	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
	1			SI GNATURE STATEMENT	
1	Kev	in A. Stagg	т	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	Date	(Dated when report is electronica			4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	38, 058	24	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	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
200.00	TOTAL	0	38, 058	24	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi c	ler CC	N: 31-4		Period: From 01/01/ To 12/31/	2024	Workshe Part I Date/Ti 5/7/202	me Pre	epared
	1.00	2.00		3.00			4	1.00			
	Hospital and Hospital Health Care Co										
0	Street: 301 SICOMAC AVENUE	PO Box:									1.
00	City: WYCKOFF	State: NJ	Zip Cod				y: BERGEN				2.
		Component Name	CCN	CBS		rovi der	1		ent Syst		
			Number	Numb	ber	Туре	Certified		0, or		
								V	XVIII	XIX	4
		1.00	2.00	3.0	00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componer		1						-		
0	Hospi tal	RAMAPO RIDGE	314019	356	14	4	01/12/1990	N	P	T	3
_		PSYCHI ATRI C									
0	Subprovider - IPF										4
0	Subprovider - IRF										5
С	Subprovider - (Other)										6
C	Swing Beds - SNF			1							7
0	Swing Beds - NF										8
0	Hospital-Based SNF	HERI TAGE MANOR	315376	356	14		12/01/1997	N	P	0	9
		1		1			12/01/1997		1	0	10
00	Hospital-Based NF	SOUTHGATE MANOR	315376	356	14		12/01/1997	N			
00	Hospital-Based OLTC										11
00	Hospital-Based HHA										12
00	Separately Certified ASC										13
00	Hospi tal -Based Hospi ce										14
00	Hospital-Based Health Clinic - RHC										15
00	Hospital-Based Health Clinic - FQHC										16
00	Hospital -Based (CMHC) I	1	1	1						1	17
00	Renal Dialysis										18
	Other										19
50		I	1	1			From:		Тс		19
											-
20	Cost Reporting Period (mm/dd/yyyy)						1.00	124	2.0		20
								524	12/31	/ 2024	
50	Type of Control (see instructions)			1			2				21
				-	1	1.00	2.00		3. (00	-
	Inpationt DDS Information				1	1.00	2.00		3.	00	
~~	Inpatient PPS Information	our post is see to be	umont- f			N	N	-			1
1()	Does this facility qualify and is it	. currently receiving pa	yments for			IM	I NI				22
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00	disproportionate share hospital adju			۲ (IN .	IN IN				
00	§412.106? In column 1, enter "Y" fc	or yes or "N" for no. Is	this	2		N	N N				
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01 02 03	<pre>§412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reporting 1. Enter in column 2, "Y" for yes or cost reporting period occurring on c instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportin Did this hospital receive a geograph as a result of the OMB standards for adopted by CMS in FY2015 or FY2025? "N" for no for the portion of the co 1. Enter in column 2, "Y" for yes or cost reporting period occurring on c instructions) Does this hospital com 499 beds (as counted in accordance w 3, "Y" for yes or "N" for no. Did this hospital receive a geograph rural as a result of the cost reporting for the portion of the cost report in for no for the portion of the co 1. Enter in column 2, "Y" for yes or cost reporting period occurring on c instructions) Does this hospital com 499 beds (as counted in accordance w 3, "Y" for yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reporting period occurring on cr aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me</pre>	pr yes or "N" for no. Is 412.106(c)(2)(Pickle and pr yes or "N" for no. Ps, including supplement a column 1, "Y" for yes ag period occurring priod "N" for no for the port or after October 1. (see requires a final UCP 1 (see instructions) En- te portion of the cost of column 2, "Y" for yes of ag period on or after Oc- tic redesignation from un- column 2, "Y" for yes of a portion of the cost of column 2, "Y" for yes of a period on or after Oc- tic redesignation from un- column 1, "Y" por the porting period pri- "N" for no for the port or after October 1. (see tain at least 100 but of a delineations for stati- tic reclassification from a delineations for stati- a for the portion of for- ter October 1. (see inst- 100 but not more than 4 2.105)? Enter in colum- edicaid days on lines 24	this endment tal UCPs, or "N" for r to Octob tion of the composition of the eporting r "N" for tober 1. rrban to ru l areas for yes or or to Octo tion of the cot more the ter in col m urban to stical area stical area for yes for r "N" for rer 1. Enten he cost ructions) 99 beds (a n 3, "Y" 1	for no per ne umn no, ural - bber ne nan umn peas no er - -		N	N		Ν	I	22
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01 02 03	<pre>§412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reporting 1. Enter in column 2, "Y" for yes or cost reporting period occurring on c instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportin Did this hospital receive a geograph as a result of the OMB standards for adopted by CMS in FY2015 or FY2025? "N" for no for the portion of the co 1. Enter in column 2, "Y" for yes or cost reporting period occurring on c instructions) Does this hospital com 499 beds (as counted in accordance w 3, "Y" for yes or "N" for no. Did this hospital receive a geograph rural as a result of the cost reporting for the portion of the cost report in for no for the portion of the co 1. Enter in column 2, "Y" for yes or cost reporting period occurring on c instructions) Does this hospital com 499 beds (as counted in accordance w 3, "Y" for yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reporting period occurring on cr aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me</pre>	br yes or "N" for no. Is 412.106(c)(2)(Pickle and pr yes or "N" for no. CPS, including supplement column 1, "Y" for yes ag period occurring prior r"N" for no for the port or after October 1. (see crequires a final UCP of column 2, "Y" for yes of ag period on or after October 1. (see instructions) Er column 2, "Y" for yes of ag period on or after October 1. column 2, "Y" for yes of a period on or after October 1. column 2, "Y" for yes of a period on or after October 1. column 1, "Y" st reporting period prior "N" for no for the port or after October 1. (see tain at least 100 but r ic reclassification from a delineations for statific column 1, "Y" for yes of a delineations for statific column 1, "Y" for yes of a period prior to October no for the portion of the portion of the cost of the portion of the cost of a delineations for statific column 1, "Y" for yes of a period prior to October 100 but not more than 4 2.105)? Enter in column edicaid days on lines 24 of admission, 2 if cens	this endment tal UCPs, or "N" for r to Octob tion of the obe ter in col reporting r "N" for tober 1. rban to ru l areas for yes or or to Octo tion of the ot more the ter in col m urban to stical are r "N" for r "N" for ren 1. Ente he cost ructions) 99 beds (a n 3, "Y" 1	for no ber ne umn no, ural a bber ne nan umn beas no er s for 5 07 3		N	N		Ν	I	22
01 02 03	<pre>§412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or cost reporting period occurring on c instructions) Is this a newly merged hospital that determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in for the portion of the cost reportin Did this hospital receive a geograph as a result of the OMB standards for adopted by CMS in FY2015 or FY2025? "N" for no for the portion of the co 1. Enter in column 2, "Y" for yes or cost reporting period occurring on c instructions) Does this hospital com 499 beds (as counted in accordance w 3, "Y" for yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on c instructions of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on c in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me bel ow? In column 1, enter 1 if date</pre>	br yes or "N" for no. Is (412.106(c)(2)(Pickle ar pr yes or "N" for no. Ps, including supplement column 1, "Y" for yes g period occurring price "N" for no for the port or after October 1. (see requires a final UCP 1 (see instructions) Er to column 2, "Y" for yes of g period on or after October 1. (see instructions) Er to column 2, "Y" for yes of delineating statisticat Enter in column 1, "Y" bst reporting period pri tr after October 1. (see tain at least 100 but r it h 42 CFR 412.105)? Er alc reclassification from delineations for stati column 1, "Y" for yes of g period prior to October 1. (see tain at least 100 but r it h 42 CFR 412.105)? Er alc reclassification for delineations for stati column 1, "Y" for yes of g period prior to October 1. (see inst 100 but not more than 4 2.105)? Enter in colum edicaid days on lines 24 of admission, 2 if cens of identifying the days	this endment tal UCPs, or "N" for r to Octob tion of the obe ter in col eporting r "N" for tober 1. rrban to ru l areas for yes or or to Octoc tion of the ot more the ter in col m urban to stical area r "N" for eer 1. Entre he cost ructions) 99 beds (a in 3, "Y" 1	for no ber ne umn no, ural a bber ne nan umn beas no er s for 5 07 3		N	N		Ν	I	22

DSPI T	Financial Systems RAMAPO AL AND HOSPITAL HEALTH CARE COMPLEX I DENTIFICATION DA	TA	Provider CC	N: 31-4019	Peri od:			sheet :		<u>, 1</u>
						/01/2024 /31/2024	Date	 /Time 2025 3		
		In-State	In-State	Out-of	Out-of	Medic	aid	0ther		
		Medicaid paid days	Medi cai d el i gi bl e unpai d	State Medicaid paid days	State Medicaic eligible		ays	Medi cai days	a	
		1.00	days 2.00	3.00	unpai d 4. 00	5.0	0	6.00	_	
4.00	If this provider is an IPPS hospital, enter the	0			4.00	0	0	0.00	0 2	24. (
	in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.									
	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid 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			25.0
						/Rural S		of Geo 2.00	ogr	
5.00	Enter your standard geographic classification (not wa		at the beg	inning of t			1		2	26. (
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status ~ "2" for r cation in	ural. If ap column 2.	pl i cabl e,			1			27. (
5.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number or	periods su	H Status Ir	1		5		3	35. (
						nni ng: . 00		ndi ng: 2. 00	_	
5. 00	Enter applicable beginning and ending dates of SCH st		cript line	36 for numb				2.00	3	36.
. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		r of period	ls MDH statu	IS		c		3	37.
. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								3	37.
. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.	s of MDH st	atus. Ifli	ne 37 is					3	38.
	enter subsequent dates.					Y/N		Y/N	_	
. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (íi), or the mileage	(iii)? Ent requiremen	er in colum nts in	ime in	<u>. 00</u> N		<u>2.00</u> N	3	39.
. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	per 1. Ente	r"Y" for y			Ν		Ν	4	10.
	no in column 2, for discharges on or after October 1.		ructrons)			V				
	Prospective Payment System (PPS)-Capital					1.0	0 2.0	00 3.	00	
6. 00	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti onat	e share in	accordanc	e N	N	N	4	15.
. 00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst					N	N	Ν	4	16.
. 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS o	capital? E	nter "Y for	yes or "N'	for no.	N	N	N	4	17.
. 00	<u>Is the facility electing full federal capital payment</u> Teaching Hospitals	t? Enter "	Y" for yes	or "N" for	no.	N	N	N	4	18.
	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter ' cost reporting periods beginning on or after December the instructions. For column 2, if the response to co involved in training residents in approved GME progra and are you are impacted by CR 11642 (or applicable ("Y" for yes; otherwise, enter "N" for no in column 2.	'Y' for yes - 27, 2020, olumn 1 is ams in the CRs) MA dir	or "N" for under 42 C "Y", or if prior year	no in colu CFR 413.78(k this hospit or penultin	umn 1. For o)(2), see al was nate year,				5	56.
. 00	For cost reporting periods beginning prior to Decembe is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no ir residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFF	er 27, 2020 residents n column 1. cost report e Worksheet	in approved If column ing period? E-4. If co	IGME progra 1 is "Y", c P Enter "Y' Diumn 2 is '	nms traine lid for yes N",				5	57.

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	.TA	Provider C		eriod: rom 01/01/2024 o 12/31/2024 V	Date/Time Pre 5/7/2025 3:54	pared:
				<u> </u>	1.0		
9.00	Are costs claimed on line 100 of Worksheet A? If yes	<u>s, compi</u>	<u>ete wkst. D-2</u>	Pt. I. NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qual i fi cati on Cri teri on Code	
	1			1.00	2.00	3.00	
0. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. CR) NAHE	see If column 1	N			60.0
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
1. 01	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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) Enter the current year total unweighted primary care	N			0.0	d 0.00	61. 0 61. 0 61. 0
	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 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. (
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's						61. (
1.06	primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 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. (
		Pro	ogram Name	Program Code	Unweighted IM FTE Count	E Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	1
	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. 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				0.00		61. 1
	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.					1.00	
2. 00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital				od for which		62.0
	your hospital received HRSA PCRE funding (see instruct Enter the number of FTE residents that rotated from a	ctions)					62.0
	during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se	<mark>gram. (</mark> s er Setti	<u>see instructio</u> ings	ıs)		 N	63.0

th Financial Systems PITAL AND HOSPITAL HEALTH CARE COMPLI		RIDGE PSYCHIATRIC	CN: 31-4019 F	Period:	u of Form CMS- Worksheet S-2	
			F	rom 01/01/2024 o 12/31/2024	Part I	pared:
			Unwei ghted	Unwei ghted	Ratio (col. 1/	1
			FTEs Nonprovider	FTEs in	$(\operatorname{col} \cdot 1 + \operatorname{col} \cdot$	
			Si te	Hospi tal	2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Base Year	FTE Residents in No	nprovider Settings				
period that begins on or after Ju				-		
20 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you	er of unweighted non ations occurring in number of unweighted r hospital. Enter in	-primary care all nonprovider non-primary care column 3 the ratio	0.00	0.00	0. 000000	64.0
of (column 1 divided by (column 1	+ column 2)). (see Program Name	Program Code			Datio (col 2/	
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
			Nonprovi der	Hospi tal	(0011 0 1 0011	
			Site			
	1.00	2.00	3.00	4.00	5.00	
D0 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		0.00 Unweighted FTEs Nonprovider Site 1.00 IsEffective f	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00	
20 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	curring in all nonpr nweighted non-primar I. Enter in column 3	ovider settings. y care resident the ratio of	0.00	0. 00	0. 000000) 66.(
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	/
	Ŭ	Ŭ	FTĔs	FTEsin	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
_	1.00	2.00	Si te 3. 00	4.00	5.00	-
00 Enter in column 1, the program	1.00	2.00	0.00) 67
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						

	Financial Systems RAMAPO RIDGE PSYCHIATRIC AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider		 Period: From 01/01/ To 12/31/	2024	u of For Workshe Part I Date/Ti 5/7/202	et S-2 me Pre	pared:
				-	1. C	0	
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065- For a cost reporting period beginning prior to October 1, 2022, did you MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Fi (August 10, 2022)?	obtain permissi	on from you			-	68.00
				1.00	2.00	3.00	
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it com	tain an IDE cut	provi dor?	Y			70.00
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teach recent cost report filed on or before November 15, 2004? Enter "Y" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residen program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for Column 3: If column 2 is Y, indicate which program year began during thi (see instructions)	hing program in yes or "N" for s in a new teac yes or "N" for	the most no. (see ching no.	N	N	0	71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it	contain an IRF		N			75.00
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teach recent cost reporting period ending on or before November 15, 2004? Enter no. Column 2: Did this facility train residents in a new teaching progra CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: indicate which program year began during this cost reporting period. (se	ning program in er "Y" for yes o am in accordance f column 2 is N	or "N" for e with 42 (,			0	76.00
				-	1.0	0	
	Long Term Care Hospital PPS						
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for Is this a LTCH co-located within another hospital for part or all of the "Y" for yes and "N" for no. TEFRA Providers		g period? En	nter	N		80. 00 81. 00
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? End Did this facility establish a new Other subprovider (excluded unit) unde §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			no.	N		85. 00 86. 00
87.00	Is this hospital an extended neoplastic disease care hospital classified [1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	l under section			Ν		87.00
			Approved Permane Adjustm (Y/N) 1.00	ent ent	Number Appro Permar Adjustr 2.0	oved nent ments	
88.00	Column 1: Is this hospital approved for a permanent adjustment to the Ti amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete 89. (see instructions)	EFRA target col. 2 and line	N		2.0		88. 00
	Column 2: Enter the number of approved permanent adjustments.	Wkst. A Line	e Effective	Date	Appro	ived	
		No.		Dute	Permai Adjust Amount Discha	nent ment Per	
80.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2.00		3. C		89.00
87.00	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	0.0				0	87.00
	TEFRA target amount per discharge.		V		XL	x	
			1.00		2.0		-
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services?	Enter "Y" for	N		N		90.00
91 00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost repo	ort either in	N		Y		91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable colur Are title XIX NF patients occupying title XVIII SNF beds (dual certifica instructions) Enter "Y" for yes or "N" for no in the applicable column.	ın.			Ŷ		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V a	and XIX? Enter	N		Ν		93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for	no in the	N		Y		94.00
	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable colu Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for		0. 00 N		10. (Y		95. 00 96. 00
97.00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable colu	ımn.	0.00		5.8	0	97.00

