

Date: 12 / 06 / 2024

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

County: Camden 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, 2025

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 full list of hospitals located in Camden 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.

Beginning with the first program year, the County, through its contractor, Eyman Partners, implemented a comprehensive process of educating, consulting with, and gathering feedback from all hospitals within the jurisdiction, and developing criteria to evaluate potential models. Those criteria continue to inform the model development process for the current year. For SFY26, the County has collected updated data from the hospitals to reevaluate the model (both assessment and payment bases) and has involved the hospitals throughout this process. Informed by insights from the original modeling process, we reviewed the impact of updated data on the current model, identified any deviations from the guidelines/priorities we set out in creating the initial model, and then reviewed targeted additional options to address those deviations. We shared this information with the hospitals by email and video conference and gathered their feedback to inform design of the program for SFY26. We also provided support to the hospitals to complete the required forms.

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 fee per 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. The County has used calendar year 2023 data, inflated through 2026, as the source for calculating the fees.

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

No.

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 proposed fee is \$2,184.20 per 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 will add interest to the amount due, not to exceed 1.5% of the outstanding payment amount per month, reflected on to 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, the County will officially notify hospitals that the fee program will take effect, and of the amount of the quarterly fee they will be required to pay throughout the program. The hospitals will have 15 days from receipt of that notice to contest the fee amount, by submitting 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?

In addition to the annual notice notifying the hospitals that the fee program will take effect, and of the annual quarterly fee amounts they will be required to pay under the program, the County will 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.

The County proposes that the amount of the assessment collected from Jefferson Washington Township Hospital, a Gloucester County location of Jefferson Health based in Camden County (less applicable fee withholdings) be utilized for County Option payments made to Camden County hospitals, as the services provided at Jefferson Washington Township Hospital will be paid through the Camden County program.

This Fee & Expenditure report was prepared by the County's contractors 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 contractors.

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 a state directed payment, to be implemented as a uniform increase to Medicaid Managed Care inpatient payments across two classes of hospitals: acute and non-acute hospitals to account for differences in acuity across the classes, as well as an outpatient payment for the acute class of hospitals. The increase in inpatient payments would be implemented as a \$3,947.30 per diem add-on for the acute care hospitals and \$10,490.32 per diem add-on for the non-acute care hospital (Northbrook Behavioral Health Hospital). The increase in outpatient payments for the acute class would be implemented as a per visit add-on of \$667.16.

The inpatient payments have been calculated using a Federal Medical Assistance Percentage (FMAP) of 68.85% for the acute class and 73.65% for the non-acute class. The outpatient payment for the acute class of hospitals has been calculated using an estimated FMAP of 69.83%. In each case, we began by calculating the FMAP based on the mix of Medicaid, expansion and CHIP patients in the state's CY2023 data.

The payment methodology would be the same for all hospitals in a class, thereby directing the expenditures equally, using the same terms of performance, as required by 42 CFR 438.6(c)(2)(ii)(B). Details of the calculation of this payment methodology are contained in the attached model, prepared by the County's contractors, who can 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. The four quarterly payments would each be equal to 25% of the projected annual rate increase amount (which is estimated in the attached model, based on the state's CY2023 encounter data forwarded to the County by DMAHS on 9/30/24). A final reconciliation adjustment would be determined after the end of the year, based on actual services provided, keeping the relative distribution of payments across the general acute and specialty hospital classes as modeled. In this way, the payments would meet the federal requirement at 42 CFR 438.6(c)(2)(ii)(A) that directed payments "be based on the utilization and delivery of services."

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?

The resources generated from the County Option Hospital Fee Program will help to stabilize the hospitals' financial positions, particularly in view of the low base Medicaid rates in the state compared to the average commercial rate, and, consequently, will strengthen their capacity to provide access to quality comprehensive and essential healthcare services to low income County residents as well as encourage the hospitals to expand their provision of Medicaid services.

