



**PHILIP D. MURPHY**  
Governor

**State of New Jersey**  
**DEPARTMENT OF HUMAN SERVICES**

**SARAH ADELMAN**  
Commissioner

**SHEILA Y. OLIVER**  
Lt. Governor

**P.O. BOX 700**  
**TRENTON, NJ 08625-0700**

February 17, 2023

The Honorable Eve Cullinan  
County Administrator of Burlington County  
49 Rancocas Road  
Mount Holly, NJ 08060

Dear Mrs. Cullinan,

Thank you for submitting the proposed Fee and Expenditure Report for the New Jersey County Option Hospital Fee Program on December 9, 2022. This Report has been under public review from January 21, 2023 through February 10, 2023. Please refer to the correspondence dated January 20, 2023, for those details.

The 21-day public review period concluded on February 10, 2023. There were no comments or requests for clarification received for Burlington County's County Option Program.

- There was a joint letter expressing full support of the program from Virtua Health and their hospitals in Burlington County.
- Jennifer Mancuso, Executive Director of Fair Share Hospital Collaborative, shared a letter expressing FSHC's full support of the County Option program.

Requests for Fee and Expenditure Reports have been disseminated to all who requested them:

- Michael Keevey, RWJBarnabas Health
- Nisha Sikder, Valley Health System
- Patricia Quinn, O'Conco Healthcare Consultants
- Margaret King, Myers and Stauffer
- Megan Nigro, McCarter & English, LLP

At this time, the NJ Department of Human Services (the Department) has approved your local hospital assessment program and it will be submitted to CMS for federal review and approval. Burlington County's program continues to be considered for a potentially effective date of July 1, 2023, pending CMS approval.

Next steps for implementation of the program include:

1. State drafts IGT agreement between Burlington County and State to outline provisions for the non-federal share of Medicaid payments to Burlington County by March 31, 2023.
2. County must pass an ordinance in compliance with N.J.A.C. 10:52B-2.2.

3. State submits preprint, quality parameters to CMS for approval for an effective date of July 1, 2023.
4. State and Burlington County finalize IGT agreement prior to SFY24 program. implementation.

Please direct all questions to [Dmahs.hospcountyfee@dhs.nj.gov](mailto:Dmahs.hospcountyfee@dhs.nj.gov). The Department will notify you upon CMS approval of the Program.

Sincerely,

A handwritten signature in black ink that reads "Eric Kaufmann". The signature is written in a cursive, flowing style.

Eric Kaufmann  
Acting Chief Financial Officer

**Date:** 12 / 9 / 2022

**Subject:** New Jersey County Option Hospital Fee Program Fee and Expenditure Report

**County:** Burlington County

## GENERAL

Describe the proposed hospital fee program the county intends to enact by providing details on all of the elements listed below.

## FEE PROGRAM

1. What is the county's proposed effective date of the fee program?

July 1, 2023

2. List of all licensed hospitals located in your county:

Please Include: Name, address, facility ownership (for profit, NFP or government owned) **and** type of facility (acute care, psychiatric, rehabilitation, children's, LTACH, Specialty)

Please see "Attachment A" for a full list of hospitals located in Burlington County.

3. Federal law and regulations require all hospitals in a jurisdiction to be taxed, unless a specific process is followed to exempt particular hospitals – a process that includes meeting a statistical test.

Does the county plan on excluding any hospitals from the fee program?  No  Yes

If so, please list name(s) and type of facility:

4. If the county plan **proposes to exempt** particular hospitals/classes of hospitals, please provide a policy justification for excluding those specific hospitals/classes of hospitals from the fee program. (If not, please leave blank)

5. The law creating the County Option Hospital Fee Program requires that counties consult with affected hospitals within their jurisdiction prior to submitting the Fee and Expenditure Report to the Commissioner of Human Services. Please detail when and how county officials consulted with affected hospitals.

The County, through its contractor, Eyman Associates, implemented a comprehensive process of consulting and gathering feedback from all hospitals within the jurisdiction. The process began with an introductory call with the county hospitals to educate them on the intent and goals of the pilot program, the relevant state and federal requirements, and the information required to inform the County's Fee and Expenditure report. The County's contractor, including its technical subcontractor, supported affected hospitals in completing the state's data, DSH template, and attestation forms. Once all data was collected, hospitals were again invited to participate in discussion of available options for both the fee and payment components of the program. The contractor collected written feedback from each affected hospital to inform the County's of a final model.

6. Please describe the basis of the proposed fee – e.g. net patient revenue, days of care, discharges? (N.J.A.C. 10:52B)

The County proposes to assess a fee on inpatient hospital services, structured as a uniform dollar amount per non-Medicare discharge for services furnished within the County's jurisdiction. Those hospitals that have provider-based facilities located outside the county, have segregated their in-county from out-of-county services and only the services provided within the County will be assessed.

7. Will the basis for the proposed fee exclude Medicare and /or Medicaid data?

Yes. The discharges assessed will exclude Medicare discharges.

8. What is the proposed fee rate or fee amount?

Please specify if different fee rates or amounts will be applied to inpatient versus outpatient services and identify respective notes/ amounts.

The assessment rate will be \$626.35 per non-Medicare discharge.

9. Will the same fee rate or fee amount apply to all hospitals included in the fee program?  No  Yes

If not, please describe which fee rate or amount is proposed to be applied to each hospital and the policy rationale.

10. If the fee program is not uniform or broad based, one or more statistical tests must be passed for the fee to comply with federal regulations. If the proposed fee program is **not broad-based** or **not uniform**, please provide a copy of the federally compliant statistical test(s) in an excel document.  N/A  Attached

Information on federally compliant statistical test (s) can be accessed at 42 CFR § 433.68

- Permissible health care-related taxes.

<https://www.govinfo.gov/content/pkg/CFR-2018-title42-vol4/xml/CFR-2018-title42-vol4-sec433-68.xml>

11. While the transfers to the state from the county must occur quarterly, what is the planned timing for collecting the fee – quarterly, monthly, biannually?

Quarterly  Monthly  Biannually  Other \_\_\_\_\_



12. What interest and/or penalties will be imposed for failure to pay the fee?

In the event a hospital fails to remit the fee by the due date, the County may apply interest to the amount due, not to exceed 1.5% of the outstanding payment amount per month, reflected on the following quarter's invoice.

13. What appeal process will be established to resolve any disputes related to the fee program?

Upon federal approval of the program and annually thereafter, the County will officially notify hospitals that the fee program will take effect, and of the annual and quarterly fee amounts they will be required to pay. Should any hospital be charged interest on late payments, they will receive a notice informing them of the imposition of the interest amount. The hospitals will have 15 days from receipt of the annual notice to contest the fee amount, and 15 days from receipt of a notice imposing interest on late payments to contest the interest payment. Such appeals will be filed by submission of a letter, including any supporting documents, to the County specifying the basis for the appeal.

14. How will hospitals be notified of their fee obligation and any other related operational requirements under the fee program?

The County will send an annual notice to the hospitals at the beginning of each program year notifying them of their fee obligations under the program. The County will also send each hospital quarterly invoices notifying them of their fee obligation and the payment deadline at least 20 days in advance of each quarterly due date.

15. Please provide any additional pertinent information that you believe would be helpful in describing the program.

This Fee & Expenditure report was prepared by the County's contracted consultants who have nationwide experience working with these types of programs. The County has relied extensively on their expertise in developing the model, responding to these questions and assuring compliance with state and federal rules. The signed certification below relies in large part on the work and advice of the contracted consultants.

## PROPOSED PAYMENT PROGRAM

As part of the program, counties may submit a proposed payment methodology detailing how program funds will be distributed to hospitals and the basis of the distribution. However, as the single State agency for the Medicaid Program, the Department's role is to review the proposed programs to assure that the assessment design and proposed expenditure methodology, if provided, comply with federal regulations governing such programs. A county's proposed payment method must include details on elements listed below.

### 1. What is the proposed basis for determining the hospital payment amounts?

The County proposes that the state implement a Medicaid managed care directed payment in the form of a uniform rate increase for inpatient hospital services provided by hospitals located in Burlington County. There are nine hospitals in the County, four of which are acute care hospitals and five of which are non-acute. Because of the differences in acuity across the two types of hospitals, the County proposes to establish two payment classes for the rate increase: Acute and Non-Acute Hospitals. The rate increase would be implemented as a dollar add-on of \$12,303.45 per Medicaid managed care discharge for the Acute Hospital class and a dollar add-on of \$256.48 per Medicaid managed care day for the Non-Acute class. The payment methodology would be the same for all hospitals within a class, thereby directing the expenditures equally, using the same terms of performance, as required by 42 CFR 438.6(c)(2)(i)(B).

Details of the calculation of this payment methodology are contained in the attached model, prepared by our contractors, and we will make our contractors available to the state to answer any questions about it or provide additional information as needed. The directed payments would be provided on a quarterly basis, paid to the managed care organizations as a separate payment term (apart from monthly capitation payments to the plans). The four quarterly payments would each be equal to 25% of the projected annual rate increase amount. The projected rate increase is primarily based on the state's SFY 2019 encounter data provided by DMAHS on 11/16/22. However, because of significant changes in utilization by two of the non-acute care hospitals after 2019, the County proposes to use more recent encounter data for the interim payments for those two hospitals in order to avoid large swings in payments upon final reconciliation. The final reconciliation adjustment would be determined after the end of the year, based on actual services provided, maintaining the same proportion of payments across the two classes. The second quarterly payment of the subsequent program year would be adjusted (upwards or downwards) by the reconciliation amount. In this way, the payments would meet the federal requirement at 42 CFR 438.6(c)(2)(i)(A) that directed payments be "based on the utilization and delivery of services."

To minimize the time between the hospitals' payment of the fee and the distribution of the managed care directed payment to the hospitals, the County requests that the managed care organizations be directed to make the requisite payments to the hospitals within 30 calendar days of receipt of transferred fee amounts from the County. Moreover, because our proposed model would impose very little, if any, administrative burden on the managed care organizations, requiring them simply to make the directed payments in the amounts provided by the state, it is our understanding that they will be permitted to retain no more of the directed payment amounts provided to them than the amount necessary to cover their incremental HMO premium fee costs (approximately 5%). The contract language with the managed care organizations should reflect this requirement in order to ensure that the program complies with the intended purpose of supporting local hospitals.

The County anticipates that the state would work with the participating hospitals in developing an evaluation plan for the program and any associated quality reporting requirements.

### 2. The purpose of the County Option Hospital Fee Program is to increase financial resources through the Medicaid/NJ FamilyCare program to support local hospitals and to ensure that they continue to provide necessary services to low-income residents. How will the payments be utilized to effectuate this purpose?

Acute care hospitals in Burlington County collectively provide significant amounts of unreimbursed health care services to uninsured and low-income patients throughout the County. Additionally, Burlington County has several non-acute hospitals that provide critical access to important specialty services for New Jersey Medicaid enrollees, such as rehabilitation (including specialized pediatric rehabilitation services) and behavioral health care. Moreover, all of the hospitals have been significantly impacted by the COVID-19 pandemic and by inflation, especially with respect to workforce costs. The new resources generated from the County Option Hospital Fee Pilot Program will help to stabilize the hospitals' financial position and strengthen their capacity to continue providing access to comprehensive and essential healthcare services to low income Burlington County residents.

Please note that the County reserves the right to use its 9% share of the fee proceeds for any purpose it deems appropriate.



## OTHER COUNTY REQUIREMENTS

### CHECK BOX TO CONFIRM COMPLETION AND/OR AGREEMENT

- The county has provided the state with all calculations for the fee, the proposed payments, and the statistical test.
- The county understands that the funds created from this program are to increase financial resources through the Medicaid/NJ FamilyCare program to support local hospitals in providing necessary services to low-income residents.
- The county understands that at least 90% of the fee amounts collected will be transferred to the state to be used as the non-federal share for federally matched hospital payments.
- The county understands that at least 1% of the fee amounts collected will be transferred to the state for the state's administrative costs.
- The county understands that fees to be collected may not exceed 2.5% of the net patient revenue of hospitals included in the fee program.
- The following FORMS and ATTESTATION must be submitted with the Fee and Expenditure Report for each hospital located in the county (Include all source documents)
  - Data Form for County Option Hospital Fee Program**
  - Preliminary DSH Calculation Template**
- Attestation**  
Signed by each hospital located in the county.