Health Financial Systems RAMAPO RIDGE F HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	CN: 31-4019	Period: From 01/01/2024 To 12/31/2024	Worksheet S- Part I Date/Time Pro	epared
			V	5/7/2025 3:5 XI X	4 pm
			1.00	2.00	-
78.00 Does title V or XIX follow Medicare (title XVIII) for the ir stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f column 1 for title V, and in column 2 for title XIX.			N	Y	98. C
28.01 Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.				Y	98. C
28. 02 Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes of for title V, and in column 2 for title XIX.			Ν	Y	98. C
28.03 Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye for title V, and in column 2 for title XIX.				Ν	98.0
28.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no ir jin column 2 for title XIX.			N	N	98. (
28.05 Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c column 2 for title XIX.				Y	98. (
 28.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX. Rural Providers 			N	Y	98. 0
105.00Does this hospital qualify as a CAH? 106.00If this facility qualifies as a CAH, has it elected the all-	inclusive meth	hod of paymen	t N		105. 0 106. 0
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for co training programs? Enter "Y" for yes or "N" for no in columr Column 2: If column 1 is Y and line 70 or line 75 is Y, do approved medical education program in the CAH's excluded IF	n 1. (see inst you train I&Rs PF and/or IRF u	tructions) s in an			107. (
Enter "Y" for yes or "N" for no in column 2. (see instructi 07.01 f this facility is a REH (line 3, column 4, is "12"), is it reimbursement for I&R training programs? Enter "Y" for yes of	eligible for				107.
instructions) 08.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sched	dule? See 42	N		108.
	Physi cal				
		Occupationa		Respiratory	_
09.00 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.	1.00 N	0ccupationa 2.00 N	I Speech 3.00 N	4.00 N	
therapy services provided by outside supplier? Enter "Y"	1.00	2.00	3.00	4.00 N	
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 N al Demonstratio	2.00 N on project (§ "N" for no.	3.00 N 410A If yes,	4.00	109.
 therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor 	1.00 N al Demonstratio	2.00 N on project (§ "N" for no.	3.00 N 410A If yes, ugh 215, as	4.00 N 1.00 N	109.
<pre>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.</pre>	1.00 N Al Demonstratio Y" for yes or ksheet E-2, li the Frontier Co ost reporting p olumn 1 is Y, e ticipating in	2.00 N on project (§ "N" for no. i nes 200 thro ommuni ty peri od? Enter enter the col umn 2.	3.00 N 410A If yes, ugh 215, as 1.00 N	4.00 N	109. (
<pre>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable. 11.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac</pre>	1.00 N Al Demonstratio Y" for yes or ksheet E-2, li the Frontier Co ost reporting p olumn 1 is Y, e ticipating in	2.00 N on project (§ "N" for no. i nes 200 thro ommuni ty peri od? Enter enter the col umn 2.	3.00 N 410A If yes, ugh 215, as 1.00 N	4.00 N 1.00 N	109.
<pre>therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable. 11.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.</pre>	1.00 N N Al Demonstration Y" for yes or ksheet E-2, li the Frontier Co ost reporting p olumn 1 is Y, e the conting in the Model porting olumn 1 is porting olumn 1 is porting in the	2.00 N N on project (§ "N" for no. i nes 200 thro ommuni ty peri od? Enter enter the col umn 2. ; and/or "C"	3.00 N 410A If yes, ugh 215, as 1.00 N	4.00 N 1.00 N 2.00	109. 110. 111.
 therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable. 11.00 If this facility qualifies as a CAH, did it participate in t Heal th Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-heal th services. 12.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "G for short term hospital or "98" percent for long term care (D) 	1.00 N N Al Demonstration Y" for yes or ksheet E-2, li che Frontier Co post reporting p olumn 1 is Y, e tricipating in Iditional beds; th Model eporting olumn 1 is pating in the ased "N" for no 8, or E only) Y3" percent (includes	2.00 N N on project (§ "N" for no. i nes 200 thro peri od? Enter enter the col umn 2. ; and/or "C" 1.00	3.00 N 410A If yes, ugh 215, as 1.00 N	4.00 N 1.00 N 2.00	1109. 1 110. 1 111. 1 111. 1
 therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable. 111.00 If this facility qualifies as a CAH, did it participate in t Heal th Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost re period? Enter "Y" for yes or "N" for no in column 1. If co "Y", enter in column 2, the date the hospital began particip demonstration. In column 3, enter the date the hospital cea participation in the demonstration in 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "G for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, \$2208.1. 	1.00 N N Al Demonstratic Y" for yes or rksheet E-2, li Che Frontier Co st reporting p olumn 1 is Y, e ticipating in dditional beds; th Model porting olumn 1 is pating in the ased "N" for no 3, or E only) 23" percent (includes "s) based on	2.00 N N on project (§ "N" for no. i nes 200 thro peri od? Enter enter the col umn 2. ; and/or "C" 1.00 N	3.00 N 410A If yes, ugh 215, as 1.00 N	4.00 N 1.00 N 2.00	109. (109. (110. (111. (111. (0 115. (116. (
 for yes or "N" for no for each therapy. 110.00 Did this hospital participate in the Rural Community Hospitat Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Wor applicable. 111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this course of the response to construct on prong of the FCHIP demonstration for this CAH is part Enter all that apply: "A" for Ambulance services; "B" for act for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Heal (PARHM) demonstration for any portion of the current cost respected? Enter "Y" for yes or "N" for no in column 1. If column 1. If column 1. If column 3, enter the date the hospital ceae participation in the demonstration. 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "S" for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider 	1.00 N N Al Demonstration Y" for yes or rksheet E-2, li the Frontier Co post reporting p lumn 1 is Y, e ticipating in dditional beds; th Model eporting olumn 1 is vating in the ased "N" for no 8, or E only) 23" percent includes s) based on for yes or rance? Enter	2.00 N N on project (§ "N" for no. i nes 200 thro peri od? Enter enter the col umn 2. ; and/or "C" 1.00 N	3.00 N 410A If yes, ugh 215, as 1.00 N	4.00 N 1.00 N 2.00	1109. 1109. 1110. 1111. 1112. 0 1115.

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	N: 31-4019		riod: om 01/01/2024 12/31/2024	Worksheet S- Part I Date/Time Pr 5/7/2025 3:5	repared
	1	Premi ums		Losses	Insurance	
		1.00		2.00	3.00	-
8.01 List amounts of malpractice premiums and paid losses:			0	0		0118.0
			+	1 00	2.00	_
8. 02 Are malpractice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein.				1.00 N	2.00	118. (
9.00 DO NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in o "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" ifies for th	for yes or e Outpatient		Ν	Ν	119. (120. (
 00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no. 	table devices	charged to		Ν		121.
2.00 Does the cost report contain healthcare related taxes as defin Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i the Worksheet A line number where these taxes are included.				Ν		122.
3.00 Did the facility and/or its subproviders (if applicable) purch services, e.g., legal, accounting, tax preparation, bookkeepir management/consulting services, from an unrelated organization for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., g professional services expenses, for services purchased from un located in a CBSA outside of the main hospital CBSA? In column "N" for no.	ng, payroll, n? In column greater than nrelated orga	and/or 1, enter "Y" 50% of total nizations		Ν		123.
4. 00 Did the hospital incur cost, either directly or through a cont supplier, to establish and maintain access to no less than a 6 one or more essential medicines according to 42 CFR 412.113(g) "N" for no. Certified Transplant Center Information	5-month buffe	r stock of				124.
5.00 Does this facility operate a Medicare-certified transplant cer and "N" for no. If yes, enter certification date(s) (mm/dd/yy)		Y" for yes		Ν		125.
6.00 If this is a Medicare-certified kidney transplant program, ent in column 1 and termination date, if applicable, in column 2.		fication dat	e			126.
. 00 If this is a Medicare-certified heart transplant program, ente in column 1 and termination date, if applicable, in column 2.	er the certif	ication date	>			127.
8.00 If this is a Medicare-certified liver transplant program, enterin column 1 and termination date, if applicable, in column 2.			9			128.
0.00 If this is a Medicare-certified lung transplant program, enter in column 1 and termination date, if applicable, in column 2.						129.
0.00 If this is a Medicare-certified pancreas transplant program, educate in column 1 and termination date, if applicable, in column .00 If this is a Medicare-certified intestinal transplant program,	nn 2.					130.
date in column 1 and termination date, if applicable, in colum 2.00 f this is a Medicare-certified islet transplant program, enter	nn 2.					132.
in column 1 and termination date, if applicable, in column 2. 3.00Removed and reserved						133.
I. 00 If this is a hospital-based organ procurement organization (OF in column 1 and termination date, if applicable, in column 2. All Providers	PO), enter th	e OPO number	-			134.
0.00 Are there any related organization or home office costs as defined chapter 10? Enter "Y" for yes or "N" for no in column 1. If yeare claimed, enter in column 2 the home office chain number.	es, and home	office costs	5	Ν		140.
1.00 2.00		ab 142 +5		3.00	of the	
If this facility is part of a chain organization, enter on lin home office and enter the home office contractor name and con-			nam	e and address	or the	
1.00 Name: Contractor's Name:			or'	s Number:		141.
2. 00 Street: PO Box:		7: 0				142.
3. 00 Ci ty: State:		Zip Code	:			143.

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	RAMAPO RIDGE	Provider CC	CN: 31-4019	Peri od		u of Form CMS Worksheet S-	
					1/01/2024	Part I	conorod.
				To 1	2/31/2024	Date/Time Pr 5/7/2025 3:5	
					1.00	2.00	-
45.00 If costs for renal services are cl							145.0
inpatient services only? Enter "Y							
no, does the dialysis facility in period? Enter "Y" for yes or "N"		for this cost	reporting				
46.00 Has the cost allocation methodolog		uslv filed cost	t report?		Ν		146.0
Enter "Y" for yes or "N" for no in				lf			
yes, enter the approval date (mm/o	dd/yyyy) in column 2.						
						1.00	
17.00Was there a change in the statisti						N	147.0
48.00Was there a change in the order of						N N	148. C
49.00Was there a change to the simplifi	ed cost finding method? E	Part A	Part B		itle V	Title XIX	149.0
		1.00	2.00	'	3.00	4.00	-
Does this facility contain a prov							
or charges? Enter "Y" for yes or	'N" for no for each compon			. (See 42			155.0
55.00 Hospital 56.00 Subprovider - IPF		N N	N N		N N	N	155. C
57. 00 Subprovider - IRF		N	N		N	N	157.0
58. 00 SUBPROVI DER							158. 0
59. 00 SNF		N	N		Ν	N	159.0
50. 00 HOME HEALTH AGENCY		N	N		N	N	160.0
61.00 CMHC			N		N	N	161.0
						1.00	
Multicampus 65.00 s this hospital part of a Multica	ampus hospital that has on	e or more campi	uses in dif	ferent CE	SAS?	N	
Enter "Y" for yes or "N" for no.		•					
	Name O	County 1.00	2. 00	Zip Code 3.00	CBSA 4.00	FTE/Campus 5.00	_
66.00 If line 165 is yes, for each	0	1.00	2.00	3.00	4.00		00 166. 0
campus enter the name in column							
O, county in column 1, state in							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
	ŀ					1.00	_
Health Information Technology (HI	T) incentive in the Americ	an Recovery an	d Reinvestm	ent Act		1.00	
67.001s this provider a meaningful use	under §1886(n)? Enter "	Y" for yes or '	'N" for no.	iont Act		N	167.0
68.00 If this provider is a CAH (line 10			e 167 is "Y	"), enter	the		168. 0
reasonable cost incurred for the I							1.00
					isni p		168. 0
	? Enter "Y" for ves or "N"				enter the	0.0	00169. 0
exception under §413.70(a)(6)(ii) 59.00 f this provider is a meaningful u	user (line 167 is "Y") and		(THE TOST	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			
exception under §413.70(a)(6)(ii)	user (line 167 is "Y") and				gi nni ng	Endi ng	
exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful of transition factor. (see instruction	user (line 167 is "Y") and ons)	is not a CAH (
exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I	user (line 167 is "Y") and ons)	is not a CAH (gi nni ng	Endi ng	170. 0
exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful of transition factor. (see instruction	user (line 167 is "Y") and ons)	is not a CAH (gi nni ng 1. 00	Endi ng 2. 00	170.0
69.00 If this provider is a meaningful of transition factor. (see instruction factor. (see instruction factor. 00 Enter in columns 1 and 2 the EHR I	user (line 167 is "Y") and ons) beginning date and ending	is not a CAH (date for the re	eporting		gi nni ng	Endi ng	0171.0

SPLL	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 31-4019	Period: From 01/01/2024	Worksheet S- Part II	2
				To 12/31/2024	Date/Time Pr 5/7/2025 3:5	epareo 4 pm
				Y/N 1.00	Date 2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT QUESTIONN	IAI RE	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente	er all dates in t	he	
	Provider Organization and Operation Has the provider changed ownership immediately prior to the	beainning of	the cost	N		1.
	reporting period? If yes, enter the date of the change in c		instructions)	1		
			Y/N 1.00	Date 2.00	V/I 3.00	
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N	2.00	0.00	2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	N			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	_
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		Ν			5
			<u> </u>	Y/N	Legal Oper.	
				1.00	2.00	
00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2: If yes, is	the provider	- N		6
00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		od during the	N N		7
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		Ū.	N		9
00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o	S.		N		10
00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			Ν		11
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
	Bad Debts				1.00	_
00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12 13
	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions.	nce amounts wa	nived? If yes,	see	Ν	14
	Bed Complement Did total beds available change from the prior cost reporti	ng period? If	Ves. see inst	ructions	N	15
		Par	rt A	Par	tВ	
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	-
	PS&R Data					-
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	02/25/2025	Y	02/25/2025	16
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	Ν		Ν		17
00	the paid-through date. (see instructions) 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.	Ν		Ν		18
00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19

RAMAPO RIDGE PSYCHIATRIC

Heal th	Financial Systems RAMAPO RIDGE	PSYCHI ATRI C		In Lie	eu of Form CN	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		F	Period: From 01/01/2024 Fo 12/31/2024	Worksheet S Part II	-2 Prepared:
		Descr	iption	Y/N	Y/N	
			0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's	N		N		21.00
	records? If yes, see instructions.					_
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	IOSPI TALS)			
	Capital Related Cost				1	
	Have assets been relifed for Medicare purposes? If yes, se					22.00
23.00	Have changes occurred in the Medicare depreciation expense	e due to apprais	sals made durir	ng the cost		23.00
	reporting period? If yes, see instructions.					
24.00	Were new leases and/or amendments to existing leases enter	ed into during	this cost repo	orting period?		24.00
	If yes, see instructions			c		05.00
25.00	Have there been new capitalized leases entered into during	the cost repor	ting period? I	f yes, see		25.00
26.00	instructions. Were assets subject to Sec.2314 of DEFRA acquired during t	he cost reporti	ng period? If	ves, see		26.00
	instructions.		0 1			
27.00	Has the provider's capitalization policy changed during th copy.	ne cost reportir	ng period?lfy	ves, submit		27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit e	entered into dur	ing the cost r	reporting		28.00
20.00	period? If yes, see instructions.	hand finada (D				20.00
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service Res	serve Fund)		29.00
30.00	Has existing debt been replaced prior to its scheduled mat		debt? If yes,	see		30.00
31.00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of new	deht? If ves	500		31.00
51.00	instructions.	SSuarree of new	debt: 11 yes,	300		51.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se		ed through cont	ractual		32.00
	arrangements with suppliers of services? If yes, see instr					
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertainir	ng to competiti	ve bidding? If		33.00
	no, see instructions.					
24 00	Provider-Based Physicians Were services furnished at the provider facility under an	arrangement wit	th provider bac	ad physicians?	1	34.00
34.00	If yes, see instructions.	arrangement wr	in provider-bas	eu priysi ci aris?		34.00
35.00	If line 34 is yes, were there new agreements or amended ex	risting agreemer	nts with the nr	ovi der-based		35.00
55.00	physicians during the cost reporting period? If yes, see i		its with the pi	ovider based		33.00
	priver of and darring the cool reporting period in yes, cool			Y/N	Date	
				1.00	2.00	
-	Home Office Costs					
36.00	Were home office costs claimed on the cost report?					36.00
	If line 36 is yes, has a home office cost statement been p	prepared by the	home office?			37.00
38 00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of			38.00
30. UU	the provider? If yes, enter in column 2 the fiscal year end					38.00
39.00	If line 36 is yes, did the provider render services to oth					39.00
40.00	see instructions. If line 36 is yes, did the provider render services to the	home office?	lf ves see			40.00
40.00	instructions.					40.00
		1	00	2	00	_
	Cost Report Preparer Contact Information			2.		
41.00	Enter the first name, last name and the title/position	KATHERI NE		BLI SSI T		41.00
	held by the cost report preparer in columns 1, 2, and 3,	1				
	respectively.					
42.00	Enter the employer/company name of the cost report	HEALTH CARE RE	SOURCES			42.00
	preparer.					
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	609-987-1440		KI TTY. BLI SSI T@	HCRNJ. NET	43.00
	report preparer in columns I and 2, respectively.	I		1		Ш

Heal th	Financial Systems RAMAPO RII	DGE I	PSYCHI ATRI C	In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 31-4019	Period: From 01/01/2024	Worksheet S-2 Part II	
				o 12/31/2024		pared:
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position		CONSULTANT			41.00
	held by the cost report preparer in columns 1, 2, and 3	8,				
	respecti vel y.					
42.00	Enter the employer/company name of the cost report					42.00
	preparer.					
43.00	Enter the telephone number and email address of the cos	st				43.00
	report preparer in columns 1 and 2, respectively.					

