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

FORM APPROVED
OMB NO. 0938-0050
EXPIRES: 09-30-2028

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time:	5/11/2026 10:04
	From: 01/01/2025	MCRIF32	**2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version:	25.3.181.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT
CERTIFICATION AND SETTLEMENT SUMMARY

Worksheet S
Parts I, II & III

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically prepared cost report — Date: — Time:
2. [ ] Manually prepared cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report.
4. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without audit
   (3) Settled with audit
   (4) Reopened
   (5) Amended
6. Date Received: _____
7. Contractor No.: _____
8. [ ] Initial Report for this Provider CCN
9. [ ] Final Report for this Provider CCN
10. NPR Date: _____
11. Contractor Vendor Code: 4
12. [0] If line 5, column 1, is 4: Enter number of times reopened = 0-9.

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

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by RAMAPO RIDGE PSYCHIATRIC, 31-4019 {Provider Name(s) and Number(s)} for the cost reporting period beginning 01/01/2025 and ending 12/31/2025 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1		2		
1	*Kevin A. Stagg*		Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name:	KEVIN A. STAGG			2
3	Signatory Title:	EXECUTIVE VICE PRESIDENT & CFO			3
4	Signature Date:	(Dated when report is electronically signed.)			4

PART III - SETTLEMENT SUMMARY

			Title XVIII				
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
1.00	HOSPITAL	0	-4,785	25	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	0	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	11,383	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
200.00	TOTAL	**0**	**6,598**	**25**	**0**	**0**	200.00

The above amount represents "due to" or "due from" the applicable program for the element of the above complex indicated.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I

PART I - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX IDENTIFICATION DATA

Hospital and Hospital Health Care Complex Address:

1.00	Street:	301 SICOMAC AVENUE	P.O. Box:						1.00
2.00	City:	WYCKOFF	State:	NJ	ZIP Code:	07481	County	BERGEN	2.00

Hospital and Hospital-Based Component Identification:

	Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
3.00	Hospital	RAMAPO RIDGE PSYCHIATRIC	314019	35614	4 - Psychiatric	01/12/1990	N	P	T	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	HERITAGE MANOR	315376	35614		12/01/1997	N	P	O	9.00
10.00	Hospital-Based NF	SOUTHGATE MANOR	315376	35614		12/01/1997	N		O	10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
18.00	Renal Dialysis									18.00
19.00	Other									19.00
20.00	Cost Reporting Period (mm/dd/yyyy)	From: 01/01/2025	To: 12/31/2025							20.00
21.00	Type of Control (see instructions)	2 - Voluntary Nonprofit, Other								21.00

Inpatient PPS Information

		1.00	2.00	3.00	
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	N	N		22.00
22.01	Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic redesignation from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015 or FY2025? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				22.04
22.05	Did this hospital receive a geographic reclassification from urban to rural in accordance with 42 CFR 412.103? Enter in column 1, "Y" for yes or "N" for no. If column 1 is Y, enter the effective date of the geographic reclassification in column 2.	N			22.05
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	2	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0	24.00
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I

		Urban/Rural Status	Date of Geographic Reclassification	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00
		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
			1.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.		0	37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)			37.01
		Beginning:	Ending:	
		1.00	2.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00
		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

Prospective Payment System (PPS)-Capital

		V	XVIII	XIX	
		1.00	2.00	3.00	
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00

Teaching Hospitals

		V	XVIII	XIX	
		1.00	2.00	3.00	
56.00	Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.	N			56.00
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N			60.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

		1.00	
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01

Teaching Hospitals that Claim Residents in Nonprovider Settings

63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I

Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010

	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))
	1.00	2.00	3.00

Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))
1.00	2.00	3.00	4.00	5.00

Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)

1.00

Inpatient Psychiatric Facility PPS

1.00	2.00	3.00

Long Term Care Hospital PPS

1.00

Approved for Permanent Adjustment (Y/N)	Number of Approved Permanent Adjustments
1.00	2.00

Wkst. A Line No.	Effective Date	Approved Permanent Adjustment Amount Per Discharge
1.00	2.00	3.00

Title V and XIX Services

V	XIX
1.00	2.00
V	XIX
1.00	2.00

Rural Providers

1.00	2.00

Physical	Occupational	Speech	Respiratory
1.00	2.00	3.00	4.00
			1.00
		1.00	2.00
	1.00	2.00	3.00
	Premiums	Losses	Insurance
	1.00	2.00	3.00
		1.00	2.00

Certified Transplant Center Information

1.00	2.00

All Providers

1.00	2.00

If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

	1.00
1.00	2.00
	1.00

Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)

Part A	Part B	Title V	Title XIX
1.00	2.00	3.00	4.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
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Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I

Multicampus								
							1.00	
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
							1.00	
						Beginning	Ending	
						1.00	2.00	
						1.00	2.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000		65.00
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000		66.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000		67.00
68.00	For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?							68.00
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y				70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			N	N	0		71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			N				75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)					0		76.00
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.					N		81.00
TEFRA Providers								
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.							86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.					N		87.00
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.			N		0		88.00
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.			0.00		0		89.00
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.					N	N	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.					N	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.						Y	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.					N	N	93.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I

		1.00	2.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	Y	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	10.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	5.80	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
107.01	If this facility is a REH (line 3, column 4, is "12"), is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no. (see instructions)			107.01
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N N N N		109.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110.00
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N	0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0		118.00
118.01	List amounts of malpractice premiums and paid losses:	0	0 0	118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N N		120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	N		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
123.00	Did the facility and/or its subproviders (if applicable) purchase professional services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, and/or management/consulting services, from an unrelated organization? In column 1, enter "Y" for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than 50% of total professional services expenses, for services purchased from unrelated organizations located in a CBSA outside of the main hospital CBSA? In column 2, enter "Y" for yes or "N" for no.	N		123.00
124.00	Did the hospital incur cost, either directly or through a contract with an outside supplier, to establish and maintain access to no less than a 6-month buffer stock of one or more essential medicines according to 42 CFR 412.113(g)? Enter "Y" for yes or "N" for no.	N		124.00
125.00	Does this facility operate a Medicare-certified transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare-certified kidney transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare-certified heart transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Worksheet S-2
Part I

									1.00	2.00	
128.00	If this is a Medicare-certified liver transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.										128.00
129.00	If this is a Medicare-certified lung transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.										129.00
130.00	If this is a Medicare-certified pancreas transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.										130.00
131.00	If this is a Medicare-certified intestinal transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.										131.00
132.00	If this is a Medicare-certified islet transplant program, enter the certification date in column 1 and termination date, if applicable, in column 2.										132.00
133.00	Removed and reserved										133.00
134.00	If this is a hospital-based organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.										134.00
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)								N		140.00
141.00	Name:		Contractor's Name:		Contractor's Number:						141.00
142.00	Street:		P.O. Box:								142.00
143.00	City:		State:		Zip Code:						143.00
144.00	Are provider based physicians' costs included in Worksheet A?									Y	144.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.										145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.									N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.									N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.									N	149.00
155.00	Hospital							N	N	N	N	155.00
156.00	Subprovider - IPF							N	N	N	N	156.00
157.00	Subprovider - IRF							N	N	N	N	157.00
158.00	SUBPROVIDER											158.00
159.00	SNF							N	N	N	N	159.00
160.00	HOME HEALTH AGENCY							N	N	N	N	160.00
161.00	CMHC								N	N	N	161.00
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.									N	165.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)									0.00	166.00
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.									N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)										168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)										168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)									0.00	169.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)										170.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)								N	0	171.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Worksheet S-2
Part II

PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.

COMPLETED BY ALL HOSPITALS

		Y/N	Date			
		1.00	2.00			
Provider Organization and Operation						
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N				1.00
		Y/N	Date	V/I		
		1.00	2.00	3.00		
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N				2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N				3.00
		Y/N	Type	Date		
		1.00	2.00	3.00		
Financial Data and Reports						
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N				5.00
			Y/N	Legal Oper.		
			1.00	2.00		
Approved Educational Activities						
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program?		N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N			7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.		N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.		N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N			11.00
				Y/N		
				1.00		
Bad Debts						
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N		13.00
14.00	If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions.			N		14.00
Bed Complement						
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N		15.00
		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
PS&R Data						
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, in columns 2 and 4, from the PS&R used to prepare this cost report, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date.(see instructions)	Y	03/20/2026	Y	03/20/2026	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, in columns 2 and 4, enter the "Paid Claims Verified Current As Of" date, if present, or the paid-through date. (see instructions)	N		N		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00
	Description	Y/N	Date	Y/N	Date	
	0	1.00	2.00	3.00	4.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Worksheet S-2
Part II

COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
				1.00	
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Were services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00	3.00	
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KATHERINE	BLISSIT	CONSULTANT	41.00
42.00	Enter the employer/company name of the cost report preparer.	HEALTH CARE RESOURCES			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	609-987-1440	KITTY.BLISSIT@HCRNJ.NET		43.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Worksheet S-3
Part I

	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH/REH Hours	I/P Days / O/P Visits / Trips				
						Title V	Title XVIII	Title XIX	Total All Patients	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
PART I - STATISTICAL DATA										
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	58	21,170	0.00	0	7,756	1,252	15,481	1.00
2.00	HMO and other (see instructions)						0	0		2.00
3.00	HMO IPF Subprovider						0	0		3.00
4.00	HMO IRF Subprovider						0	0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	0	0	0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0		0	0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		**58**	**21,170**	**0.00**	**0**	**7,756**	**1,252**	**15,481**	7.00
8.00	INTENSIVE CARE UNIT									8.00
9.00	CORONARY CARE UNIT									9.00
10.00	BURN INTENSIVE CARE UNIT									10.00
11.00	SURGICAL INTENSIVE CARE UNIT									11.00
12.00	OTHER SPECIAL CARE (SPECIFY)									12.00
13.00	NURSERY									13.00
14.00	Total (see instructions)		**58**	**21,170**	**0.00**	**0**	**7,756**	**1,252**	**15,481**	14.00
15.00	CAH visits					0	0	0	0	15.00
15.10	REH hours and visits				0.00	0	0	0	0	15.10
16.00	SUBPROVIDER - IPF									16.00
17.00	SUBPROVIDER - IRF									17.00
18.00	SUBPROVIDER									18.00
19.00	SKILLED NURSING FACILITY	44.00	254	92,710		0	20,395	33,821	86,806	19.00
20.00	NURSING FACILITY	45.00	50	18,250		0		11,053	16,047	20.00
21.00	OTHER LONG TERM CARE	46.00	134	48,910					45,553	21.00
22.00	HOME HEALTH AGENCY									22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)									23.00
24.00	HOSPICE									24.00
24.10	HOSPICE (non-distinct part)	30.00							0	24.10
25.00	CMHC - CMHC									25.00
26.00	RURAL HEALTH CLINIC									26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	0	0	0	26.25
27.00	Total (sum of lines 14-26)		**496**							27.00
28.00	Observation Bed Days					0		0	0	28.00
29.00	Ambulance Trips						0			29.00
30.00	Employee discount days (see instruction)								0	30.00
31.00	Employee discount days - IRF								0	31.00
32.00	Labor & delivery days (see instructions)		0	0			0	0	0	32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								**0**	32.01
33.00	LTCH non-covered days						0			33.00
33.01	LTCH site neutral days and discharges						0			33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care									34.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Worksheet S-3
Part I

		Full Time Equivalents			Discharges					
	Component	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients		
		9.00	10.00	11.00	12.00	13.00	14.00	15.00		
PART I - STATISTICAL DATA										
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)				0	287	87	746		1.00
2.00	HMO and other (see instructions)					0	0			2.00
3.00	HMO IPF Subprovider						0			3.00
4.00	HMO IRF Subprovider						0			4.00
5.00	Hospital Adults & Peds. Swing Bed SNF									5.00
6.00	Hospital Adults & Peds. Swing Bed NF									6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)									7.00
8.00	INTENSIVE CARE UNIT									8.00
9.00	CORONARY CARE UNIT									9.00
10.00	BURN INTENSIVE CARE UNIT									10.00
11.00	SURGICAL INTENSIVE CARE UNIT									11.00
12.00	OTHER SPECIAL CARE (SPECIFY)									12.00
13.00	NURSERY									13.00
14.00	Total (see instructions)	**0.00**	**132.90**	**0.00**	**0**	**287**	**87**	**746**		14.00
15.00	CAH visits									15.00
15.10	REH hours and visits									15.10
16.00	SUBPROVIDER - IPF									16.00
17.00	SUBPROVIDER - IRF									17.00
18.00	SUBPROVIDER									18.00
19.00	SKILLED NURSING FACILITY	0.00	398.70	0.00						19.00
20.00	NURSING FACILITY	0.00	71.30	0.00						20.00
21.00	OTHER LONG TERM CARE	0.00	146.40	0.00				33		21.00
22.00	HOME HEALTH AGENCY									22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)									23.00
24.00	HOSPICE									24.00
24.10	HOSPICE (non-distinct part)									24.10
25.00	CMHC - CMHC									25.00
26.00	RURAL HEALTH CLINIC									26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00						26.25
27.00	Total (sum of lines 14-26)	**0.00**	**749.30**	**0.00**						27.00
28.00	Observation Bed Days									28.00
29.00	Ambulance Trips									29.00
30.00	Employee discount days (see instruction)									30.00
31.00	Employee discount days - IRF									31.00
32.00	Labor & delivery days (see instructions)									32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33.00	LTCH non-covered days					0				33.00
33.01	LTCH site neutral days and discharges					0				33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care									34.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

