

**Date:** 2/ 6 / 2025

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

**County:** Middlesex 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 Middlesex 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:

Please note that Rutgers Health-University Behavioral Health Care, a public psychiatric hospital, is not being included in the fee. However, pursuant to 42 CFR 433.68(c)(1), a provider assessment is considered to be "broad based" if it is imposed on all providers of the applicable services "furnished by all non-Federal, non-public providers...". Notwithstanding the exclusion of Rutgers Health, the county's proposed fee will be imposed on all non-Federal, non-public providers of inpatient hospital services, and therefore no waiver is necessary and the statistical test is not required.

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

Penn Medicine Princeton Medical Center's main campus is located in Middlesex County and has a provider-based facility, Princeton House, located in Mercer County. We request that the state use the proceeds of the fees paid to Mercer County by Princeton House to help fund the non-federal share of County Option payments to the hospitals in Middlesex County. Similarly, we request that the state use proceeds of fees on outpatient services provided by Children's Specialized Hospital in Essex, Monmouth and Ocean counties, all of which are provider-based to Children's Specialized Hospital located in Middlesex County, to help fund the non-federal share of County Option payments to the hospitals in Middlesex County. These transfers of funds will promote the program's purpose of supporting local hospitals as the payments to Penn Medicine Princeton Medical Center and Children's Specialized Hospital in Middlesex County will include the out-of-county services they provide.

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 \$3,183.48 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 will add 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, 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.

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 and outpatient payments to acute care hospitals whose main campus is within Middlesex County. The increase in inpatient payments would be implemented as a per-discharge add on of \$26,358.02 and the increase in outpatient payments would be implemented as a per-visit add on of \$451.32.

The payments have been calculated using a weighted Federal Medical Assistance Percentage (FMAP) of 66.12%. We calculated the applicable FMAP for inpatient (66.49%) and outpatient payments (64.76%) based on the mix of Medicaid, expansion and CHIP patients in the state's CY2023 data. We then calculated a weighted FMAP based on the relative amount of fees used to make inpatient and outpatient payments.

The payment methodology would be the same for all hospitals, 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 be 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 (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. 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 <sup>5%</sup>~~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.

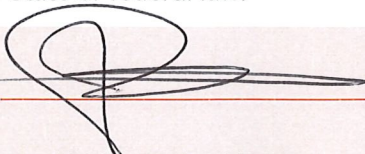
## ATTESTATION

### 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:** JOHN PULOMENA

Full Name (Printed)