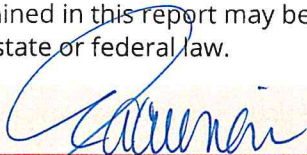
## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM FEE AND EXPENDITURE ATTESTATION

#### CERTIFICATION BY COUNTY OFFICER OR ADMINISTRATOR

I hereby certify that I have examined the Fee & Expenditure Report for the reporting periods specified and that to the best of my knowledge and belief it is true, correct and complete statement prepared from the county option hospital fee state data set created from reports submitted by the hospitals within the county's jurisdiction in accordance with applicable instructions, except as noted. I understand that misrepresentation or falsification of any information contained in this report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under state or federal law.

Signed



County Officer or Administrator

Name:

E.A. Cullinan

Full Name (Printed)

Title:

County Administrator - Burlington County

Date:

12 / 8 / 22

Email Address:

ECullinan@CO.Burlington.nj.us



## Attachment A

### New Jersey County Option Hospital Fee Program List of hospitals located in Burlington County

#### Aspen Hills Healthcare Center

600 Pemberton Browns Mills Rd, Pemberton, NJ 08068

- Psychiatric
- For-Profit

#### Deborah Heart and Lung

200 Trenton Rd, Browns Mills, NJ 08015

- General Acute Care
- Not-For-Profit

#### Hampton Behavioral Health

650 Rancocas Rd, Westampton, NJ 08060

- Psychiatric
- For-Profit

#### Kessler Institute for Rehabilitation - Marlton

92 Brick Rd, Marlton, NJ 08053

- Rehabilitation
- For-Profit

#### Select Specialty Hospital – Willingboro

218 Sunset Road, Willingboro, NJ 08046

- Long-Term Acute Care
- For-Profit

#### Virtua Health System – Marlton

90 Brick Road, Marlton, NJ 08053

- General Acute Care
- Not-For-Profit

#### Virtua Health System – Memorial (Mount Holly)

175 Madison Avenue, Mount Holly, NJ 08060

- General Acute Care
- Not-For-Profit

#### Virtual Health System – Willingboro

218A Sunset Road, Willingboro, NJ 08046

- General Acute Care
- Not-For-Profit

Weisman Children's Rehabilitation Hospital  
92 Brick Rd, Marlton, NJ 08053

- Rehabilitation
- For-Profit

# BURLINGTON COUNTY HOSPITAL FEE

Fee Basis: \$626.35 per Non-Medicare Discharge

State Directed Medicaid Payment (Acute Care Hospitals): \$12,303.45 per Discharge

State Directed Medicaid Payment (Non-acute Care Hospitals): \$261.13 per Diem

<b>Total Fee Receipts</b>	<b>\$22,097,146</b>
<b>County's Resource</b>	<b>\$1,988,743</b>
State's Resource	\$220,971
<i>Non-federal Share of Medicaid Payments</i>	<i>\$19,887,432</i>

HOSPITAL	Fees Paid	State Directed Medicaid MCO Payments	Lost DSH Payments
Virtua West Jersey - Marlton	\$3,411,124	\$4,355,423	\$0
Virtua Memorial	\$12,821,469	\$31,865,949	(\$1,032,292)
Virtua Willingboro	\$3,284,601	\$8,993,826	\$0
Deborah	\$777,305	\$2,632,939	\$0
<b>Acute Care Hospitals</b>	<b>\$20,294,499</b>	<b>\$47,848,138</b>	<b>(\$1,032,292)</b>

Aspen Hills	\$292,507	\$1,018,145	\$0
Hampton BHC	\$1,051,022	\$2,596,412	\$0
Kessler Marlton	\$326,330	\$410,235	\$0
Weisman Children's Rehab	\$65,141	\$318,317	\$0
Select Specialty Hosp - So. NJ	\$67,646	\$234,233	\$0
<b>Non-Acute Care Hospitals</b>	<b>\$1,802,647</b>	<b>\$4,577,342</b>	<b>\$0</b>



# BURLINGTON COUNTY HOSPITAL FEE

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State Directed Medicaid Payment (Acute Care Hospitals): \$12,303.45 per Discharge

State Directed Medicaid Payment (Non-acute Care Hospitals): \$261.13 per Diem

\$626.35	Per Non-Medicare Discharge	$fee\ rate = d_{sum} / c_{sum}$
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	HOSPITAL	a	b	d = a - b - c	e = d * fee rate
		All-Payer	Medicare	Revenue Basis	Fee Receipts
<b>Discharges</b>	Virtua West Jersey - Marlton	10,096	4,650	5,446	\$3,411,124
	Virtua Memorial	26,627	6,157	20,470	\$12,821,469
	Virtua Willingboro	7,409	2,165	5,244	\$3,284,601
	Deborah	3,838	2,597	1,241	\$777,305
	Aspen Hills	602	135	467	\$292,507
	Hampton BHC	1,998	320	1,678	\$1,051,022
	Kessler Marlton	1,465	944	521	\$326,330
	Weisman Children's Rehab	104	0	104	\$65,141
	Select Specialty Hosp - So. NJ	420	312	108	\$67,646
<b>Total</b>		<b>52,559</b>	<b>17,280</b>	<b>35,279</b>	<b>\$22,097,146</b>

<b>Total Fee Receipts</b>	<b>\$22,097,146</b>	$j = i$
County Resource	\$1,988,743	$k = j * 9\%$
State Resource	\$220,971	$l = j * 1\%$
State Share Medicaid Payments	\$19,887,432	$m = j - k - l$
Est Effective FMAP	64.00%	$n$
State + Federal Share of Medicaid Payments	\$55,242,866	$o = m / (1 - n)$
5% HMO Admin Fee	\$2,817,386	$p = o * 5.1\%$
State + Federal Share of Medicaid Payments Going to Hospitals	\$52,425,480	$q = o - p$
State + Federal Share of Medicaid Payments Going to Non-acute Hospitals	\$4,577,342	$r = q * 8.73\%$
State + Federal Share of Medicaid Payments Going to General Acute Hospitals	\$47,848,138	$s = q - r$

# BURLINGTON COUNTY HOSPITAL FEE

Fee Basis: \$626.35 per Non-Medicare Discharge

State Directed Medicaid Payment (Acute Care Hospitals): \$12,303.45 per Discharge

State Directed Medicaid Payment (Non-acute Care Hospitals): \$261.13 per Diem

Total Inpatient Hospital Enhanced Payments - Acute	\$47,848,138	a
Inpatient Hospital Add-On Payment (Acute)	\$12,303.46	b = a / e <sub>sum</sub>
Total Inpatient Hospital Enhanced Payments - Non-acute	\$4,577,342	c
Inpatient Hospital Add-On Payment (Per Diem Non-acute)	\$261.13	d = c / g <sub>sum</sub>

## Acute Medicaid MC Directed Payment

HOSPITAL	DISCHARGES	PAYMENTS
Virtua West Jersey - Marlton	354	4,355,423
Virtua Memorial	2,590	31,865,949
Virtua Willingboro	731	8,993,826
Deborah	214	2,632,939
<b>Acute Care Hospitals</b>	<b>3,889</b>	<b>47,848,138</b>

## Non-acute Medicaid MC Directed Payment

HOSPITAL	PATIENT DAYS	PAYMENTS
Aspen Hills	3,899	1,018,145
Hampton BHC	9,943	2,596,412
Kessler Marlton	1,571	410,235
Weisman Children's Rehab	1,219	318,317
Select Specialty Hosp - So. NJ	897	234,233
<b>Non-Acute Care Hospitals</b>	<b>17,529</b>	<b>\$4,577,342</b>

dd = \$0; if z < bb  
 dd = -cc; if z > bb AND if (z-bb) > cc  
 dd = bb - z; if z > bb AND if z - bb < cc  
 ee = z - aa + dd

ACUTE CARE HOSPITAL	State Directed Medicaid Payments	Fees Paid	DSH Room	Charity Care & HRSF-MH Payments	Lost DSH Payments	GAIN / (LOSS)
Virtua West Jersey - Marlton	\$4,355,423	\$3,411,124	\$0	\$0	\$0	\$944,299
Virtua Memorial	\$31,865,949	\$12,821,469	\$23,108,604	\$1,032,292	(\$1,032,292)	\$18,012,189
Virtua Willingboro	\$8,993,826	\$3,284,601	\$12,708,233	\$1,571,540	\$0	\$5,709,225
Deborah	\$2,632,939	\$777,305	\$6,376,638	\$730,045	\$0	\$1,855,634
<b>Acute Care Hospitals</b>	<b>\$47,848,138</b>	<b>\$20,294,499</b>			<b>(\$1,032,292)</b>	<b>\$26,521,346</b>
NON-ACUTE CARE HOSPITAL	State Directed Medicaid Payments	Fees Paid	DSH Room	Charity Care & HRSF-MH Payments	Lost DSH Payments	GAIN / (LOSS)
Aspen Hills	\$1,018,145	\$292,507	\$0	\$0	\$0	\$725,637
Hampton BHC	\$2,596,412	\$1,051,022	\$0	\$0	\$0	\$1,545,390
Kessler Marlton	\$410,235	\$326,330	\$0	\$0	\$0	\$83,904
Weisman Children's Rehab	\$318,317	\$65,141	\$0	\$0	\$0	\$253,176
Select Specialty Hosp - So. NJ	\$234,233	\$67,646	\$0	\$0	\$0	\$166,587
<b>Non-Acute Care Hospitals</b>	<b>\$4,577,342</b>	<b>\$1,802,647</b>				<b>\$2,774,695</b>

# BURLINGTON COUNTY OPTION FEE

## MAXIMUM ASSESSMENT

Fee Basis: \$626.35 per Non-Medicare Discharge

State Directed Medicaid Payment (Acute Care Hospitals): \$12,303.45 per Discharge

State Directed Medicaid Payment (Non-acute Care Hospitals): \$261.13 per Diem

### INPATIENT HOSPITAL

		Data Form Line 1	2.5% NPSR
		NPSR Revenue	
310022	Virtua West Jersey - Marlton	\$99,076,252	\$2,476,906
310057	Virtua Memorial	\$191,294,689	\$4,782,367
310061	Virtua Willingboro	\$43,245,679	\$1,081,142
310031	Deborah	\$112,586,570	\$2,814,664
314023	Aspen Hills	\$7,682,565	\$192,064
314021	Hampton BHC	\$28,298,879	\$707,472
313032	Kessler Marlton	\$36,127,484	\$903,187
313302	Weisman Children's Rehab	\$8,297,721	\$207,443
312022	Select Specialty Hosp - So. NJ	\$29,946,191	\$748,655

### OUTPATIENT HOSPITAL

		Data Form Line 1	
		NPSR Revenue	2.5% NPSR
310022	Virtua West Jersey - Marlton	\$45,216,532	\$1,130,413
310057	Virtua Memorial	\$144,287,778	\$3,607,194
310061	Virtua Willingboro	\$54,340,090	\$1,358,502
310031	Deborah	\$75,690,528	\$1,892,263
314023	Aspen Hills	\$0	\$0
314021	Hampton BHC	\$3,830,554	\$95,764
313032	Kessler Marlton	\$1,329,118	\$33,228
313302	Weisman Children's Rehab	\$2,635,229	\$65,881
312022	Select Specialty Hosp - So. NJ	\$0	\$0

<b>Maximum Fee Receipts</b>	<b>\$22,097,146</b>
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Affordable health coverage. Quality care.

## DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name Aspen Hills Healthcare Center

Facility address(es) within Authorized County \_\_\_\_\_

County Burlington

Medicaid Provider Number 0339521

Medicare Provider Number 314023

Hospital Parent Company (if applicable) \_\_\_\_\_

Contact Person Name Scott B. Stolbach, Esq.

Title General Counsel

Phone ( 908 ) - 617 - 5217 Ext: \_\_\_\_\_

Email Address sstolbach@icloud.com

Period Covered: January 1, 2021 to December 31, 2021

### INSTRUCTIONS

#### DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

If the reporting hospital chooses to use their Medicare cost report as a source document then two or more cost reports may be used to generate this verification.

This form should be submitted with the county's submission of the Fee and Expenditure Report. The data contained within will be used by the State of New Jersey, Department of Human Services and the Centers for Medicare and Medicaid Services (CMS) to design the payment mechanism and to verify and approve the local assessments.

The hospital administrator or officer must attest to the accuracy of the data contained in the form.

The hospital will be required to submit the source material that was used to complete the data fields and as marked on the form. Acceptable sources are the Medicare Cost report, other sourced financials, and/or materials supporting the documents. The State of New Jersey reserves the right to request additional documentation.

Please email any questions you have on completing this form to: [Dmahs.hospcountyfee@dhs.nj.gov](mailto:Dmahs.hospcountyfee@dhs.nj.gov).

## SECTION 1

Complete Column A for inpatient services and Column B for outpatient services.

### Line 1: Total Net Patient Revenue

Include revenue received for inpatient and outpatient services for the state fiscal year period. This amount excludes revenue from other operations such as cafeteria, parking, rent, research and educational activities. This amount also excludes non-operating revenue such as investment income and donations. Include any Medicaid supplemental payments and disproportionate share payments. **Please note that the sum of the inpatient and outpatient net patient revenue (NPR) should be equivalent to the NPR reported on Wksht G-3, Col 1, Line 3 of the Medicare Cost Report.**

### Line 2: Revenue from Distinct Part Hospital-Based Nursing Home Unit

Report revenue that is included in Line 1 received during the period for services provided in a distinct part hospital-based nursing home unit, only. If no such revenue is included in Line 1, enter "0".

### Line 3: Revenue Related to Physicians' Services

Report revenue that is included in Line 1 that is for physician direct care services, only. If no such revenue is included in Line 1, enter "0".

### Line 4: Other Non-Hospital Service-Specific Revenue

Report revenue that is included in Line 1 for other services, such as hospice services, pharmaceutical services, home health services, cafeteria, parking, rent, research and educational activities that are not hospital inpatient and outpatient services. If no such revenue is included in Line 1, enter "0".

### Line 5: Revenue Related to Services Provided at Locations Outside of the County

Report any inpatient and outpatient revenue included in Line 1 that was received for services provided at hospital campuses, clinics or other sites that are not located within the legislatively authorized county per N.J.S.A. 30:4D-7r - 30:4D-7x. If no such revenue is included in Line 1, enter "0".

### Line 6: Total Medicaid Revenue for the Period

Include all Medicaid inpatient and outpatient revenue received for the period including any Medicaid supplemental payments and disproportionate share payments.

### Line 7: Total Medicare Revenue for the Period

Include inpatient and outpatient revenue received for the period from Medicare Parts A, B and C. Include revenue received for the period through the Medicare Advantage Program including IME and DME payments. Include Medicare revenue for DSH, DME, organ acquisition, capital adjustments and allied health services. This amount does not include Medicare co-payments and deductible amounts paid under Medicare Parts A, B or C.

### Line 8: Bad Debt Included In Line 1

Enter any bad debt amounts that were included in Line 1. If no bad debt was included in Line 1, enter "0".

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## SECTION 2

### Line 9: Inpatient Days, Fee-For-Service

Include the number of fee-for-service days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 10: Inpatient Days, Managed Care

Include the number of managed care days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 11: Discharges, Inpatient Fee-For-Service

Include the number of fee-for-service discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 12: Discharges, Inpatient Managed Care

Include the number of managed care discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 13: Licensed Beds

Total Licensed inpatient beds at end of state fiscal year reporting period.

**SECTION 1**

LINE	REVENUE CATEGORY	Amount Verified From Hospital Records		SOURCE
		INPATIENT (Column A)	OUTPATIENT (Column B)	
1	Total Net Patient Revenue	\$7,682,565	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
2	Revenue from Distinct Part Hospital-Based Nursing Home Unit, If Included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
3	Revenue Related to Physicians' Services, If Included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
4	Other Non-Hospital Service-Specific Revenue	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
5	Revenue Related to Services Provided at Locations Outside of the County, if included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
6	Total Medicaid Revenue for the Period	\$ 3,811,864	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
7	Total Medicare Revenue for the Period	\$ 1,631,837	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
8	Bad Debt, if included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)

**SECTION 2**

LINE	REVENUE CATEGORY	COLUMN A	COLUMN B	COLUMN C	SOURCE
		MEDICAID	MEDICARE	OTHER	
9	Days, Inpatient Fee-for-Service	0	1,817	2,277	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
10	Days, Inpatient Managed Care	4,371	555	0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
11	Discharges, Inpatient Fee-for-Service	0	99	186	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
12	Discharges, Inpatient Managed Care	281	36	0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
13	Total Number of Licensed Beds at End of Period	30			



## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

**Hospital Name:** Aspen Hills Healthcare Center LLC

#### CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of Aspen Hills Healthcare Center hospital ("the hospital"), I hereby certify that:

- I have examined the accompanying Data Form & Preliminary DSH Limit Calculation Form for the reporting period specified and, to the best of my knowledge and belief, the information contained in the reports is true, correct, and complete and accurately reflect the information in the hospital's Medicare cost report, the hospital's financial statements and other accounting records.
- I understand that projected payments to the hospital under the New Jersey County Option Hospital Fee Program, when combined with other Medicaid and Disproportionate Share Hospital (DSH) payments, such as Charity Care payments, may exceed the federal maximum hospital-specific disproportionate share (DSH) limit in 42 U.S.C. § 1396r-4. I acknowledge that if the hospital's projected payments exceed its Hospital Specific DSH Limit, the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B)
- I understand that misrepresentation or falsification of any information contained in this report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under state or federal law.
- I certify that that the cost of the fee shall not be assigned to any patient, insurer, self-insured employer program, or other responsible party, nor shall the fee be listed separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

I am authorized to make this Certification on behalf of Aspen Hills Healthcare Center hospital.

**Signature** 

**Name**

Avraham Feigenbaum

Full Name (Printed)

**Title**

Manager

**Date**

11 / 15 / 2022



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## DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name DeborahHeart and Lung Center

Facility address(es) within Authorized County 200 Trenton Road, Browns Mills, NJ 08015

County Burlington

Medicaid Provider Number 4137205

Medicare Provider Number 310031

Hospital Parent Company (if applicable) N/A

Contact Person Name Joe Vescio

Title Director of Budget, Reimbursement, Cost & Decision Support

Phone ( 609 ) - 893 - 1200 Ext: 5794

Email Address vescioj@deborah.org

Period Covered: 01/01/2021 to 12/31/2021

## INSTRUCTIONS

### DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

If the reporting hospital chooses to use their Medicare cost report as a source document then two or more cost reports may be used to generate this verification.

This form should be submitted with the county's submission of the Fee and Expenditure Report. The data contained within will be used by the State of New Jersey, Department of Human Services and the Centers for Medicare and Medicaid Services (CMS) to design the payment mechanism and to verify and approve the local assessments.

The hospital administrator or officer must attest to the accuracy of the data contained in the form.

The hospital will be required to submit the source material that was used to complete the data fields and as marked on the form. Acceptable sources are the Medicare Cost report, other sourced financials, and/or materials supporting the documents. The State of New Jersey reserves the right to request additional documentation.

Please email any questions you have on completing this form to: [Dmahs.hospcountyfee@dhs.nj.gov](mailto:Dmahs.hospcountyfee@dhs.nj.gov).

## SECTION 1

Complete Column A for inpatient services and Column B for outpatient services.

### Line 1: Total Net Patient Revenue

Include revenue received for inpatient and outpatient services for the state fiscal year period. This amount excludes revenue from other operations such as cafeteria, parking, rent, research and educational activities. This amount also excludes non-operating revenue such as investment income and donations. Include any Medicaid supplemental payments and disproportionate share payments. **Please note that the sum of the inpatient and outpatient net patient revenue (NPR) should be equivalent to the NPR reported on Wksht G-3, Col 1, Line 3 of the Medicare Cost Report.**

### Line 2: Revenue from Distinct Part Hospital-Based Nursing Home Unit

Report revenue that is included in Line 1 received during the period for services provided in a distinct part hospital-based nursing home unit, only. If no such revenue is included in Line 1, enter "0".

### Line 3: Revenue Related to Physicians' Services

Report revenue that is included in Line 1 that is for physician direct care services, only. If no such revenue is included in Line 1, enter "0".

### Line 4: Other Non-Hospital Service-Specific Revenue

Report revenue that is included in Line 1 for other services, such as hospice services, pharmaceutical services, home health services, cafeteria, parking, rent, research and educational activities that are not hospital inpatient and outpatient services. If no such revenue is included in Line 1, enter "0".

### Line 5: Revenue Related to Services Provided at Locations Outside of the County

Report any inpatient and outpatient revenue included in Line 1 that was received for services provided at hospital campuses, clinics or other sites that are not located within the legislatively authorized county per N.J.S.A. 30:4D-7r - 30:4D-7x. If no such revenue is included in Line 1, enter "0".

### Line 6: Total Medicaid Revenue for the Period

Include all Medicaid inpatient and outpatient revenue received for the period including any Medicaid supplemental payments and disproportionate share payments.

### Line 7: Total Medicare Revenue for the Period

Include inpatient and outpatient revenue received for the period from Medicare Parts A, B and C. Include revenue received for the period through the Medicare Advantage Program including IME and DME payments. Include Medicare revenue for DSH, DME, organ acquisition, capital adjustments and allied health services. This amount does not include Medicare co-payments and deductible amounts paid under Medicare Parts A, B or C.

### Line 8: Bad Debt Included In Line 1

Enter any bad debt amounts that were included in Line 1. If no bad debt was included in Line 1, enter "0".

---

## SECTION 2

### Line 9: Inpatient Days, Fee-For-Service

Include the number of fee-for-service days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 10: Inpatient Days, Managed Care

Include the number of managed care days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 11: Discharges, Inpatient Fee-For-Service

Include the number of fee-for-service discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 12: Discharges, Inpatient Managed Care

Include the number of managed care discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 13: Licensed Beds

Total Licensed inpatient beds at end of state fiscal year reporting period.