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~~ 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 Template Hospital Fee Program** ☒ **Preliminary DSH Calculation**
- ☒ **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 Ross H. Angilella / H
County Officer or Administrator

Name: Ross Angilella
Full Name (Printed)

Title: County Administrator Date: 12 / 6 / 24

Email Address: rossa@camdencounty.com

Attachment A
New Jersey County Option Hospital Fee Program
List of hospitals located in Camden County

Cooper Hospital University Medical Center

1 Cooper Plaza
Camden, NJ 08103
General Acute Care
Non-profit

Virtua - West Jersey Hospital Voorhees

100 Bowman Dr.
Voorhees, NJ 08043
General Acute Care
Non-profit

Virtua Our Lady of Lourdes Hospital

1600 Haddon Ave.
Camden, NJ 08103
General Acute Care
Non-profit

Jefferson Cherry Hill Hospital

2201 Chapel Ave. West
Cherry Hill, NJ 08002
General Acute Care
Non-profit

Jefferson Stratford Hospital

18 East Laurel Rd.
Stratford, NJ 08084
General Acute Care
Non-profit

Northbrook Behavioral Health Hospital

425 Woodbury Turnersville Rd.
Blackwood, NJ 08012
Psychiatric hospital
For profit

CAMDEN COUNTY HOSPITAL FEE

12/6/2024

Fee Basis: \$2,184.20 per Discharge

State Directed Payments

Acute : \$3,947.30 per diem (inpatient) and \$667.16 per visit (outpatient)

Non-Acute : \$10,490.32 per discharge (inpatient)

Total Fee Receipts	\$181,081,012
County's Resource	\$16,297,291
State's Resource	\$1,810,810
<i>Non-federal Share of Medicaid Payments</i>	<i>\$179,085,748</i>

HOSPITAL	Fees Paid	State Directed Medicaid Payments	Lost DSH Payments
Cooper University	\$68,483,373	\$269,046,767	\$0
Virtua West Jersey - Voorhees	\$52,761,509	\$103,856,015	\$0
Virtua OLOL	\$27,046,935	\$68,906,438	\$0
Jefferson UMC *	\$27,038,198	\$110,988,132	\$0
Northbrook Hospital	\$5,750,996	\$13,438,104	\$0
	\$181,081,012	\$566,235,456	\$0

CAMDEN COUNTY HOSPITAL FEE

12/6/2024

Fee Basis: \$2,184.20 per Discharge

State Directed Payments

Acute : \$3,947.30 per diem (inpatient) and \$667.16 per visit (outpatient)

Non-Acute : \$10,490.32 per discharge (inpatient)

\$2,184.20	Inpatient Unit Fee
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	<i>a</i>	<i>b = a * \$2,184.20</i>	
	HOSPITAL	All Payer Discharges	Fee Receipts
	Cooper University	31,354	\$68,483,373
	Virtua West Jersey - Voorhees	24,156	\$52,761,509
	Virtua OLOL	12,383	\$27,046,935
	Jefferson UMC	12,379	\$27,038,198
	Northbrook	2,633	\$5,750,996
	Total IP	82,905	\$181,081,012
			<i>c = b_{sum}</i>
	Total Fee Receipts	\$181,081,012	<i>d = c</i>
	County Resource	\$16,297,291	<i>e = d * 9%</i>
	State Resource	\$1,810,810	<i>f = d * 1%</i>
	Transfer from Gloucester Co.	\$16,112,837	<i>g</i>
	State Share Medicaid Payments	\$179,085,748	<i>h = d - e - f + g</i>
	State Share Medicaid IPH Acute Payments	\$131,000,000	<i>i</i>
	<i>Est Effective FMAP</i>	68.85%	<i>j</i>
	State + Federal Share of Medicaid Acute IPH Payments	\$420,507,528	<i>k = i / (1 - j)</i>
	6% HMO Admin Fee	\$25,650,959	<i>l = k * 6.1%</i>
	State + Federal Share of Medicaid Payments Going to IPH Acute Hospitals	\$394,856,569	<i>m = k - l</i>
	State Share Medicaid IPH Psych Payments	\$3,770,484	<i>n</i>
	<i>Est Effective FMAP</i>	73.65%	<i>o</i>
	State + Federal Share of Medicaid Psych IPH Payments	\$14,311,080	<i>p = n / (1 - o)</i>
	6% HMO Admin Fee	\$872,976	<i>q = p * 6.1%</i>
	State + Federal Share of Medicaid Payments Going to IPH Psych Hospitals	\$13,438,104	<i>r = p - q</i>
	State Share Medicaid OPH Acute Payments	\$44,315,264	<i>s = h - i - n</i>
	<i>Est Effective FMAP</i>	69.83%	<i>t</i>
	State + Federal Share of Medicaid Acute OPH Payments	\$168,201,047	<i>u = s / (1 - t)</i>
	6% HMO Admin Fee	\$10,260,264	<i>v = u * 6.1%</i>
	State + Federal Share of Medicaid Payments Going to OPH Acute Hospitals	\$157,940,783	<i>w = u - v</i>