PA 00 Hc 8 4 00 HM 00 HM 00 HC 00 HC 00 HC 00 HC 00 TC 00 LC 00 L 10 CC 00 SL 2.00 CZ 2.00 CZ 2.00 CZ 2.00 SL 3.00 SL 3.00 SL	AND HOSPITAL HEALTH CARE COMPLEX STATISTIC. Component MRT I - STATISTICAL DATA Dospital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and pospice days)(see instructions for col. 2 or the portion of LDP room available beds) MO and other (see instructions) MO IPF Subprovider MO IRF Subprovider MO IRF Subprovider MO IRF Subprovider Dospital Adults & Peds. Swing Bed SNF Dospital Adults & Peds. Swing Bed NF Dotal Adults and Peds. (exclude observation eds) (see instructions) NTENSIVE CARE UNIT	Worksheet A Line No. 1.00 30.00	Provider CC No. of Beds 2.00 58		CAH/REH Hours 4.00	Worksheet S-3 Part I Date/Time Prep 5/7/2025 3:54 I/P Days / 0/P Visits / Trips Title V 5.00	epare
00 HC 8 HC 7 C 00 HM 00 HM 00 HC 00	ART I - STATISTICAL DATA ospital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and ospice days)(see instructions for col. 2 or the portion of LDP room available beds) 40 and other (see instructions) 40 IPF Subprovider 40 IPF Subprovider 50 IRF Subprovider 50 IRF Subprovider 50 Spital Adults & Peds. Swing Bed SNF 50 Spital Adults & Peds. (exclude observation 51 eds) (see instructions) 51 VENSIVE CARE UNIT	Li ne No. 1.00	2.00	Bed Days Avai I abl e 3.00	CAH/REH Hours 4.00	5/7/2025 3:54 I/P Days / O/P Visits / Trips Title V 5.00	pm s
00 HC 8 HC 7 C 00 HM 00 HM 00 HC 00	ART I - STATISTICAL DATA ospital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and ospice days)(see instructions for col. 2 or the portion of LDP room available beds) 40 and other (see instructions) 40 IPF Subprovider 40 IPF Subprovider 50 IRF Subprovider 50 IRF Subprovider 50 Spital Adults & Peds. Swing Bed SNF 50 Spital Adults & Peds. (exclude observation 51 eds) (see instructions) 51 VENSIVE CARE UNIT	Li ne No. 1.00	2.00	Avai I abl e 3. 00	CAH/REH Hours 4.00	I/P Days / O/P Visits / Trips Title V 5.00	
00 HC 8 HC 7 C 00 HM 00 HM 00 HC 00	ART I - STATISTICAL DATA ospital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and ospice days)(see instructions for col. 2 or the portion of LDP room available beds) 40 and other (see instructions) 40 IPF Subprovider 40 IPF Subprovider 50 IRF Subprovider 50 IRF Subprovider 50 Spital Adults & Peds. Swing Bed SNF 50 Spital Adults & Peds. (exclude observation 51 eds) (see instructions) 51 VENSIVE CARE UNIT	Li ne No. 1.00	2.00	Avai I abl e 3. 00	CAH/REH Hours 4.00	Visits / Trips Title V 5.00	
00 HC 8 HC 7 C 00 HM 00 HM 00 HC 00	ART I - STATISTICAL DATA ospital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and ospice days)(see instructions for col. 2 or the portion of LDP room available beds) 40 and other (see instructions) 40 IPF Subprovider 40 IPF Subprovider 50 IRF Subprovider 50 IRF Subprovider 50 Spital Adults & Peds. Swing Bed SNF 50 Spital Adults & Peds. (exclude observation 51 eds) (see instructions) 51 VENSIVE CARE UNIT	Li ne No. 1.00	2.00	Avai I abl e 3. 00	CAH/REH Hours 4.00	Title V 5.00	
00 HC 8 HC 7 C 00 HM 00 HM 00 HC 00	ospital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and ospice days)(see instructions for col. 2 or the portion of LDP room available beds) MO and other (see instructions) MO IPF Subprovider MO IRF Subprovider ospital Adults & Peds. Swing Bed SNF ospital Adults & Peds. Swing Bed NF otal Adults and Peds. (exclude observation eds) (see instructions) NTENSIVE CARE UNIT	1.00	58	3.00	-		1
00 HC 8 HC 7 C 00 HM 00 HM 00 HC 00	ospital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and ospice days)(see instructions for col. 2 or the portion of LDP room available beds) MO and other (see instructions) MO IPF Subprovider MO IRF Subprovider ospital Adults & Peds. Swing Bed SNF ospital Adults & Peds. Swing Bed NF otal Adults and Peds. (exclude observation eds) (see instructions) NTENSIVE CARE UNIT		58		-		1
00 HC 8 HC 7 C 00 HM 00 HM 00 HC 00	ospital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and ospice days)(see instructions for col. 2 or the portion of LDP room available beds) MO and other (see instructions) MO IPF Subprovider MO IRF Subprovider ospital Adults & Peds. Swing Bed SNF ospital Adults & Peds. Swing Bed NF otal Adults and Peds. (exclude observation eds) (see instructions) NTENSIVE CARE UNIT	30. 00		21, 22	8 0.00	0	1
8 Hc fc 00 HM 00 HM 00 Hc 00 Hc 00 Tc be 00 Tc be 00 Tc be 00 TC 00 CC 0.00 SL 2.00 0T 3.00 NU 4.00 Tc 5.00 CA 5.10 RE 5.10 SL 3.00 SL 3.00 SL	exclude Swing Bed, Observation Bed and ospice days)(see instructions for col. 2 or the portion of LDP room available beds) MO and other (see instructions) MO IPF Subprovider MO IRF Subprovider ospital Adults & Peds. Swing Bed SNF ospital Adults & Peds. Swing Bed NF otal Adults and Peds. (exclude observation eds) (see instructions) NTENSIVE CARE UNIT	30.00		21, 22	8 0.00	0	
Hc fc 00 HM 00 HM 00 HA 00 HC 00 HC 00 TC be 00 TC be 00 TC be 00 TC 00 CC 0.00 BU 0.00 SU 3.00 NU 5.00 SU 3.00 SU	ospice days)(see instructions for col. 2 for the portion of LDP room available beds) MO and other (see instructions) MO IPF Subprovider MO IRF Subprovider ospital Adults & Peds. Swing Bed SNF ospital Adults & Peds. Swing Bed NF otal Adults and Peds. (exclude observation eds) (see instructions) NTENSIVE CARE UNIT						
fc 00 HM 00 HM 00 HA 00 SU 00 HA 00 HA 00 HA 00 HA 00 HA 00 SU 00 SU	by the portion of LDP room available beds) MO and other (see instructions) MO IPF Subprovider MO IRF Subprovider ospital Adults & Peds. Swing Bed SNF ospital Adults & Peds. Swing Bed NF otal Adults and Peds. (exclude observation eds) (see instructions) NTENSIVE CARE UNIT		50				
00 HM 00 HM 00 HA 00 HC 00 To 00 CC 0.00 BL 0.00 SL 0.00 To 5.00 CC 5.10 RE 7.00 SL 3.00 SL	MO and other (see instructions) MO IPF Subprovider MO IRF Subprovider ospital Adults & Peds. Swing Bed SNF ospital Adults & Peds. Swing Bed NF otal Adults and Peds. (exclude observation eds) (see instructions) NTENSIVE CARE UNIT						
00 HM 00 HO 00 HC 00 HC 00 HC 00 HC 00 To 00 To 00 To 00 To 1.00 SL 2.00 To 3.00 NU 4.00 To 5.00 C/ 5.10 RE 7.00 SL 3.00 SL	MO IPF Subprovider MO IRF Subprovider ospital Adults & Peds. Swing Bed SNF ospital Adults & Peds. Swing Bed NF otal Adults and Peds. (exclude observation eds) (see instructions) NTENSIVE CARE UNIT		50				2
00 HM 00 Hc 00 Hc 00 Tc be be 00 I 00 C 00 I 00 C 00 I 00 C 00 SL 1.00 SL 2.00 OT 3.00 NL 4.00 Tc 5.00 C 5.10 RE 5.00 SL 7.00 SL 3.00 SL	MO IRF Subprovider ospital Adults & Peds. Swing Bed SNF ospital Adults & Peds. Swing Bed NF otal Adults and Peds. (exclude observation eds) (see instructions) NTENSIVE CARE UNIT		50				
00 Hc 00 Hc 00 Tc be be 00 IN 000 CC 000 SL 1.00 SL 2.00 OT 3.00 NU 4.00 Tc 5.00 CA 5.10 RE 7.00 SL 3.00 SL	ospital Adults & Peds. Swing Bed SNF ospital Adults & Peds. Swing Bed NF otal Adults and Peds. (exclude observation eds) (see instructions) NTENSIVE CARE UNIT		50			1 1	4
00 Hc 00 Tc be be 00 IN 00 CC 0.00 BL 1.00 SL 2.00 OT 3.00 NL 4.00 Tc 5.00 CC 5.10 RE 5.00 SL 7.00 SL 3.00 SL	ospital Adults & Peds. Swing Bed NF otal Adults and Peds. (exclude observation eds) (see instructions) NTENSIVE CARE UNIT		50			0	
00 Tc be 00 IN 00 CC 0.00 BL 0.00 SL 2.00 0T 3.00 NL 4.00 Tc 5.00 CC 5.10 RE 5.10 RE 5.00 SL 7.00 SL 3.00 SL	oral Adults and Peds. (exclude observation eds) (see instructions) NTENSIVE CARE UNIT		50			0	
ba 00 I M 00 CC 0.00 BL 1.00 SU 2.00 OT 3.00 NU 4.00 To 5.00 CA 5.10 RE 5.00 SU 7.00 SU 3.00 SU	eds) (see instructions) NTENSIVE CARE UNIT			21, 22	8 0.00		
00 I M 00 CC 0.00 BL 0.00 SL	NTEŃSIVE CARE UNIT		50	21,22	0.00	Ŭ	'
OO CC 0.00 BL 0.00 SL 2.00 OT 3.00 NL 4.00 Tc 5.00 CA 5.00 SL 5.00 SL 7.00 SL 3.00 SL							6
0.00 BL 0.00 SL 0.00 OI 0.00 NL 0.00 Tc 0.00 CA 0.00 CA 0.00 SL	DRONARY CARE UNIT						
. 00 SU . 00 01 . 00 NU . 00 To . 00 CA . 10 RE . 00 SU . 00 SU . 00 SU . 00 SU	JRN INTENSIVE CARE UNIT						10
2. 00 01 3. 00 NL 5. 00 CA 5. 00 CA 5. 10 RE 5. 00 SL 5. 00 SL 5. 00 SL	JRGI CAL I NTENSI VE CARE UNI T						11
B. 00 NL J. 00 To J. 00 To J. 00 CA J. 10 RE J. 00 SL J. 00 SL J. 00 SL J. 00 SL	THER SPECIAL CARE (SPECIFY)						12
5. 00 CA 5. 10 RE 5. 00 SL 7. 00 SL 8. 00 SL	JRSERY						13
5. 00 CA 5. 10 RE 5. 00 SL 7. 00 SL 8. 00 SL	otal (see instructions)		58	21, 22	8 0.00	0	
5.00 SU 7.00 SU 3.00 SU	AH visits					0	15
7.00 SL 3.00 SL	EH hours and visits				0.00	0	15
3. 00 SL	JBPROVIDER - IPF						16
	JBPROVIDER – IRF						17
	JBPROVI DER						18
1. UU SK	KILLED NURSING FACILITY	44.00	254	92, 96	4	0	19
). OO NU	JRSING FACILITY	45.00	44	16, 10	4	0	20
. 00 01	THER LONG TERM CARE	46.00	134	49, 04	4		21
2. OO HO	OME HEALTH AGENCY						22
	MBULATORY SURGICAL CENTER (D. P.)						23
	OSPI CE						24
	OSPICE (non-distinct part)	30.00					24
	MHC – CMHC						25
	JRAL HEALTH CLINIC						26
	EDERALLY QUALIFIED HEALTH CENTER	89.00				0	
	otal (sum of lines 14-26)		490				27
	oservation Bed Days					0	
	nbul ance Trips						29
	mployee discount days (see instruction)						30
	mployee discount days - IRF						31
	abor & delivery days (see instructions)		0		0		32
	otal ancillary labor & delivery room						32
	5						1
	utpatient days (see instructions)						33
3. 01 LT I. 00 Te	5						33

)SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2024 To 12/31/2024	Worksheet S-3 Part I Date/Time Pre 5/7/2025 3:54	pare
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
~~	PART I - STATISTICAL DATA	0.404	0.100	14.01	4		
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	8, 104	2, 199	16, 01	4		1.
00	for the portion of LDP room available beds) HMO and other (see instructions)	0	0				2.
00	HMO IPF Subprovider	0	0				2.
00	HMO IRF Subprovider	0	0				4.
00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.
00	Hospital Adults & Peds. Swing Bed SM	0	0		0		6.
00	Total Adults and Peds. (exclude observation beds) (see instructions)	8, 104	2, 199	16, 01	-		7.
00	INTENSI VE CARE UNI T						8
00	CORONARY CARE UNI T						9
. 00	BURN INTENSIVE CARE UNIT						10
. 00	SURGI CAL I NTENSI VE CARE UNI T						111
. 00	OTHER SPECIAL CARE (SPECIFY)						12
. 00	NURSERY						13
. 00	Total (see instructions)	8, 104	2, 199	16, 01	4 0.00	163.20	
. 00	CAH visits	0, 104	2, 1, 7,		0.00	103.20	15
. 10	REH hours and visits	0	0		0		15
. 00	SUBPROVIDER - IPF	0	J		0		16
. 00	SUBPROVIDER - IRF						17
. 00	SUBPROVI DER						18
. 00	SKILLED NURSING FACILITY	20, 219	33, 821	86, 80	6 0.00	348, 10	
. 00	NURSING FACILITY		10, 317	15, 54			
. 00	OTHER LONG TERM CARE			45, 78		89.10	
.00	HOME HEALTH AGENCY						22
. 00	AMBULATORY SURGICAL CENTER (D. P.)						23
. 00	HOSPI CE						24
. 10	HOSPICE (non-distinct part)				0		24
. 00	CMHC - CMHC						25
. 00	RURAL HEALTH CLINIC						26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	26
. 00	Total (sum of lines 14-26)				0.00	652.10	27
. 00	Observation Bed Days		0		0		28
. 00	Ambul ance Trips	0					29
. 00	Employee discount days (see instruction)				0		30
. 00	Employee discount days - IRF				0		31
. 00	Labor & delivery days (see instructions)	0	0		0		32
. 01	Total ancillary labor & delivery room				0		32
	outpatient days (see instructions)						
. 00	LTCH non-covered days	0					33
3. 01	LTCH site neutral days and discharges	0					33
$\cap \cap$	Temporary Expansion COVID-19 PHE Acute Care						34

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 31-4019	Period: From 01/01/2024 To 12/31/2024	Worksheet S-3 Part I Date/Time Pre 5/7/2025 3:54	pared:
		Full Time		Di s	charges	57772025 3. 54	
		Equi val ents					
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	PART I – STATISTICAL DATA	11.00	12.00	13.00	14.00	15.00	
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	35	54 109	849	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider				0 0 0 0 0 0 0 0		2.00 3.00 4.00
5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						5.00 6.00 7.00
8.00 9.00 10.00 11.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						8.00 9.00 10.00 11.00
12.00 13.00 14.00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions)	0. 00	0	35	54 109	849	12.00 13.00
15.00 15.10 16.00 17.00	CAH visits REH hours and visits SUBPROVIDER - IPF SUBPROVIDER - IRF						15.00 15.10 16.00 17.00
18.00 19.00 20.00	SUBPROVI DER SKI LLED NURSI NG FACI LI TY NURSI NG FACI LI TY	0. 00 0. 00					18.00 19.00 20.00
21. 00 22. 00 23. 00 24. 00 24. 10	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part)	0.00				38	22.00 23.00 24.00 24.10
25.00 26.00 26.25 27.00 28.00	CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	0. 00 0. 00					25.00 26.00 26.25 27.00 28.00
28.00 29.00 30.00 31.00 32.00	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF						29.00 30.00 31.00
32.00 32.01 33.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)				0		32.00 32.01 33.00
33. 01	LTCH non-covered days LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care				0		33.00 33.01 34.00