**SECTION 1**

LINE	REVENUE CATEGORY	Amount Verified From Hospital Records		SOURCE
		INPATIENT (Column A)	OUTPATIENT (Column B)	
1	Total Net Patient Revenue	\$112,586,570	\$ 90,874,390	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
2	Revenue from Distinct Part Hospital-Based Nursing Home Unit, If Included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
3	Revenue Related to Physicians' Services, If Included in Line 1	\$ 0	\$ 15,183,862	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
4	Other Non-Hospital Service-Specific Revenue	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
5	Revenue Related to Services Provided at Locations Outside of the County, if included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
6	Total Medicaid Revenue for the Period	\$ 8,758,932	\$ 4,333,421	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
7	Total Medicare Revenue for the Period	\$ 75,356,991	\$ 31,764,941	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
8	Bad Debt, if included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)

**SECTION 2**

LINE	REVENUE CATEGORY	COLUMN A	COLUMN B	COLUMN C	SOURCE
		MEDICAID	MEDICARE	OTHER	
9	Days, Inpatient Fee-for-Service	369	8,466	1,210	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
10	Days, Inpatient Managed Care	2,053	5,964	3,186	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
11	Discharges, Inpatient Fee-for-Service	51	1,549	210	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
12	Discharges, Inpatient Managed Care	308	1,048	672	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
13	Total Number of Licensed Beds at End of Period	89			

## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name: Deborah Heart and Lung Center

#### CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of Deborah Heart and Lung Center hospital ("the hospital"), I hereby certify that:

- I have examined the accompanying Data Form & Preliminary DSH Limit Calculation Form for the reporting period specified and, to the best of my knowledge and belief, the information contained in the reports is true, correct, and complete and accurately reflect the information in the hospital's Medicare cost report, the hospital's financial statements and other accounting records.
- I understand that projected payments to the hospital under the New Jersey County Option Hospital Fee Program, when combined with other Medicaid and Disproportionate Share Hospital (DSH) payments, such as Charity Care payments, may exceed the federal maximum hospital-specific disproportionate share (DSH) limit in 42 U.S.C. § 1396r-4. I acknowledge that if the hospital's projected payments exceed its Hospital Specific DSH Limit, the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B)
- I understand that misrepresentation or falsification of any information contained in this report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under state or federal law.
- I certify that that the cost of the fee shall not be assigned to any patient, insurer, self-insured employer program, or other responsible party, nor shall the fee be listed separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

I am authorized to make this Certification on behalf of Deborah Heart and Lung Center hospital.

Signature Tom Percello

Name Tom Percello

Full Name (Printed)

Title Executive Vice President Finance & CFO Date 11 / 21 / 2022





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## DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name Hampton Behavioral Health Center

Facility address(es) within Authorized County RANCOCAS ROAD

County Burlington

Medicaid Provider Number 5446406

Medicare Provider Number 314021

Hospital Parent Company (if applicable) UHS

Contact Person Name Melissa Zinni

Title CFO

Phone ( 609 ) - 518 - 2156 Ext: \_\_\_\_\_

Email Address Melissa.zinni@uhsinc.com

Period Covered: 1/1/2021 to 12/31/2021

### INSTRUCTIONS

#### DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

If the reporting hospital chooses to use their Medicare cost report as a source document then two or more cost reports may be used to generate this verification.

This form should be submitted with the county's submission of the Fee and Expenditure Report. The data contained within will be used by the State of New Jersey, Department of Human Services and the Centers for Medicare and Medicaid Services (CMS) to design the payment mechanism and to verify and approve the local assessments.

The hospital administrator or officer must attest to the accuracy of the data contained in the form.

The hospital will be required to submit the source material that was used to complete the data fields and as marked on the form. Acceptable sources are the Medicare Cost report, other sourced financials, and/or materials supporting the documents. The State of New Jersey reserves the right to request additional documentation.

Please email any questions you have on completing this form to: [Dmahs.hospcountyfee@dhs.nj.gov](mailto:Dmahs.hospcountyfee@dhs.nj.gov).



## SECTION 1

Complete Column A for inpatient services and Column B for outpatient services.

### Line 1: Total Net Patient Revenue

Include revenue received for inpatient and outpatient services for the state fiscal year period. This amount excludes revenue from other operations such as cafeteria, parking, rent, research and educational activities. This amount also excludes non-operating revenue such as investment income and donations. Include any Medicaid supplemental payments and disproportionate share payments. **Please note that the sum of the inpatient and outpatient net patient revenue (NPR) should be equivalent to the NPR reported on Wksht G-3, Col 1, Line 3 of the Medicare Cost Report.**

### Line 2: Revenue from Distinct Part Hospital-Based Nursing Home Unit

Report revenue that is included in Line 1 received during the period for services provided in a distinct part hospital-based nursing home unit, only. If no such revenue is included in Line 1, enter "0".

### Line 3: Revenue Related to Physicians' Services

Report revenue that is included in Line 1 that is for physician direct care services, only. If no such revenue is included in Line 1, enter "0".

### Line 4: Other Non-Hospital Service-Specific Revenue

Report revenue that is included in Line 1 for other services, such as hospice services, pharmaceutical services, home health services, cafeteria, parking, rent, research and educational activities that are not hospital inpatient and outpatient services. If no such revenue is included in Line 1, enter "0".

### Line 5: Revenue Related to Services Provided at Locations Outside of the County

Report any inpatient and outpatient revenue included in Line 1 that was received for services provided at hospital campuses, clinics or other sites that are not located within the legislatively authorized county per N.J.S.A. 30:4D-7r - 30:4D-7x. If no such revenue is included in Line 1, enter "0".

### Line 6: Total Medicaid Revenue for the Period

Include all Medicaid inpatient and outpatient revenue received for the period including any Medicaid supplemental payments and disproportionate share payments.

### Line 7: Total Medicare Revenue for the Period

Include inpatient and outpatient revenue received for the period from Medicare Parts A, B and C. Include revenue received for the period through the Medicare Advantage Program including IME and DME payments. Include Medicare revenue for DSH, DME, organ acquisition, capital adjustments and allied health services. This amount does not include Medicare co-payments and deductible amounts paid under Medicare Parts A, B or C.

### Line 8: Bad Debt Included In Line 1

Enter any bad debt amounts that were included in Line 1. If no bad debt was included in Line 1, enter "0".

---

## SECTION 2

### Line 9: Inpatient Days, Fee-For-Service

Include the number of fee-for-service days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 10: Inpatient Days, Managed Care

Include the number of managed care days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 11: Discharges, Inpatient Fee-For-Service

Include the number of fee-for-service discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 12: Discharges, Inpatient Managed Care

Include the number of managed care discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 13: Licensed Beds

Total Licensed inpatient beds at end of state fiscal year reporting period.

**SECTION 1**

LINE	REVENUE CATEGORY	Amount Verified From Hospital Records		SOURCE
		INPATIENT (Column A)	OUTPATIENT (Column B)	
1	Total Net Patient Revenue	\$30,025,932	\$ 4,339,078	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
2	Revenue from Distinct Part Hospital-Based Nursing Home Unit, If Included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
3	Revenue Related to Physicians' Services, If Included in Line 1	\$ 1,228,628	\$ 251,501	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
4	Other Non-Hospital Service-Specific Revenue	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
5	Revenue Related to Services Provided at Locations Outside of the County, if included in Line 1	\$ 0	\$ 200,409	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
6	Total Medicaid Revenue for the Period	\$ 9,807,823	\$ 872,337	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
7	Total Medicare Revenue for the Period	\$ 7,223,280	\$ 436,520	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
8	Bad Debt, if included in Line 1	\$ 498,425	\$ 56,614	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)

**SECTION 2**

LINE	REVENUE CATEGORY	COLUMN A	COLUMN B	COLUMN C	SOURCE
		MEDICAID	MEDICARE	OTHER	
9	Days, Inpatient Fee-for-Service	305	4,090	1,087	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
10	Days, Inpatient Managed Care	12,900	3,057	13,306	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
11	Discharges, Inpatient Fee-for-Service	9	174	47	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
12	Discharges, Inpatient Managed Care	724	145	898	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
13	Total Number of Licensed Beds at End of Period	120			





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## DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name Marlton Rehabilitation Hospital

Facility address(es) within Authorized County 92 Brick Road, Marlton NJ 08053

County Burlington

Medicaid Provider Number 0565911

Medicare Provider Number 31-3032

Hospital Parent Company (if applicable) Select Medical Corporation

Contact Person Name Deb Caloiaro

Title Regional Director of Finance

Phone ( 717 ) - 547 - 1540 Ext: \_\_\_\_\_

Email Address dcaloiaro@selectmedical.com

Period Covered: 01/01/2021 to 12/31/2021

### INSTRUCTIONS

#### DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

If the reporting hospital chooses to use their Medicare cost report as a source document then two or more cost reports may be used to generate this verification.

This form should be submitted with the county's submission of the Fee and Expenditure Report. The data contained within will be used by the State of New Jersey, Department of Human Services and the Centers for Medicare and Medicaid Services (CMS) to design the payment mechanism and to verify and approve the local assessments.

The hospital administrator or officer must attest to the accuracy of the data contained in the form.

The hospital will be required to submit the source material that was used to complete the data fields and as marked on the form. Acceptable sources are the Medicare Cost report, other sourced financials, and/or materials supporting the documents. The State of New Jersey reserves the right to request additional documentation.

Please email any questions you have on completing this form to: [Dmahs.hospcountyfee@dhs.nj.gov](mailto:Dmahs.hospcountyfee@dhs.nj.gov).

## SECTION 1

Complete Column A for inpatient services and Column B for outpatient services.

### Line 1: Total Net Patient Revenue

Include revenue received for inpatient and outpatient services for the state fiscal year period. This amount excludes revenue from other operations such as cafeteria, parking, rent, research and educational activities. This amount also excludes non-operating revenue such as investment income and donations. Include any Medicaid supplemental payments and disproportionate share payments. **Please note that the sum of the inpatient and outpatient net patient revenue (NPR) should be equivalent to the NPR reported on Wksht G-3, Col 1, Line 3 of the Medicare Cost Report.**

### Line 2: Revenue from Distinct Part Hospital-Based Nursing Home Unit

Report revenue that is included in Line 1 received during the period for services provided in a distinct part hospital-based nursing home unit, only. If no such revenue is included in Line 1, enter "0".

### Line 3: Revenue Related to Physicians' Services

Report revenue that is included in Line 1 that is for physician direct care services, only. If no such revenue is included in Line 1, enter "0".

### Line 4: Other Non-Hospital Service-Specific Revenue

Report revenue that is included in Line 1 for other services, such as hospice services, pharmaceutical services, home health services, cafeteria, parking, rent, research and educational activities that are not hospital inpatient and outpatient services. If no such revenue is included in Line 1, enter "0".

### Line 5: Revenue Related to Services Provided at Locations Outside of the County

Report any inpatient and outpatient revenue included in Line 1 that was received for services provided at hospital campuses, clinics or other sites that are not located within the legislatively authorized county per N.J.S.A. 30:4D-7r - 30:4D-7x. If no such revenue is included in Line 1, enter "0".

### Line 6: Total Medicaid Revenue for the Period

Include all Medicaid inpatient and outpatient revenue received for the period including any Medicaid supplemental payments and disproportionate share payments.

### Line 7: Total Medicare Revenue for the Period

Include inpatient and outpatient revenue received for the period from Medicare Parts A, B and C. Include revenue received for the period through the Medicare Advantage Program including IME and DME payments. Include Medicare revenue for DSH, DME, organ acquisition, capital adjustments and allied health services. This amount does not include Medicare co-payments and deductible amounts paid under Medicare Parts A, B or C.

### Line 8: Bad Debt Included In Line 1

Enter any bad debt amounts that were included in Line 1. If no bad debt was included in Line 1, enter "0".

---

## SECTION 2

### Line 9: Inpatient Days, Fee-For-Service

Include the number of fee-for-service days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 10: Inpatient Days, Managed Care

Include the number of managed care days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 11: Discharges, Inpatient Fee-For-Service

Include the number of fee-for-service discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 12: Discharges, Inpatient Managed Care

Include the number of managed care discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 13: Licensed Beds

Total Licensed inpatient beds at end of state fiscal year reporting period.