CAMDEN COUNTY HOSPITAL FEE

12/6/2024

Fee Basis: \$2,184.20 per Discharge

State Directed Payments

Acute : \$3,947.30 per diem (inpatient) and \$667.16 per visit (outpatient)

Non-Acute : \$10,490.32 per discharge (inpatient)

Total Inpatient Hospital Enhanced Payments - Acute	\$394,856,569	a
<i>Inpatient Hospital Add-On Payment (Acute)</i>	\$3,947.30	$b = a / g$ sum
Total Inpatient Hospital Enhanced Payments - Psych	\$13,438,104	c
<i>Inpatient Hospital Add-On Payment (Per Discharge Psych)</i>	\$10,490.32	$d = c / 1,281$
Total Outpatient Hospital Enhanced Payments - Acute	\$157,940,783	e
<i>Outpatient Hospital Add-On Payment (Acute)</i>	\$667.16	$f = e / j$ sum

ACUTE - INPATIENT

g

$h = b * g$

Medicaid Managed Care Directed Payment

HOSPITAL	PATIENT DAYS	PAYMENTS
Cooper University	52,139	205,808,408
Virtua West Jersey - Voorhees	15,744	62,146,331
Virtua OLOL	11,830	46,696,589
Jefferson UMC	20,319	80,205,241
	100,032	\$394,856,569

ACUTE - OUTPATIENT

j

$k = f * j$

Medicaid Managed Care Directed Payment

HOSPITAL	VISITS	PAYMENTS
Cooper University	94,787	63,238,359
Virtua West Jersey - Voorhees	62,518	41,709,683
Virtua OLOL	33,290	22,209,849
Jefferson UMC	46,140	30,782,891
	236,735	\$157,940,783

$l = h + k$

HOSPITAL	State Directed Medicaid Payments
Cooper University	\$269,046,767
Virtua West Jersey - Voorhees	\$103,856,015
Virtua OLOL	\$68,906,438
Jefferson UMC	\$110,988,132
Northbrook BH Hospital	\$13,438,104
	\$566,235,456

State Statutory 5% Cap Calculation

As Submitted on Data Forms

	Inpatient	Outpatient
	NPSR Revenue	NPSR Revenue
Cooper University	\$1,056,336,000	\$651,994,000
Virtua West Jersey - Voorhees	\$401,053,409	\$389,362,447
Virtua OLOL	\$280,003,918	\$171,859,820
Jefferson UMC	\$178,586,279	\$156,400,530
Northbrook Behavioral Healthcare	\$48,375,292	\$0
	1,964,354,898	\$1,369,616,797

1.0863	Inflation Factor
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INFLATED FEE BASIS

	Inpatient	Outpatient
Cooper University	\$1,147,474,600	\$708,246,764
Virtua West Jersey - Voorhees	\$435,655,511	\$422,955,876
Virtua OLOL	\$304,162,107	\$186,687,548
Jefferson UMC	\$193,994,353	\$169,894,461
Northbrook Behavioral Healthcare	\$52,549,017	\$0
	\$2,133,835,588	\$1,487,784,650

\$3,621,620,238 Total Inflated Revenue

\$181,081,012 5% NPSR Rev Cap

ACR EQUIVALENT ANALYSIS

Inpatient Hospital (Acute)

Per Diem ACR Threshold		\$6,680.20	a
Aggregate CY23 Patient Days	100,032		
Medicaid HMO Payments	\$245,456,038.37	\$2,453.78	b
QIP-NJ	\$21,597,640.00	\$215.91	c
		\$2,669.68	d = b + c
<i>Remaining Room Under ACR Threshold (Pre County Option)</i>		<i>\$4,010.52</i>	<i>e = a - d</i>
County Option SDPs	\$394,856,568.99	\$3,947.30	f
Post County Option Remaining ACR Room		\$63.22	g = e - f
Percentage of ACR Equivalent		99.05%	h = (d + f) / a

Outpatient Hospital (Acute)