HOSPITAL WAGE INDEX INFORMATION

Worksheet S-3
Part II

PART II - WAGE DATA

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
SALARIES								
1.00	Total salaries (see instructions)	200.00	56,077,780	0	56,077,780	1,558,539.00	35.98	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	17,306,946	0	17,306,946	461,026.00	37.54	9.00
10.00	Excluded area salaries (see instructions)		8,149,702	0	8,149,702	190,266.00	42.83	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		0	0	0	0.00	0.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
15.01	Home office Physicians Part A - Administrative		0	0	0	0.00	0.00	15.01
15.02	Home office contract Physicians Part A - Administrative		0	0	0	0.00	0.00	15.02
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.02
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		11,090,552	0	11,090,552			17.00
18.00	Wage-related costs (other) (see instructions)							18.00
19.00	Excluded areas		2,101,036	0	2,101,036			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	0	0	0	0.00	0.00	26.00
27.00	Administrative & General	5.00	8,500,297	0	8,500,297	153,429.00	55.40	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,800,138	0	1,800,138	60,501.00	29.75	30.00
31.00	Laundry & Linen Service	8.00	673,483	0	673,483	28,342.00	23.76	31.00
32.00	Housekeeping	9.00	1,691,621	0	1,691,621	77,177.00	21.92	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	4,666,359	0	4,666,359	167,922.00	27.79	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

HOSPITAL WAGE INDEX INFORMATION

Worksheet S-3
Part II

PART II - WAGE DATA

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	0	0	0	0.00	0.00	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	0.00	0.00	41.00
42.00	Social Service	17.00	0	0	0	0.00	0.00	42.00
43.00	Other General Service	18.00	534,267	0	534,267	12,433.00	42.97	43.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time:	5/11/2026 10:04
	From: 01/01/2025	MCRIF32	**2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version:	25.3.181.0

HOSPITAL WAGE INDEX INFORMATION

Worksheet S-3
Part III

PART III - HOSPITAL WAGE INDEX SUMMARY

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
1.00	Net salaries (see instructions)		56,077,780	0	56,077,780	1,558,539.00	35.98	1.00
2.00	Excluded area salaries (see instructions)		25,456,648	0	25,456,648	651,292.00	39.09	2.00
3.00	Subtotal salaries (line 1 minus line 2)		**30,621,132**	**0**	**30,621,132**	**907,247.00**	**33.75**	3.00
4.00	Subtotal other wages & related costs (see inst.)		0	0	0	0.00	0.00	4.00
5.00	Subtotal wage-related costs (see inst.)		11,090,552	0	11,090,552	0.00	36.22	5.00
6.00	Total (sum of lines 3 thru 5)		**41,711,684**	**0**	**41,711,684**	**907,247.00**	**45.98**	6.00
7.00	Total overhead cost (see instructions)		17,866,165	0	17,866,165	499,804.00	35.75	7.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

HOSPITAL WAGE RELATED COSTS

Worksheet S-3
Part IV

PART IV - WAGE RELATED COSTS			
Part A - Core List			
		Amount Reported	
		1.00	
RETIREMENT COST			
1.00	401K Employer Contributions	1,182,304	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	241,787	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	6,574,068	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	121,984	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	57,961	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,077,435	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Noncumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	3,491,615	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	157,550	19.00
20.00	State or Federal Unemployment Taxes	262,789	20.00
OTHER			
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	24,095	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	**13,191,588**	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Worksheet S-3
Part V

PART V - Contract Labor and Benefit Cost

Hospital and Hospital-Based Component Identification:

		Contract Labor	Benefit Cost	
		1.00	2.00	
1.00	Total facility's contract labor and benefit cost	0	13,286,186	1.00
2.00	Hospital	0	2,116,103	2.00
3.00	SUBPROVIDER - IPF			3.00
4.00	SUBPROVIDER - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	SKILLED NURSING FACILITY	0	4,097,969	8.00
9.00	NURSING FACILITY	0	762,670	9.00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospital-Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D.P.) I			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	RENAL DIALYSIS I			17.00
18.00	Other	0	6,309,444	18.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES **Worksheet A**

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	Adjustments (See A-8)	Net Expenses For Allocation	
			1.00	2.00	3.00	4.00	5.00	6.00	7.00	
GENERAL SERVICE COST CENTERS										
1.00	00100	CAP REL COSTS-BLDG & FIXT		8,007,838	**8,007,838**	0	**8,007,838**	-744,341	**7,263,497**	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	**0**	0	**0**	0	**0**	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	13,286,185	**13,286,185**	0	**13,286,185**	0	**13,286,185**	4.00
5.01	00505	ADMINISTRATIVE AND GENERAL - WYCOFF	869,857	2,336,268	**3,206,125**	0	**3,206,125**	-2,416,166	**789,959**	5.01
5.02	00506	ADMINISTRATIVE AND GENERAL - MULTI	7,630,440	4,643,027	**12,273,467**	0	**12,273,467**	0	**12,273,467**	5.02
6.00	00600	MAINTENANCE & REPAIRS	0	0	**0**	0	**0**	0	**0**	6.00
7.00	00700	OPERATION OF PLANT	1,682,349	1,296,498	**2,978,847**	0	**2,978,847**	-10,949	**2,967,898**	7.00
7.01	00701	OTHER OPERATION OF PLANT	117,789	1,489,491	**1,607,280**	0	**1,607,280**	0	**1,607,280**	7.01
8.00	00800	LAUNDRY & LINEN SERVICE	673,483	278,387	**951,870**	0	**951,870**	0	**951,870**	8.00
9.00	00900	HOUSEKEEPING	1,691,621	881,937	**2,573,558**	0	**2,573,558**	0	**2,573,558**	9.00
10.00	01000	DIETARY	4,666,359	2,423,338	**7,089,697**	0	**7,089,697**	-32,403	**7,057,294**	10.00
11.00	01100	CAFETERIA	0	0	**0**	0	**0**	0	**0**	11.00
13.00	01300	NURSING ADMINISTRATION	0	0	**0**	0	**0**	0	**0**	13.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	**0**	0	**0**	0	**0**	16.00
17.00	01700	SOCIAL SERVICE	0	0	**0**	0	**0**	0	**0**	17.00
18.00	01850	PASTORAL CARE	534,267	9,244	**543,511**	0	**543,511**	0	**543,511**	18.00
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	8,936,934	324,392	**9,261,326**	0	**9,261,326**	-361,392	**8,899,934**	30.00
44.00	04400	SKILLED NURSING FACILITY	17,306,946	2,310,100	**19,617,046**	0	**19,617,046**	0	**19,617,046**	44.00
45.00	04500	NURSING FACILITY	3,220,982	439,814	**3,660,796**	0	**3,660,796**	0	**3,660,796**	45.00
46.00	04600	OTHER LONG TERM CARE	3,674,482	128,917	**3,803,399**	0	**3,803,399**	0	**3,803,399**	46.00
ANCILLARY SERVICE COST CENTERS										
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	178,275	**178,275**	0	**178,275**	0	**178,275**	54.00
60.00	06000	LABORATORY	0	338,887	**338,887**	0	**338,887**	0	**338,887**	60.00
65.00	06500	RESPIRATORY THERAPY	0	163,587	**163,587**	0	**163,587**	0	**163,587**	65.00
66.00	06600	PHYSICAL THERAPY	0	2,541,975	**2,541,975**	0	**2,541,975**	0	**2,541,975**	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,914,460	**1,914,460**	0	**1,914,460**	0	**1,914,460**	67.00
68.00	06800	SPEECH PATHOLOGY	0	449,508	**449,508**	0	**449,508**	0	**449,508**	68.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	368,555	**368,555**	0	**368,555**	0	**368,555**	71.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,841,097	**1,841,097**	0	**1,841,097**	0	**1,841,097**	73.00
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	3,818,033	71	**3,818,104**	0	**3,818,104**	-1,328,244	**2,489,860**	90.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART								92.00
SPECIAL PURPOSE COST CENTERS										
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	**54,823,542**	**45,651,851**	**100,475,393**	**0**	**100,475,393**	**-4,893,495**	**95,581,898**	118.00
NONREIMBURSABLE COST CENTERS										
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	234,589	**234,589**	0	**234,589**	0	**234,589**	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	**0**	0	**0**	0	**0**	192.00
192.10	19202	OTHER NONREIMBURSABLE	0	0	**0**	0	**0**	0	**0**	192.10
192.50	19201	MEDICAL DAY CARE	0	0	**0**	0	**0**	0	**0**	192.50
194.00	07950	MARKETING/GROUP	1,133,711	2,343,215	**3,476,926**	0	**3,476,926**	0	**3,476,926**	194.00
194.01	07951	VILLAGE	120,527	20,253	**140,780**	0	**140,780**	0	**140,780**	194.01
194.02	07952	HOME HEALTH SERVICES	0	0	**0**	0	**0**	0	**0**	194.02
200.00		TOTAL (SUM OF LINES 118 through 199)	**56,077,780**	**48,249,908**	**104,327,688**	**0**	**104,327,688**	**-4,893,495**	**99,434,193**	200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

RECLASSIFICATIONS **Worksheet A-6**

	Increases				Decreases					
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00	
A - DEFAULT										
1.00		0.00	0	0		0.00	0	0	0	1.00
	Totals		**0**	**0**			**0**	**0**		
500.00	**TOTAL RECLASSIFICATIONS (sum of columns 4 and 5 must equal sum of columns 8 and 9)**		**0**	**0**			**0**	**0**		500.00

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
(2) Transfer the amounts in columns 4, 5, 8 and 9 to Worksheet A, column 4, line as appropriate.

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

RECONCILIATION OF CAPITAL COSTS CENTERS

Worksheet A-7
Part I

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES

	Description	Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	Land	1,017,368	0	0	**0**	25,335	**992,033**	0	1.00
2.00	Land Improvements	4,752,200	0	0	**0**	186,763	**4,565,437**	0	2.00
3.00	Buildings and Fixtures	166,106,361	0	0	**0**	26,362,198	**139,744,163**	0	3.00
4.00	Building Improvements	0	0	0	**0**	0	**0**	0	4.00
5.00	Fixed Equipment	0	0	0	**0**	0	**0**	0	5.00
6.00	Movable Equipment	36,538,990	0	0	**0**	688,500	**35,850,490**	0	6.00
7.00	HIT designated Assets	0	0	0	**0**	0	**0**	0	7.00
8.00	Subtotal (sum of lines 1-7)	**208,414,919**	**0**	**0**	**0**	**27,262,796**	**181,152,123**	**0**	8.00
9.00	Reconciling Items	0	0	0	**0**	0	**0**	0	9.00
10.00	Total (line 8 minus line 9)	**208,414,919**	**0**	**0**	**0**	**27,262,796**	**181,152,123**	**0**	10.00

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2

	Description	SUMMARY OF CAPITAL: Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		9.00	10.00	11.00	12.00	13.00	14.00	15.00	
1.00	CAP REL COSTS-BLDG & FIXT	5,710,554	209,633	1,856,674	230,977	0	0	**8,007,838**	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	0	**0**	2.00
3.00	Total (sum of lines 1-2)	**5,710,554**	**209,633**	**1,856,674**	**230,977**	**0**	**0**	**8,007,838**	3.00

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

	Description	COMPUTATION OF RATIOS: Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
1.00	CAP REL COSTS-BLDG & FIXT	290,728,819	0	290,728,819	1.000000	0	0	0	**0**	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	0	0	**0**	2.00
3.00	Total (sum of lines 1-2)	**290,728,819**	**0**	**290,728,819**	**1.000000**	**0**	**0**	**0**	**0**	3.00

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS

	Description	SUMMARY OF CAPITAL: Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		9.00	10.00	11.00	12.00	13.00	14.00	15.00	
1.00	CAP REL COSTS-BLDG & FIXT	5,642,666	209,633	1,180,221	230,977	0	0	**7,263,497**	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	0	**0**	2.00
3.00	Total (sum of lines 1-2)	**5,642,666**	**209,633**	**1,180,221**	**230,977**	**0**	**0**	**7,263,497**	3.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