**SECTION 1**

LINE	REVENUE CATEGORY	Amount Verified From Hospital Records		SOURCE
		INPATIENT (Column A)	OUTPATIENT (Column B)	
1	Total Net Patient Revenue	\$36,127,484	\$ 1,329,118	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="lws G-3 line 3 total net revenue"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
2	Revenue from Distinct Part Hospital-Based Nursing Home Unit, If Included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
3	Revenue Related to Physicians' Services, If Included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
4	Other Non-Hospital Service-Specific Revenue	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
5	Revenue Related to Services Provided at Locations Outside of the County, if included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
6	Total Medicaid Revenue for the Period	\$ 4,064,667	\$ 57,003	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
7	Total Medicare Revenue for the Period	\$ 25,379,686	\$ 592,437	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
8	Bad Debt, if included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)

**SECTION 2**

LINE	REVENUE CATEGORY	COLUMN A	COLUMN B	COLUMN C	SOURCE
		MEDICAID	MEDICARE	OTHER	
9	Days, Inpatient Fee-for-Service	522	9,594	4,555	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
10	Days, Inpatient Managed Care	2,166	3,786	0	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
11	Discharges, Inpatient Fee-for-Service	31	695	354	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
12	Discharges, Inpatient Managed Care	136	249		<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
13	Total Number of Licensed Beds at End of Period	61			



## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

**Hospital Name:** Kessler Institute of Rehabilitation Marlton

#### CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of Kessler Institute of Rehabilitation Marlton hospital ("the hospital"), I hereby certify that:

- I have examined the accompanying Data Form & Preliminary DSH Limit Calculation Form for the reporting period specified and, to the best of my knowledge and belief, the information contained in the reports is true, correct, and complete and accurately reflect the information in the hospital's Medicare cost report, the hospital's financial statements and other accounting records.
- I understand that projected payments to the hospital under the New Jersey County Option Hospital Fee Program, when combined with other Medicaid and Disproportionate Share Hospital (DSH) payments, such as Charity Care payments, may exceed the federal maximum hospital-specific disproportionate share (DSH) limit in 42 U.S.C. § 1396r-4. I acknowledge that if the hospital's projected payments exceed its Hospital Specific DSH Limit, the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B)
- I understand that misrepresentation or falsification of any information contained in this report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under state or federal law.
- I certify that that the cost of the fee shall not be assigned to any patient, insurer, self-insured employer program, or other responsible party, nor shall the fee be listed separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

I am authorized to make this Certification on behalf of Kessler Institute of Rehabilitation Marlton hospital.

**Signature** Sue Kida

**Name** Sue Kida

Full Name (Printed)

**Title** President

**Date** 11, 15, 2022



Affordable health coverage. Quality care.

## DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name Lourdes Specialty Hospital (dba Select Specialty Hospital - Willingboro)

Facility address(es) within Authorized County 218 Sunset Road, 3rd Floor, Willingboro NJ 08046

County Burlington

Medicaid Provider Number \_\_\_\_\_

Medicare Provider Number 31-2022

Hospital Parent Company (if applicable) Select Medical Corporation

Contact Person Name David Huffman

Title Regional Director of Finance

Phone ( 717 ) - 730 - 6881 Ext: \_\_\_\_\_

Email Address djhuffman@selectmedical.com

Period Covered: 09/01/2020 to 08/31/2021

### INSTRUCTIONS

#### DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

If the reporting hospital chooses to use their Medicare cost report as a source document then two or more cost reports may be used to generate this verification.

This form should be submitted with the county's submission of the Fee and Expenditure Report. The data contained within will be used by the State of New Jersey, Department of Human Services and the Centers for Medicare and Medicaid Services (CMS) to design the payment mechanism and to verify and approve the local assessments.

The hospital administrator or officer must attest to the accuracy of the data contained in the form.

The hospital will be required to submit the source material that was used to complete the data fields and as marked on the form. Acceptable sources are the Medicare Cost report, other sourced financials, and/or materials supporting the documents. The State of New Jersey reserves the right to request additional documentation.

Please email any questions you have on completing this form to: [Dmahs.hospcountyfee@dhs.nj.gov](mailto:Dmahs.hospcountyfee@dhs.nj.gov).

## SECTION 1

Complete Column A for inpatient services and Column B for outpatient services.

### Line 1: Total Net Patient Revenue

Include revenue received for inpatient and outpatient services for the state fiscal year period. This amount excludes revenue from other operations such as cafeteria, parking, rent, research and educational activities. This amount also excludes non-operating revenue such as investment income and donations. Include any Medicaid supplemental payments and disproportionate share payments. **Please note that the sum of the inpatient and outpatient net patient revenue (NPR) should be equivalent to the NPR reported on Wksht G-3, Col 1, Line 3 of the Medicare Cost Report.**

### Line 2: Revenue from Distinct Part Hospital-Based Nursing Home Unit

Report revenue that is included in Line 1 received during the period for services provided in a distinct part hospital-based nursing home unit, only. If no such revenue is included in Line 1, enter "0".

### Line 3: Revenue Related to Physicians' Services

Report revenue that is included in Line 1 that is for physician direct care services, only. If no such revenue is included in Line 1, enter "0".

### Line 4: Other Non-Hospital Service-Specific Revenue

Report revenue that is included in Line 1 for other services, such as hospice services, pharmaceutical services, home health services, cafeteria, parking, rent, research and educational activities that are not hospital inpatient and outpatient services. If no such revenue is included in Line 1, enter "0".

### Line 5: Revenue Related to Services Provided at Locations Outside of the County

Report any inpatient and outpatient revenue included in Line 1 that was received for services provided at hospital campuses, clinics or other sites that are not located within the legislatively authorized county per N.J.S.A. 30:4D-7r - 30:4D-7x. If no such revenue is included in Line 1, enter "0".

### Line 6: Total Medicaid Revenue for the Period

Include all Medicaid inpatient and outpatient revenue received for the period including any Medicaid supplemental payments and disproportionate share payments.

### Line 7: Total Medicare Revenue for the Period

Include inpatient and outpatient revenue received for the period from Medicare Parts A, B and C. Include revenue received for the period through the Medicare Advantage Program including IME and DME payments. Include Medicare revenue for DSH, DME, organ acquisition, capital adjustments and allied health services. This amount does not include Medicare co-payments and deductible amounts paid under Medicare Parts A, B or C.

### Line 8: Bad Debt Included In Line 1

Enter any bad debt amounts that were included in Line 1. If no bad debt was included in Line 1, enter "0".

---

## SECTION 2

### Line 9: Inpatient Days, Fee-For-Service

Include the number of fee-for-service days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 10: Inpatient Days, Managed Care

Include the number of managed care days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 11: Discharges, Inpatient Fee-For-Service

Include the number of fee-for-service discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 12: Discharges, Inpatient Managed Care

Include the number of managed care discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 13: Licensed Beds

Total Licensed inpatient beds at end of state fiscal year reporting period.

**SECTION 1**

LINE	REVENUE CATEGORY	Amount Verified From Hospital Records		SOURCE
		INPATIENT (Column A)	OUTPATIENT (Column B)	
1	Total Net Patient Revenue	\$29,946,191	\$ 0	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="ws G-3 line 3"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
2	Revenue from Distinct Part Hospital-Based Nursing Home Unit, If Included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
3	Revenue Related to Physicians' Services, If Included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
4	Other Non-Hospital Service-Specific Revenue	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
5	Revenue Related to Services Provided at Locations Outside of the County, if included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
6	Total Medicaid Revenue for the Period	\$ 0	\$ 0	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="S-3 reports zero Medicaid days"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
7	Total Medicare Revenue for the Period	\$ 16,722,306	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="E-3 part IV line 7"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
8	Bad Debt, if included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)

**SECTION 2**

LINE	REVENUE CATEGORY	COLUMN A	COLUMN B	COLUMN C	SOURCE
		MEDICAID	MEDICARE	OTHER	
9	Days, Inpatient Fee-for-Service	0	7,664	3,638	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="S-3"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
10	Days, Inpatient Managed Care	0	852		<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="S-3"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
11	Discharges, Inpatient Fee-for-Service	0	283	108	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="S-3"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
12	Discharges, Inpatient Managed Care	0	29		<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="S-3"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
13	Total Number of Licensed Beds at End of Period	<input type="text" value="69"/>			

## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name: Acuity Specialty Hospital of Southern New Jersey - d.b.a. Select Specialty Hospital - Willingboro

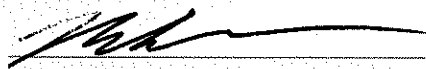
#### CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of Select Specialty Hospital - Willingboro hospital ("the hospital"), I hereby certify that:

- I have examined the accompanying Data Form & Preliminary DSH Limit Calculation Form for the reporting period specified and, to the best of my knowledge and belief, the information contained in the reports is true, correct, and complete and accurately reflect the information in the hospital's Medicare cost report, the hospital's financial statements and other accounting records.
- I understand that projected payments to the hospital under the New Jersey County Option Hospital Fee Program, when combined with other Medicaid and Disproportionate Share Hospital (DSH) payments, such as Charity Care payments, may exceed the federal maximum hospital-specific disproportionate share (DSH) limit in 42 U.S.C. § 1396r-4. I acknowledge that if the hospital's projected payments exceed its Hospital Specific DSH Limit, the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B)
- I understand that misrepresentation or falsification of any information contained in this report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under state or federal law.
- I certify that that the cost of the fee shall not be assigned to any patient, insurer, self-insured employer program, or other responsible party, nor shall the fee be listed separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

I am authorized to make this Certification on behalf of Select Specialty Hospital - Willingboro hospital.

Signature



Name

Matt Cannon

Full Name (Printed)

Title

Regional President

Date

12 / 6 / 22

## DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name Virtua Marlton Hospital

Facility address(es) within Authorized County 90 Brick Road, Marlton, NJ 08053

County Burlington

Medicaid Provider Number 3674304

Medicare Provider Number 310022

Hospital Parent Company (if applicable) Virtua Health System

Contact Person Name Christine Gordon

Title Director of Reimbursement

Phone ( 856 ) - 355 - 0655 Ext: \_\_\_\_\_

Email Address cgordon@virtua.org

Period Covered: 01/01/2021 to 12/31/2021

### INSTRUCTIONS

#### DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

If the reporting hospital chooses to use their Medicare cost report as a source document then two or more cost reports may be used to generate this verification.

This form should be submitted with the county's submission of the Fee and Expenditure Report. The data contained within will be used by the State of New Jersey, Department of Human Services and the Centers for Medicare and Medicaid Services (CMS) to design the payment mechanism and to verify and approve the local assessments.

The hospital administrator or officer must attest to the accuracy of the data contained in the form.

The hospital will be required to submit the source material that was used to complete the data fields and as marked on the form. Acceptable sources are the Medicare Cost report, other sourced financials, and/or materials supporting the documents. The State of New Jersey reserves the right to request additional documentation.

Please email any questions you have on completing this form to: [Dmahs.hospcountyfee@dhs.nj.gov](mailto:Dmahs.hospcountyfee@dhs.nj.gov).



## SECTION 1

Complete Column A for inpatient services and Column B for outpatient services.

### Line 1: Total Net Patient Revenue

Include revenue received for inpatient and outpatient services for the state fiscal year period. This amount excludes revenue from other operations such as cafeteria, parking, rent, research and educational activities. This amount also excludes non-operating revenue such as investment income and donations. Include any Medicaid supplemental payments and disproportionate share payments. **Please note that the sum of the inpatient and outpatient net patient revenue (NPR) should be equivalent to the NPR reported on Wksht G-3, Col 1, Line 3 of the Medicare Cost Report.**

### Line 2: Revenue from Distinct Part Hospital-Based Nursing Home Unit

Report revenue that is included in Line 1 received during the period for services provided in a distinct part hospital-based nursing home unit, only. If no such revenue is included in Line 1, enter "0".

### Line 3: Revenue Related to Physicians' Services

Report revenue that is included in Line 1 that is for physician direct care services, only. If no such revenue is included in Line 1, enter "0".

### Line 4: Other Non-Hospital Service-Specific Revenue

Report revenue that is included in Line 1 for other services, such as hospice services, pharmaceutical services, home health services, cafeteria, parking, rent, research and educational activities that are not hospital inpatient and outpatient services. If no such revenue is included in Line 1, enter "0".

### Line 5: Revenue Related to Services Provided at Locations Outside of the County

Report any inpatient and outpatient revenue included in Line 1 that was received for services provided at hospital campuses, clinics or other sites that are not located within the legislatively authorized county per N.J.S.A. 30:4D-7r - 30:4D-7x. If no such revenue is included in Line 1, enter "0".