PET	AL WAGE INDEX INFORMATION			Provider C		In Lie Period: From 01/01/2024 Fo 12/31/2024		pared
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)		Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	 PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES							1
0	Total salaries (see instructions)	200.00	54, 462, 150	0	54, 462, 150	1, 476, 975. 00	36. 87	1.0
0	Non-physician anesthetist Part		C	0		0.00	0. 00	2.0
0	A Non-physician anesthetist Part		(0		0.00	0.00	3. (
	В		· · · · ·	_				
0	Physician-Part A - Administrative		C	0		0.00	0.00	4.
	Physicians - Part A - Teaching		C	-		0.00		
0	Physician and Non Physician-Part B		C	0		0.00	0.00	5.
0	Non-physician-Part B for		C	0		0.00	0. 00	6.
	hospital-based RHC and FQHC services							
0	Interns & residents (in an	21.00	C	0		0.00	0. 00	7.
1	approved program) Contracted interns and		C	0		0.00	0.00	7.
	residents (in an approved			-				
0	programs) Home office and/or related		C	0		0.00	0.00	8.
	organization personnel	44.00	44 005 000		14 005 00			
	SNF Excluded area salaries (see	44.00	16, 025, 939 7, 062, 616	-				
	instructions)			-				
	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient) 0		0.00	0.00	11
	Care							
00	Contract labor: Top level management and other management and administrative		(0		0.00	0.00	12
00	services Contract Labor: Physician-Part		C	o		0.00	0.00	13
	A - Administrative							
00	Home office and/or related organization salaries and		(0		0.00	0.00	14
	wage-related costs Home office salaries		(0		0.00	0.00	11
	Related organization salaries		(-		0.00		
00	Home office: Physician Part A		C	0		0.00	0.00	15
01	- Administrative Home office Physicians Part A		C	0		0.00	0.00	15
02	- Administrative		C	0			0.00	15
02	Home office contract Physicians Part A -		(0.00	0.00	15
00	Administrative Home office and Contract		(0		0.00	0.00	16
	Physicians Part A - Teaching		· · · · ·					
01	Home office Physicians Part A - Teaching		C	0		0.00	0.00	16
	Home office contract Physicians Part A - Teaching		(0 0		0.00	0.00	16
	WAGE-RELATED COSTS Wage-related costs (core) (see		10, 234, 574	0	10, 234, 57	4	1	17
	instructions) Wage-related costs (other)							10
UU	(see instructions)							18
	Excluded areas Non-physician anesthetist Part		2, 109, 708	0	2, 109, 70	3		19 20
	A Non-physician anesthetist Part		(0				20
00	B Physician Part A -		(0		D		22
	Admi ni strati ve							
	Physician Part A - Teaching Physician Part B		(22
00	Wage-related costs (RHC/FQHC)		(0				24
00	Interns & residents (in an approved program)		(0	(L		25
50	Home office wage-related		C	0		D		25
	(core)			1	1	1	1	1

Heal th	Financial Systems		RAMAPO RIDGE	PSYCHI ATRI C		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2024 To 12/31/2024	Date/Time Pre 5/7/2025 3:54	pared: _pm
		Wkst. A Line		Reclassi fi cati			Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col		col. 5)	
		1.00		A-6)	3)	<u>col. 4</u>	(00	
05 50		1.00	2.00	3.00	4.00	5.00	6.00	05 50
25.52	Home office: Physician Part A		0	0		0		25.52
	- Administrative -							
0E E0	wage-related (core) Home office: Physicians Part A		0	0		0		25.53
20.00	- Teaching - wage-related		0	0		0		25.55
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE	S			1			
26.00	Employee Benefits Department	4.00	0	0		0 0.00	0.00	26.00
27.00	Administrative & General	5.00	7, 745, 094	0	7, 745, 09			27.00
28.00	Administrative & General under		0	0		0 0.00		28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0 0.00	0.00	29.00
30.00	Operation of Plant	7.00	1, 944, 497	0	1, 944, 49	61, 929. 00	31.40	30.00
31.00	Laundry & Linen Service	8.00	653, 027	0	653, 02	27 29, 322. 00	22. 27	31.00
32.00	Housekeepi ng	9.00	1, 660, 782	0	1, 660, 78	32 77, 806. 00	21.35	32.00
33.00	Housekeeping under contract		0	0		0 0.00	0.00	33.00
	(see instructions)							
	Di etary	10. 00	4, 295, 236	0	4, 295, 23			34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	0		0 0.00		36.00
	Maintenance of Personnel	12.00	0	0		0 0.00		
	Nursing Administration	13.00	0	0		0 0.00		38.00
39.00	Central Services and Supply	14.00	0	0		0 0.00		39.00
40.00	Pharmacy	15.00	0	0		0 0.00		40.00
41.00	Medical Records & Medical	16.00	0	0		0 0.00	0.00	41.00
	Records Library							
	Social Service	17.00	0	0		0 0.00		42.00
43.00	Other General Service	18.00	564, 385	0	564, 38	35 13, 491. 00	41.83	43.00

Heal th	Financial Systems		RAMAPO RIDGE	PSYCHI ATRI C		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2024 To 12/31/2024		pared:
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es		Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		54, 462, 150	0	54, 462, 15	0 1, 476, 975. 00	36.87	1.00
	instructions)							
2.00	Excluded area salaries (see		23, 088, 555	0	23, 088, 55	5 595, 352. 00	38. 78	2.00
	instructions)							
3.00	Subtotal salaries (line 1		31, 373, 595	0	31, 373, 59	5 881, 623. 00	35. 59	3.00
	minus line 2)							
4.00	Subtotal other wages & related		0	0		0 0.00	0.00	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		10, 234, 574	0	10, 234, 57	4 0.00	32.62	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		41, 608, 169		41, 608, 16			
7.00	Total overhead cost (see		16, 863, 021	0	16, 863, 02	1 488, 598. 00	34. 51	7.00
	instructions)							

Heal th	Financial Systems	RAMAPO RIDGE PS	YCHI ATRI C	In Li	eu of Form CMS-:	2552-10
HOSPI T	AL WAGE RELATED COSTS		Provider CCN: 31-4	019 Period: From 01/01/2024 To 12/31/2024		pared:
					Amount	
					Reported	
	I				1.00	
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					-
	RETIREMENT COST				1 007 000	1
1.00	401K Employer Contributions				1, 097, 023	
2.00	Tax Sheltered Annuity (TSA) Employer Contribu				0	
3.00	Nonqualified Defined Benefit Plan Cost (see i				0	
4.00	Qualified Defined Benefit Plan Cost (see inst				241, 933	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External C	Organi zati on)			1	
5.00	401K/TSA Plan Administration fees				0	
6.00	Legal /Accounting/Management Fees-Pension Plar				0	6.00
7.00	Employee Managed Care Program Administration	Fees			0	7.00
	HEALTH AND INSURANCE COST				1	
8.00	Heal th Insurance (Purchased or Self Funded)				0	
8.01	Health Insurance (Self Funded without a Third				0	
8.02	Health Insurance (Self Funded with a Third Pa	arty Administrato	or)		0	
8.03	Heal th Insurance (Purchased)				6, 872, 540	
9.00	Prescription Drug Plan				0	
10.00	Dental, Hearing and Vision Plan				0	
11.00	Life Insurance (If employee is owner or benef				63, 526	
12.00	Accident Insurance (If employee is owner or b					12.00
13.00	Disability Insurance (If employee is owner or		`			13.00
14.00	Long-Term Care Insurance (If employee is owned	er or beneficiary	()		0	
15.00	'Workers' Compensation Insurance				977, 210	
16.00	Retirement Health Care Cost (Only current yea	ar, not the extra	iordinary accruai re	quired by FASB 106.	0	16.00
	Noncumulative portion) TAXES					
17 00	FICA-Employers Portion Only				3, 721, 644	17.00
17.00	Medicare Taxes - Employers Portion Only					18.00
18.00	Unemployment Insurance				268, 267	
20.00	State or Federal Unemployment Taxes				165, 019	
20.00	OTHER				105,019	20.00
21 00	Executive Deferred Compensation (Other Than F	Potiromont Cost P	Poportod on Linos 1	through 4 above (see	0	21.00
21.00	instructions))	Retriement COSt F	reported on times I	Chi ough 4 above. (See		21.00
22.00	Day Care Cost and Allowances				0	22.00
22.00	Tuition Reimbursement				0	•
	Total Wage Related cost (Sum of lines 1 -23)				13, 445, 715	
27.00	Part B - Other than Core Related Cost				1 13, 43, 713	27.00
25 00	OTHER WAGE RELATED COSTS (SPECIFY)					25.00
25.00	TOTHER WHOLE RELATED GUIDS (SECTED)				1	25.00

Health Financial Systems	RAMAPO I	RI DGE PSYCHI ATRI C	In Lie	u of Form CMS-2	2552-10
HOSPITAL CONTRACT LABOR AND BENEFI	T COST	Provider CCN: 31-4019	Peri od:	Worksheet S-3	
			From 01/01/2024 To 12/31/2024	Part V Date/Time Pre	narod
			10 12/ 51/ 2024	5/7/2025 3: 54	pm
Cost Center Descriptio	n		Contract Labor		
			1.00	2.00	
PART V - Contract Labor and					
Hospital and Hospital-Based					
1.00 Total facility's contract la	abor and benefit cost		0	13, 720, 144	
2.00 Hospi tal			0	2, 588, 994	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, 037, 266	
9.00 NURSING FACILITY			0	562, 721	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					14.00
15.00 Hospital-Based Health Clinic	E FQHC				15.00
16.00 Hospital-Based-CMHC					16.00
17.00 RENAL DIALYSIS I					17.00
18.00 Other			0	6, 531, 163	18.00

Heal th	Financial Systems	RAMAPO RIDGE PS	SYCHI ATRI C		In Lie	u of Form CMS-:	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C		Period:	Worksheet A	
					From 01/01/2024 To 12/31/2024	Data /Tima Dra	norod.
					10 12/31/2024	Date/Time Pre 5/7/2025 3:54	pareu:
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Recl assi fi ed	
		our ur roo	o thoi	+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		6, 921, 080	6, 921, 080	0 0	6, 921, 080	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0		0 0		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	13, 720, 145	13, 720, 14	5 0	13, 720, 145	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	7, 745, 094	4, 283, 300	12, 028, 394	4 0	12, 028, 394	5.00
6.00	00600 MAI NTENANCE & REPAI RS	0	0	(0 0	0	6.00
7.00	00700 OPERATION OF PLANT	1, 944, 497	3, 663, 191	5, 607, 688	З О	5, 607, 688	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	653, 027	283, 581	936, 608	З О	936, 608	8.00
9.00	00900 HOUSEKEEPI NG	1, 660, 782	808, 380			2, 469, 162	9.00
10.00	01000 DI ETARY	4, 295, 236	2, 598, 765	6, 894, 00	1 0	6, 894, 001	10.00
11.00	01100 CAFETERI A	0	0	(0 0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	(0 0	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	(0 0	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	(0 0	0	17.00
18.00	01850 PASTORAL CARE	564, 385	7, 314	571, 699	9 0	571, 699	18.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	10, 277, 018	133, 741	10, 410, 759	9 0	10, 410, 759	30.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	16, 025, 939	2, 518, 554				•
45.00	04500 NURSING FACILITY	2, 233, 724	68, 313				
46.00	04600 OTHER LONG TERM CARE	3, 520, 054	109, 038	3, 629, 092	2 0	3, 629, 092	46.00
	ANCILLARY SERVICE COST CENTERS				-		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	185, 553				
60.00	06000 LABORATORY	0	322, 655			322, 655	
65.00	06500 RESPI RATORY THERAPY	0	155, 492			155, 492	•
66.00	06600 PHYSI CAL THERAPY	0	2, 384, 643				
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 834, 365			1, 834, 365	
68.00	06800 SPEECH PATHOLOGY	0	429, 056			429, 056	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	467, 663			467, 663	•
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 673, 816	1, 673, 810	6 0	1, 673, 816	73.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	4, 233, 556	1, 653	4, 235, 209	9 0	4, 235, 209	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS				-1 -		
118.00		53, 153, 312	42, 570, 298	95, 723, 610	0 0	95, 723, 610	118.00
100.0	NONREI MBURSABLE COST CENTERS		0/4 570	0/4 53		0/4 570	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	261, 573				
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192.00
	19202 OTHER NONREL MBURSABLE	0	0		0		192.10
	19201 MEDI CAL DAY CARE 07950 MARKETI NG/GROUP		0	2 470 (4			192.50
	107950 MARKETTNG/GROUP	1, 231, 544	2, 239, 100				
	207952 HOME HEALTH SERVICES	77, 294 0	8, 042, 386 2, 928, 693			8, 119, 680	
200.00		-				2, 928, 693 110, 504, 200	
200.00	I TOTAL (SUM OF LINES TTO LITUUUUT 199)	54, 462, 150	56, 042, 050	110, 304, 200	0	110, 304, 200	I200.00

Health Financial Systems	RAMAPO RIDGE P	PSYCHI ATRI C	In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CCN: 31-4019	Peri od:	Worksheet A	
			From 01/01/2024		
			To 12/31/2024	Date/Time Pre 5/7/2025 3:54	
Cost Center Description	Adjustments	Net Expenses		0/1/2020 0.01	
		or Allocation			
	6.00	7.00			
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT	-1, 007, 999	5, 913, 081			1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP	0	0			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	13, 720, 145			4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	-2, 206, 028	9, 822, 366			5.00
6. 00 00600 MAI NTENANCE & REPAI RS	0	0			6.00
7.00 00700 OPERATION OF PLANT	-14,077	5, 593, 611			7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	936, 608			8.00
9.00 00900 HOUSEKEEPI NG	0	2, 469, 162			9.00
10. 00 01000 DI ETARY	-30, 542	6, 863, 459			10.00
11. 00 01100 CAFETERIA	0	0			11.00
13.00 01300 NURSI NG ADMI NI STRATI ON	0	0			13.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0			16.00
17.00 01700 SOCIAL SERVICE	0	0			17.00
18. 00 01850 PASTORAL CARE	0	571, 699			18.00
INPATIENT ROUTINE SERVICE COST CENTERS	1 1				
30. 00 03000 ADULTS & PEDI ATRI CS	-607, 452	9, 803, 307			30.00
44.00 04400 SKILLED NURSING FACILITY	0	18, 544, 493			44.00
45.00 04500 NURSING FACILITY	0	2, 302, 037			45.00
46.00 04600 OTHER LONG TERM CARE	0	3, 629, 092			46.00
ANCI LLARY SERVI CE COST CENTERS	-				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	185, 553			54.00
60. 00 06000 LABORATORY	0	322, 655			60.00
65. 00 06500 RESPI RATORY THERAPY	0	155, 492			65.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 384, 643			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1,834,365			67.00
68.00 06800 SPEECH PATHOLOGY	0	429, 056			68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	467, 663			71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	1, 673, 816			73.00
	1 (04 40/	2 (00 722			00.00
90.00 09000 CLINIC	-1, 634, 486	2, 600, 723			90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART SPECIAL PURPOSE COST CENTERS					92.00
		00.000			118.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	-5, 500, 584	90, 223, 026			118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	261, 573			190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0			190.00
192. 10 19200 OTHER NONRELIMBURSABLE	0	0			192.00
192. 50 19201 MEDI CAL DAY CARE	0	0			192.10
192. SO 1920 MEDICAL DAT CARE 194. 00 07950 MARKETI NG/GROUP	0	3, 470, 644			192. 50
194. 01 07950 MARKETING/GROUP	0	8, 119, 680			194.00
194. 02 07952 HOME_HEALTH_SERVICES	0	2, 928, 693			194.01
200.00 TOTAL (SUM OF LINES 118 through 199)	-5, 500, 584	105, 003, 616			200.00
	-3, 300, 304	105,005,010			200.00

Heal th	Financial Systems		RAMAPO RIDGE	PSYCHI ATRI C		In Lie	u of Form CMS-	2552-10
RECLASS	SEFECATIONS			Provider (CCN: 31-4019	Period: From 01/01/2024	Worksheet A-6	5
							Date/Time Pre 5/7/2025 3:54	
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	A – DEFAULT							
1.00		0.00	0	C				1.00
	0		0	C				
500.00	Grand Total: Increases		0	C				500.00

Heal th	Financial Systems		RAMAPO RIDGE	PSYCHI ATRI C		In Lie	u of Form CMS-	2552-10
RECLAS	RECLASSI FI CATI ONS			Provi der (CCN: 31-4019	Period: From 01/01/2024	Worksheet A-e	6
						To 12/31/2024	Date/Time Pre 5/7/2025 3:54	
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	°.		
	6.00	7.00	8.00	9.00	10.00			
	A – DEFAULT							
1.00		0.00	0	C)	0		1.00
	0		0	C)			
500.00	Grand Total: Decreases		0	C				500.00

Heal th	Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 31-4019		i od: m 01/01/2024 12/31/2024		pared:
				Acqui si ti or	าร		0, 172020 0.01	
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	992, 033	25, 335		0	25, 335	0	1.00
2.00	Land Improvements	4, 973, 237	0		0	0	221, 037	2.00
3.00	Buildings and Fixtures	260, 489, 227	0		0	0	94, 382, 866	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	40, 765, 092	0		0	0	4, 226, 102	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	307, 219, 589	25, 335		0	25, 335	98, 830, 005	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	307, 219, 589	25, 335		0	25, 335	98, 830, 005	10.00
		Endi ng Bal ance						
			Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	1, 017, 368	0					1.00
2.00	Land Improvements	4, 752, 200	0					2.00
3.00	Buildings and Fixtures	166, 106, 361	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	36, 538, 990	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	208, 414, 919	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	208, 414, 919	0					10.00

Heal th	Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lieu of Form CMS-255			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period:	Worksheet A-7		
					From 01/01/2024 To 12/31/2024		narod	
					10 12/31/2024	Date/Time Pre 5/7/2025 3:54		
			SU	JMMARY OF CAPI	TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see			
						instructions)		
		9.00	10.00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK				_		1	
1.00	CAP REL COSTS-BLDG & FIXT	5, 169, 197	280, 238	1, 231, 17	3 240, 472	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00	
3.00	Total (sum of lines 1-2)	5, 169, 197	280, 238	1, 231, 17	3 240, 472	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	0ther	Total (1) (sum					
		Capi tal -Rel ate						
		d Costs (see	through 14)					
		instructions)						
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM						
1.00	CAP REL COSTS-BLDG & FIXT	0	6, 921, 080				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00	
3.00	Total (sum of lines 1-2)	0	6, 921, 080				3.00	