ADJUSTMENTS TO EXPENSES **Worksheet A-8**

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
	Description (1)	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	B	-676,453	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0	ADMINISTRATIVE AND GENERAL - WYCOFF	5.01	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	B	-6,420	ADMINISTRATIVE AND GENERAL - WYCOFF	5.01	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	B	0	ADMINISTRATIVE AND GENERAL - WYCOFF	5.01	0	7.00
8.00	Television and radio service (chapter 21)	B	-10,949	OPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2,386,872			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-32,403	DIETARY	10.00	0	14.00
15.00	Rental of quarters to employee and others	B	-67,888	CAP REL COSTS-BLDG & FIXT	1.00	9	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	B	-1,392	ADMINISTRATIVE AND GENERAL - WYCOFF	5.01	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	JURY DUTY	B	-120	ADMINISTRATIVE AND GENERAL - WYCOFF	5.01	0	33.00
36.00	SALE OF MEDICAL RECORDS	B	-6,178	ADMINISTRATIVE AND GENERAL - WYCOFF	5.01	0	36.00
37.00	MEMBERSHIP DUES	A	-7,681	ADMINISTRATIVE AND GENERAL - WYCOFF	5.01	0	37.00
40.00	SALE OF NEWSPAPERS	B	-7,841	ADMINISTRATIVE AND GENERAL - WYCOFF	5.01	0	40.00
42.00	REFUND BED TAX	B	-1,689,138	ADMINISTRATIVE AND GENERAL - WYCOFF	5.01	0	42.00
42.01	BADGE REPLACEMENT	B	-160	ADMINISTRATIVE AND GENERAL - WYCOFF	5.01	0	42.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		**-4,893,495**				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions)
A. Costs - if cost, including applicable overhead, can be determined
B. Amount Received - if cost cannot be determined
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

PROVIDER BASED PHYSICIAN ADJUSTMENT **Worksheet A-8-2**

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	474,776	250,815	223,961	181,300	1,290	112,441	5,622	1.00
2.00	5.01	AGGREGATE-ADMINISTRATIVE AND GENERAL	963,956	96,396	867,560	181,300	3,060	266,720	13,336	2.00
3.00	90.00	AGGREGATE-CLINIC	1,976,740	197,674	1,779,066	181,300	7,440	648,496	32,425	3.00
4.00	0.00		0	0	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	0	0	10.00
200.00		**TOTAL**	**3,415,472**	**544,885**	**2,870,587**		**11,790**	**1,027,657**	**51,383**	200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

PROVIDER BASED PHYSICIAN ADJUSTMENT **Worksheet A-8-2**

	Wkst. A Line #	Cost Center/Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	
1.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	2,000	943	113,384	110,577	**361,392**	1.00
2.00	5.01	AGGREGATE-ADMINISTRATIVE AND GENERAL	0	0	0	0	266,720	600,840	**697,236**	2.00
3.00	90.00	AGGREGATE-CLINIC	0	0	0	0	648,496	1,130,570	**1,328,244**	3.00
4.00	0.00		0	0	0	0	0	0	**0**	4.00
5.00	0.00		0	0	0	0	0	0	**0**	5.00
6.00	0.00		0	0	0	0	0	0	**0**	6.00
7.00	0.00		0	0	0	0	0	0	**0**	7.00
8.00	0.00		0	0	0	0	0	0	**0**	8.00
9.00	0.00		0	0	0	0	0	0	**0**	9.00
10.00	0.00		0	0	0	0	0	0	**0**	10.00
200.00		**TOTAL**	**0**	**0**	**2,000**	**943**	**1,028,600**	**1,841,987**	**2,386,872**	200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I

			CAPITAL RELATED COSTS					
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE AND GENERAL - WYCOFF	
		0	1.00	2.00	4.00	4A	5.01	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	7,263,497	**7,263,497**					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		**0**				2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	13,286,185	75,596	0	**13,361,781**			4.00
5.01	ADMINISTRATIVE AND GENERAL - WYCOFF	789,959	0	0	207,263	997,222	**997,222**	5.01
5.02	ADMINISTRATIVE AND GENERAL - MULTI	12,273,467	0	0	1,818,120	14,091,587	142,762	5.02
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	2,967,898	278,706	0	400,857	3,647,461	36,952	7.00
7.01	OTHER OPERATION OF PLANT	1,607,280	0	0	28,066	1,635,346	16,568	7.01
8.00	LAUNDRY & LINEN SERVICE	951,870	125,201	0	160,472	1,237,543	12,538	8.00
9.00	HOUSEKEEPING	2,573,558	16,206	0	403,066	2,992,830	30,320	9.00
10.00	DIETARY	7,057,294	0	0	1,111,863	8,169,157	82,762	10.00
11.00	CAFETERIA	0	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	0	17.00
18.00	PASTORAL CARE	543,511	0	0	127,301	670,812	6,796	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	8,899,934	931,600	0	2,129,421	11,960,955	121,176	30.00
44.00	SKILLED NURSING FACILITY	19,617,046	1,815,773	0	4,123,776	25,556,595	258,873	44.00
45.00	NURSING FACILITY	3,660,796	483,229	0	767,470	4,911,495	49,758	45.00
46.00	OTHER LONG TERM CARE	3,803,399	2,432,397	0	875,526	7,111,322	72,045	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	178,275	0	0	0	178,275	1,806	54.00
60.00	LABORATORY	338,887	0	0	0	338,887	3,433	60.00
65.00	RESPIRATORY THERAPY	163,587	0	0	0	163,587	1,657	65.00
66.00	PHYSICAL THERAPY	2,541,975	301,555	0	0	2,843,530	28,808	66.00
67.00	OCCUPATIONAL THERAPY	1,914,460	0	0	0	1,914,460	19,395	67.00
68.00	SPEECH PATHOLOGY	449,508	0	0	0	449,508	4,554	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	368,555	0	0	0	368,555	3,734	71.00
73.00	DRUGS CHARGED TO PATIENTS	1,841,097	0	0	0	1,841,097	18,652	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	CLINIC	2,489,860	538,445	0	909,730	3,938,035	39,896	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART							92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**95,581,898**	**6,998,708**	**0**	**13,062,931**	**95,018,259**	**952,485**	118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	234,589	23,141	0	0	257,730	2,611	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	14,253	0	0	14,253	144	192.00
192.10	OTHER NONREIMBURSABLE	0	0	0	0	0	0	192.10
192.50	MEDICAL DAY CARE	0	207,419	0	0	207,419	2,101	192.50
194.00	MARKETING/GROUP	3,476,926	19,976	0	270,132	3,767,034	38,164	194.00
194.01	VILLAGE	140,780	0	0	28,718	169,498	1,717	194.01
194.02	HOME HEALTH SERVICES	0	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers		0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	**99,434,193**	**7,263,497**	**0**	**13,361,781**	**99,434,193**	**997,222**	202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I

	Cost Center Description	ADMINISTRATIVE AND GENERAL - MULTI	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OTHER OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.02	6.00	7.00	7.01	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT							4.00
5.01	ADMINISTRATIVE AND GENERAL - WYCOFF							5.01
5.02	ADMINISTRATIVE AND GENERAL - MULTI	**14,234,349**						5.02
6.00	MAINTENANCE & REPAIRS	0	**0**					6.00
7.00	OPERATION OF PLANT	0	0	**3,684,413**				7.00
7.01	OTHER OPERATION OF PLANT	0	0	0	**1,651,914**			7.01
8.00	LAUNDRY & LINEN SERVICE	0	0	66,765	0	**1,316,846**		8.00
9.00	HOUSEKEEPING	0	0	8,642	0	0	**3,031,792**	9.00
10.00	DIETARY	0	0	0	0	0	0	10.00
11.00	CAFETERIA	0	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	0	17.00
18.00	PASTORAL CARE	0	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,963,119	0	496,787	330,383	250,200	417,333	30.00
44.00	SKILLED NURSING FACILITY	5,926,425	0	968,283	660,766	684,760	813,419	44.00
45.00	NURSING FACILITY	2,521,298	0	257,688	330,383	263,369	216,474	45.00
46.00	OTHER LONG TERM CARE	1,426,355	0	1,297,105	165,191	118,517	1,089,649	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	160,808	0	0	135,089	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	CLINIC	0	0	287,132	0	0	241,209	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART							92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**12,837,197**	**0**	**3,543,210**	**1,486,723**	**1,316,846**	**2,913,173**	118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	12,340	0	0	10,367	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	7,601	0	0	6,385	192.00
192.10	OTHER NONREIMBURSABLE	0	0	0	0	0	0	192.10
192.50	MEDICAL DAY CARE	0	0	110,609	0	0	92,918	192.50
194.00	MARKETING/GROUP	0	0	10,653	0	0	8,949	194.00
194.01	VILLAGE	1,397,152	0	0	165,191	0	0	194.01
194.02	HOME HEALTH SERVICES	0	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	**14,234,349**	**0**	**3,684,413**	**1,651,914**	**1,316,846**	**3,031,792**	202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PASTORAL CARE	
		10.00	11.00	13.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT							4.00
5.01	ADMINISTRATIVE AND GENERAL - WYCOFF							5.01
5.02	ADMINISTRATIVE AND GENERAL - MULTI							5.02
6.00	MAINTENANCE & REPAIRS							6.00
7.00	OPERATION OF PLANT							7.00
7.01	OTHER OPERATION OF PLANT							7.01
8.00	LAUNDRY & LINEN SERVICE							8.00
9.00	HOUSEKEEPING							9.00
10.00	DIETARY	**8,251,919**						10.00
11.00	CAFETERIA	1,340,580	**1,340,580**					11.00
13.00	NURSING ADMINISTRATION	0	0	**0**				13.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	**0**			16.00
17.00	SOCIAL SERVICE	0	0	0	0	**0**		17.00
18.00	PASTORAL CARE	0	13,406	0	0	0	**691,014**	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	761,975	308,330	0	0	0	166,473	30.00
44.00	SKILLED NURSING FACILITY	3,726,470	683,688	0	0	0	233,106	44.00
45.00	NURSING FACILITY	736,291	120,651	0	0	0	166,473	45.00
46.00	OTHER LONG TERM CARE	1,427,396	160,882	0	0	0	99,895	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	CLINIC	0	13,406	0	0	0	0	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART							92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**7,992,712**	**1,300,363**	**0**	**0**	**0**	**665,947**	118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00
192.10	OTHER NONREIMBURSABLE	0	0	0	0	0	0	192.10
192.50	MEDICAL DAY CARE	259,207	0	0	0	0	0	192.50
194.00	MARKETING/GROUP	0	40,217	0	0	0	0	194.00
194.01	VILLAGE	0	0	0	0	0	25,067	194.01
194.02	HOME HEALTH SERVICES	0	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	**8,251,919**	**1,340,580**	**0**	**0**	**0**	**691,014**	202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	ADMINISTRATIVE AND GENERAL - WYCOFF					5.01
5.02	ADMINISTRATIVE AND GENERAL - MULTI					5.02
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT					7.00
7.01	OTHER OPERATION OF PLANT					7.01
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
17.00	SOCIAL SERVICE					17.00
18.00	PASTORAL CARE					18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	**17,776,731**	0	**17,776,731**		30.00
44.00	SKILLED NURSING FACILITY	**39,512,385**	0	**39,512,385**		44.00
45.00	NURSING FACILITY	**9,573,880**	0	**9,573,880**		45.00
46.00	OTHER LONG TERM CARE	**12,968,357**	0	**12,968,357**		46.00
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	**180,081**	0	**180,081**		54.00
60.00	LABORATORY	**342,320**	0	**342,320**		60.00
65.00	RESPIRATORY THERAPY	**165,244**	0	**165,244**		65.00
66.00	PHYSICAL THERAPY	**3,168,235**	0	**3,168,235**		66.00
67.00	OCCUPATIONAL THERAPY	**1,933,855**	0	**1,933,855**		67.00
68.00	SPEECH PATHOLOGY	**454,062**	0	**454,062**		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	**372,289**	0	**372,289**		71.00
73.00	DRUGS CHARGED TO PATIENTS	**1,859,749**	0	**1,859,749**		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	**4,519,678**	0	**4,519,678**		90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**92,826,866**	**0**	**92,826,866**		118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	**283,048**	0	**283,048**		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	**28,383**	0	**28,383**		192.00
192.10	OTHER NONREIMBURSABLE	**0**	0	**0**		192.10
192.50	MEDICAL DAY CARE	**672,254**	0	**672,254**		192.50
194.00	MARKETING/GROUP	**3,865,017**	0	**3,865,017**		194.00
194.01	VILLAGE	**1,758,625**	0	**1,758,625**		194.01
194.02	HOME HEALTH SERVICES	**0**	0	**0**		194.02
200.00	Cross Foot Adjustments	**0**	0	**0**		200.00
201.00	Negative Cost Centers	**0**	0	**0**		201.00
202.00	TOTAL (sum lines 118 through 201)	**99,434,193**	**0**	**99,434,193**		202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I