**Title:** COUNTY ADMINISTRATOR

**Date:** 2 / 6 / 2025

**Email Address:** john.pulomena@co.middlesex.nj.us

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

**JFK Medical Center**

65 JAMES STREET

EDISON, NJ 08818

- General Acute Care
- Non-profit

**JFK Johnson Rehabilitation Institute**

65 JAMES STREET

EDISON, NJ 08818

- Rehabilitation Hospital
- Non-profit

**Robert Wood Johnson University Hospital**

ONE ROBERT WOOD JOHNSON PLACE

NEW BRUNSWICK, NJ 08901

- General Acute Care
- Non-profit

**Saint Peter's University Hospital**

254 EASTON AVE

NEW BRUNSWICK, NJ 08901

- General Acute Care
- Non-profit

**Children's Specialized Hospital**

200 SOMERSET STREET

NEW BRUNSWICK, NJ 08901

- Rehabilitation Hospital
- Non-profit

**Raritan Bay Medical Center-Old Bridge Division**

ONE HOSPITAL PLAZA

OLD BRIDGE, NJ 08857

- General Acute Care
- Non-profit

**Raritan Bay Medical Center Perth Amboy Division**

530 NEW BRUNSWICK AVE

PERTH AMBOY, NJ 08861

- General Acute Care
- Non-profit



**LTACH CareOne At Saint Peter’s University Hospital**

254 EASTON AVE

NEW BRUNSWICK, NJ 08901

- Specialty
- For profit

**Rutgers Health - University Behavioral Health Care**

671 HOES LANE WEST

PISCATAWAY, NJ 08854

- Psychiatric Hospital
- Public

**Penn Medicine Princeton Medical Center**

ONE-FIVE PLAINSBORO ROAD

PLAINSBORO, NJ 08536

- General Acute Care
- Non-profit

**Hackensack Meridian Long Term Acute Care Hospital**

530 NEW BRUNSWICK AVENUE 4<sup>TH</sup> FLOOR

PERTH AMBOY, NJ 08861

- LTACH
- Non-profit
- Under the County resolution establishing the fee program, New Hospitals become Assessed Hospitals and are to be subject to the County Option assessment in the program year that begins at least two years following the year in which the hospital begins operations, unless the County determines, in consultation with DMAHS, that there is insufficient data to include the New Hospital in the model until the next Program Year. As discussed with the State’s contractors on May 17, 2024, because the hospital only received approval from CMS to operate as an LTACH in May 2024, there is insufficient financial data regarding the hospital's operations as an LTACH to develop an appropriate fee amount for SFY2026. As a result, pursuant to the County resolution, the hospital does not yet qualify as an Assessed Hospital and will not be subject to the assessment or eligible for payment in SFY 2026.



## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

**Hospital Name:** The Rehab Hospital at Ravitan Bay

### CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of The Rehab Hospital at Ravitan Bay 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 The Rehab Hospital at Raritan Bay hospital.

Signature 

Name MARGARET NOLAN  
Full Name (Printed)

Title CEO 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:** Saint Peter's University Hospital

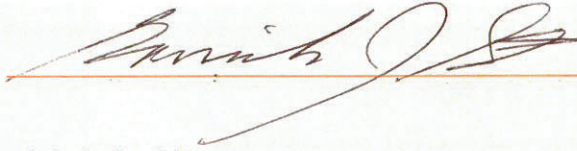
### CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

**On behalf of** Saint Peter's University **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.
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I am authorized to make this Certification on behalf of Saint Peter's University hospital.

Signature



Name Garrick J. Stoldt

Full Name (Printed)

Title Chief Financial Officer

Date 11 / 11 / 2024

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**ATTESTATION**

**NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM**

**Hospital Name:** Penn Medicine Princeton Health (PMPH)

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

**On behalf of** PMPH **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 PMPH hospital.

Signature Gui Valladares  
Name [Signature]  
Full Name (Printed)  
Title Sr VP Finance  
CFO Date 11 / 12 / 24

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## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

**Hospital Name:** Children's Specialized Hospital

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

On behalf of Children's Specialized 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.
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I am authorized to make this Certification on behalf of Children's Specialized Hospital hospital.

Signature



Name Matthew McDonald III

Full Name (Printed)

Title President & CEO, Children's Specialized Hospital

Date

11 / 12 / 24

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## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

**Hospital Name:** Robert Wood Johnson University Hospital-New Brunswick

### CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

**On behalf of** Robert Wood Johnson University Hospital-New Brunswick **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 Robert Wood Johnson University Hospital-New Brunswick hospital.

Signature



Name Alan Lee

Full Name (Printed)

Title President, Robert Wood Johnson University Hospital-New Brunswick

Date 11 / 14 / 2024

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## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

**Hospital Name:** JFK Medical Center

### CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of JFK Medical 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 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 JFK Medical Center hospital.

**Signature**  060594E556C04E0...

**Name** James De Rosa  
Full Name (Printed)

**Title** EVP Financial Services **Date** 11/11/2024

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## ATTESTATION

### NEW JERSEY COUNTY OPTION HOSPITAL FEE PROGRAM

**Hospital Name:** Raritan Bay Medical Center

### CERTIFICATION BY HOSPITAL CHIEF EXECUTIVE OFFICER OR ADMINISTRATOR

On behalf of Raritan Bay Medical 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 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 Raritan Bay Medical Center hospital.

**Signature**  060594E556C04E0...

**Name** James De Rosa  
Full Name (Printed)

**Title** EVP Financial Services **Date** 11/11/2024

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