Per Diem ACR Threshold		\$1,730.87	j
Aggregate CY23 Visits	236,735		
Medicaid HMO Payments	\$172,645,227	\$729.28	k
Interim State Directed Payments	\$41,863,050	\$176.84	l
		\$906.11	m = k + l
<i>Remaining Room Under ACR Threshold (Pre County Option)</i>		<i>\$824.76</i>	<i>n = j - m</i>
County Option SDPs	\$157,940,783	\$667.16	o
Post County Option Remaining ACR Room		\$157.59	p = n - o
Percentage of ACR Equivalent		90.90%	q = (m + o) / j

Inpatient Hospital (Non-acute)

Per Diem ACR Threshold		\$6,680.20	a
Aggregate CY23 Patient Days	24,132		
Medicaid HMO Payments	\$20,804,536.30	\$207.98	b
QIP-NJ		\$0.00	c
		\$207.98	d = b + c
<i>Remaining Room Under ACR Threshold (Pre County Option)</i>		<i>\$6,472.23</i>	<i>e = a - d</i>
County Option SDPs	\$13,438,104.42	\$556.86	f
Post County Option Remaining ACR Room		\$5,915.37	g = e - f
Percentage of ACR Equivalent		11.45%	h = (d + f) / a

INFLATION FACTOR CALCULATION

Summary Web Table - CMS Market Basket Index Levels and Four-Quarter Moving Average Percent Changes *

Market Basket		Forecast	Forecast	Forecast
	2023	2024	2025	2026
	Q4	Q4	Q4	Q2
2018-based Inpatient Hospital:				
Index Levels	1.216	1.259	1.299	1.321

Inflation 1.035 1.032 1.017

INFLATION FACTOR 1.0863

Note: All market basket index levels do not reflect a productivity adjustment. The four-quarter moving average percent change of the 2017-based Medicare Economic Index reflects a productivity adjustment. Due to interpretation of the statute regarding the MEI update, the productivity adjustment has been shifted forward two quarters so the latest historical CY 2023 productivity adjustment is aligned with the 2024Q2 percent change in the MEI.

* Quarterly index levels and four-quarter moving average percent changes are reported on a calendar year (CY) basis. For example, the Q4 index level corresponds with October 1 through December 31 and the Q4 four-quarter moving average percent change reflects the CY growth rate. Percent change moving averages are calculated using more than ten decimal places.

Source: IHS Global Inc. (IGI) 2024Q2 Forecast

Historical Data through 2024Q1

Released by CMS, OACT, National Health Statistics Group, dnhs@cms.hhs.gov

09/15/2024

ATTESTATION

NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM


Hospital Name: Kennedy University Hospitals, Inc. DBA Jefferson Health New Jersey

CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of Kennedy University Hospitals, Inc.
DBA Jefferson Health New Jersey 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 acknowledge 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 may choose to prospectively decline, in full or in part, its Charity Care payments for the State Fiscal Year (SFY) by notifying the Commissioner of Health on a form designated by the Department of Health. Additionally, I understand that the hospital's DSH payments may be reduced for the SFY, as necessary and at the discretion of the State, to comply with federal (42 U.S.C. § 1396r-4) and state requirements (N.J.A.C. 10:52B), the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B).
- I acknowledge that the Charity Care payments prospectively declined by the hospital for the SFY, whether full or partial, will be redistributed to other hospitals in accordance with the provisions of Section 3 of P.L. 2004, c.113 (N.J.S.A 26:2H-18.59i), as modified annually by the State Appropriations Act. If the hospital chooses not to prospectively decline its Charity Care payments but is found through subsequent DSH audits to have exceeded its hospital-specific DSH limit, the hospital will be subject to recoupment by the State for any amounts exceeding its hospital-specific DSH limits.
- I acknowledge 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 Kennedy University Hospitals, Inc.
DBA Jefferson Health New Jersey hospital.

Signature 

Name Aaron Chang
Full Name (Printed)

Title President **Date** 11 / 6 / 24

NJ FamilyCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age or disability. If you speak any other language, language assistance services are available at no cost to you. Call 1-800-701-0710 (TTY: 1-800-701-0720).