	Cost Center Description	Total		
		26.00		
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT			1.00
2.00	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	ADMINISTRATIVE AND GENERAL - WYCOFF			5.01
5.02	ADMINISTRATIVE AND GENERAL - MULTI			5.02
6.00	MAINTENANCE & REPAIRS			6.00
7.00	OPERATION OF PLANT			7.00
7.01	OTHER OPERATION OF PLANT			7.01
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
17.00	SOCIAL SERVICE			17.00
18.00	PASTORAL CARE			18.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	**17,776,731**		30.00
44.00	SKILLED NURSING FACILITY	**39,512,385**		44.00
45.00	NURSING FACILITY	**9,573,880**		45.00
46.00	OTHER LONG TERM CARE	**12,968,357**		46.00
ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	**180,081**		54.00
60.00	LABORATORY	**342,320**		60.00
65.00	RESPIRATORY THERAPY	**165,244**		65.00
66.00	PHYSICAL THERAPY	**3,168,235**		66.00
67.00	OCCUPATIONAL THERAPY	**1,933,855**		67.00
68.00	SPEECH PATHOLOGY	**454,062**		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	**372,289**		71.00
73.00	DRUGS CHARGED TO PATIENTS	**1,859,749**		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	**4,519,678**		90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**92,826,866**		118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	**283,048**		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	**28,383**		192.00
192.10	OTHER NONREIMBURSABLE	**0**		192.10
192.50	MEDICAL DAY CARE	**672,254**		192.50
194.00	MARKETING/GROUP	**3,865,017**		194.00
194.01	VILLAGE	**1,758,625**		194.01
194.02	HOME HEALTH SERVICES	**0**		194.02
200.00	Cross Foot Adjustments	**0**		200.00
201.00	Negative Cost Centers	**0**		201.00
202.00	TOTAL (sum lines 118 through 201)	**99,434,193**		202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II

			CAPITAL RELATED COSTS					
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE AND GENERAL - WYCOFF	
		0	1.00	2.00	2A	4.00	5.01	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	0	75,596	0	75,596	**75,596**		4.00
5.01	ADMINISTRATIVE AND GENERAL - WYCOFF	0	0	0	0	1,173	**1,173**	5.01
5.02	ADMINISTRATIVE AND GENERAL - MULTI	0	0	0	0	10,286	169	5.02
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	0	278,706	0	278,706	2,268	44	7.00
7.01	OTHER OPERATION OF PLANT	0	0	0	0	159	20	7.01
8.00	LAUNDRY & LINEN SERVICE	0	125,201	0	125,201	908	15	8.00
9.00	HOUSEKEEPING	0	16,206	0	16,206	2,280	36	9.00
10.00	DIETARY	0	0	0	0	6,290	98	10.00
11.00	CAFETERIA	0	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	0	17.00
18.00	PASTORAL CARE	0	0	0	0	720	8	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	0	931,600	0	931,600	12,047	144	30.00
44.00	SKILLED NURSING FACILITY	0	1,815,773	0	1,815,773	23,333	300	44.00
45.00	NURSING FACILITY	0	483,229	0	483,229	4,342	59	45.00
46.00	OTHER LONG TERM CARE	0	2,432,397	0	2,432,397	4,953	85	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2	54.00
60.00	LABORATORY	0	0	0	0	0	4	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	2	65.00
66.00	PHYSICAL THERAPY	0	301,555	0	301,555	0	34	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	23	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	5	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	4	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	22	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	CLINIC	0	538,445	0	538,445	5,147	47	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART							92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**0**	**6,998,708**	**0**	**6,998,708**	**73,906**	**1,121**	118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23,141	0	23,141	0	3	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	14,253	0	14,253	0	0	192.00
192.10	OTHER NONREIMBURSABLE	0	0	0	0	0	0	192.10
192.50	MEDICAL DAY CARE	0	207,419	0	207,419	0	2	192.50
194.00	MARKETING/GROUP	0	19,976	0	19,976	1,528	45	194.00
194.01	VILLAGE	0	0	0	0	162	2	194.01
194.02	HOME HEALTH SERVICES	0	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers		0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	**0**	**7,263,497**	**0**	**7,263,497**	**75,596**	**1,173**	202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II

	Cost Center Description	ADMINISTRATIVE AND GENERAL - MULTI	MAINTENANCE & REPAIRS	OPERATION OF PLANT	OTHER OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.02	6.00	7.00	7.01	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT							4.00
5.01	ADMINISTRATIVE AND GENERAL - WYCOFF							5.01
5.02	ADMINISTRATIVE AND GENERAL - MULTI	**10,455**						5.02
6.00	MAINTENANCE & REPAIRS	0	**0**					6.00
7.00	OPERATION OF PLANT	0	0	**281,018**				7.00
7.01	OTHER OPERATION OF PLANT	0	0	0	**179**			7.01
8.00	LAUNDRY & LINEN SERVICE	0	0	5,092	0	**131,216**		8.00
9.00	HOUSEKEEPING	0	0	659	0	0	**19,181**	9.00
10.00	DIETARY	0	0	0	0	0	0	10.00
11.00	CAFETERIA	0	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	0	17.00
18.00	PASTORAL CARE	0	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	2,176	0	37,891	36	24,931	2,640	30.00
44.00	SKILLED NURSING FACILITY	4,353	0	73,853	71	68,233	5,146	44.00
45.00	NURSING FACILITY	1,852	0	19,654	36	26,243	1,370	45.00
46.00	OTHER LONG TERM CARE	1,048	0	98,934	18	11,809	6,893	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	12,265	0	0	855	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	CLINIC	0	0	21,900	0	0	1,526	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART							92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**9,429**	**0**	**270,248**	**161**	**131,216**	**18,430**	118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	941	0	0	66	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	580	0	0	40	192.00
192.10	OTHER NONREIMBURSABLE	0	0	0	0	0	0	192.10
192.50	MEDICAL DAY CARE	0	0	8,436	0	0	588	192.50
194.00	MARKETING/GROUP	0	0	813	0	0	57	194.00
194.01	VILLAGE	1,026	0	0	18	0	0	194.01
194.02	HOME HEALTH SERVICES	0	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	**10,455**	**0**	**281,018**	**179**	**131,216**	**19,181**	202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II

	Cost Center Description	DIETARY	CAFETERIA	NURSING ADMINISTRATION	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE PASTORAL CARE	
		10.00	11.00	13.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT							4.00
5.01	ADMINISTRATIVE AND GENERAL - WYCOFF							5.01
5.02	ADMINISTRATIVE AND GENERAL - MULTI							5.02
6.00	MAINTENANCE & REPAIRS							6.00
7.00	OPERATION OF PLANT							7.00
7.01	OTHER OPERATION OF PLANT							7.01
8.00	LAUNDRY & LINEN SERVICE							8.00
9.00	HOUSEKEEPING							9.00
10.00	DIETARY	**6,388**						10.00
11.00	CAFETERIA	1,038	**1,038**					11.00
13.00	NURSING ADMINISTRATION	0	0	**0**				13.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	**0**			16.00
17.00	SOCIAL SERVICE	0	0	0	0	**0**		17.00
18.00	PASTORAL CARE	0	10	0	0	0	**738**	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	590	239	0	0	0	178	30.00
44.00	SKILLED NURSING FACILITY	2,884	530	0	0	0	248	44.00
45.00	NURSING FACILITY	570	93	0	0	0	178	45.00
46.00	OTHER LONG TERM CARE	1,105	125	0	0	0	107	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	CLINIC	0	10	0	0	0	0	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART							92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**6,187**	**1,007**	**0**	**0**	**0**	**711**	118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	0	192.00
192.10	OTHER NONREIMBURSABLE	0	0	0	0	0	0	192.10
192.50	MEDICAL DAY CARE	201	0	0	0	0	0	192.50
194.00	MARKETING/GROUP	0	31	0	0	0	0	194.00
194.01	VILLAGE	0	0	0	0	0	27	194.01
194.02	HOME HEALTH SERVICES	0	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	**6,388**	**1,038**	**0**	**0**	**0**	**738**	202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II

	Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
		24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	ADMINISTRATIVE AND GENERAL - WYCOFF					5.01
5.02	ADMINISTRATIVE AND GENERAL - MULTI					5.02
6.00	MAINTENANCE & REPAIRS					6.00
7.00	OPERATION OF PLANT					7.00
7.01	OTHER OPERATION OF PLANT					7.01
8.00	LAUNDRY & LINEN SERVICE					8.00
9.00	HOUSEKEEPING					9.00
10.00	DIETARY					10.00
11.00	CAFETERIA					11.00
13.00	NURSING ADMINISTRATION					13.00
16.00	MEDICAL RECORDS & LIBRARY					16.00
17.00	SOCIAL SERVICE					17.00
18.00	PASTORAL CARE					18.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	**1,012,472**	0	**1,012,472**		30.00
44.00	SKILLED NURSING FACILITY	**1,994,724**	0	**1,994,724**		44.00
45.00	NURSING FACILITY	**537,626**	0	**537,626**		45.00
46.00	OTHER LONG TERM CARE	**2,557,474**	0	**2,557,474**		46.00
ANCILLARY SERVICE COST CENTERS						
54.00	RADIOLOGY-DIAGNOSTIC	**2**	0	**2**		54.00
60.00	LABORATORY	**4**	0	**4**		60.00
65.00	RESPIRATORY THERAPY	**2**	0	**2**		65.00
66.00	PHYSICAL THERAPY	**314,709**	0	**314,709**		66.00
67.00	OCCUPATIONAL THERAPY	**23**	0	**23**		67.00
68.00	SPEECH PATHOLOGY	**5**	0	**5**		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	**4**	0	**4**		71.00
73.00	DRUGS CHARGED TO PATIENTS	**22**	0	**22**		73.00
OUTPATIENT SERVICE COST CENTERS						
90.00	CLINIC	**567,075**	0	**567,075**		90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**6,984,142**	**0**	**6,984,142**		118.00
NONREIMBURSABLE COST CENTERS						
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	**24,151**	0	**24,151**		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	**14,873**	0	**14,873**		192.00
192.10	OTHER NONREIMBURSABLE	**0**	0	**0**		192.10
192.50	MEDICAL DAY CARE	**216,646**	0	**216,646**		192.50
194.00	MARKETING/GROUP	**22,450**	0	**22,450**		194.00
194.01	VILLAGE	**1,235**	0	**1,235**		194.01
194.02	HOME HEALTH SERVICES	**0**	0	**0**		194.02
200.00	Cross Foot Adjustments	**0**	0	**0**		200.00
201.00	Negative Cost Centers	**0**	0	**0**		201.00
202.00	TOTAL (sum lines 118 through 201)	**7,263,497**	**0**	**7,263,497**		202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B
Part II

	Cost Center Description	Total		
		26.00		
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT			1.00
2.00	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	ADMINISTRATIVE AND GENERAL - WYCOFF			5.01
5.02	ADMINISTRATIVE AND GENERAL - MULTI			5.02
6.00	MAINTENANCE & REPAIRS			6.00
7.00	OPERATION OF PLANT			7.00
7.01	OTHER OPERATION OF PLANT			7.01
8.00	LAUNDRY & LINEN SERVICE			8.00
9.00	HOUSEKEEPING			9.00
10.00	DIETARY			10.00
11.00	CAFETERIA			11.00
13.00	NURSING ADMINISTRATION			13.00
16.00	MEDICAL RECORDS & LIBRARY			16.00
17.00	SOCIAL SERVICE			17.00
18.00	PASTORAL CARE			18.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	**1,012,472**		30.00
44.00	SKILLED NURSING FACILITY	**1,994,724**		44.00
45.00	NURSING FACILITY	**537,626**		45.00
46.00	OTHER LONG TERM CARE	**2,557,474**		46.00
ANCILLARY SERVICE COST CENTERS				
54.00	RADIOLOGY-DIAGNOSTIC	**2**		54.00
60.00	LABORATORY	**4**		60.00
65.00	RESPIRATORY THERAPY	**2**		65.00
66.00	PHYSICAL THERAPY	**314,709**		66.00
67.00	OCCUPATIONAL THERAPY	**23**		67.00
68.00	SPEECH PATHOLOGY	**5**		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	**4**		71.00
73.00	DRUGS CHARGED TO PATIENTS	**22**		73.00
OUTPATIENT SERVICE COST CENTERS				
90.00	CLINIC	**567,075**		90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART			92.00
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**6,984,142**		118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	**24,151**		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	**14,873**		192.00
192.10	OTHER NONREIMBURSABLE	**0**		192.10
192.50	MEDICAL DAY CARE	**216,646**		192.50
194.00	MARKETING/GROUP	**22,450**		194.00
194.01	VILLAGE	**1,235**		194.01
194.02	HOME HEALTH SERVICES	**0**		194.02
200.00	Cross Foot Adjustments	**0**		200.00
201.00	Negative Cost Centers	**0**		201.00
202.00	TOTAL (sum lines 118 through 201)	**7,263,497**		202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COST ALLOCATION - STATISTICAL BASIS **Worksheet B-1**

	Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE AND GENERAL - WYCOFF (ACCUM. COST)	ADMINISTRATIVE AND GENERAL - MULTI (TIME SPENT)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	5A.01	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	**323,606**						1.00
2.00	CAP REL COSTS-MVBLE EQUIP		**0**					2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	3,368	0	**56,077,780**				4.00
5.01	ADMINISTRATIVE AND GENERAL - WYCOFF	0	0	869,857	-997,222	**98,436,971**		5.01
5.02	ADMINISTRATIVE AND GENERAL - MULTI	0	0	7,630,440	0	14,091,587	**151,100**	5.02
6.00	MAINTENANCE & REPAIRS	0	0	0	0	0	0	6.00
7.00	OPERATION OF PLANT	12,417	0	1,682,349	0	3,647,461	0	7.00
7.01	OTHER OPERATION OF PLANT	0	0	117,789	0	1,635,346	0	7.01
8.00	LAUNDRY & LINEN SERVICE	5,578	0	673,483	0	1,237,543	0	8.00
9.00	HOUSEKEEPING	722	0	1,691,621	0	2,992,830	0	9.00
10.00	DIETARY	0	0	4,666,359	0	8,169,157	0	10.00
11.00	CAFETERIA	0	0	0	0	0	0	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	0	17.00
18.00	PASTORAL CARE	0	0	534,267	0	670,812	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	41,505	0	8,936,934	0	11,960,955	31,454	30.00
44.00	SKILLED NURSING FACILITY	80,897	0	17,306,946	0	25,556,595	62,910	44.00
45.00	NURSING FACILITY	21,529	0	3,220,982	0	4,911,495	26,764	45.00
46.00	OTHER LONG TERM CARE	108,369	0	3,674,482	0	7,111,322	15,141	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	178,275	0	54.00
60.00	LABORATORY	0	0	0	0	338,887	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	163,587	0	65.00
66.00	PHYSICAL THERAPY	13,435	0	0	0	2,843,530	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	1,914,460	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	449,508	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	368,555	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,841,097	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	CLINIC	23,989	0	3,818,033	0	3,938,035	0	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART							92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**311,809**	**0**	**54,823,542**	**-997,222**	**94,021,037**	**136,269**	118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,031	0	0	0	257,730	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	635	0	0	0	14,253	0	192.00
192.10	OTHER NONREIMBURSABLE	0	0	0	0	0	0	192.10
192.50	MEDICAL DAY CARE	9,241	0	0	0	207,419	0	192.50
194.00	MARKETING/GROUP	890	0	1,133,711	0	3,767,034	0	194.00
194.01	VILLAGE	0	0	120,527	0	169,498	14,831	194.01
194.02	HOME HEALTH SERVICES	0	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers							201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	7,263,497	0	13,361,781		997,222	14,234,349	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	22.445495	0.000000	0.238272		0.010131	94.204825	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			75,596		1,173	10,455	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001348		0.000012	0.069193	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)							206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)							207.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COST ALLOCATION - STATISTICAL BASIS **Worksheet B-1**

	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	OTHER OPERATION OF PLANT (TIME SPENT)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	7.01	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT							4.00
5.01	ADMINISTRATIVE AND GENERAL - WYCOFF							5.01
5.02	ADMINISTRATIVE AND GENERAL - MULTI							5.02
6.00	MAINTENANCE & REPAIRS	**0**						6.00
7.00	OPERATION OF PLANT	0	**307,821**					7.00
7.01	OTHER OPERATION OF PLANT	0	0	**4,680**				7.01
8.00	LAUNDRY & LINEN SERVICE	0	5,578	0	**1,237,171**			8.00
9.00	HOUSEKEEPING	0	722	0	0	**301,521**		9.00
10.00	DIETARY	0	0	0	0	0	**578,000**	10.00
11.00	CAFETERIA	0	0	0	0	0	93,900	11.00
13.00	NURSING ADMINISTRATION	0	0	0	0	0	0	13.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	0	16.00
17.00	SOCIAL SERVICE	0	0	0	0	0	0	17.00
18.00	PASTORAL CARE	0	0	0	0	0	0	18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	0	41,505	936	235,062	41,505	53,372	30.00
44.00	SKILLED NURSING FACILITY	0	80,897	1,872	643,329	80,897	261,018	44.00
45.00	NURSING FACILITY	0	21,529	936	247,434	21,529	51,573	45.00
46.00	OTHER LONG TERM CARE	0	108,369	468	111,346	108,369	99,981	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	LABORATORY	0	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0	13,435	0	0	13,435	0	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	CLINIC	0	23,989	0	0	23,989	0	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART							92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**0**	**296,024**	**4,212**	**1,237,171**	**289,724**	**559,844**	118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,031	0	0	1,031	0	190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	635	0	0	635	0	192.00
192.10	OTHER NONREIMBURSABLE	0	0	0	0	0	0	192.10
192.50	MEDICAL DAY CARE	0	9,241	0	0	9,241	18,156	192.50
194.00	MARKETING/GROUP	0	890	0	0	890	0	194.00
194.01	VILLAGE	0	0	468	0	0	0	194.01
194.02	HOME HEALTH SERVICES	0	0	0	0	0	0	194.02
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers							201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	3,684,413	1,651,914	1,316,846	3,031,792	8,251,919	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	11.969336	352.973077	1.064401	10.054995	14.276676	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	281,018	179	131,216	19,181	6,388	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.912927	0.038248	0.106061	0.063614	0.011052	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)							206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)							207.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COST ALLOCATION - STATISTICAL BASIS **Worksheet B-1**

	Cost Center Description	CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (DIRECT NURS. HRS.)	OTHER GENERAL SERVICE PASTORAL CARE (COSTED REQUIS.)		
		11.00	13.00	16.00	17.00	18.00		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT							4.00
5.01	ADMINISTRATIVE AND GENERAL - WYCOFF							5.01
5.02	ADMINISTRATIVE AND GENERAL - MULTI							5.02
6.00	MAINTENANCE & REPAIRS							6.00
7.00	OPERATION OF PLANT							7.00
7.01	OTHER OPERATION OF PLANT							7.01
8.00	LAUNDRY & LINEN SERVICE							8.00
9.00	HOUSEKEEPING							9.00
10.00	DIETARY							10.00
11.00	CAFETERIA	**93,901**						11.00
13.00	NURSING ADMINISTRATION	0	**0**					13.00
16.00	MEDICAL RECORDS & LIBRARY	0	0	**0**				16.00
17.00	SOCIAL SERVICE	0	0	0	**14,831**			17.00
18.00	PASTORAL CARE	939	0	0	0	**12,901**		18.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	21,597	0	0	0	3,108		30.00
44.00	SKILLED NURSING FACILITY	47,889	0	0	0	4,352		44.00
45.00	NURSING FACILITY	8,451	0	0	0	3,108		45.00
46.00	OTHER LONG TERM CARE	11,269	0	0	0	1,865		46.00
ANCILLARY SERVICE COST CENTERS								
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0		54.00
60.00	LABORATORY	0	0	0	0	0		60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0		65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0		66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0		67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0		71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0		73.00
OUTPATIENT SERVICE COST CENTERS								
90.00	CLINIC	939	0	0	0	0		90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART							92.00
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	**91,084**	**0**	**0**	**0**	**12,433**		118.00
NONREIMBURSABLE COST CENTERS								
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0		190.00
192.00	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0		192.00
192.10	OTHER NONREIMBURSABLE	0	0	0	0	0		192.10
192.50	MEDICAL DAY CARE	0	0	0	0	0		192.50
194.00	MARKETING/GROUP	2,817	0	0	0	0		194.00
194.01	VILLAGE	0	0	0	14,831	468		194.01
194.02	HOME HEALTH SERVICES	0	0	0	0	0		194.02
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers							201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,340,580	0	0	0	691,014		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	14.276525	0.000000	0.000000	0.000000	53.562825		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	1,038	0	0	0	738		204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.011054	0.000000	0.000000	0.000000	0.057205		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)							206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)							207.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Worksheet C
Part I

Title XVIII Hospital PPS

				Costs			Charges			
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	Inpatient	Outpatient	Total (col. 6 + col. 7)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	ADULTS & PEDIATRICS	**17,776,731**		**17,776,731**	110,577	**17,887,308**	27,104,357		**27,104,357**	30.00
44.00	SKILLED NURSING FACILITY	**39,512,385**		**39,512,385**	0	**39,512,385**	43,198,886		**43,198,886**	44.00
45.00	NURSING FACILITY	**9,573,880**		**9,573,880**	0	**9,573,880**	11,119,210		**11,119,210**	45.00
46.00	OTHER LONG TERM CARE	**12,968,357**		**12,968,357**	0	**12,968,357**	1,126,280		**1,126,280**	46.00
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	**180,081**		**180,081**	0	**180,081**	217,252	0	**217,252**	54.00
60.00	LABORATORY	**342,320**		**342,320**	0	**342,320**	646,304	0	**646,304**	60.00
65.00	RESPIRATORY THERAPY	**165,244**	0	**165,244**	0	**165,244**	273,625	0	**273,625**	65.00
66.00	PHYSICAL THERAPY	**3,168,235**	0	**3,168,235**	0	**3,168,235**	4,477,765	0	**4,477,765**	66.00
67.00	OCCUPATIONAL THERAPY	**1,933,855**	0	**1,933,855**	0	**1,933,855**	3,372,377	0	**3,372,377**	67.00
68.00	SPEECH PATHOLOGY	**454,062**	0	**454,062**	0	**454,062**	791,821	0	**791,821**	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	**372,289**		**372,289**	0	**372,289**	649,221	0	**649,221**	71.00
73.00	DRUGS CHARGED TO PATIENTS	**1,859,749**		**1,859,749**	0	**1,859,749**	2,243,628	0	**2,243,628**	73.00
OUTPATIENT SERVICE COST CENTERS										
90.00	CLINIC	**4,519,678**		**4,519,678**	1,130,570	**5,650,248**	0	6,164,810	**6,164,810**	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**		**0**		**0**	0	0	**0**	92.00
200.00	Subtotal (see instructions)	**92,826,866**	**0**	**92,826,866**	**1,241,147**	**94,068,013**	**95,220,726**	**6,164,810**	**101,385,536**	200.00
201.00	Less Observation Beds	**0**		**0**		**0**				201.00
202.00	Total (see instructions)	**92,826,866**	**0**	**92,826,866**	**1,241,147**	**94,068,013**	**95,220,726**	**6,164,810**	**101,385,536**	202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Worksheet C
Part I

Title XVIII Hospital PPS

	Cost Center Description	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		9.00	10.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
44.00	SKILLED NURSING FACILITY				44.00
45.00	NURSING FACILITY				45.00
46.00	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0.828904	0.000000	0.828904	54.00
60.00	LABORATORY	0.529658	0.000000	0.529658	60.00
65.00	RESPIRATORY THERAPY	0.603907	0.000000	0.603907	65.00
66.00	PHYSICAL THERAPY	0.707548	0.000000	0.707548	66.00
67.00	OCCUPATIONAL THERAPY	0.573440	0.000000	0.573440	67.00
68.00	SPEECH PATHOLOGY	0.573440	0.000000	0.573440	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0.573440	0.000000	0.573440	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.828903	0.000000	0.828903	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.733141	0.000000	0.916532	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0.000000	0.000000	92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Worksheet C
Part I