Health Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2024 To 12/31/2024		pared:
	COM	PUTATION OF RAT	-1 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 CAP REL COSTS-BLDG & FIXT	290, 728, 819	0	290, 728, 81		0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 0.000000	0	2.00
3.00 Total (sum of lines 1-2)	290, 728, 819		290, 728, 81		0	3.00
	ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CH						
1.00 CAP REL COSTS-BLDG & FLXT	0	0		0 5, 103, 697	280, 238	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0			0	2.00
3.00 Total (sum of lines 1-2)	0	U	IMMARY OF CAPI	0 5, 103, 697	280, 238	3.00
		SL	IMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
	44.00	10.00	10.00	instructions)	45.00	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	288, 674	240, 472		0 0	5, 913, 081	1.00
2.00 CAP REL COSTS-BEDG & FIXT	200,074				5, 913, 061	2.00
3.00 Total (sum of lines 1-2)	288, 674	, i i i i i i i i i i i i i i i i i i i		0 0	5, 913, 081	3.00
	200,074	240,472	I	0 ₁ 0	5, 715, 001	0.00

leal th	Financial Systems		RAMAPO RIDGE	PSYCHI ATRI C	In Lieu of Form CMS-25		
ADJUST	MENTS TO EXPENSES		Provider CCN: 31-401		Period: From 01/01/2024	Worksheet A-8	
						Date/Time Prep 5/7/2025 3:54	pm
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-942, 499	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
. 00	Investment income - other (chapter 2)		0		0.00	0	3.00
00	Trade quantity and time		0	ADMINISTRATIVE & GENERAL	5.00		4 00

3.00	(chapter 2)		0	0.00	0 3.00
4.00	Trade, quantity, and time		OADMI NI STRATI VE & GENERAL	5.00	0 4.00
5.00	di scounts (chapter 8) Refunds and rebates of	В	OADMINI STRATI VE & GENERAL	5.00	0 5.00
5.00	expenses (chapter 8)		O ADMINI STRATIVE & GENERAL	5.00	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	В	OADMI NI STRATI VE & GENERAL	5.00	0 7.00
8.00	21) Television and radio service (chapter 21)	В	-14, 077 OPERATI ON OF PLANT	7.00	0 8.00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -2, 659, 428	0.00	0 9.00 0 10.00
11.00	Sale of scrap, waste, etc.		0	0.00	0 11.00
12.00	(chapter 23) 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		-30, 542 DI ETARY	10.00	0 14.00
15.00	Rental of quarters to employee and others	В	-65, 500 CAP REL COSTS-BLDG & FIXT	1.00	9 15.00
16. 00	Sale of medical and surgical supplies to other than		0	0.00	0 16.00
17.00	patients Sale of drugs to other than		0	0.00	0 17.00
18.00	patients Sale of medical records and		0	0.00	0 18.00
19.00	abstracts		0		0 19.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0.00	0 19.00
20.00	Vending machines	D D		0.00	0 20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	В	-828 ADMI NI STRATI VE & GENERAL	5.00	0 21.00
22.00	Interest expense on Medicare overpayments and borrowings to		0	0.00	0 22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	ORESPI RATORY THERAPY	65.00	23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OPHYSI CAL THERAPY	66.00	24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0 *** Cost Center Deleted ***	114.00	25.00
26.00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		OCAP REL COSTS-BLDG & FIXT	1.00	0 26.00
27.00	Depreciation - CAP REL		OCAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00	COSTS-MVBLE EQUIP 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	OOCCUPATI ONAL THERAPY	67.00	30.00
30. 99	Hospice (non-distinct) (see		OADULTS & PEDIATRICS	30. 00	30. 99
31.00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	OSPEECH PATHOLOGY	68.00	31.00
32.00	I i mi tati on (chapter 14) CAH HIT Adjustment for		0	0.00	0 32.00
22.00	Depreciation and Interest			F 00	
33.00	CONSULTING FEES	В	-543, 374 ADMI NI STRATI VE & GENERAL	5.00	0 33.00

Health Financial Systems		RAMAPO RIDGE	PSYCHI ATRI C	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES				Period:	Worksheet A-8	
				From 01/01/2024 To 12/31/2024	Date/Time Pre	narod
				10 12/31/2024	5/7/2025 3:54	
			Expense Classification or	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
34.00 JURY DUTY	В	-25	ADMI NI STRATI VE & GENERAL	5.00	0	34.00
36.00 SALE OF MEDICAL RECORDS	В	-8, 003	ADMI NI STRATI VE & GENERAL	5.00	0	36.00
37.00 MEMBERSHIP DUES	A	-1, 082	ADMINISTRATIVE & GENERAL	5.00	0	37.00
38.00 RETURNED CHECK CHARGE	В	0	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00 OTHER REVENUE	В	-245	ADMI NI STRATI VE & GENERAL	5.00	0	39.00
40.00 SALE OF NEWSPAPERS	В	-10, 636	ADMI NI STRATI VE & GENERAL	5.00	0	40.00
41.00 INTERNAL MGMT FEES	A	0	VI LLAGE	194.01	0	41.00
42.00 REFUND BED TAX	В	-1, 224, 175	ADMINISTRATIVE & GENERAL	5.00		42.00
42.01 BADGE REPLACEMENT	В	-170	ADMI NI STRATI VE & GENERAL	5.00	0	42.01
42.02 BAD DEBTS	A	0	ADMI NI STRATI VE & GENERAL	5.00	0	42.02
42.03 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	42.03
(3)						
50.00 TOTAL (sum of lines 1 thru 49)		-5, 500, 584				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

	Financial Syste		RAMAPO RIDGE	PSYCHI ATRI C		In Lie	eu of Form CMS-	
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider C	CCN: 31-4019	Period: From 01/01/2024 To 12/31/2024	Date/Time Pre	epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professi onal Component	Provider Component	RCE Amount	5/7/2025 3:54 Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	AGGREGATE-ADULTS &	689, 455	400, 772	288, 68	3 181, 300	926	1.00
2.00	5.00	PEDI ATRI CS AGGREGATE - ADMI NI STRATI VE & GENERAL	431, 088	387, 979	43, 10	9 181, 300	156	2.00
3.00	90.00	AGGREGATE-CLI NI C	1, 708, 226	1, 537, 403	170, 82	3 181, 300	846	3.00
4.00	0.00		0	0		0 0	0	4.00
5.00	0.00		0	0		0 0	0	5.00
6.00	0.00		0	0		o l	0	6.00
7.00	0.00		0	0		o l	0	7.00
8.00	0.00		0	0		0 0	0	8.00
9.00	0.00		0	0		0 0	0	9.00
10.00	0.00		0	0		0 0	0	10.00
200.00			2, 828, 769	2, 326, 154	502, 61	5	1, 928	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identi fi er	Limit	Unadjusted RCE			of Mal practi ce	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	0.00		0.00	Education	12	44.00	
1 00	1.00	2.00	8.00	9.00	12.00	13.00	14.00	1.00
1.00	30.00	AGGREGATE - ADULTS & PEDI ATRI CS	80, 713	4, 036		0 0	3, 080	1.00
2.00	5.00	AGGREGATE - ADMI NI STRATI VE & GENERAL	13, 598	680		o o	0	2.00
3.00	90.00	AGGREGATE-CLINIC	73, 740	3, 687		0 0	0	3.00
4.00	0.00		0	0			l o	
5.00	0.00		0	0		0 0	0	5.00
6.00	0.00		0	0		o l	0	6.00
7.00	0.00		0	0		o o	0	7.00
8.00	0.00		0	0		o o	0	8.00
9.00	0.00		0	0		o o	0	9.00
10.00	0.00		0	0		o o	0	10.00
200.00			168, 051	8, 403		0 0	3, 080	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14	1/ 00	17.00	10.00	-	
1.00	1.00		15.00	16.00	17.00	18.00		1.00
1.00		AGGREGATE - ADULTS & PEDI ATRI CS	1, 290		206, 68			1.00
2.00	5.00	AGGREGATE – ADMI NI STRATI VE & GENERAL	0	13, 598	29, 51	1 417, 490		2.00
3.00	90.00	AGGREGATE-CLI NI C	0	73, 740	97, 08	3 1, 634, 486		3.00
4.00	0.00		0	0		0 0		4.00
5.00	0.00		0	0		o o		5.00
6.00	0.00		0	0		0 0		6.00
7.00	0.00		0	0		0 0		7.00
8.00	0.00		0	0		0 0		8.00
9.00	0.00		0	0		0 0		9.00
10.00	0.00		0	0		0 0		10.00
200.00			1, 290	169, 341	333, 27	4 2, 659, 428		200.00

	tems	RAMAPO RIDGE I				u of Form CMS-	2552-10
COST ALLOCATION - GE	NERAL SERVICE COSTS		Provider CC		Period: From 01/01/2024 To 12/31/2024	Worksheet B Part I Date/Time Pre 5/7/2025 3:54	
			CAPI TAL REL	ATED COSTS			
Cost Cer	ter Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
		col . 7)	1.00	2.00	4.00	4.0	
	CE COST CENTERS	0	1.00	2.00	4.00	4A	
	COSTS-BLDG & FIXT	5, 913, 081	5, 913, 081				1.00
	COSTS-MVBLE EQUIP	0	3, 713, 001		0		2.00
	BENEFITS DEPARTMENT	13, 720, 145	54, 932		0 13, 775, 077		4.00
	RATIVE & GENERAL	9, 822, 366	635, 063		0 1, 958, 959	12, 416, 388	
6.00 00600 MAI NTENA		0	0		0 0	0	
7.00 00700 OPERATI C		5, 593, 611	202, 521		0 491, 820	6, 287, 952	
	& LINEN SERVICE	936, 608	90, 977		0 165, 169	1, 192, 754	8.00
9.00 00900 HOUSEKEE		2, 469, 162	11, 776		0 420,060	2, 900, 998	9.00
10.00 01000 DI ETARY		6, 863, 459	0		0 1, 086, 390	7, 949, 849	10.00
11.00 01100 CAFETERI	A	0	0		0 0	0	11.00
13.00 01300 NURSI NG	ADMI NI STRATI ON	0	0		0 0	0	13.00
16.00 01600 MEDI CAL	RECORDS & LI BRARY	0	0		0 0	0	16.00
17.00 01700 SOCIAL S		0	0		0 0	0	17.00
18.00 01850 PASTORAL	CARE	571, 699	0		0 142, 749	714, 448	18.00
INPATIENT ROUT	TINE SERVICE COST CENTERS						
30.00 03000 ADULTS &		9, 803, 307	676, 947		0 2, 599, 356	13, 079, 610	
	NURSING FACILITY	18, 544, 493	1, 319, 431		0 4, 053, 444	23, 917, 368	
45.00 04500 NURSI NG		2, 302, 037	351, 138		0 564, 974	3, 218, 149	
46.00 04600 OTHER LC		3, 629, 092	1, 767, 500		0 890, 324	6, 286, 916	46.00
	/I CE_COST_CENTERS	105 550				105 550	1 - 4 - 00
54.00 05400 RADI 0L00		185, 553	0		0 0	185, 553	
60.00 06000 LABORATO		322, 655	0		0 0	322, 655	•
65.00 06500 RESPI RAT		155, 492	0		0 0	155, 492	
66. 00 06600 PHYSI CAL		2, 384, 643	219, 125		0 0	2, 603, 768	
67.00 06700 0CCUPATI 68.00 06800 SPEECH P		1, 834, 365	0		0 0	1, 834, 365	
		429,056	0		0 0	429, 056	•
	SUPPLIES CHARGED TO PATIENT NARGED TO PATIENTS	467, 663 1, 673, 816	0		0 0	467, 663 1, 673, 816	
	RVICE COST CENTERS	1,073,010	0		0 0	1,073,010	13.00
90. 00 09000 CLINIC	VICE COST CENTERS	2, 600, 723	391, 261		0 1, 070, 789	4, 062, 773	90.00
	ION BEDS (NON-DISTINCT PART	2,000,723	571,201		1,070,709	4,002,773	•
	SE COST CENTERS					0	/2.00
	S (SUM OF LINES 1 through 117)	90, 223, 026	5, 720, 671		0 13, 444, 034	89, 699, 573	1118 00
	LE COST CENTERS	70, 220, 020	0,720,071		10, 111, 001	07,077,070	1110.00
190, 00 19000 GLET. EL	OWER, COFFEE SHOP & CANTEEN	261, 573	16, 816		0 0	278, 389	190.00
192.00 19200 PHYSI CI A	NS' PRIVATE OFFICES	0	10, 357		0 0	10, 357	
192.10 19202 OTHER NO	NREIMBURSABLE	0	0		0 0		192.10
192. 50 19201 MEDI CAL		0	150, 721		0 0	150, 721	•
194.00 07950 MARKETI N		3, 470, 644	14, 516		0 311, 493	3, 796, 653	
		8, 119, 680	0		0 19, 550	8, 139, 230	
194.0107951 VI LLAGE							
194.0107951 VI LLAGE 194.0207952 HOME HEA	LTH SERVICES	2, 928, 693	0		0 0	2, 928, 693	194.02
194.0207952 HOME HEA	LTH SERVICES ot Adjustments	2, 928, 693	0		0 0		194. 02 200. 00
194.02 07952 HOME HEA 200.00 Cross For 201.00 Negative		2, 928, 693	0		0 0 0 0	0	