ATTESTATION

NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name: Cooper University Hospital

CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of Cooper University Hospital **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 acknowledge 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 may choose to prospectively decline, in full or in part, its Charity Care payments for the State Fiscal Year (SFY) by notifying the Commissioner of Health on a form designated by the Department of Health. Additionally, I understand that the hospital's DSH payments may be reduced for the SFY, as necessary and at the discretion of the State, to comply with federal (42 U.S.C. § 1396r-4) and state requirements (N.J.A.C. 10:52B), the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B).
- I acknowledge that the Charity Care payments prospectively declined by the hospital for the SFY, whether full or partial, will be redistributed to other hospitals in accordance with the provisions of Section 3 of P.L. 2004, c.113 (N.J.S.A 26:2H-18.59i), as modified annually by the State Appropriations Act. If the hospital chooses not to prospectively decline its Charity Care payments but is found through subsequent DSH audits to have exceeded its hospital-specific DSH limit, the hospital will be subject to recoupment by the State for any amounts exceeding its hospital-specific DSH limits.
- I acknowledge 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 Cooper University Hospital hospital.

Signature 

Name Brian Reilly

Full Name (Printed)

Title CFO

Date 11 / 06 / 2024

NJ FamilyCare complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, sex, age or disability. If you speak any other language, language assistance services are available at no cost to you. Call 1-800-701-0710 (TTY: 1-800-701-0720).

ATTESTATION

NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name: Virtua - Our Lady of Lourdes Hospital, Inc

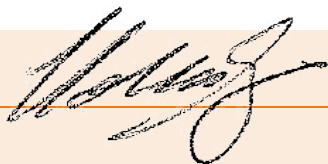
CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of Virtua - Our Lady of Lourdes 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 acknowledge 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 may choose to prospectively decline, in full or in part, its Charity Care payments for the State Fiscal Year (SFY) by notifying the Commissioner of Health on a form designated by the Department of Health. Additionally, I understand that the hospital's DSH payments may be reduced for the SFY, as necessary and at the discretion of the State, to comply with federal (42 U.S.C. § 1396r-4) and state requirements (N.J.A.C. 10:52B), the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B).
- I acknowledge that the Charity Care payments prospectively declined by the hospital for the SFY, whether full or partial, will be redistributed to other hospitals in accordance with the provisions of Section 3 of P.L. 2004, c.113 (N.J.S.A 26:2H-18.59i), as modified annually by the State Appropriations Act. If the hospital chooses not to prospectively decline its Charity Care payments but is found through subsequent DSH audits to have exceeded its hospital-specific DSH limit, the hospital will be subject to recoupment by the State for any amounts exceeding its hospital-specific DSH limits.
- I acknowledge 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 - Our Lady of Lourdes Hospital, Inc **hospital.**

Signature _____



Name _____

Robert Segin

Full Name (Printed)

Title _____

EVP/CFO

Date 11 / 5 / 2024

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Affordable health coverage. Quality care.

ATTESTATION

NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name: Elmwood Hills Healthcare Center LLC d/b/a Northbrook Behavioral Health Hospital

CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of Elmwood Hills Healthcare Center LLC d/b/a hospital ("the hospital"), I hereby certify that:
Northbrook Behavioral health Hospital

- 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 acknowledge 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 may choose to prospectively decline, in full or in part, its Charity Care payments for the State Fiscal Year (SFY) by notifying the Commissioner of Health on a form designated by the Department of Health. Additionally, I understand that the hospital's DSH payments may be reduced for the SFY, as necessary and at the discretion of the State, to comply with federal (42 U.S.C. § 1396r-4) and state requirements (N.J.A.C. 10:52B), the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B).
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I am authorized to make this Certification on behalf of ~~Elmwood Hills Healthcare Center LLC d/b/a Northbrook Behavioral Health Hospital~~ **hospital.**

Signature AVRAHAM FEIGENBAUM

Name Avraham Feigenbaum
Full Name (Printed)

Title Manager **Date** 11/ 12 / 2024

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ATTESTATION

NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

Hospital Name: Virtua - West Jersey Health System, Inc. - Voorhees


CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of Virtua - West Jersey Health System, Inc. - Voorhees **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 acknowledge 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 may choose to prospectively decline, in full or in part, its Charity Care payments for the State Fiscal Year (SFY) by notifying the Commissioner of Health on a form designated by the Department of Health. Additionally, I understand that the hospital's DSH payments may be reduced for the SFY, as necessary and at the discretion of the State, to comply with federal (42 U.S.C. § 1396r-4) and state requirements (N.J.A.C. 10:52B), the hospital's DSH payments may be reduced as necessary to comply with federal law. (N.J.A.C. 10:52B).
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I am authorized to make this Certification on behalf of _____ hospital.

Signature _____



Name _____

Robert Segin

Full Name (Printed)

Title _____

EVP/CFO

Date

11 / 5 / 2024

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