Title XIX Hospital TEFRA

				Costs			Charges			
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs	Inpatient	Outpatient	Total (col. 6 + col. 7)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	ADULTS & PEDIATRICS	**17,776,731**		**17,776,731**	110,577	**17,887,308**	27,104,357		**27,104,357**	30.00
44.00	SKILLED NURSING FACILITY	**39,512,385**		**39,512,385**	0	**39,512,385**	43,198,886		**43,198,886**	44.00
45.00	NURSING FACILITY	**9,573,880**		**9,573,880**	0	**9,573,880**	11,119,210		**11,119,210**	45.00
46.00	OTHER LONG TERM CARE	**12,968,357**		**12,968,357**	0	**12,968,357**	1,126,280		**1,126,280**	46.00
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	**180,081**		**180,081**	0	**180,081**	217,252	0	**217,252**	54.00
60.00	LABORATORY	**342,320**		**342,320**	0	**342,320**	646,304	0	**646,304**	60.00
65.00	RESPIRATORY THERAPY	**165,244**	0	**165,244**	0	**165,244**	273,625	0	**273,625**	65.00
66.00	PHYSICAL THERAPY	**3,168,235**	0	**3,168,235**	0	**3,168,235**	4,477,765	0	**4,477,765**	66.00
67.00	OCCUPATIONAL THERAPY	**1,933,855**	0	**1,933,855**	0	**1,933,855**	3,372,377	0	**3,372,377**	67.00
68.00	SPEECH PATHOLOGY	**454,062**	0	**454,062**	0	**454,062**	791,821	0	**791,821**	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	**372,289**		**372,289**	0	**372,289**	649,221	0	**649,221**	71.00
73.00	DRUGS CHARGED TO PATIENTS	**1,859,749**		**1,859,749**	0	**1,859,749**	2,243,628	0	**2,243,628**	73.00
OUTPATIENT SERVICE COST CENTERS										
90.00	CLINIC	**4,519,678**		**4,519,678**	1,130,570	**5,650,248**	0	6,164,810	**6,164,810**	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**		**0**		**0**	0	0	**0**	92.00
200.00	Subtotal (see instructions)	**92,826,866**	**0**	**92,826,866**	**1,241,147**	**94,068,013**	**95,220,726**	**6,164,810**	**101,385,536**	200.00
201.00	Less Observation Beds	**0**		**0**		**0**				201.00
202.00	Total (see instructions)	**92,826,866**	**0**	**92,826,866**	**1,241,147**	**94,068,013**	**95,220,726**	**6,164,810**	**101,385,536**	202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Worksheet C
Part I

Title XIX Hospital TEFRA

	Cost Center Description	Cost or Other Ratio	TEFRA Inpatient Ratio	PPS Inpatient Ratio	
		9.00	10.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
44.00	SKILLED NURSING FACILITY				44.00
45.00	NURSING FACILITY				45.00
46.00	OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0.828904	0.828904	0.000000	54.00
60.00	LABORATORY	0.529658	0.529658	0.000000	60.00
65.00	RESPIRATORY THERAPY	0.603907	0.603907	0.000000	65.00
66.00	PHYSICAL THERAPY	0.707548	0.707548	0.000000	66.00
67.00	OCCUPATIONAL THERAPY	0.573440	0.573440	0.000000	67.00
68.00	SPEECH PATHOLOGY	0.573440	0.573440	0.000000	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0.573440	0.573440	0.000000	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.828903	0.828903	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.733141	0.733141	0.000000	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0.000000	0.000000	92.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

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

Worksheet C
Part II

Title XIX Hospital TEFRA

	Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	**180,081**	2	**180,079**	0	10,445	**169,636**	**217,252**	0.780826	54.00
60.00	LABORATORY	**342,320**	4	**342,316**	0	19,854	**322,466**	**646,304**	0.498939	60.00
65.00	RESPIRATORY THERAPY	**165,244**	2	**165,242**	0	9,584	**155,660**	**273,625**	0.568881	65.00
66.00	PHYSICAL THERAPY	**3,168,235**	314,709	**2,853,526**	31,471	165,505	**2,971,259**	**4,477,765**	0.663558	66.00
67.00	OCCUPATIONAL THERAPY	**1,933,855**	23	**1,933,832**	2	112,162	**1,821,691**	**3,372,377**	0.540180	67.00
68.00	SPEECH PATHOLOGY	**454,062**	5	**454,057**	1	26,335	**427,726**	**791,821**	0.540180	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	**372,289**	4	**372,285**	0	21,593	**350,696**	**649,221**	0.540180	71.00
73.00	DRUGS CHARGED TO PATIENTS	**1,859,749**	22	**1,859,727**	2	107,864	**1,751,883**	**2,243,628**	0.780826	73.00
OUTPATIENT SERVICE COST CENTERS										
90.00	CLINIC	**4,519,678**	567,075	**3,952,603**	56,708	229,251	**4,233,719**	**6,164,810**	0.686756	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**	0	**0**	0	0	**0**	**0**	0.000000	92.00
200.00	Subtotal (sum of lines 50 thru 199)	**12,995,513**	**881,846**	**12,113,667**	**88,184**	**702,593**	**12,204,736**	**18,836,803**		200.00
201.00	Less Observation Beds	**0**	0	**0**	0	0	**0**	**0**		201.00
202.00	Total (line 200 minus line 201)	**12,995,513**	**881,846**	**12,113,667**	**88,184**	**702,593**	**12,204,736**	**18,836,803**		202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time:	5/11/2026 10:04
	From: 01/01/2025	MCRIF32	**2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version:	25.3.181.0

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Worksheet D
Part I

Title XVIII Hospital PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	ADULTS & PEDIATRICS	**1,012,472**	0	**1,012,472**	**15,481**	65.40	7,756	**507,242**	30.00
44.00	SKILLED NURSING FACILITY	**1,994,724**		**1,994,724**	**86,806**	22.98	20,395	**468,677**	44.00
45.00	NURSING FACILITY	**537,626**		**537,626**	**16,047**	33.50	0	**0**	45.00
200.00	Total (lines 30 through 199)	**3,544,822**		**3,544,822**	**118,334**		**28,151**	**975,919**	200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Worksheet D
Part II

Title XVIII Hospital PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	**2**	**217,252**	0.000009	6,777	**0**	54.00
60.00	LABORATORY	**4**	**646,304**	0.000006	22,714	**0**	60.00
65.00	RESPIRATORY THERAPY	**2**	**273,625**	0.000007	0	**0**	65.00
66.00	PHYSICAL THERAPY	**314,709**	**4,477,765**	0.070283	0	**0**	66.00
67.00	OCCUPATIONAL THERAPY	**23**	**3,372,377**	0.000007	0	**0**	67.00
68.00	SPEECH PATHOLOGY	**5**	**791,821**	0.000006	0	**0**	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	**4**	**649,221**	0.000006	0	**0**	71.00
73.00	DRUGS CHARGED TO PATIENTS	**22**	**2,243,628**	0.000010	144,349	**1**	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	**567,075**	**6,164,810**	0.091986	0	**0**	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**	**0**	0.000000	0	**0**	92.00
200.00	Total (lines 50 through 199)	**881,846**	**18,836,803**		**173,840**	**1**	200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Worksheet D
Part III

Title XVIII Hospital PPS

	Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1A	1.00	2A	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	0	**0**	30.00
44.00	SKILLED NURSING FACILITY	0	0	0	0			**0**	44.00
45.00	NURSING FACILITY	0	0	0	0			**0**	45.00
200.00	Total (lines 30 through 199)	**0**	**0**	**0**	**0**	**0**		**0**	200.00

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
		6.00	7.00	8.00	9.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	**15,481**	0.00	7,756	**0**	30.00
44.00	SKILLED NURSING FACILITY	**86,806**	0.00	20,395	**0**	44.00
45.00	NURSING FACILITY	**16,047**	0.00	0	**0**	45.00
200.00	Total (lines 30 through 199)	**118,334**		**28,151**	**0**	200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Worksheet D
Part IV

Title XVIII Hospital PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	
		1.00	2A	2.00	3A	3.00	4.00	5.00	6.00	
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	**0**	**0**	54.00
60.00	LABORATORY	0	0	0	0	0	0	**0**	**0**	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	**0**	**0**	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	**0**	**0**	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	**0**	**0**	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	**0**	**0**	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	**0**	**0**	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	**0**	**0**	73.00
OUTPATIENT SERVICE COST CENTERS										
90.00	CLINIC	0	0	0	0	0	0	**0**	**0**	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	0	**0**	**0**	92.00
200.00	Total (lines 50 through 199)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Worksheet D
Part IV

Title XVIII Hospital PPS

	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		7.00	8.00	9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	**217,252**	0.000000	0.000000	6,777	**0**	0	**0**		54.00
60.00	LABORATORY	**646,304**	0.000000	0.000000	22,714	**0**	0	**0**		60.00
65.00	RESPIRATORY THERAPY	**273,625**	0.000000	0.000000	0	**0**	0	**0**		65.00
66.00	PHYSICAL THERAPY	**4,477,765**	0.000000	0.000000	0	**0**	0	**0**		66.00
67.00	OCCUPATIONAL THERAPY	**3,372,377**	0.000000	0.000000	0	**0**	0	**0**		67.00
68.00	SPEECH PATHOLOGY	**791,821**	0.000000	0.000000	0	**0**	0	**0**		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	**649,221**	0.000000	0.000000	0	**0**	0	**0**		71.00
73.00	DRUGS CHARGED TO PATIENTS	**2,243,628**	0.000000	0.000000	144,349	**0**	0	**0**		73.00
OUTPATIENT SERVICE COST CENTERS										
90.00	CLINIC	**6,164,810**	0.000000	0.000000	0	**0**	2,488,437	**0**		90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**	0.000000	0.000000	0	**0**	0	**0**		92.00
200.00	Total (lines 50 through 199)	**18,836,803**			**173,840**	**0**	**2,488,437**	**0**		200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Worksheet D
Part V

Title XVIII Hospital PPS

			Charges			Costs			
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
ANCILLARY SERVICE COST CENTERS									
54.00	RADIOLOGY-DIAGNOSTIC	0.828904	0	0	0	0	0	0	54.00
60.00	LABORATORY	0.529658	0	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0.603907	0	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0.707548	0	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.573440	0	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.573440	0	0	0	0	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0.573440	0	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.828903	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	CLINIC	0.733141	2,488,437	0	0	1,824,375	0	0	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	0	92.00
200.00	Subtotal (see instructions)		**2,488,437**	**0**	**0**	**1,824,375**	**0**	**0**	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		0		201.00
202.00	Net Charges (line 200 - line 201)		**2,488,437**	**0**	**0**	**1,824,375**	**0**	**0**	202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Component CCN: 315376

Worksheet D
Part IV

Title XVIII Skilled Nursing Facility PPS

	Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	
		1.00	2A	2.00	3A	3.00	4.00	5.00	6.00	
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	**0**	**0**	54.00
60.00	LABORATORY	0	0	0	0	0	0	**0**	**0**	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	**0**	**0**	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	**0**	**0**	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	**0**	**0**	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	**0**	**0**	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	**0**	**0**	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	**0**	**0**	73.00
OUTPATIENT SERVICE COST CENTERS										
90.00	CLINIC	0	0	0	0	0	0	**0**	**0**	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	0	**0**	**0**	92.00
200.00	Total (lines 50 through 199)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Component CCN: 315376

Worksheet D
Part IV

Title XVIII Skilled Nursing Facility PPS

	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		7.00	8.00	9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	**217,252**	0.000000	0.000000	34,503	**0**	0	**0**		54.00
60.00	LABORATORY	**646,304**	0.000000	0.000000	100,753	**0**	0	**0**		60.00
65.00	RESPIRATORY THERAPY	**273,625**	0.000000	0.000000	50	**0**	0	**0**		65.00
66.00	PHYSICAL THERAPY	**4,477,765**	0.000000	0.000000	1,714,226	**0**	0	**0**		66.00
67.00	OCCUPATIONAL THERAPY	**3,372,377**	0.000000	0.000000	1,789,974	**0**	0	**0**		67.00
68.00	SPEECH PATHOLOGY	**791,821**	0.000000	0.000000	456,923	**0**	0	**0**		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	**649,221**	0.000000	0.000000	88,636	**0**	0	**0**		71.00
73.00	DRUGS CHARGED TO PATIENTS	**2,243,628**	0.000000	0.000000	339,513	**0**	0	**0**		73.00
OUTPATIENT SERVICE COST CENTERS										
90.00	CLINIC	**6,164,810**	0.000000	0.000000	0	**0**	0	**0**		90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**	0.000000	0.000000	0	**0**	0	**0**		92.00
200.00	Total (lines 50 through 199)	**18,836,803**			**4,524,578**	**0**	**0**	**0**		200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Component CCN: 315376 **Worksheet D Part V**

Title XVIII Skilled Nursing Facility PPS

			Charges			Costs			
	Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
ANCILLARY SERVICE COST CENTERS									
54.00	RADIOLOGY-DIAGNOSTIC	0.828904	0	0	0	0	0	0	54.00
60.00	LABORATORY	0.529658	0	0	0	0	0	0	60.00
65.00	RESPIRATORY THERAPY	0.603907	0	0	0	0	0	0	65.00
66.00	PHYSICAL THERAPY	0.707548	0	0	0	0	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.573440	0	0	0	0	0	0	67.00
68.00	SPEECH PATHOLOGY	0.573440	0	0	0	0	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0.573440	0	0	0	0	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.828903	0	0	0	0	0	0	73.00
OUTPATIENT SERVICE COST CENTERS									
90.00	CLINIC	0.733141	0	0	0	0	0	0	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	0	92.00
200.00	Subtotal (see instructions)		**0**	**0**	**0**	**0**	**0**	**0**	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		0		201.00
202.00	Net Charges (line 200 - line 201)		**0**	**0**	**0**	**0**	**0**	**0**	202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Worksheet D
Part I