Heal th	n Financial Systems	RAMAPO RIDGE P	SYCHI ATRI C		In Lie	u of Form CMS-	2552-10
COST	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 31-4019	Period:	Worksheet B	
					rom 01/01/2024	Part I	
				-	Го 12/31/2024	Date/Time Pre	
				005047101105		5/7/2025 3:54	pm
	Cost Center Description	ADMI NI STRATI VE I		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	12, 416, 388					5.00
6.00	00600 MAI NTENANCE & REPAI RS	0	0				6.00
7.00	00700 OPERATION OF PLANT	843, 246	0	7, 131, 198	3		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	159, 954	0	129, 224	4 1, 481, 932		8.00
9.00	00900 HOUSEKEEPI NG	389, 038	0	16, 720	5 0	3, 306, 762	9.00
10.00	01000 DI ETARY	1, 066, 115	0		0 0	0	10.00
11.00	01100 CAFETERI A	0	0	(0 0	0	11.00
13.00	01300 NURSING ADMINISTRATION	0	0	(0 0	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0	0	16.00
17.00	01700 SOCIAL SERVICE	0	0		0	0	17.00
18.00	01850 PASTORAL CARE	95, 811	0		0	0	•
101.00	INPATIENT ROUTINE SERVICE COST CENTERS	,,,,,,,					
30.00	03000 ADULTS & PEDI ATRI CS	1, 754, 041	0	961, 534	1 281, 567	455, 183	30.00
44.00	04400 SKILLED NURSING FACILITY	3, 207, 417	0			887, 192	
45.00	04500 NURSI NG FACI LI TY	431, 570	0			236, 107	45.00
46.00		843, 107	0			1, 188, 476	
40.00	ANCI LLARY SERVICE COST CENTERS	043,107	0	2, 510, 552	100, 074	1, 100, 470	40.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	24, 884	0	(0 0	0	54.00
60.00	06000 LABORATORY	43, 270	0			0	60.00
65.00	06500 RESPI RATORY THERAPY	20, 852	0			0	65.00
66.00	06600 PHYSI CAL THERAPY	349, 178	0		-	147, 341	66.00
67.00		245, 998	0			147, 341	67.00
68.00	06800 SPEECH PATHOLOGY	245, 998	0			0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0			0	71.00
		62, 716	-				
73.00		224, 467	0		0	0	73.00
~~~~~	OUTPATIENT SERVICE COST CENTERS	F 4 4 999		555 74		0/0.00/	00.00
90.00		544, 838	0	555, 740	5 0	263, 086	•
92.00							92.00
	SPECIAL PURPOSE COST CENTERS					0 477 005	
118.00		10, 364, 041	0	6, 857, 900	1, 481, 932	3, 177, 385	118.00
	NONREI MBURSABLE COST CENTERS	· · · · · ·					
	D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	37, 333	0				190. 00
	D 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 389	0				192.00
	0 19202 OTHER NONREI MBURSABLE	0	0		0 0		192. 10
192.50	D 19201 MEDI CAL DAY CARE	20, 212	0	214, 084	4 0	101, 345	192.50
194.00	D 07950 MARKETI NG/GROUP	509, 150	0	20, 618	3 0	9, 761	194.00
194. O	1 07951 VI LLAGE	1, 091, 511	0	(	0 0	0	194. 01
194.02	2 07952 HOME HEALTH SERVICES	392, 752	0	(	0 0	0	194. 02
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	(	o o	0	201.00
202.00	TOTAL (sum lines 118 through 201)	12, 416, 388	0	7, 131, 198	1, 481, 932	3, 306, 762	202.00
				•			•

Heal th	Financial Systems	RAMAPO RIDGE P	SYCHI ATRI C		In Lie	u of Form CMS-:	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2024 To 12/31/2024	Worksheet B Part I Date/Time Pre 5/7/2025 3:54	pm
	Cost Center Description	DI ETARY	CAFETERI A	NURSING ADMINISTRATI		SOCIAL SERVICE	
		10.00	11.00	13.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY	9, 015, 964					10.00
11.00	01100 CAFETERI A	1, 922, 784	1, 922, 784				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0		0		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0		16.00
17.00	01700 SOCI AL SERVI CE	0	0		0 0	0	
18.00	01850 PASTORAL CARE	0	30, 437		0 0	0	18.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1			-
30.00	03000 ADULTS & PEDIATRICS	734, 181	503, 419		0 0	0	•
44.00	04400 SKILLED NURSING FACILITY	3, 876, 276	947, 268		0 0	0	
45.00	04500 NURSING FACILITY	708, 324	140, 683		0 0	0	
46.00	04600 OTHER LONG TERM CARE	1, 484, 264	242, 445		0 0	0	46.00
F 4 00	ANCI LLARY SERVICE COST CENTERS	0		1	0	0	54.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	0		0 0	0	•
65.00	06500 RESPIRATORY THERAPY	0	0		0 0	0	
		0	0		0 0		
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	•
75.00	OUTPATIENT SERVICE COST CENTERS	<u>ч</u>		′′	0 0	0	/ 5. 00
90.00	09000 CLINIC	0	13, 920		0 0	0	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	Ű	10, 720		0	0	92.00
	SPECIAL PURPOSE COST CENTERS			1			1
118.00		8, 725, 829	1, 878, 172		0 0	0	118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	)	0 0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	C		0 0	0	192.00
192.10	19202 OTHER NONREI MBURSABLE	0	0		0 0	0	192.10
192.50	19201 MEDI CAL DAY CARE	290, 135	0		0 0	0	192.50
194.00	07950 MARKETI NG/GROUP	0	44, 612		0 0	0	194.00
	07951 VI LLAGE	0	0		0 0	0	194.01
194.02	07952 HOME HEALTH SERVICES	О	C	)	0 0	0	194. 02
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	О	C	)	0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	9, 015, 964	1, 922, 784		0 0	0	202.00

	Financial Systems	RAMAPO RIDGE P					u of Form CMS-	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 31-4019	Peri Fron To	od: n 01/01/2024 12/31/2024	Worksheet B Part I Date/Time Pre 5/7/2025 3:54	pared:
	Cost Center Description	OTHER GENERAL SERVI CE PASTORAL CARE	Subtotal	Intern & Residents Co & Post Stepdown Adjustments		Total		
		18.00	24.00	25.00	,	26.00		
	GENERAL SERVICE COST CENTERS							
1.00 2.00 4.00 5.00 6.00 7.00 8.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE							1.00 2.00 4.00 5.00 6.00 7.00 8.00
9.00 10.00 11.00 13.00 16.00	00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY							9.00 10.00 11.00 13.00 16.00
17. 00 18. 00	01700 SOCI AL SERVI CE 01850 PASTORAL CARE I NPATI ENT ROUTI NE SERVI CE COST CENTERS	840, 696						17.00 18.00
30.00 44.00 45.00 46.00	03000 ADULTS & PEDIATRICS 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	455, 894 309, 038 75, 764 0	18, 225, 429 35, 789, 281 5, 605, 739 12, 689, 134	2	0 0 0 0	18, 225, 429 35, 789, 281 5, 605, 739 12, 689, 134		30.00 44.00 45.00 46.00
	ANCILLARY SERVICE COST CENTERS	1						
54.00 60.00 65.00 66.00 67.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 0 0	210, 437 365, 925 176, 344 3, 411, 532	5 4 2	0 0 0 0	210, 437 365, 925 176, 344 3, 411, 532		54.00 60.00 65.00 66.00
68. 00 71. 00 73. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVICE COST CENTERS	0 0 0	2, 080, 363 486, 595 530, 379 1, 898, 283	5	0 0 0	2, 080, 363 486, 595 530, 379 1, 898, 283		67.00 68.00 71.00 73.00
90. 00 92. 00	09000 CLINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS	0	5, 440, 363	3	0 0	5, 440, 363		90. 00 92. 00
118.00	NONREI MBURSABLE COST CENTERS	840, 696	86, 909, 804		0	86, 909, 804		118.00
192.00 192.10 192.50 194.00 194.0	19000       GIFT, FLOWER, COFFEE SHOP & CANTEEN         19200       PHYSICIANS' PRIVATE OFFICES         19202       OTHER NONREI MBURSABLE         19201       MEDICAL DAY CARE         07950       MARKETING/GROUP         107951       VILLAGE         207952       HOME HEALTH SERVICES         Cross Foot Adjustments	0 0 0 0 0 0	350, 914 33, 421 776, 497 4, 380, 794 9, 230, 741 3, 321, 445	1 7 7 5		350, 914 33, 421 0 776, 497 4, 380, 794 9, 230, 741 3, 321, 445 0		190. 00 192. 00 192. 10 192. 50 194. 00 194. 01 194. 02 200. 00
201.00 202.00	D Negative Cost Centers	0 840, 696	0 105, 003, 616	) 5	0 0	0 105, 003, 616		201. 00 202. 00

Health Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	1	Period: From 01/01/2024 To 12/31/2024	Worksheet B Part II Date/Time Pre 5/7/2025 3:54	pared:
		CAPI TAL REL	ATED COSTS		0/1/2020 0.04	
Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	Related Costs	1 00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-BEDG & TTXT						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	54, 932		54, 932	54, 932	
5. 00 00500 ADMINI STRATI VE & GENERAL	0	635, 063		635, 063	7, 815	
6. 00 00600 MAI NTENANCE & REPAI RS	0	000,000		000,000	0	
7. 00 00700 OPERATION OF PLANT	0	202, 521		202, 521	1, 962	
8.00 00800 LAUNDRY & LINEN SERVICE	0	90, 977		90, 977	659	
9. 00 00900 HOUSEKEEPI NG	0	11, 776		0 11, 776	1, 676	
10. 00 01000 DI ETARY	0	0		0 0	4, 334	
11. 00 01100 CAFETERIA	0	0		0	0	
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	0		0	0	
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	
17. 00 01700 SOCIAL SERVICE	0	0		0 0	0	
18.00 01850 PASTORAL CARE	0	0		0 0	569	
INPATIENT ROUTINE SERVICE COST CENTERS			I			
30. 00 03000 ADULTS & PEDIATRICS	0	676, 947	(	0 676, 947	10, 370	30.00
44.00 04400 SKILLED NURSING FACILITY	0	1, 319, 431	(	0 1, 319, 431	16, 148	44.00
45.00 04500 NURSING FACILITY	0	351, 138	(	351, 138	2, 254	45.00
46.00 04600 OTHER LONG TERM CARE	0	1, 767, 500	(	0 1, 767, 500	3, 552	46.00
ANCI LLARY SERVICE COST CENTERS			-			
54.00 05400 RADI OLOGY-DI AGNOSTI C	0			0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0	219, 125		219, 125	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATI ENT SERVI CE COST CENTERS		001.0(1		004.0(4	4 070	00.00
90. 00 09000 CLINIC	0	391, 261		391, 261	4, 272	
92. 00 09200 OBSERVATION BEDS (NON-DI STINCT PART				0		92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	5, 720, 671		5, 720, 671	ED (11	118.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	5, 720, 671		5,720,671	53, 011	1118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16, 816		0 16, 816	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0			10, 310		192.00
192. 10 19202 OTHER NONRELMBURSABLE	0	0, 357		0,357		192.10
192. 50 19201 MEDICAL DAY CARE	0	150, 721		0 150, 721		192.50
194. 00 07950 MARKETI NG/GROUP		14, 516		0 14, 516		192.00
194. 01 07951 VI LLAGE		14, 510		0 14,510		194.00
194. 02 07952 HOME HEALTH SERVICES						194.01
200.00 Cross Foot Adjustments			l '		0	200.00
201.00 Negative Cost Centers		n –	(	0 0	n	201.00
202.00 TOTAL (sum lines 118 through 201)	0	5, 913, 081		5, 913, 081		202.00
					, . OL	

Heal th	Financial Systems	RAMAPO RIDGE I	PSYCHI ATRI C			In Lie	u of Form CMS-2	2552-10
ALLOC	ATION OF CAPITAL RELATED COSTS		Provider (	CCN: 31-4019	Pe	eriod:	Worksheet B	
						rom 01/01/2024	Part II	
					To	12/31/2024	Date/Time Pre	
					0		5/7/2025 3:54	pm
	Cost Center Description	ADMI NI STRATI VE			OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT		LINEN SERVICE		
		5.00	6.00	7.00		8.00	9.00	
	GENERAL SERVICE COST CENTERS							
1.00	00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP							2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT							4.00
5.00	00500 ADMINI STRATI VE & GENERAL	642, 878						5.00
6.00	00600 MAI NTENANCE & REPAI RS	0		0				6.00
7.00	00700 OPERATION OF PLANT	43, 657		0 248,				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	8, 281		0 4,	497	104, 414		8.00
9.00	00900 HOUSEKEEPI NG	20, 142	(	0	582	0	34, 176	9.00
10.00	01000 DI ETARY	55, 196	(	0	0	0	0	10.00
11.00	01100 CAFETERI A	0	(	0	0	0	0	11.00
13.00	01300 NURSING ADMINISTRATION	0		o	0	0	0	13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0		o	0	0	0	16.00
17.00	01700 SOCIAL SERVICE	0		o	0	0	0	17.00
18.00	01850 PASTORAL CARE	4,960		0	0	0	0	18.00
	INPATIENT ROUTINE SERVICE COST CENTERS	.,		-1				
30.00	03000 ADULTS & PEDIATRICS	90, 812		0 33.	458	19, 839	4, 704	30.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	166, 103			213	54, 295	9, 169	44.00
45.00	04500 NURSING FACILITY	22, 344			355	20, 883	2, 440	
46.00	04600 OTHER LONG TERM CARE	43,650			358	9, 397	12, 284	46.00
10.00	ANCI LLARY SERVICE COST CENTERS	10,000		01,	000	7,077	12,201	10.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 288		0	0	0	0	54.00
60.00	06000 LABORATORY	2, 240		o	Ő	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	1,080		0	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	18,078		-	830	0	1, 523	66.00
67.00	06700 OCCUPATI ONAL THERAPY	12, 736		n 10,	030	0	1, 525	67.00
68.00	06800 SPEECH PATHOLOGY	2,979			0	0	0	68.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 247		0	0	0	0	71.00
73.00		11, 621			0	0	0	73.00
73.00	OUTPATIENT SERVICE COST CENTERS	11, 021			U	U	0	/3.00
00.00		20.200		0 19.	220	0	2 710	00.00
90.00		28, 208		19,	338	0	2, 719	90.00
92.00								92.00
110 0	SPECIAL PURPOSE COST CENTERS	504 400			(04	404 444		110 00
118.00		536, 622		0 238,	631	104, 414	32, 839	118.00
100.0	NONREI MBURSABLE COST CENTERS	1 000			0.04			1.00.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 933			831	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	72			512	0		192.00
	0 19202 OTHER NONREI MBURSABLE	0		0	0	0		192. 10
	0 19201 MEDICAL DAY CARE	1, 046			449	0		192. 50
	07950 MARKETI NG/GROUP	26, 360		0	717	0		194.00
	1 07951  VI LLAGE	56, 511		0	0	0		194.01
	207952 HOME HEALTH SERVICES	20, 334		0	0	0	0	194. 02
200.00								200.00
201.00	5	0		0	0	0		201.00
202.00	) TOTAL (sum lines 118 through 201)	642, 878		0 248,	140	104, 414	34, 176	202.00

Health Financial Systems	RAMAPO RIDGE I	PSYCHI ATRI C		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2024 To 12/31/2024	Date/Time Pre 5/7/2025 3:54	pm
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O		SOCIAL SERVICE	
	10.00	11.00	13.00	16.00	17.00	
GENERAL SERVICE COST CENTERS	· · · · · ·			· · · · · · · · · · · · · · · · · · ·		
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMEN	r					4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
6.00 00600 MAI NTENANCE & REPAI RS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY	59, 530					10.00
11. 00 01100 CAFETERIA	12, 696	12, 696				11.00
13.00 01300 NURSING ADMINISTRATION	0	0		0		13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0		0 0		16.00
17.00 01700 SOCIAL SERVICE	0	0		0 0		
18.00 01850 PASTORAL CARE		201		0 0	0	18.00
INPATIENT ROUTINE SERVICE COST CE		2.224	1		0	200.00
30. 00 03000 ADULTS & PEDIATRICS	4, 848	3, 324		0 0 0 0		
44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY	25, 593	6, 254 929		0 0 0 0		
45.00 04600 OTHER LONG TERM CARE	4, 677 9, 800	929 1, 601		0 0		
ANCI LLARY SERVICE COST CENTERS	9,800	1,001		0 0	0	40.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0		1
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	
67. 00 06700 OCCUPATIONAL THERAPY	0	0		0 0	0	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO	PATI ENT 0	0		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	· · ·					1
90. 00 09000 CLI NI C	0	92		0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTI	NCT PART					92.00
SPECIAL PURPOSE COST CENTERS				_		
118.00 SUBTOTALS (SUM OF LINES 1 th	nrough 117) 57,614	12, 401		0 0	0	118.00
NONREI MBURSABLE COST CENTERS			1	-	1	
190.00 19000 GIFT, FLOWER, COFFEE SHOP &		0		0 0		190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		192.00
192. 10 19202 OTHER NONREI MBURSABLE	0	0		0 0		192.10
192. 50 19201 MEDI CAL DAY CARE	1, 916	0		0 0		192.50
194. 00 07950 MARKETI NG/GROUP	0	295		0 0		194.00
194. 01 07951  VI LLAGE	0	0		0 0		194.01
194. 02 07952 HOME HEALTH SERVICES	0	0		0 0	0	194.02
200.00 Cross Foot Adjustments	0	0			_	200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through	0	12, 696		0 0		201.00 202.00
202.00  TOTAL (sum lines 118 through	1 2017   39, 530	12,090	1	u U	I 0	1202. UU

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	CN: 31-4019	Peri od:	Worksheet B
					From 01/01/2024 To 12/31/2024	Part II Date/Time Prepared 5/7/2025 3:54 pm
		OTHER GENERAL				07772020 0. 04 pm
		SERVI CE				
	Cost Center Description	PASTORAL CARE	Subtotal	Intern &	Total	
				Residents Co	st	
				& Post		
				Stepdown		
		18.00	24.00	Adjustments 25.00	26.00	
	GENERAL SERVICE COST CENTERS	10.00	24.00	23.00	20.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.
5.00	00500 ADMINI STRATI VE & GENERAL					5.
6.00	00600 MAI NTENANCE & REPAI RS					6.
7.00	00700 OPERATION OF PLANT					7.
8.00	00800 LAUNDRY & LINEN SERVICE					8.
9.00	00900 HOUSEKEEPI NG					9.
10.00	01000 DI ETARY					10.
11.00	01100 CAFETERI A					11.
13.00	01300 NURSI NG ADMI NI STRATI ON					13.
16.00	01600 MEDI CAL RECORDS & LI BRARY					16.
17.00	01700 SOCI AL SERVI CE					17.
18.00	01850 PASTORAL CARE	5, 730				18.
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	2 100	0.47 410	J	0 047 410	20
30.00 44.00	03000 ADULTS & PEDIATRICS 04400 SKILLED NURSING FACILITY	3, 108 2, 106	847, 410		0 847, 410 0 1, 664, 312	30. 44.
44.00	04400 SKILLED NORSING FACILITY	2,108	1, 664, 312 422, 536		0 1, 664, 312 0 422, 536	44. 45.
45.00	04600 OTHER LONG TERM CARE	0	1, 935, 142		0 1, 935, 142	45.
40.00	ANCI LLARY SERVICE COST CENTERS	0	1, 755, 142	·]	0 1,733,142	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 288	3	0 1, 288	54.
60.00	06000 LABORATORY	Ő	2, 240		0 2,240	60.
65.00	06500 RESPI RATORY THERAPY	0	1, 080		0 1,080	65.
66.00	06600 PHYSI CAL THERAPY	0	249, 556		0 249, 556	66.
