor (see instructions)			0	
. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. (
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
	Program inpatient capital costs (see instructions)			0	1. (
. 00	Program inpatient capital costs for extraordinary circu	mstances (see instructions)		0	2.0
	program ripatrent capital costs for extraordinary crice			0	3.0
. 00 . 00	Net program inpatient capital costs (line 1 minus line	2)			
. 00 . 00 . 00	Net program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions)	•		0.00	1
. 00 . 00 . 00 . 00	Net program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line	4)		0. 00 0	5.
. 00 . 00 . 00 . 00	Net program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line Percentage adjustment for extraordinary circumstances (4) see instructions)		0. 00 0 0. 00	5. 6.
. 00 . 00 . 00 . 00	Net program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line Percentage adjustment for extraordinary circumstances (Adjustment to capital minimum payment level for extraor	4) see instructions)	(line 6)	0. 00 0 0. 00 0	5. (6. (7. (
2. 00 3. 00 4. 00 5. 00 5. 00 7. 00 3. 00	Net program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line Percentage adjustment for extraordinary circumstances (Adjustment to capital minimum payment level for extraor Capital minimum payment level (line 5 plus line 7)	4) see instructions) dinary circumstances (line 2 x	(line 6)	0. 00 0 0. 00 0 0	5. (6. (7. (8. (
2. 00 2. 00 3. 00 4. 00 5. 00 7. 00 3. 00 9. 00	Net program inpatient capital costs (line 1 minus line Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line Percentage adjustment for extraordinary circumstances (Adjustment to capital minimum payment level for extraor	4) (see instructions) (dinary circumstances (line 2 x	,	0. 00 0 0. 00 0	5. 6. 7. 8. 9.

11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)

(if line 12 is negative, enter the amount on this line)

17.00 | Current year exception offset amount (see instructions)

15.00 Current year allowable operating and capital payment (see instructions)

16.00 Current year operating and capital costs (see instructions)

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Carryover of accumulated capital minimum payment level over capital payment for the following period

0 12.00

0 13.00

0 14.00

0 15.00

0 16.00 0 17.00

11.00

12.00

13.00

14.00