Title XIX Hospital TEFRA

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	ADULTS & PEDIATRICS	**1,012,472**	0	**1,012,472**	**15,481**	65.40	1,252	**81,881**	30.00
44.00	SKILLED NURSING FACILITY	**1,994,724**		**1,994,724**	**86,806**	22.98	33,821	**777,207**	44.00
45.00	NURSING FACILITY	**537,626**		**537,626**	**16,047**	33.50	11,053	**370,276**	45.00
200.00	Total (lines 30 through 199)	**3,544,822**		**3,544,822**	**118,334**		**46,126**	**1,229,364**	200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Worksheet D
Part II

Title XIX Hospital TEFRA

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	RADIOLOGY-DIAGNOSTIC	**2**	**217,252**	0.000009	0	**0**	54.00
60.00	LABORATORY	**4**	**646,304**	0.000006	0	**0**	60.00
65.00	RESPIRATORY THERAPY	**2**	**273,625**	0.000007	0	**0**	65.00
66.00	PHYSICAL THERAPY	**314,709**	**4,477,765**	0.070283	0	**0**	66.00
67.00	OCCUPATIONAL THERAPY	**23**	**3,372,377**	0.000007	0	**0**	67.00
68.00	SPEECH PATHOLOGY	**5**	**791,821**	0.000006	0	**0**	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	**4**	**649,221**	0.000006	0	**0**	71.00
73.00	DRUGS CHARGED TO PATIENTS	**22**	**2,243,628**	0.000010	0	**0**	73.00
OUTPATIENT SERVICE COST CENTERS							
90.00	CLINIC	**567,075**	**6,164,810**	0.091986	0	**0**	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**	**0**	0.000000	0	**0**	92.00
200.00	Total (lines 50 through 199)	**881,846**	**18,836,803**		**0**	**0**	200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Worksheet D
Part III

Title XIX Hospital TEFRA

	Cost Center Description	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
		1A	1.00	2A	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	ADULTS & PEDIATRICS	0	0	0	0	0	0	**0**	30.00
44.00	SKILLED NURSING FACILITY	0	0	0	0			**0**	44.00
45.00	NURSING FACILITY	0	0	0	0			**0**	45.00
200.00	Total (lines 30 through 199)	**0**	**0**	**0**	**0**	**0**		**0**	200.00

	Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
		6.00	7.00	8.00	9.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	**15,481**	0.00	1,252	**0**	30.00
44.00	SKILLED NURSING FACILITY	**86,806**	0.00	33,821	**0**	44.00
45.00	NURSING FACILITY	**16,047**	0.00	11,053	**0**	45.00
200.00	Total (lines 30 through 199)	**118,334**		**46,126**	**0**	200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Worksheet D
Part IV

Title XIX Hospital TEFRA

	Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	
		1.00	2A	2.00	3A	3.00	4.00	5.00	6.00	
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	**0**	**0**	54.00
60.00	LABORATORY	0	0	0	0	0	0	**0**	**0**	60.00
65.00	RESPIRATORY THERAPY	0	0	0	0	0	0	**0**	**0**	65.00
66.00	PHYSICAL THERAPY	0	0	0	0	0	0	**0**	**0**	66.00
67.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	**0**	**0**	67.00
68.00	SPEECH PATHOLOGY	0	0	0	0	0	0	**0**	**0**	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	**0**	**0**	71.00
73.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	**0**	**0**	73.00
OUTPATIENT SERVICE COST CENTERS										
90.00	CLINIC	0	0	0	0	0	0	**0**	**0**	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	0	**0**	**0**	92.00
200.00	Total (lines 50 through 199)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Worksheet D
Part IV

Title XIX Hospital TEFRA

	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		7.00	8.00	9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS										
54.00	RADIOLOGY-DIAGNOSTIC	**217,252**	0.000000	0.000000	0	**0**	0	**0**		54.00
60.00	LABORATORY	**646,304**	0.000000	0.000000	0	**0**	0	**0**		60.00
65.00	RESPIRATORY THERAPY	**273,625**	0.000000	0.000000	0	**0**	0	**0**		65.00
66.00	PHYSICAL THERAPY	**4,477,765**	0.000000	0.000000	0	**0**	0	**0**		66.00
67.00	OCCUPATIONAL THERAPY	**3,372,377**	0.000000	0.000000	0	**0**	0	**0**		67.00
68.00	SPEECH PATHOLOGY	**791,821**	0.000000	0.000000	0	**0**	0	**0**		68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	**649,221**	0.000000	0.000000	0	**0**	0	**0**		71.00
73.00	DRUGS CHARGED TO PATIENTS	**2,243,628**	0.000000	0.000000	0	**0**	0	**0**		73.00
OUTPATIENT SERVICE COST CENTERS										
90.00	CLINIC	**6,164,810**	0.000000	0.000000	0	**0**	0	**0**		90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	**0**	0.000000	0.000000	0	**0**	0	**0**		92.00
200.00	Total (lines 50 through 199)	**18,836,803**			**0**	**0**	**0**	**0**		200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COMPUTATION OF INPATIENT OPERATING COST **Worksheet D-1**

Title XVIII Hospital PPS

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

		1.00	
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,481	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,481	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	15,481	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	**7,756**	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	**17,887,308**	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	**0**	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	**17,887,308**	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	**17,887,308**	37.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COMPUTATION OF INPATIENT OPERATING COST **Worksheet D-1**

Title XVIII Hospital PPS

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

						1.00	
38.00	Adjusted general inpatient routine service cost per diem (see instructions)					1,155.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)					8,961,593	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)					0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)					**8,961,593**	41.00
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					137,299	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					**9,098,892**	49.00

PASS THROUGH COST ADJUSTMENTS

50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	507,242	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	1	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	**507,243**	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	**8,591,649**	53.00

TARGET AMOUNT AND LIMIT COMPUTATION

54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
55.03	CAR T-cell amount paid as an interim payment	0	55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	**0**	63.00

PROGRAM INPATIENT ROUTINE SWING BED COST

64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	**0**	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	**0**	69.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COMPUTATION OF INPATIENT OPERATING COST **Worksheet D-1**

Title XVIII Hospital PPS

PART III - SNF, NF, AND ICF/IID ONLY

		1.00	
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		1.00	
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	**0**	89.00

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
90.00	Capital-related cost	1,012,472	17,887,308	0.056603	0	**0**	90.00
91.00	Nursing Program cost	0	17,887,308	0.000000	0	**0**	91.00
92.00	Allied health cost	0	17,887,308	0.000000	0	**0**	92.00
93.00	All other Medical Education	0	17,887,308	0.000000	0	**0**	93.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COMPUTATION OF INPATIENT OPERATING COST — Component CCN: 315376 — **Worksheet D-1**

Title XVIII — Skilled Nursing Facility — PPS

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

		1.00	
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	86,806	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	86,806	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	86,806	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	**20,395**	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	**39,512,385**	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	**0**	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	**39,512,385**	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	**39,512,385**	37.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COMPUTATION OF INPATIENT OPERATING COST — Component CCN: 315376 — **Worksheet D-1**

Title XVIII — Skilled Nursing Facility — PPS

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

						1.00	
38.00	Adjusted general inpatient routine service cost per diem (see instructions)						38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)						39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)						41.00
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)						48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)						49.00
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
55.01	Permanent adjustment amount per discharge						55.01
55.02	Adjustment amount per discharge (contractor use only)						55.02
55.03	CAR T-cell amount paid as an interim payment						55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)						59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)						60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COMPUTATION OF INPATIENT OPERATING COST — Component CCN: 315376 — **Worksheet D-1**

Title XVIII — Skilled Nursing Facility — PPS

PART III - SNF, NF, AND ICF/IID ONLY

		1.00	
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	39,512,385	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	455.18	71.00
72.00	Program routine service cost (line 9 x line 71)	9,283,396	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	**9,283,396**	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	**0**	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	9,283,396	83.00
84.00	Program inpatient ancillary services (see instructions)	2,915,603	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	**12,198,999**	86.00

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		1.00	
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	**0**	89.00

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
90.00	Capital-related cost	0	0	0.000000	0	**0**	90.00
91.00	Nursing Program cost	0	0	0.000000	0	**0**	91.00
92.00	Allied health cost	0	0	0.000000	0	**0**	92.00
93.00	All other Medical Education	0	0	0.000000	0	**0**	93.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COMPUTATION OF INPATIENT OPERATING COST **Worksheet D-1**

Title XIX Hospital TEFRA

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

		1.00	
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,481	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,481	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	15,481	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	**1,252**	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	**17,776,731**	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	**0**	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	**17,776,731**	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	**17,776,731**	37.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COMPUTATION OF INPATIENT OPERATING COST **Worksheet D-1**

Title XIX Hospital TEFRA

PART II - HOSPITAL AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS

						1.00	
38.00	Adjusted general inpatient routine service cost per diem (see instructions)					1,148.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)					1,437,659	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)					0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)					**1,437,659**	41.00
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
48.01	Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)					0	48.01
49.00	Total Program inpatient costs (sum of lines 41 through 48.01)(see instructions)					**1,437,659**	49.00

PASS THROUGH COST ADJUSTMENTS

50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	81,881	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	**81,881**	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	**1,355,778**	53.00

TARGET AMOUNT AND LIMIT COMPUTATION

54.00	Program discharges	87	54.00
55.00	Target amount per discharge	0.00	55.00
55.01	Permanent adjustment amount per discharge	0.00	55.01
55.02	Adjustment amount per discharge (contractor use only)	0.00	55.02
55.03	CAR T-cell amount paid as an interim payment	0	55.03
56.00	Target amount ((line 54 x sum of lines 55, 55.01, and 55.02) plus line 55.03)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	-1,355,778	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)	0.00	60.00
61.00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	**81,881**	63.00

PROGRAM INPATIENT ROUTINE SWING BED COST

64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions	**0**	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	**0**	69.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

COMPUTATION OF INPATIENT OPERATING COST **Worksheet D-1**

Title XIX Hospital TEFRA

PART III - SNF, NF, AND ICF/IID ONLY

		1.00	
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		1.00	
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	**0**	89.00

COMPUTATION OF OBSERVATION BED PASS THROUGH COST

		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
90.00	Capital-related cost	1,012,472	17,776,731	0.056955	0	**0**	90.00
91.00	Nursing Program cost	0	17,776,731	0.000000	0	**0**	91.00
92.00	Allied health cost	0	17,776,731	0.000000	0	**0**	92.00
93.00	All other Medical Education	0	17,776,731	0.000000	0	**0**	93.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT **Worksheet D-3**

Title XVIII Hospital PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS		12,553,600		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0.828904	6,777	5,617	54.00
60.00	LABORATORY	0.529658	22,714	12,031	60.00
65.00	RESPIRATORY THERAPY	0.603907	0	0	65.00
66.00	PHYSICAL THERAPY	0.707548	0	0	66.00
67.00	OCCUPATIONAL THERAPY	0.573440	0	0	67.00
68.00	SPEECH PATHOLOGY	0.573440	0	0	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0.573440	0	0	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.828903	144,349	119,651	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.916532	0	0	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		**173,840**	**137,299**	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		**173,840**		202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT — Component CCN: 315376 — **Worksheet D-3**

Title XVIII — Skilled Nursing Facility — PPS

	Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	ADULTS & PEDIATRICS				30.00
ANCILLARY SERVICE COST CENTERS					
54.00	RADIOLOGY-DIAGNOSTIC	0.828904	34,503	28,600	54.00
60.00	LABORATORY	0.529658	100,753	53,365	60.00
65.00	RESPIRATORY THERAPY	0.603907	50	30	65.00
66.00	PHYSICAL THERAPY	0.707548	1,714,226	1,212,897	66.00
67.00	OCCUPATIONAL THERAPY	0.573440	1,789,974	1,026,443	67.00
68.00	SPEECH PATHOLOGY	0.573440	456,923	262,018	68.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	0.573440	88,636	50,827	71.00
73.00	DRUGS CHARGED TO PATIENTS	0.828903	339,513	281,423	73.00
OUTPATIENT SERVICE COST CENTERS					
90.00	CLINIC	0.916532	0	0	90.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		**4,524,578**	**2,915,603**	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		**4,524,578**		202.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

CALCULATION OF REIMBURSEMENT SETTLEMENT

Worksheet E
Part B

Title XVIII Hospital PPS

		1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	1,824,375	2.00
3.00	OPPS or REH payments	2,356,161	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	**0**	11.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable charges			
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	**0**	14.00
Customary charges			
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	**0**	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	**2,356,161**	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	556,146	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	**1,800,015**	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	**1,800,015**	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	**1,800,015**	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	**1,800,015**	37.00
38.00	MSP-LCC reconciliation amount from PS&R	0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	1,800,015	40.00
40.01	Sequestration adjustment (see instructions)	36,000	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	1,763,990	41.00
41.01	Interim payments-PARHM		41.01