67.00	06700 OCCUPATI ONAL THERAPY	0	12, 736		0 12, 736	67.
68.00	06800 SPEECH PATHOLOGY	0	2, 979		0 2, 979	68.
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 247	7	0 3, 247	71.
73.00	07300 DRUGS CHARGED TO PATIENTS	0	11, 621		0 11, 621	73.
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0	445, 890		0 445, 890	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0	92.
	SPECIAL PURPOSE COST CENTERS					
118.00		5, 730	5, 600, 037		0 5, 600, 037	118.
100.00	NONREI MBURSABLE COST CENTERS		10 (07		0 10 (07	100
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	19, 697		0 19, 697 0 11, 013	190. 192.
	19200 PHYSICIANS PRIVATE OFFICES	0	11, 013 0		0 11,013 0 0	192.
	19202 OTHER NORREIMBORSABLE	0	162, 179		0 162, 179	192.
	07950 MARKETI NG/GROUP	0	43, 232		0 43, 232	192.
	07951 VI LLAGE	0	56, 589		0 56, 589	194.
	07952 HOME HEALTH SERVICES	0	20, 334		0 20, 334	194.
200.00			20, 334		0 0	200.
201.00		о	C		0 0	201.
	TOTAL (sum lines 118 through 201)	5, 730	5, 913, 081	1	0 5, 913, 081	202.

Heal th	Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider CC	CN: 31-4019	Period: From 01/01/2024	Worksheet B-1	
					To 12/31/2024	Date/Time Pre	
		CAPI TAL REI	ATED COSTS			5/7/2025 3:54	pm
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	cost center bescription	(SQUARE	(DOLLAR VALUE)	BENEFITS	Reconciliation	& GENERAL	
		FEET))	. ,	DEPARTMENT		(ACCUM COST)	
				(GROSS			
		1.00	2.00	SALARI ES) 4.00	5A	5.00	
	GENERAL SERVICE COST CENTERS		2100		0.1	0,00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	362, 543					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	2 2 4 0	0	E4 440 15			2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	3, 368 38, 937		54, 462, 15 7, 745, 09		92, 587, 228	4.00 5.00
6.00	00600 MAI NTENANCE & REPAI RS	0		7,743,07	0 0	0	1
7.00	00700 OPERATION OF PLANT	12, 417	0	1, 944, 49	07 0	6, 287, 952	
8.00	00800 LAUNDRY & LINEN SERVICE	5, 578		653, 02		1, 192, 754	8.00
9.00	00900 HOUSEKEEPING	722		1, 660, 78		2, 900, 998	•
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	0	4, 295, 23	0 0	7, 949, 849 0	10.00
	01300 NURSI NG ADMI NI STRATI ON		0		0 0	0	13.00
	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16.00
17.00	01700 SOCIAL SERVICE	0	0		0 0	0	17.00
18.00	01850 PASTORAL CARE	0	0	564, 38	0	714, 448	18.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	41 505		10 077 01	0	12 070 (10	
	03000 ADULTS & PEDIATRICS 04400 SKILLED NURSING FACILITY	41, 505 80, 897				13, 079, 610 23, 917, 368	•
	04500 NURSING FACILITY	21, 529				3, 218, 149	
	04600 OTHER LONG TERM CARE	108, 369				6, 286, 916	•
	ANCILLARY SERVICE COST CENTERS						
	05400 RADI OLOGY-DI AGNOSTI C	0	-		0 0	185, 553	•
	06000 LABORATORY	0	0		0 0	322, 655	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 13, 435	0		0 0	155, 492 2, 603, 768	•
	06700 OCCUPATI ONAL THERAPY	13, 433	0		0 0	1, 834, 365	•
68.00	06800 SPEECH PATHOLOGY	0	0		0 0	429, 056	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	467, 663	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	1, 673, 816	73.00
00.00	OUTPATIENT SERVICE COST CENTERS	23, 989	0	4 222 55	6 0	4 0(2 772	
	09000 OBSERVATION BEDS (NON-DISTINCT PART	23, 989	0	4, 233, 55	0 0	4, 062, 773	90.00 92.00
72.00	SPECIAL PURPOSE COST CENTERS						/2.00
118.00		350, 746	0	53, 153, 31	2 -12, 416, 388	77, 283, 185	118.00
	NONREI MBURSABLE COST CENTERS	1		[			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,031	0		0 0	278, 389	
	19200 PHYSI CLANS' PRI VATE OFFI CES 19202 OTHER NONREI MBURSABLE	635 0			0 0		192.00 192.10
	19201 MEDICAL DAY CARE	9, 241			0 0	150, 721	
	07950 MARKETI NG/GROUP	890		1, 231, 54	4 0	3, 796, 653	
	07951 VI LLAGE	0	0	77, 29		8, 139, 230	
	07952 HOME HEALTH SERVICES	0	0		0 0	2, 928, 693	
200.00							200.00
201.00 202.00		5, 913, 081	0	13, 775, 07	7	12, 416, 388	201.00
202.00	Part I)	3, 713, 001		13,773,07	·	12,410,300	202.00
203.00		16. 310013	0. 000000	0. 25292	9	0. 134105	203.00
204.00	Cost to be allocated (per Wkst. B,			54, 93	2	642, 878	
205 63	Part II)			0.0000		0.00/010	205 00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.00100	19	0. 006943	205.00
206.00	NAHE adjustment amount to be allocated						206.00
207 22	(per Wkst. B-2)						207 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00
							•

OST ALLOCATI	ial Systems ON - STATISTICAL BASIS	RAMAPO RIDGE	Provider C		Period:	u of Form CMS- Worksheet B-1	
					From 01/01/2024 To 12/31/2024	Date/Time Pre	par
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	5/7/2025 3: 54 DI ETARY	- piii
		REPAI RS	PLANT	LINEN SERVICE		((MEALS	
		(SQUARE FEET)	((SQUARE	((POUNDS OF	FEET))	SERVED))	
			FEET))	LAUNDRY))		02.0020))	
		6.00	7.00	8.00	9.00	10.00	-
CENEDA	L SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	-
		1		1	1		1 1
	CAP REL COSTS-BLDG & FIXT						1
	CAP REL COSTS-MVBLE EQUIP						2
00 00400	EMPLOYEE BENEFITS DEPARTMENT						4
00 00500	ADMINISTRATIVE & GENERAL						5
00 00600 1	MAINTENANCE & REPAIRS	0					6
	OPERATION OF PLANT	0	307, 821				1 7
	LAUNDRY & LINEN SERVICE	0	5, 578		0		8
	HOUSEKEEPING	0	722		0 301, 521		9
		0				(00, 400	
	DIETARY	0	0		0 0	600, 433	
	CAFETERIA	0	0		0 0	128, 051	
	NURSING ADMINISTRATION	0	0		0 0	0	13
o. 00  01600 I	MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16
7.00 01700	SOCIAL SERVICE	0	0		0 0	0	17
. 00 01850 1	PASTORAL CARE	0	l a		0 0	0	18
	ENT ROUTINE SERVICE COST CENTERS		-		-	-	
	ADULTS & PEDI ATRI CS	0	41, 505	235, 08	7 41, 505	48, 894	30
	SKILLED NURSING FACILITY	0				258, 147	
	NURSING FACILITY	0					
	OTHER LONG TERM CARE	0	108, 369	111, 35	7 108, 369	98, 847	46
ANCI LL	ARY SERVICE COST CENTERS						
. 00 05400 1	RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54
0.00 06000	LABORATORY	0			0 0	0	60
	RESPIRATORY THERAPY	0			0 0	0	65
	PHYSI CAL THERAPY	0	13, 435		0 13, 435	0	66
		0				-	
	OCCUPATIONAL THERAPY	0	0		0 0	0	
	SPEECH PATHOLOGY	0	0		0 0	0	
. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71
. 00 07300 1	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73
OUTPAT	IENT SERVICE COST CENTERS		•	•			
0.00 09000		0	23, 989		0 23, 989	0	90
	OBSERVATION BEDS (NON-DISTINCT PART	-				-	92
	L PURPOSE COST CENTERS						1 11
		0	204 024	1 227 20	0 200 724	E01 111	1110
	SUBTOTALS (SUM OF LINES 1 through 117)	0	296, 024	1, 237, 30	0 289, 724	581, 111	1118
	MBURSABLE COST CENTERS	1		1			
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0 1, 031		190
	PHYSICIANS' PRIVATE OFFICES	0	635		0 635		192
2. 10 19202 0	OTHER NONREIMBURSABLE	0	0		0 0	0	192
2. 50 19201 1	MEDICAL DAY CARE	0	9, 241		0 9, 241	19, 322	192
	MARKETI NG/GROUP	0	890		0 890		194
4.0107951					0 0		194
	HOME HEALTH SERVICES						194
		0			0	0	
	Cross Foot Adjustments						200
	Negative Cost Centers						201
	Cost to be allocated (per Wkst. B,	0	7, 131, 198	1, 481, 93	2 3, 306, 762	9, 015, 964	202
	Part I)						1
3.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	23. 166704	1. 19771	4 10. 966938	15. 015770	203
	Cost to be allocated (per Wkst. B,	0	248, 140			59, 530	
	Part II)		270, 140	107,41	. 37, 170	57, 550	1201
1 1		0 000000	0 004110	0 00400	0 0 112245	0 000145	201
	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 806118	0. 08438	9 0. 113345	0. 099145	1205
	NAHE adjustment amount to be allocated						206
	(per Wkst. B-2)						1
07.00	NAHE unit cost multiplier (Wkst. D,						207

Heal th F	inancial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lie	u of Form CMS-2	2552-10
	OCATION - STATISTICAL BASIS		Provider CO		Period:	Worksheet B-1	
					From 01/01/2024 To 12/31/2024	Date/Time Pre	pared [.]
						5/7/2025 3:54	
						OTHER GENERAL	
	Cost Center Description	CAFETERI A	NURSI NG	MEDICAL	SOCI AL SERVI CE	SERVICE PASTORAL CARE	
			ADMI NI STRATI ON			(TIME SPENT)	
				LI BRARY	(TIME SPENT)		
			(DI RECT NRSI NG	(TIME SPENT)			
		11.00	HRS) 13.00	16.00	17.00	18.00	
GE	ENERAL SERVICE COST CENTERS	11100	10100	10100	17100	10100	
	0100 CAP REL COSTS-BLDG & FIXT						1.00
	0200 CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	0500 ADMINISTRATIVE & GENERAL 0600 MAINTENANCE & REPAIRS						5.00 6.00
	0700 OPERATION OF PLANT						7.00
	0800 LAUNDRY & LINEN SERVICE						8.00
9.00 00	0900 HOUSEKEEPI NG						9.00
	1000 DI ETARY						10.00
		128, 051					11.00
	1300 NURSING ADMINISTRATION 1600 MEDICAL RECORDS & LIBRARY	0			0		13.00 16.00
-	1700 SOCIAL SERVICE		0				17.00
-	1850 PASTORAL CARE	2,027			0	13, 493	1
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDI ATRI CS	33, 526			0 0	7, 317	
	4400 SKI LLED NURSI NG FACI LI TY	63, 085			0 0	4, 960	1
	4500 NURSING FACILITY	9, 369				1, 216	1
	4600 OTHER LONG TERM CARE NCILLARY SERVICE COST CENTERS	16, 146	107, 482		0	0	46.00
	5400 RADI OLOGY-DI AGNOSTI C	0	0	(	0 0	0	54.00
	6000 LABORATORY	0	0		0 0	0	60.00
65.00 00	6500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
	6600 PHYSI CAL THERAPY	0	0	(	0 0	0	66.00
	6700 OCCUPATIONAL THERAPY	0	0		0	0	67.00
	6800 SPEECH PATHOLOGY 7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	68.00 71.00
	7300 DRUGS CHARGED TO PATTENT	0	0			0	73.00
	JTPATIENT SERVICE COST CENTERS			· · · · · · · · · · · · · · · · · · ·		0	/ 0. 00
	9000 CLI NI C	927	0	(	0 0	0	90.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	PECIAL PURPOSE COST CENTERS	105 000	010.075			12 402	110.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) ONREIMBURSABLE COST CENTERS	125, 080	812, 975	(	0 0	13, 493	118.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	9200 PHYSI CLANS' PRI VATE OFFICES	0			0		192.00
	9202 OTHER NONREI MBURSABLE	0	0	(	o o	0	192. 10
	9201 MEDI CAL DAY CARE	0	0	(	0 0		192. 50
	7950 MARKETI NG/GROUP	2, 971	0	(	0 0		194.00
		0	0		0		194. 01 194. 02
200.00	7952 HOME HEALTH SERVICES Cross Foot Adjustments	0	0		0	0	200.00
200.00	Negative Cost Centers						200.00
202.00	Cost to be allocated (per Wkst. B,	1, 922, 784	0		o o	840, 696	
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	15. 015767		0.00000	0. 000000	62.306085	
204.00	Cost to be allocated (per Wkst. B,	12, 696	0	(	0 0	5, 730	204.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 099148	0. 000000	0. 000000	0. 000000	0. 424665	205 00
203.00	II)	0. 077140	0.00000	0.00000	0.00000	0. 424000	200.00
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
I	Parts III and IV)	I	I	I	1		I

Health Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 31-4019	Period: From 01/01/2024 To 12/31/2024		pared:
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Cost		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00 03000 ADULTS & PEDI ATRI CS	18, 225, 429		18, 225, 4			
44.00 04400 SKILLED NURSING FACILITY	35, 789, 281		35, 789, 2		35, 789, 281	1
45.00 04500 NURSING FACILITY	5, 605, 739		5, 605, 7		5, 605, 739	1
46.00 04600 OTHER LONG TERM CARE	12, 689, 134		12, 689, 1	34 0	12, 689, 134	46.00
ANCI LLARY SERVI CE COST CENTERS	1			1		_
54.00 05400 RADI OLOGY-DI AGNOSTI C	210, 437		210, 4		210, 437	
60. 00 06000 LABORATORY	365, 925		365, 9		365, 925	1
65. 00 06500 RESPI RATORY THERAPY	176, 344		176, 3		176, 344	1
66. 00 06600 PHYSI CAL THERAPY	3, 411, 532		3, 411, 5		3, 411, 532	1
67.00 06700 OCCUPATI ONAL THERAPY	2, 080, 363		2, 080, 3		2, 080, 363	
68.00 06800 SPEECH PATHOLOGY	486, 595		486, 5		486, 595	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	530, 379		530, 3		530, 379	1
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 898, 283		1, 898, 2	83 0	1, 898, 283	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	5, 440, 363		5, 440, 3	63 97, 083	5, 537, 446	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	1 2.00
200.00 Subtotal (see instructions)	86, 909, 804	0	86, 909, 8	04 303, 763		
201.00 Less Observation Beds	0			0		201.00
202.00   Total (see instructions)	86, 909, 804	0	86, 909, 8	04 303, 763	87, 213, 567	202.00

Heal th	Financial Systems	RAMAPO RIDGE F	PSYCHI ATRI C		In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 31-4019	Period: From 01/01/2024 To 12/31/2024		
				XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Charges Outpati ent	+ col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				1		
30.00	03000 ADULTS & PEDIATRICS	27, 211, 119		27, 211, 1			30.00
44.00	04400 SKI LLED NURSI NG FACI LI TY	42, 823, 889		42, 823, 88			44.00
45.00	04500 NURSING FACILITY	10, 455, 062		10, 455, 00			45.00
46.00	04600 OTHER LONG TERM CARE	1, 176, 989		1, 176, 98	39		46.00
F 4 00	ANCI LLARY SERVICE COST CENTERS	070.440		070 4	0 770054	0.000000	1 54 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	272, 463	0	272, 40		0.00000	
60.00	06000 LABORATORY	466, 617	0	466, 6			60.00
65.00		195, 700	0	195, 70			
66.00	06600 PHYSI CAL THERAPY	4, 592, 768	0	4, 592, 70			•
67.00	06700 OCCUPATIONAL THERAPY	3, 532, 945	0	3, 532, 94			
68.00	06800 SPEECH PATHOLOGY	826, 353	0	826, 3			•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	686, 708	0	686, 70			71.00
73.00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	1, 895, 150	0	1, 895, 1	1. 001653	0. 000000	73.00
90, 00	09000 CLINIC		( ( )7 715	( ()) 7	0. 820850	0. 000000	90.00
90.00 92.00	09000 CEINIC 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	6, 627, 715	6, 627, 7	0 0.000000		•
		04 125 742		100 742 4		0.00000	•
200.00		94, 135, 763	6, 627, 715	100, 763, 47	10		200.00
		04 125 742	4 407 715	100 742 4	70		
202.00	Total (see instructions)	94, 135, 763	6, 627, 715	100, 763, 4	0		202.00

Heal th	Financial Systems	RAMAPO RIDGE P	SYCHI ATRI C	In Lie	」of Form CMS-2552-1	10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider CCN: 31-4019	Peri od: From 01/01/2024 To 12/31/2024	Worksheet C Part I Date/Time Prepared: 5/7/2025 3:54 pm	:
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	NPATIENT ROUTINE SERVICE COST CENTERS					_
30.00	D3000 ADULTS & PEDIATRICS				30. 0	0
44.00	04400 SKILLED NURSING FACILITY				44.0	0
	D4500 NURSING FACILITY				45.0	0
	04600 OTHER LONG TERM CARE				46. 0	0
	ANCILLARY SERVICE COST CENTERS					
	05400 RADI OLOGY-DI AGNOSTI C	0. 772351			54.0	
	D6000 LABORATORY	0. 784208			60. 0	
	06500 RESPI RATORY THERAPY	0. 901094			65.0	
	06600 PHYSI CAL THERAPY	0. 742805			66. 0	
	06700 OCCUPATI ONAL THERAPY	0. 588847			67.0	
	D6800 SPEECH PATHOLOGY	0. 588846			68.0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 772350			71.0	
-	07300 DRUGS CHARGED TO PATIENTS	1.001653			73.0	0
	DUTPATIENT SERVICE COST CENTERS	1				
	09000 CLI NI C	0.835499			90.0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.0	
200.00	Subtotal (see instructions)				200. 0	
201.00	Less Observation Beds				201.0	
202.00	Total (see instructions)				202.0	Ю

Health Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 31-4019	Period: From 01/01/2024 To 12/31/2024		pared:
		Ti tl	e XIX	Hospi tal	TEFRA	
				Costs		
Cost Center Description		Therapy Limit	Total Cost		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00 03000 ADULTS & PEDIATRICS	18, 225, 429		18, 225, 4			1
44.00 04400 SKILLED NURSING FACILITY	35, 789, 281		35, 789, 2		35, 789, 281	1
45.00 04500 NURSING FACILITY	5, 605, 739		5, 605, 7		5, 605, 739	1
46.00 04600 OTHER LONG TERM CARE	12, 689, 134		12, 689, 1	34 0	12, 689, 134	46.00
ANCI LLARY SERVI CE COST CENTERS	1	-		1		_
54. 00 05400 RADI OLOGY-DI AGNOSTI C	210, 437		210, 4		210, 437	1
60. 00 06000 LABORATORY	365, 925		365, 9		365, 925	1
65. 00 06500 RESPI RATORY THERAPY	176, 344		176, 3		176, 344	1
66. 00 06600 PHYSI CAL THERAPY	3, 411, 532		3, 411, 5		3, 411, 532	1
67.00 06700 OCCUPATI ONAL THERAPY	2,080,363		2, 080, 3		2, 080, 363	1
68.00 06800 SPEECH PATHOLOGY	486, 595		486, 5		486, 595	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	530, 379		530, 3		530, 379	1
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 898, 283		1, 898, 2	83 0	1, 898, 283	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	5, 440, 363		5, 440, 3	63 97, 083	5, 537, 446	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00 Subtotal (see instructions)	86, 909, 804	0	86, 909, 8	04 303, 763	87, 213, 567	200.00
201.00 Less Observation Beds	0			0		201.00
202.00  Total (see instructions)	86, 909, 804	0	86, 909, 8	04 303, 763	87, 213, 567	202.00

Heal th	Financial Systems	RAMAPO RIDGE I	PSYCHI ATRI C		In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 31-4019	Period: From 01/01/2024 To 12/31/2024		
				e XIX	Hospi tal	TEFRA	
	Cost Center Description	I npati ent	Charges Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						_