### Line 6: Total Medicaid Revenue for the Period

Include all Medicaid inpatient and outpatient revenue received for the period including any Medicaid supplemental payments and disproportionate share payments.

### Line 7: Total Medicare Revenue for the Period

Include inpatient and outpatient revenue received for the period from Medicare Parts A, B and C. Include revenue received for the period through the Medicare Advantage Program including IME and DME payments. Include Medicare revenue for DSH, DME, organ acquisition, capital adjustments and allied health services. This amount does not include Medicare co-payments and deductible amounts paid under Medicare Parts A, B or C.

### Line 8: Bad Debt Included In Line 1

Enter any bad debt amounts that were included in Line 1. If no bad debt was included in Line 1, enter "0".

---

## SECTION 2

### Line 9: Inpatient Days, Fee-For-Service

Include the number of fee-for-service days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 10: Inpatient Days, Managed Care

Include the number of managed care days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 11: Discharges, Inpatient Fee-For-Service

Include the number of fee-for-service discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 12: Discharges, Inpatient Managed Care

Include the number of managed care discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 13: Licensed Beds

Total Licensed inpatient beds at end of state fiscal year reporting period.

**SECTION 1**

LINE	REVENUE CATEGORY	Amount Verified From Hospital Records		SOURCE
		INPATIENT (Column A)	OUTPATIENT (Column B)	
1	Total Net Patient Revenue	\$101,141,727	\$ 49,045,770	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
2	Revenue from Distinct Part Hospital-Based Nursing Home Unit, If Included in Line 1			<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
3	Revenue Related to Physicians' Services, If Included in Line 1			<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
4	Other Non-Hospital Service-Specific Revenue			<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
5	Revenue Related to Services Provided at Locations Outside of the County, if included in Line 1			<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
6	Total Medicaid Revenue for the Period	\$ 7,652,221	\$ 3,353,846	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
7	Total Medicare Revenue for the Period	\$ 56,692,642	\$ 14,487,941	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
8	Bad Debt, if included in Line 1	\$ 2,065,475	\$ 3,829,238	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)

**SECTION 2**

LINE	REVENUE CATEGORY	COLUMN A	COLUMN B	COLUMN C	SOURCE
		MEDICAID	MEDICARE	OTHER	
9	Days, Inpatient Fee-for-Service	812	17,972	19,015	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
10	Days, Inpatient Managed Care	2,701	9,396	5,440	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
11	Discharges, Inpatient Fee-for-Service	110	3,230	3,560	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
12	Discharges, Inpatient Managed Care	577	1,420	5,440	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
13	Total Number of Licensed Beds at End of Period	198			

**ATTESTATION**

NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

**Hospital Name:** Virtua - West Jersey Health System, Inc - Marlton

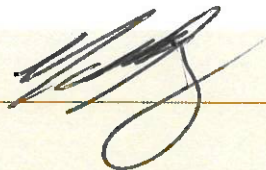
**CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR**

On behalf of Virtua - West Jersey Health System, Inc - Marlton hospital ("the hospital"), I hereby certify that:

- I have examined the accompanying Data Form & Preliminary DSH Limit Calculation Form for the reporting period specified and, to the best of my knowledge and belief, the information contained in the reports is true, correct, and complete and accurately reflect the information in the hospital's Medicare cost report, the hospital's financial statements and other accounting records.
- I understand that projected payments to the hospital under the New Jersey County Option Hospital Fee Program, when combined with other Medicaid and Disproportionate Share Hospital (DSH) payments, such as Charity Care payments, may exceed the federal maximum hospital-specific disproportionate share (DSH) limit in 42 U.S.C. § 1396r-4. I acknowledge that if the hospital's projected payments exceed its Hospital Specific DSH Limit, the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B)
- I understand that misrepresentation or falsification of any information contained in this report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under state or federal law.
- I certify that that the cost of the fee shall not be assigned to any patient, insurer, self-insured employer program, or other responsible party, nor shall the fee be listed separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

I am authorized to make this Certification on behalf of Virtua - West Jersey Health System, Inc - Marlton hospital.

**Signature** \_\_\_\_\_



**Name** Robert Segin

Full Name (Printed)

**Title** EVP/CFO

**Date** 11 / 22 / 22

## DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name Virtua Mt. Holly Hospital

Facility address(es) within Authorized County 175 Madison Avenue, Mt. Holly, NJ 08060

County Burlington

Medicaid Provider Number 4138902

Medicare Provider Number 310057

Hospital Parent Company (if applicable) Virtua Health System

Contact Person Name Christine Gordon

Title Director of Reimbursement

Phone ( 856 ) - 355 - 0655 Ext: \_\_\_\_\_

Email Address cgordon@virtua.org

Period Covered: 01/01/2021 to 12/31/2021

## INSTRUCTIONS

### DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

If the reporting hospital chooses to use their Medicare cost report as a source document then two or more cost reports may be used to generate this verification.

This form should be submitted with the county's submission of the Fee and Expenditure Report. The data contained within will be used by the State of New Jersey, Department of Human Services and the Centers for Medicare and Medicaid Services (CMS) to design the payment mechanism and to verify and approve the local assessments.

The hospital administrator or officer must attest to the accuracy of the data contained in the form.

The hospital will be required to submit the source material that was used to complete the data fields and as marked on the form. Acceptable sources are the Medicare Cost report, other sourced financials, and/or materials supporting the documents. The State of New Jersey reserves the right to request additional documentation.

Please email any questions you have on completing this form to: [Dmahs.hospcountyfee@dhs.nj.gov](mailto:Dmahs.hospcountyfee@dhs.nj.gov).

## SECTION 1

Complete Column A for inpatient services and Column B for outpatient services.

### Line 1: Total Net Patient Revenue

Include revenue received for inpatient and outpatient services for the state fiscal year period. This amount excludes revenue from other operations such as cafeteria, parking, rent, research and educational activities. This amount also excludes non-operating revenue such as investment income and donations. Include any Medicaid supplemental payments and disproportionate share payments. **Please note that the sum of the inpatient and outpatient net patient revenue (NPR) should be equivalent to the NPR reported on Wksht G-3, Col 1, Line 3 of the Medicare Cost Report.**

### Line 2: Revenue from Distinct Part Hospital-Based Nursing Home Unit

Report revenue that is included in Line 1 received during the period for services provided in a distinct part hospital-based nursing home unit, only. If no such revenue is included in Line 1, enter "0".

### Line 3: Revenue Related to Physicians' Services

Report revenue that is included in Line 1 that is for physician direct care services, only. If no such revenue is included in Line 1, enter "0".

### Line 4: Other Non-Hospital Service-Specific Revenue

Report revenue that is included in Line 1 for other services, such as hospice services, pharmaceutical services, home health services, cafeteria, parking, rent, research and educational activities that are not hospital inpatient and outpatient services. If no such revenue is included in Line 1, enter "0".

### Line 5: Revenue Related to Services Provided at Locations Outside of the County

Report any inpatient and outpatient revenue included in Line 1 that was received for services provided at hospital campuses, clinics or other sites that are not located within the legislatively authorized county per N.J.S.A. 30:4D-7r - 30:4D-7x. If no such revenue is included in Line 1, enter "0".

### Line 6: Total Medicaid Revenue for the Period

Include all Medicaid inpatient and outpatient revenue received for the period including any Medicaid supplemental payments and disproportionate share payments.

### Line 7: Total Medicare Revenue for the Period

Include inpatient and outpatient revenue received for the period from Medicare Parts A, B and C. Include revenue received for the period through the Medicare Advantage Program including IME and DME payments. Include Medicare revenue for DSH, DME, organ acquisition, capital adjustments and allied health services. This amount does not include Medicare co-payments and deductible amounts paid under Medicare Parts A, B or C.

### Line 8: Bad Debt Included In Line 1

Enter any bad debt amounts that were included in Line 1. If no bad debt was included in Line 1, enter "0".

---

## SECTION 2

### Line 9: Inpatient Days, Fee-For-Service

Include the number of fee-for-service days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 10: Inpatient Days, Managed Care

Include the number of managed care days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 11: Discharges, Inpatient Fee-For-Service

Include the number of fee-for-service discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 12: Discharges, Inpatient Managed Care

Include the number of managed care discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 13: Licensed Beds

Total Licensed inpatient beds at end of state fiscal year reporting period.

**SECTION 1**

LINE	REVENUE CATEGORY	Amount Verified From Hospital Records		SOURCE
		INPATIENT (Column A)	OUTPATIENT (Column B)	
1	Total Net Patient Revenue	\$196,200,762	\$ 153,623,924	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
2	Revenue from Distinct Part Hospital-Based Nursing Home Unit, If Included in Line 1			<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
3	Revenue Related to Physicians' Services, If Included in Line 1			<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
4	Other Non-Hospital Service-Specific Revenue			<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
5	Revenue Related to Services Provided at Locations Outside of the County, if included in Line 1			<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
6	Total Medicaid Revenue for the Period	\$ 29,091,685	\$ 15,199,850	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> E-3 P.VII, Ln 41 Col 1&2, Internal Medicaid Managed Care <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
7	Total Medicare Revenue for the Period	\$ 68,915,795	\$ 27,228,625	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> E Part A, E Part B, Internal Medicare Managed Care <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
8	Bad Debt, if included in Line 1	\$ 4,906,073	\$ 9,336,146	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)

**SECTION 2**

LINE	REVENUE CATEGORY	COLUMN A	COLUMN B	COLUMN C	SOURCE
		MEDICAID	MEDICARE	OTHER	
9	Days, Inpatient Fee-for-Service	2,613	21,373	49,278	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> Worksheet S-3 Part I <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
10	Days, Inpatient Managed Care	11,515	15,431	12,972	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> Worksheet S-3 Part I <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
11	Discharges, Inpatient Fee-for-Service	531	3,750	12,475	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> Worksheet S-3 Part I <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
12	Discharges, Inpatient Managed Care	3,607	2,407	3,857	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> Worksheet S-3 Part I <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
13	Total Number of Licensed Beds at End of Period	<b>383</b>			



**ATTESTATION**

NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

**Hospital Name:** Virtua - Memorial Hospital of Burlington County, Inc.

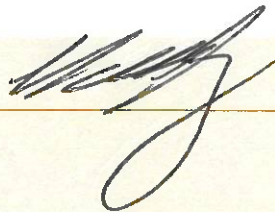
**CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR**

On behalf of Virtua - Memorial Hospital of Burlington County, Inc. hospital ("the hospital"), I hereby certify that:

- I have examined the accompanying Data Form & Preliminary DSH Limit Calculation Form for the reporting period specified and, to the best of my knowledge and belief, the information contained in the reports is true, correct, and complete and accurately reflect the information in the hospital's Medicare cost report, the hospital's financial statements and other accounting records.
- I understand that projected payments to the hospital under the New Jersey County Option Hospital Fee Program, when combined with other Medicaid and Disproportionate Share Hospital (DSH) payments, such as Charity Care payments, may exceed the federal maximum hospital-specific disproportionate share (DSH) limit in 42 U.S.C. § 1396r-4. I acknowledge that if the hospital's projected payments exceed its Hospital Specific DSH Limit, the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B)
- I understand that misrepresentation or falsification of any information contained in this report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under state or federal law.
- I certify that that the cost of the fee shall not be assigned to any patient, insurer, self-insured employer program, or other responsible party, nor shall the fee be listed separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

I am authorized to make this Certification on behalf of Virtua - Memorial Hospital of Burlington County, Inc. hospital.