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

CALCULATION OF REIMBURSEMENT SETTLEMENT

Worksheet E
Part B

Title XVIII Hospital PPS

PART B - MEDICAL AND OTHER HEALTH SERVICES			
		1.00	
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	**25**	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
TO BE COMPLETED BY CONTRACTOR			
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	**0**	94.00
WORKSHEET OVERRIDE VALUES			
		Overrides	
112.00	Override of Ancillary service charges (line 12)	0	112.00
MEDICARE PART B ANCILLARY COSTS			
200.00	Part B Combined Billed Days	0	200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

CALCULATION OF REIMBURSEMENT SETTLEMENT — Component CCN: 315376 — **Worksheet E Part B**

Title XVIII — Skilled Nursing Facility — PPS

		1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES			
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS or REH payments		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs including REH direct graduate medical education costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	**0**	11.00
COMPUTATION OF LESSER OF COST OR CHARGES			
Reasonable charges			
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	**0**	14.00
Customary charges			
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	**0**	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	**0**	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	**0**	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
28.50	REH facility payment amount (see instructions)		28.50
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)	**0**	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	**0**	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	36.00
37.00	Subtotal (see instructions)	**0**	37.00
38.00	MSP-LCC reconciliation amount from PS&R		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50
39.75	N95 respirator payment adjustment amount (see instructions)	0	39.75
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	0	40.00
40.01	Sequestration adjustment (see instructions)	0	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03
41.00	Interim payments	0	41.00
41.01	Interim payments-PARHM		41.01

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

CALCULATION OF REIMBURSEMENT SETTLEMENT — Component CCN: 315376 — **Worksheet E Part B**

Title XVIII — Skilled Nursing Facility — PPS

PART B - MEDICAL AND OTHER HEALTH SERVICES			
		1.00	
42.00	Tentative settlement (for contractors use only)	0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01
43.00	Balance due provider/program (see instructions)	**0**	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	44.00
TO BE COMPLETED BY CONTRACTOR			
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00
WORKSHEET OVERRIDE VALUES			
		Overrides	
112.00	Override of Ancillary service charges (line 12)	0	112.00
MEDICARE PART B ANCILLARY COSTS			
200.00	Part B Combined Billed Days		200.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Worksheet E-1
Part I

Title XVIII Hospital PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		9,408,352		1,763,990	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		**9,408,352**		**1,763,990**	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		**0**		**0**	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		25	6.01
6.02	SETTLEMENT TO PROGRAM		4,785		0	6.02
7.00	Total Medicare program liability (see instructions)		**9,403,567**		**1,764,015**	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

(1) On lines 3, 5, and 6, where an amount is due "Provider to Program", show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED — Component CCN: 315376 — **Worksheet E-1 Part I**

Title XVIII — Skilled Nursing Facility — PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		16,205,923		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		**16,205,923**		**0**	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		**0**		**0**	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		11,383		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		**16,217,306**		**0**	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

(1) On lines 3, 5, and 6, where an amount is due "Provider to Program", show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

CALCULATION OF REIMBURSEMENT SETTLEMENT

Worksheet E-3
Part II

Title XVIII Hospital PPS

PART II - MEDICARE PART A SERVICES - IPF PPS

		1.00	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	10,572,471	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	42.413699	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	**10,572,471**	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	**10,572,471**	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	**10,572,471**	18.00
19.00	Deductibles	270,898	19.00
20.00	Subtotal (line 18 minus line 19)	**10,301,573**	20.00
21.00	Coinsurance	769,836	21.00
22.00	Subtotal (line 20 minus line 21)	**9,531,737**	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	98,061	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	63,740	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	48,125	25.00
26.00	Subtotal (sum of lines 22 and 24)	**9,595,477**	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.98	Recovery of accelerated depreciation.	0	30.98
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	**9,595,477**	31.00
31.01	Sequestration adjustment (see instructions)	191,910	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	9,408,352	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	**-4,785**	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
TO BE COMPLETED BY CONTRACTOR			
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	**0**	53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE END OF THE COVID-19 PHE)			
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

CALCULATION OF REIMBURSEMENT SETTLEMENT — Component CCN: 315376 — **Worksheet E-3 Part VI**

Title XVIII — Skilled Nursing Facility — PPS

PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES

		1.00	
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)			
1.00	Resource Utilization Group Payment (RUGS)	18,222,398	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	**18,222,398**	4.00
COMPUTATION OF NET COST OF COVERED SERVICES			
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	1,685,742	7.00
8.00	Allowable bad debts (see instructions)	17,869	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	12,361	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	11,615	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	**16,548,271**	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.98	Recovery of accelerated depreciation.	0	14.98
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	**16,548,271**	15.00
15.01	Sequestration adjustment (see instructions)	330,733	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)	232	15.75
16.00	Interim payments	16,205,923	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)	**11,383**	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	0	19.00

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	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

CALCULATION OF REIMBURSEMENT SETTLEMENT

Worksheet E-3
Part VII

Title XIX Hospital TEFRA

		Inpatient	Outpatient	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	81,881		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	**81,881**	**0**	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	**81,881**	**0**	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	**0**	**0**	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	**0**	**0**	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	81,881	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	**0**	**0**	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	**0**	**0**	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	**0**	**0**	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	81,881	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	**0**	**0**	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	**0**	**0**	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	**0**	**0**	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	**0**	**0**	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	**0**	**0**	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
OVERRIDES				
109.00	Override Ancillary service charges (line 9)	0	0	109.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

CALCULATION OF REIMBURSEMENT SETTLEMENT — Component CCN: 315376 — **Worksheet E-3 Part VII**

Title XIX — Skilled Nursing Facility — Cost

		Inpatient	Outpatient	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	**0**	**0**	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	**0**	**0**	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	**0**	**0**	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	**0**	**0**	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	**0**	**0**	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	**0**	**0**	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	**0**	**0**	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	**0**	**0**	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	**0**	**0**	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	**0**	**0**	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	**0**	**0**	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	**0**	**0**	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
OVERRIDES				
109.00	Override Ancillary service charges (line 9)	0	0	109.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

CALCULATION OF REIMBURSEMENT SETTLEMENT — Component CCN: 315376 — **Worksheet E-3 Part VII**

Title XIX — Nursing Facility — Cost

		Inpatient	Outpatient	
		1.00	2.00	
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant programs only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	**0**	**0**	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	**0**	**0**	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	**0**	**0**	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	**0**	**0**	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	**0**	**0**	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0		24.00
25.00	Capital exception payments (see instructions)	0		25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	**0**	**0**	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	**0**	**0**	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	**0**	**0**	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	**0**	**0**	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	**0**	**0**	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	**0**	**0**	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	**0**	**0**	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00
OVERRIDES				
109.00	Override Ancillary service charges (line 9)	0	0	109.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Worksheet G

	Assets (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	2,538,486	0	0	0	1.00
2.00	Temporary investments	233,977	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	6,547,972	0	0	0	4.00
5.00	Other receivable	6,088,406	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	303,764	0	0	0	7.00
8.00	Prepaid expenses	977,983	0	0	0	8.00
9.00	Other current assets	593,880	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	**17,284,468**	**0**	**0**	**0**	11.00
FIXED ASSETS						
12.00	Land	992,033	0	0	0	12.00
13.00	Land improvements	4,565,437	0	0	0	13.00
14.00	Accumulated depreciation	-3,009,204	0	0	0	14.00
15.00	Buildings	139,744,162	0	0	0	15.00
16.00	Accumulated depreciation	-59,675,766	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	3,198,372	0	0	0	21.00
22.00	Accumulated depreciation	-3,013,221	0	0	0	22.00
23.00	Major movable equipment	32,652,119	0	0	0	23.00
24.00	Accumulated depreciation	-37,769,833	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	**77,684,099**	**0**	**0**	**0**	30.00
OTHER ASSETS						
31.00	Investments	19,293,314	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	125,004	0	0	0	33.00
34.00	Other assets	14,414,469	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	33,832,787	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	**128,801,354**	**0**	**0**	**0**	36.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) **Worksheet G**

	Liabilities and Fund Balances (Omit cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT LIABILITIES						
37.00	Accounts payable	6,591,738	0	0	0	37.00
38.00	Salaries, wages, and fees payable	1,384,281	0	0	0	38.00
39.00	Payroll taxes payable	5,123,888	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,168,500	0	0	0	40.00
41.00	Deferred income	1,571,237	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1,341,880	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	**18,181,524**	**0**	**0**	**0**	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	49,266,737	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	49,266,737	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	**67,448,261**	**0**	**0**	**0**	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	61,353,093				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	**61,353,093**	**0**	**0**	**0**	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	**128,801,354**	**0**	**0**	**0**	60.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

STATEMENT OF CHANGES IN FUND BALANCES **Worksheet G-1**

		General Fund		Special Purpose Fund		Endowment Fund		Plant Fund		
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
1.00	Fund balances at beginning of period		51,590,174		0		0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-3,947,747							2.00
3.00	Total (sum of line 1 and line 2)		**47,642,427**		**0**		**0**		**0**	3.00
4.00	Additions (credit adjustments) (specify)	0		0		0		0		4.00
5.00	ADJUSTMENTS TO OPENING BALANCE	13,755,023		0		0		0		5.00
6.00		0		0		0		0		6.00
7.00		0		0		0		0		7.00
8.00		0		0		0		0		8.00
9.00		0		0		0		0		9.00
10.00	Total additions (sum of line 4-9)		**13,755,023**		**0**		**0**		**0**	10.00
11.00	Subtotal (line 3 plus line 10)		**61,397,450**		**0**		**0**		**0**	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0		0		12.00
13.00	ROUNDING	0		0		0		0		13.00
14.00		0		0		0		0		14.00
15.00		0		0		0		0		15.00
16.00		0		0		0		0		16.00
17.00		0		0		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		**0**		**0**		**0**		**0**	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		**61,397,450**		**0**		**0**		**0**	19.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Worksheet G-2
Parts I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
General Inpatient Routine Services					
1.00	Hospital	27,104,357		27,104,357	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	43,198,886		43,198,886	7.00
8.00	NURSING FACILITY	11,119,210		11,119,210	8.00
9.00	OTHER LONG TERM CARE	8,815,834		8,815,834	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	**90,238,287**		**90,238,287**	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	**0**		**0**	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	**90,238,287**		**90,238,287**	17.00
18.00	Ancillary services	12,671,993	6,164,810	18,836,803	18.00
19.00	Outpatient services	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER PATIENT REVENUE	3,381,764	0	3,381,764	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	**106,292,044**	**6,164,810**	**112,456,854**	28.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time:	5/11/2026 10:04
	From: 01/01/2025	MCRIF32	**2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version:	25.3.181.0

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Worksheet G-2
Parts I & II

PART II - OPERATING EXPENSES

		1.00	2.00	
29.00	Operating expenses (per Wkst. A, column 3, line 200)		**104,327,688**	29.00
30.00	ADD (SPECIFY)	0		30.00
31.00		0		31.00
32.00		0		32.00
33.00		0		33.00
34.00		0		34.00
35.00		0		35.00
36.00	Total additions (sum of lines 30-35)		**0**	36.00
37.00	DEDUCT (SPECIFY)	0		37.00
38.00		0		38.00
39.00		0		39.00
40.00		0		40.00
41.00		0		41.00
42.00	Total deductions (sum of lines 37-41)		**0**	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		**104,327,688**	43.00

RAMAPO RIDGE PSYCHIATRIC	Period:	Run Date Time: 5/11/2026 10:04
	From: 01/01/2025	MCRIF32 **2552-10**
Provider CCN: 31-4019	To: 12/31/2025	Version: 25.3.181.0

STATEMENT OF REVENUES AND EXPENSES **Worksheet G-3**

	Description		
		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	112,456,854	1.00
2.00	Less contractual allowances and discounts on patients' accounts	22,388,049	2.00
3.00	Net patient revenues (line 1 minus line 2)	90,068,805	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	104,327,688	4.00
5.00	Net income from service to patients (line 3 minus line 4)	**-14,258,883**	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	2,202,496	6.00
7.00	Income from investments	676,453	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	10,949	9.00
10.00	Purchase discounts	6,420	10.00
11.00	Rebates and refunds of expenses	8,001	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	32,403	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	6,178	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	264,733	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	67,888	22.00
23.00	Governmental appropriations	0	23.00
24.00	BARBER BEAUTY	140,072	24.00
24.01	MISCELLANEOUS	6,282,695	24.01
24.02	INDEPENDENT LIVING	612,848	24.02
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	**10,311,136**	25.00
26.00	Total (line 5 plus line 25)	**-3,947,747**	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	**0**	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	**-3,947,747**	29.00