**Signature** \_\_\_\_\_



**Name** Robert Segin

Full Name (Printed)

**Title** EVP/CFO

**Date** 11 / 22 / 22

## DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name Virtua Willingboro Hospital

Facility address(es) within Authorized County 218A Sunset Rd, Willingboro, NJ 08046

County Burlington

Medicaid Provider Number 3675203

Medicare Provider Number 310061

Hospital Parent Company (if applicable) Virtua Health System

Contact Person Name Christine Gordon

Title Director of Reimbursement

Phone ( 856 ) - 355 - 0655 Ext: \_\_\_\_\_

Email Address cgordon@virtua.org

Period Covered: 01/01/2021 to 12/31/2021

## INSTRUCTIONS

### DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

If the reporting hospital chooses to use their Medicare cost report as a source document then two or more cost reports may be used to generate this verification.

This form should be submitted with the county's submission of the Fee and Expenditure Report. The data contained within will be used by the State of New Jersey, Department of Human Services and the Centers for Medicare and Medicaid Services (CMS) to design the payment mechanism and to verify and approve the local assessments.

The hospital administrator or officer must attest to the accuracy of the data contained in the form.

The hospital will be required to submit the source material that was used to complete the data fields and as marked on the form. Acceptable sources are the Medicare Cost report, other sourced financials, and/or materials supporting the documents. The State of New Jersey reserves the right to request additional documentation.

Please email any questions you have on completing this form to: [Dmahs.hospcountyfee@dhs.nj.gov](mailto:Dmahs.hospcountyfee@dhs.nj.gov).

## SECTION 1

Complete Column A for inpatient services and Column B for outpatient services.

### Line 1: Total Net Patient Revenue

Include revenue received for inpatient and outpatient services for the state fiscal year period. This amount excludes revenue from other operations such as cafeteria, parking, rent, research and educational activities. This amount also excludes non-operating revenue such as investment income and donations. Include any Medicaid supplemental payments and disproportionate share payments. **Please note that the sum of the inpatient and outpatient net patient revenue (NPR) should be equivalent to the NPR reported on Wksht G-3, Col 1, Line 3 of the Medicare Cost Report.**

### Line 2: Revenue from Distinct Part Hospital-Based Nursing Home Unit

Report revenue that is included in Line 1 received during the period for services provided in a distinct part hospital-based nursing home unit, only. If no such revenue is included in Line 1, enter "0".

### Line 3: Revenue Related to Physicians' Services

Report revenue that is included in Line 1 that is for physician direct care services, only. If no such revenue is included in Line 1, enter "0".

### Line 4: Other Non-Hospital Service-Specific Revenue

Report revenue that is included in Line 1 for other services, such as hospice services, pharmaceutical services, home health services, cafeteria, parking, rent, research and educational activities that are not hospital inpatient and outpatient services. If no such revenue is included in Line 1, enter "0".

### Line 5: Revenue Related to Services Provided at Locations Outside of the County

Report any inpatient and outpatient revenue included in Line 1 that was received for services provided at hospital campuses, clinics or other sites that are not located within the legislatively authorized county per N.J.S.A. 30:4D-7r - 30:4D-7x. If no such revenue is included in Line 1, enter "0".

### Line 6: Total Medicaid Revenue for the Period

Include all Medicaid inpatient and outpatient revenue received for the period including any Medicaid supplemental payments and disproportionate share payments.

### Line 7: Total Medicare Revenue for the Period

Include inpatient and outpatient revenue received for the period from Medicare Parts A, B and C. Include revenue received for the period through the Medicare Advantage Program including IME and DME payments. Include Medicare revenue for DSH, DME, organ acquisition, capital adjustments and allied health services. This amount does not include Medicare co-payments and deductible amounts paid under Medicare Parts A, B or C.

### Line 8: Bad Debt Included In Line 1

Enter any bad debt amounts that were included in Line 1. If no bad debt was included in Line 1, enter "0".

---

## SECTION 2

### Line 9: Inpatient Days, Fee-For-Service

Include the number of fee-for-service days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 10: Inpatient Days, Managed Care

Include the number of managed care days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 11: Discharges, Inpatient Fee-For-Service

Include the number of fee-for-service discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 12: Discharges, Inpatient Managed Care

Include the number of managed care discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 13: Licensed Beds

Total Licensed inpatient beds at end of state fiscal year reporting period.

**SECTION 1**

LINE	REVENUE CATEGORY	Amount Verified From Hospital Records		SOURCE
		INPATIENT (Column A)	OUTPATIENT (Column B)	
1	Total Net Patient Revenue	\$50,419,402	\$ 58,202,864	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
2	Revenue from Distinct Part Hospital-Based Nursing Home Unit, If Included in Line 1			<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
3	Revenue Related to Physicians' Services, If Included in Line 1			<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
4	Other Non-Hospital Service-Specific Revenue			<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
5	Revenue Related to Services Provided at Locations Outside of the County, if included in Line 1			<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
6	Total Medicaid Revenue for the Period	\$ 11,237,045	\$ 9,779,913	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> E-3 P.VII, Ln 41 Col 1&2, Internal Medicaid Managed Care <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
7	Total Medicare Revenue for the Period	\$ 23,841,897	\$ 7,569,736	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> E Part A, E Part B, Internal Medicare Managed Care <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
8	Bad Debt, if included in Line 1	\$ 7,173,723	\$ 3,862,774	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input checked="" type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)

**SECTION 2**

LINE	REVENUE CATEGORY	COLUMN A	COLUMN B	COLUMN C	SOURCE
		MEDICAID	MEDICARE	OTHER	
9	Days, Inpatient Fee-for-Service	1,277	8,775	20,663	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> Worksheet S-3 Part I <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
10	Days, Inpatient Managed Care	5,872	5,199	3,540	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> Worksheet S-3 Part I <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
11	Discharges, Inpatient Fee-for-Service	208	1,394	3,321	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> Worksheet S-3 Part I <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
12	Discharges, Inpatient Managed Care	1,035	771	680	<input checked="" type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> Worksheet S-3 Part I <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
13	Total Number of Licensed Beds at End of Period	169			

**ATTESTATION**

NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

**Hospital Name:** Virtua - Willingboro Hospital Inc.

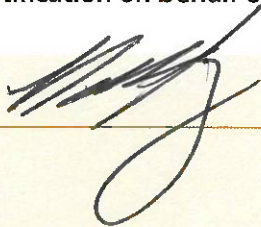
**CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR**

On behalf of Virtua - Willingboro Hospital Inc. hospital ("the hospital"), I hereby certify that:

- I have examined the accompanying Data Form & Preliminary DSH Limit Calculation Form for the reporting period specified and, to the best of my knowledge and belief, the information contained in the reports is true, correct, and complete and accurately reflect the information in the hospital's Medicare cost report, the hospital's financial statements and other accounting records.
- I understand that projected payments to the hospital under the New Jersey County Option Hospital Fee Program, when combined with other Medicaid and Disproportionate Share Hospital (DSH) payments, such as Charity Care payments, may exceed the federal maximum hospital-specific disproportionate share (DSH) limit in 42 U.S.C. § 1396r-4. I acknowledge that if the hospital's projected payments exceed its Hospital Specific DSH Limit, the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B)
- I understand that misrepresentation or falsification of any information contained in this report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under state or federal law.
- I certify that that the cost of the fee shall not be assigned to any patient, insurer, self-insured employer program, or other responsible party, nor shall the fee be listed separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

I am authorized to make this Certification on behalf of Virtua - Willingboro Hospital Inc. hospital.

**Signature** \_\_\_\_\_



**Name** Robert Segin

Full Name (Printed)

**Title** EVP/CFO

**Date** 11 / 22 / 22





Affordable health coverage. Quality care.

## DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name Weisman Childrens Rehab Hospital

Facility address(es) within Authorized County 92 Brick Rd, Marlton NJ 08503

County Burlington

Medicaid Provider Number 7584407

Medicare Provider Number 313302

Hospital Parent Company (if applicable) \_\_\_\_\_

Contact Person Name Carol Braun

Title Business Office Director

Phone ( 856 ) - 489 - 4520 Ext: 233

Email Address cbraun@weismanchildrens.com

Period Covered: 01/01/21 to 12/31/21

## INSTRUCTIONS

### DATA FORM FOR COUNTY OPTION HOSPITAL FEE PROGRAM

If the reporting hospital chooses to use their Medicare cost report as a source document then two or more cost reports may be used to generate this verification.

This form should be submitted with the county's submission of the Fee and Expenditure Report. The data contained within will be used by the State of New Jersey, Department of Human Services and the Centers for Medicare and Medicaid Services (CMS) to design the payment mechanism and to verify and approve the local assessments.

The hospital administrator or officer must attest to the accuracy of the data contained in the form.

The hospital will be required to submit the source material that was used to complete the data fields and as marked on the form. Acceptable sources are the Medicare Cost report, other sourced financials, and/or materials supporting the documents. The State of New Jersey reserves the right to request additional documentation.

Please email any questions you have on completing this form to: [Dmahs.hospcountyfee@dhs.nj.gov](mailto:Dmahs.hospcountyfee@dhs.nj.gov).



## SECTION 1

Complete Column A for inpatient services and Column B for outpatient services.

### Line 1: Total Net Patient Revenue

Include revenue received for inpatient and outpatient services for the state fiscal year period. This amount excludes revenue from other operations such as cafeteria, parking, rent, research and educational activities. This amount also excludes non-operating revenue such as investment income and donations. Include any Medicaid supplemental payments and disproportionate share payments. **Please note that the sum of the inpatient and outpatient net patient revenue (NPR) should be equivalent to the NPR reported on Wksht G-3, Col 1, Line 3 of the Medicare Cost Report.**

### Line 2: Revenue from Distinct Part Hospital-Based Nursing Home Unit

Report revenue that is included in Line 1 received during the period for services provided in a distinct part hospital-based nursing home unit, only. If no such revenue is included in Line 1, enter "0".

### Line 3: Revenue Related to Physicians' Services

Report revenue that is included in Line 1 that is for physician direct care services, only. If no such revenue is included in Line 1, enter "0".

### Line 4: Other Non-Hospital Service-Specific Revenue

Report revenue that is included in Line 1 for other services, such as hospice services, pharmaceutical services, home health services, cafeteria, parking, rent, research and educational activities that are not hospital inpatient and outpatient services. If no such revenue is included in Line 1, enter "0".

### Line 5: Revenue Related to Services Provided at Locations Outside of the County

Report any inpatient and outpatient revenue included in Line 1 that was received for services provided at hospital campuses, clinics or other sites that are not located within the legislatively authorized county per N.J.S.A. 30:4D-7r - 30:4D-7x. If no such revenue is included in Line 1, enter "0".

### Line 6: Total Medicaid Revenue for the Period

Include all Medicaid inpatient and outpatient revenue received for the period including any Medicaid supplemental payments and disproportionate share payments.

### Line 7: Total Medicare Revenue for the Period

Include inpatient and outpatient revenue received for the period from Medicare Parts A, B and C. Include revenue received for the period through the Medicare Advantage Program including IME and DME payments. Include Medicare revenue for DSH, DME, organ acquisition, capital adjustments and allied health services. This amount does not include Medicare co-payments and deductible amounts paid under Medicare Parts A, B or C.

### Line 8: Bad Debt Included In Line 1

Enter any bad debt amounts that were included in Line 1. If no bad debt was included in Line 1, enter "0".

---

## SECTION 2

### Line 9: Inpatient Days, Fee-For-Service

Include the number of fee-for-service days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 10: Inpatient Days, Managed Care

Include the number of managed care days, by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 11: Discharges, Inpatient Fee-For-Service

Include the number of fee-for-service discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 12: Discharges, Inpatient Managed Care

Include the number of managed care discharges by payer for the fiscal period. 'Other' is all other insurance and self pay. Exclude days that are part of a distinct part hospital-based nursing home unit and days provided in a facility/campus located outside of the county.

### Line 13: Licensed Beds

Total Licensed inpatient beds at end of state fiscal year reporting period.

**SECTION 1**

LINE	REVENUE CATEGORY	Amount Verified From Hospital Records		SOURCE
		INPATIENT (Column A)	OUTPATIENT (Column B)	
1	Total Net Patient Revenue	\$11,406,391	\$ 9,472,449	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="Trial Balance"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
2	Revenue from Distinct Part Hospital-Based Nursing Home Unit, If Included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
3	Revenue Related to Physicians' Services, If Included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
4	Other Non-Hospital Service-Specific Revenue	\$ 169,074	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="Drugs. Trial Balance"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
5	Revenue Related to Services Provided at Locations Outside of the County, if included in Line 1	\$ 2,939,596	\$ 6,837,220	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="Net income from Trial Balance"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
6	Total Medicaid Revenue for the Period	\$ 5,699,396	\$ 2,179,368	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="net FFS &amp; mgd care only burlington cty"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
7	Total Medicare Revenue for the Period	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)
8	Bad Debt, if included in Line 1	\$ 0	\$ 0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text"/> <input type="checkbox"/> Financials <input type="checkbox"/> Other Source Materials (supporting documents)

**SECTION 2**

LINE	REVENUE CATEGORY	COLUMN A	COLUMN B	COLUMN C	SOURCE
		MEDICAID	MEDICARE	OTHER	
9	Days, Inpatient Fee-for-Service	424	0	688	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="census"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
10	Days, Inpatient Managed Care	1,694	0	0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="census"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
11	Discharges, Inpatient Fee-for-Service	9	0	29	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="census"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
12	Discharges, Inpatient Managed Care	66	0	0	<input type="checkbox"/> Medicare Cost Report Indicate Wksht(s), Line(s)# <input type="text" value="census"/> <input type="checkbox"/> Financials <input checked="" type="checkbox"/> Other Source Materials (supporting documents)
13	Total Number of Licensed Beds at End of Period	18			

## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

**Hospital Name:** Weisman Children's Rehab Hospital

### CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of Weisman Children's hospital ("the hospital"), I hereby certify that:

- I have examined the accompanying Data Form & Preliminary DSH Limit Calculation Form for the reporting period specified and, to the best of my knowledge and belief, the information contained in the reports is true, correct, and complete and accurately reflect the information in the hospital's Medicare cost report, the hospital's financial statements and other accounting records.
- I understand that projected payments to the hospital under the New Jersey County Option Hospital Fee Program, when combined with other Medicaid and Disproportionate Share Hospital (DSH) payments, such as Charity Care payments, may exceed the federal maximum hospital-specific disproportionate share (DSH) limit in 42 U.S.C. § 1396r-4. I acknowledge that if the hospital's projected payments exceed its Hospital Specific DSH Limit, the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B)
- I understand that misrepresentation or falsification of any information contained in this report may be punishable by criminal, civil and administrative action, fine and/or imprisonment under state or federal law.
- I certify that the cost of the fee shall not be assigned to any patient, insurer, self-insured employer program, or other responsible party, nor shall the fee be listed separately on any invoice or statement sent to a patient, insurer, self-insured employer program, or other responsible party.

I am authorized to make this Certification on behalf of Weisman Children's hospital.

**Signature** Patricia E. Oliver

**Name** Patricia E. Oliver

Full Name (Printed)

**Title** Hospital Administrator

**Date** 12 / 4 / 2020

# BURLINGTON COUNTY HOSPITAL FEE

Fee Basis: \$626.35 per Non-Medicare Discharge

State Directed Medicaid Payment (Acute Care Hospitals): \$12,303.45 per Discharge

State Directed Medicaid Payment (Non-acute Care Hospitals): \$261.13 per Diem

<b>Total Fee Receipts</b>	<b>\$22,097,146</b>
<b>County's Resource</b>	<b>\$1,988,743</b>
State's Resource	\$220,971
<i>Non-federal Share of Medicaid Payments</i>	<i>\$19,887,432</i>

HOSPITAL	Fees Paid	State Directed Medicaid MCO Payments	Lost DSH Payments
Virtua West Jersey - Marlton	\$3,411,124	\$4,355,423	\$0
Virtua Memorial	\$12,821,469	\$31,865,949	(\$1,032,292)
Virtua Willingboro	\$3,284,601	\$8,993,826	\$0
Deborah	\$777,305	\$2,632,939	\$0
<b>Acute Care Hospitals</b>	<b>\$20,294,499</b>	<b>\$47,848,138</b>	<b>(\$1,032,292)</b>

Aspen Hills	\$292,507	\$1,018,145	\$0
Hampton BHC	\$1,051,022	\$2,596,412	\$0
Kessler Marlton	\$326,330	\$410,235	\$0
Weisman Children's Rehab	\$65,141	\$318,317	\$0
Select Specialty Hosp - So. NJ	\$67,646	\$234,233	\$0
<b>Non-Acute Care Hospitals</b>	<b>\$1,802,647</b>	<b>\$4,577,342</b>	<b>\$0</b>

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\$626.35	Per Non-Medicare Discharge	$fee\ rate = d_{sum} / c_{sum}$
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		a	b	d = a - b - c	e = d * fee rate
	HOSPITAL	All-Payer	Medicare	Revenue Basis	Fee Receipts
<b>Discharges</b>	Virtua West Jersey - Marlton	10,096	4,650	5,446	\$3,411,124
	Virtua Memorial	26,627	6,157	20,470	\$12,821,469
	Virtua Willingboro	7,409	2,165	5,244	\$3,284,601
	Deborah	3,838	2,597	1,241	\$777,305
	Aspen Hills	602	135	467	\$292,507
	Hampton BHC	1,998	320	1,678	\$1,051,022
	Kessler Marlton	1,465	944	521	\$326,330
	Weisman Children's Rehab	104	0	104	\$65,141
	Select Specialty Hosp - So. NJ	420	312	108	\$67,646
	<b>Total</b>	<b>52,559</b>	<b>17,280</b>	<b>35,279</b>	<b>\$22,097,146</b>

<b>Total Fee Receipts</b>	<b>\$22,097,146</b>	$j = i$
County Resource	\$1,988,743	$k = j * 9\%$
State Resource	\$220,971	$l = j * 1\%$
State Share Medicaid Payments	\$19,887,432	$m = j - k - l$
Est Effective FMAP	64.00%	$n$
State + Federal Share of Medicaid Payments	\$55,242,866	$o = m / (1 - n)$
5% HMO Admin Fee	\$2,817,386	$p = o * 5.1\%$
State + Federal Share of Medicaid Payments Going to Hospitals	\$52,425,480	$q = o - p$
State + Federal Share of Medicaid Payments Going to Non-acute Hospitals	\$4,577,342	$r = q * 8.73\%$
State + Federal Share of Medicaid Payments Going to General Acute Hospitals	\$47,848,138	$s = q - r$



# BURLINGTON COUNTY HOSPITAL FEE

Fee Basis: \$626.35 per Non-Medicare Discharge

State Directed Medicaid Payment (Acute Care Hospitals): \$12,303.45 per Discharge

State Directed Medicaid Payment (Non-acute Care Hospitals): \$261.13 per Diem

Total Inpatient Hospital Enhanced Payments - Acute	\$47,848,138	a
Inpatient Hospital Add-On Payment (Acute)	\$12,303.46	b = a / e <sub>sum</sub>
Total Inpatient Hospital Enhanced Payments - Non-acute	\$4,577,342	c
Inpatient Hospital Add-On Payment (Per Diem Non-acute)	\$261.13	d = c / g <sub>sum</sub>

## Acute Medicaid MC Directed Payment

HOSPITAL	DISCHARGES	PAYMENTS
Virtua West Jersey - Marlton	354	4,355,423
Virtua Memorial	2,590	31,865,949
Virtua Willingboro	731	8,993,826
Deborah	214	2,632,939
<b>Acute Care Hospitals</b>	<b>3,889</b>	<b>47,848,138</b>

## Non-acute Medicaid MC Directed Payment

HOSPITAL	PATIENT DAYS	PAYMENTS
Aspen Hills	3,899	1,018,145
Hampton BHC	9,943	2,596,412
Kessler Marlton	1,571	410,235
Weisman Children's Rehab	1,219	318,317
Select Specialty Hosp - So. NJ	897	234,233
<b>Non-Acute Care Hospitals</b>	<b>17,529</b>	<b>\$4,577,342</b>

dd = \$0; if z < bb  
 dd = -cc; if z > bb AND if (z-bb) > cc  
 dd = bb - z; if z > bb AND if z - bb < cc  
 ee = z - aa + dd

ACUTE CARE HOSPITAL	State Directed Medicaid Payments	Fees Paid	DSH Room	Charity Care & HRSF-MH Payments	Lost DSH Payments	GAIN / (LOSS)
Virtua West Jersey - Marlton	\$4,355,423	\$3,411,124	\$0	\$0	\$0	\$944,299
Virtua Memorial	\$31,865,949	\$12,821,469	\$23,108,604	\$1,032,292	(\$1,032,292)	\$18,012,189
Virtua Willingboro	\$8,993,826	\$3,284,601	\$12,708,233	\$1,571,540	\$0	\$5,709,225
Deborah	\$2,632,939	\$777,305	\$6,376,638	\$730,045	\$0	\$1,855,634
<b>Acute Care Hospitals</b>	<b>\$47,848,138</b>	<b>\$20,294,499</b>			<b>(\$1,032,292)</b>	<b>\$26,521,346</b>
NON-ACUTE CARE HOSPITAL	State Directed Medicaid Payments	Fees Paid	DSH Room	Charity Care & HRSF-MH Payments	Lost DSH Payments	GAIN / (LOSS)
Aspen Hills	\$1,018,145	\$292,507	\$0	\$0	\$0	\$725,637
Hampton BHC	\$2,596,412	\$1,051,022	\$0	\$0	\$0	\$1,545,390
Kessler Marlton	\$410,235	\$326,330	\$0	\$0	\$0	\$83,904
Weisman Children's Rehab	\$318,317	\$65,141	\$0	\$0	\$0	\$253,176
Select Specialty Hosp - So. NJ	\$234,233	\$67,646	\$0	\$0	\$0	\$166,587
<b>Non-Acute Care Hospitals</b>	<b>\$4,577,342</b>	<b>\$1,802,647</b>				<b>\$2,774,695</b>



# BURLINGTON COUNTY OPTION FEE

## MAXIMUM ASSESSMENT

Fee Basis: \$626.35 per Non-Medicare Discharge

State Directed Medicaid Payment (Acute Care Hospitals): \$12,303.45 per Discharge

State Directed Medicaid Payment (Non-acute Care Hospitals): \$261.13 per Diem

### INPATIENT HOSPITAL

		Data Form Line 1	2.5% NPSR
		NPSR Revenue	
310022	Virtua West Jersey - Marlton	\$99,076,252	\$2,476,906
310057	Virtua Memorial	\$191,294,689	\$4,782,367
310061	Virtua Willingboro	\$43,245,679	\$1,081,142
310031	Deborah	\$112,586,570	\$2,814,664
314023	Aspen Hills	\$7,682,565	\$192,064
314021	Hampton BHC	\$28,298,879	\$707,472
313032	Kessler Marlton	\$36,127,484	\$903,187
313302	Weisman Children's Rehab	\$8,297,721	\$207,443
312022	Select Specialty Hosp - So. NJ	\$29,946,191	\$748,655

### OUTPATIENT HOSPITAL

		Data Form Line 1	
		NPSR Revenue	2.5% NPSR
310022	Virtua West Jersey - Marlton	\$45,216,532	\$1,130,413
310057	Virtua Memorial	\$144,287,778	\$3,607,194
310061	Virtua Willingboro	\$54,340,090	\$1,358,502
310031	Deborah	\$75,690,528	\$1,892,263
314023	Aspen Hills	\$0	\$0
314021	Hampton BHC	\$3,830,554	\$95,764
313032	Kessler Marlton	\$1,329,118	\$33,228
313302	Weisman Children's Rehab	\$2,635,229	\$65,881
312022	Select Specialty Hosp - So. NJ	\$0	\$0

<b>Maximum Fee Receipts</b>	<b>\$22,097,146</b>
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