30.00	03000 ADULTS & PEDIATRICS	27, 211, 119		27, 211, 11			30.00
44.00	04400 SKILLED NURSING FACILITY	42, 823, 889		42, 823, 88			44.00
45.00	04500 NURSING FACILITY	10, 455, 062		10, 455, 00			45.00
46.00	04600 OTHER LONG TERM CARE	1, 176, 989		1, 176, 98	39		46.00
	ANCILLARY SERVICE COST CENTERS	· · · · · ·					-
54.00	05400 RADI OLOGY-DI AGNOSTI C	272, 463	0	272, 40			
60.00	06000 LABORATORY	466, 617	0	466, 61			
65.00	06500 RESPI RATORY THERAPY	195, 700	0	195, 70			1
66.00	06600 PHYSI CAL THERAPY	4, 592, 768	0	4, 592, 70			1
67.00	06700 OCCUPATI ONAL THERAPY	3, 532, 945	0	3, 532, 94			
68.00	06800 SPEECH PATHOLOGY	826, 353	0	826, 3			
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	686, 708	0	686, 70			1
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 895, 150	0	1, 895, 1	1. 001653	1.001653	73.00
	OUTPATIENT SERVICE COST CENTERS	т — т				[	
90.00	09000 CLI NI C	0	6, 627, 715	6, 627, 7			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0.000000	0. 000000	1
200.00		94, 135, 763	6, 627, 715	100, 763, 4	78		200.00
201.00							201.00
202.00	Total (see instructions)	94, 135, 763	6, 627, 715	100, 763, 4	78		202.00

Health Financial Systems	RAMAPO RIDGE P	SYCHI ATRI C	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 31-4019	Period: From 01/01/2024 To 12/31/2024	Worksheet C Part I Date/Time Prepared: 5/7/2025 3:54 pm
		Title XIX	Hospi tal	TEFRA
Cost Center Description	PPS Inpatient Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
44.00 04400 SKILLED NURSING FACILITY				44.00
45.00 04500 NURSING FACILITY				45.00
46.00 04600 OTHER LONG TERM CARE				46.00
ANCILLARY SERVICE COST CENTERS				
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OUTPATIENT SERVICE COST CENTERS	· · ·			
90. 00 09000 CLINIC	0. 000000			90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	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

Health Financial Systems RAMAPO RIDGE PSYCHIATRIC In Lieu of Form CMS-255.					2552-10	
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA	TIOS NET OF	Provider C		Period: From 01/01/2024	Worksheet C Part II	
REDUCTIONS FOR MEDICAID ONLY				To 12/31/2024	Date/Time Pre	
					5/7/2025 3:54	pm
			e XIX	Hospi tal	TEFRA	
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
	(Wkst. B, Part				Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	210, 437			9 129		54.00
60. 00 06000 LABORATORY	365, 925	2, 240	363, 68	35 224		60.00
65. 00 06500 RESPI RATORY THERAPY	176, 344	1, 080	175, 26	4 108	10, 165	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 411, 532	249, 556	3, 161, 97	6 24, 956	183, 395	66.00
67.00 06700 OCCUPATI ONAL THERAPY	2, 080, 363	12, 736	2, 067, 62	1, 274	119, 922	67.00
68.00 06800 SPEECH PATHOLOGY	486, 595	2, 979	483, 61	6 298	28, 050	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	530, 379	3, 247	527, 13	325	30, 574	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 898, 283	11, 621	1, 886, 66	2 1, 162	109, 426	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	5, 440, 363	445, 890	4, 994, 47	44, 589	289, 679	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	92.00
200.00 Subtotal (sum of lines 50 thru 199)	14, 600, 221	730, 637	13, 869, 58	73, 065	804, 436	200.00
201.00 Less Observation Beds	0	0		0 0	0	201.00
202.00 Total (line 200 minus line 201)	14, 600, 221	730, 637	13, 869, 58	73, 065	804, 436	202.00
				1		•

Health Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA	ATIOS NET OF	Provider CO	CN: 31-4019	Peri od:	Worksheet C	
REDUCTIONS FOR MEDICAID ONLY				From 01/01/2024	Part II	
				To 12/31/2024	Date/Time Pre 5/7/2025 3:54	
		Titl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Cost Net of	Total Charges				
		(Worksheet C,		pe		
	Operating Cost	Part I, column	Ratio (col.	6		
	Reducti on	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVICE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	198, 177					54.00
60. 00 06000 LABORATORY	344, 607					60.00
65. 00 06500 RESPI RATORY THERAPY	166, 071	195, 700	0.84860	00		65.00
66. 00 06600 PHYSI CAL THERAPY	3, 203, 181					66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 959, 167					67.00
68.00 06800 SPEECH PATHOLOGY	458, 247					68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	499, 480	686, 708				71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 787, 695	1, 895, 150	0. 94330	00		73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	5, 106, 095	6, 627, 715				90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.0000	00		92.00
200.00 Subtotal (sum of lines 50 thru 199)	13, 722, 720	19, 096, 419				200.00
201.00 Less Observation Beds	0	0				201.00
202.00  Total (line 200 minus line 201)	13, 722, 720	19, 096, 419				202.00

Health Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Peri od:	Worksheet D	
				From 01/01/2024		
				To 12/31/2024	Date/Time Pre 5/7/2025 3:54	
		Title	e XVIII	Hospi tal	PPS	piii
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col, 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	847, 410	0	847, 41	0 16, 014	52.92	30.00
44.00 SKILLED NURSING FACILITY	1, 664, 312		1, 664, 31	2 86, 806	19. 17	44.00
45.00 NURSING FACILITY	422, 536		422, 53	6 15, 544	27.18	45.00
200.00 Total (lines 30 through 199)	2, 934, 258		2, 934, 25	8 118, 364		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	-			
	6.00	7.00			-	
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 ADULTS & PEDIATRICS	8, 104					30.00
44.00 SKILLED NURSING FACILITY	20, 219	387, 598				44.00
45.00 NURSING FACILITY	0	0				45.00
200.00 Total (lines 30 through 199)	28, 323	816, 462	1			200.00

Health Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 31-4019	Period: From 01/01/2024 To 12/31/2024		pared: pm
	_	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Total Charges (from Wkst. C, Part I, col.	to Charges	Program	Capital Costs (column 3 x column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 288	272, 463	0.00472	6, 777	32	54.00
60. 00 06000 LABORATORY	2, 240	466, 617	0.00480	22, 714	109	60.00
65. 00 06500 RESPI RATORY THERAPY	1,080	195, 700	0.0055	19 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	249, 556	4, 592, 768	0. 05433	37 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	12, 736	3, 532, 945	0.00360	05 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	2,979	826, 353	0.00360	05 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 247	686, 708	0.00472	28 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	11, 621	1, 895, 150	0.00613	32 144, 349	885	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	445, 890	6, 627, 715	0.0672	77 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.0000	0 0	0	92.00
200.00 Total (lines 50 through 199)	730, 637	19, 096, 419	,	173, 840	1, 026	200. 00

Health Financial Systems	RAMAPO RIDGE P	PSYCHI ATRI C		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST			Period: From 01/01/2024 To 12/31/2024	Date/Time Pre 5/7/2025 3:54	pared:
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	n Cost	Medi cal	
	Post-Stepdown	÷	Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
44.00 04400 SKILLED NURSING FACILITY	0	0		o o		44.00
45.00 04500 NURSING FACILITY	ol	0		o o		45.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.		
		(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		· · · ·		
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	16, 01	4 0.00	8, 104	30.00
44.00 04400 SKILLED NURSING FACILITY		0	86, 80	6 0.00	20, 219	44.00
45.00 04500 NURSING FACILITY		0	15, 54	4 0.00	0	45.00
200.00 Total (lines 30 through 199)		0	118, 36	4	28, 323	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9,00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
						44.00
44.00 04400 SKILLED NURSING FACILITY	0					
44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY	0					45.00

Health Financial Systems RAMAPO RIDGE PSYCHIATRIC In Lieu of Form CMS-2						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	S Provider CO		Period: From 01/01/2024 To 12/31/2024		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems	RAMAPO RIDGE I	PSYCHI ATRI C		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS			Peri od:	Worksheet D	
THROUGH COSTS			From 01/01/2024			
				To 12/31/2024		
		Titlo	XVIII	Hospi tal	5/7/2025 3:54 PPS	pili
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
cost center bescription	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost				$(col. 5 \div col.$	
		1, 2, 3, and 4)	cols. 2, 3,	8)	7)	
		4)		0)	· ·	
			and 4)		(see instructions)	
	4.00	5.00	6,00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
	0	0		0 272 462	0,00000	54.00
	0	0		0 272, 463		
60. 00 06000 LABORATORY	0	0		0 466, 617		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 195, 700		1
66. 00 06600 PHYSI CAL THERAPY	0	0		0 4, 592, 768		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 532, 945		1
68.00 06800 SPEECH PATHOLOGY	0	0		0 826, 353	0. 000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 686, 708	0.000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 1, 895, 150	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 6, 627, 715	0.000000	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0		0 19, 096, 419		200.00
			1	1	1	

Health Financial Systems	RAMAPO RIDGE P	SYCHI ATRI C	In Lie	eu of Form CMS-2	2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider CO		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2024		
				To 12/31/2024	Date/Time Pre 5/7/2025 3:54	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	Ũ	Costs (col.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	6, 777		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	22, 714		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	144, 349		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 2, 761, 096	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		173, 840		0 2, 761, 096	0	200. 00

Health Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 31-4019	Period: From 01/01/2024 To 12/31/2024	Date/Time Pre	
		Ti +L c	e XVIII	Hospi tal	5/7/2025 3:54 PPS	pili
			Charges	nospi tai	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Servi ces (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coi ns	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 772351			0 0	0	
60. 00 06000 LABORATORY	0. 784208			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 901094			0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 742805			0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 588847			0 0	0	01.00
68.00 06800 SPEECH PATHOLOGY	0. 588846			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 772350			0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	1. 001653	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	1		1			
90. 00 09000 CLINIC	0. 820850		•	0 0	2, 266, 446	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			0 0	0	
200.00 Subtotal (see instructions)		2, 761, 096		0 0	2, 266, 446	
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		0 7/1 00/				202.00
202.00  Net Charges (line 200 - line 201)	I	2, 761, 096	1	0 0	2, 266, 446	202.00

Health Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lie	u of Form CMS-2552	-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2024 To 12/31/2024	Worksheet D Part V Date/Time Prepare 5/7/2025 3:54 pm	ed:
			XVIII	Hospi tal	PPS	
		sts	-			
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			54	. 00
60, 00 06000 LABORATORY		0				. 00
65. 00 06500 RESPI RATORY THERAPY		0				. 00
66. 00 06600 PHYSI CAL THERAPY		0				. 00
67.00 06700 OCCUPATI ONAL THERAPY	l c	0			67.	. 00
68.00 06800 SPEECH PATHOLOGY	C	0			68.	. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	l c	0			71.	. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	c c	0 0			73.	. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	C	0 0			90.	. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	C	0			92.	. 00
200.00 Subtotal (see instructions)	C	0			200.	. 00
201.00 Less PBP Clinic Lab. Services-Program	C				201.	. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	C	0			202.	. 00

Health Financial Systems	RAMAPO RIDGE PSYCHIATRIC				In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	<b>VICE OTHER PASS</b>	S Provider CO	CN: 31-4019	Peri od:	Worksheet D		
THROUGH COSTS				From 01/01/2024	Part IV		
		Component (	CCN: 31-5376	To 12/31/2024		pared:	
		T; +1 o	W/LLL	Chilled Nursing	5/7/2025 3:54 PPS	pm	
		ntre	XVIII	Skilled Nursing Facility	PPS		
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health		
cost center bescription	Anesthetist	0	Program	Post-Stepdown	Allieu nealth		
		Program Post-Stepdown		Adj ustments			
	CUSI	Adjustments		Aujustilients			
	1.00	2A	2.00	3A	3, 00		
ANCI LLARY SERVI CE COST CENTERS	1.00	25	2.00	55	5.00		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00	
60. 00 06000 LABORATORY	0	0			0	60.00	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00	
	0	0		0 0	-		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00	
OUTPATIENT SERVICE COST CENTERS	1						
90. 00 09000 CLI NI C	0	0		0 0	0	90.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00	
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 31-4019 Period: Worksheet D From 01/01/2024 Part IV Component CCN: 31-5376 To 12/31/2024 Date/Time Prepared	
UCOMPONENT ULN: 31-5376   10   12/31/2024   Date/ 11 me Prepared	
5/7/2025 3:54 pm	
Title XVIII Skilled Nursing PPS	
Facility	
Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost	
Medical (sum of cols. Outpatient (from Wkst. C, to Charges	
Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col.)	
4) col s. 2, 3, 8) 7)	
and 4) (see	
instructions)	
4.00 5.00 6.00 7.00 8.00	
ANCI LLARY SERVICE COST CENTERS	
54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         0         0         272, 463         0. 000000         54.	
	0.00
65. 00 06500 RESPI RATORY THERAPY 0 0 195, 700 0. 000000 65.	
	b. 00
	. 00
	3.00
	. 00
	3.00
OUTPATIENT SERVICE COST CENTERS	
	0. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 0 0.000000 92.	
200.00         Total (lines 50 through 199)         0         0         19,096,419         200.	). 00

Health Financial Systems RAMAPO RIDGE PSYCHIATRIC In Lieu of Form CMS						2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider CO	CN: 31-4019	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2024	Part IV	
		Component (	CCN: 31-5376	To 12/31/2024		
			XVIII	Skilled Nursing	5/7/2025 3:54 PPS	pili
		nue	AVIII	Facility	FFJ	
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpatient	Outpati ent	
cost center bescription	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	$(col. 6 \div col.$	ondi geo	Costs (col.		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	34, 503		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	100, 753		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	50		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 714, 226		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 789, 974		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	456, 923		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	88, 636		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	339, 513		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		4, 524, 578		0 0	0	200.00

Health Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C	In Lie	u of Form CMS-	2552-10	
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2024		
				To 12/31/2024	Date/Time Pre 5/7/2025 3:54	pared:
		Ti †I	e XIX	Hospi tal	TEFRA	piii
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS					•	
30. 00 ADULTS & PEDIATRICS	847, 410	0	847, 41	0 16, 014	52.92	30.00
44.00 SKILLED NURSING FACILITY	1, 664, 312		1, 664, 31	2 86, 806	19. 17	44.00
45.00 NURSING FACILITY	422, 536		422, 53	6 15, 544	27.18	45.00
200.00 Total (lines 30 through 199)	2, 934, 258		2, 934, 25	8 118, 364		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	-			
	6.00	7.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	2, 199					30.00
44.00 SKILLED NURSING FACILITY	33, 821					44.00
45.00 NURSING FACILITY	10, 317		1			45.00
200.00 Total (lines 30 through 199)	46, 337	1, 045, 136				200.00

Health Financial Systems	PSYCHI ATRI C		In Lie	In Lieu of Form CMS-2552-1		
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 31-4019	Period: From 01/01/2024 To 12/31/2024	Date/Time Pre 5/7/2025 3:54	
		Titl	e XIX	Hospi tal	TEFRA	
Cost Center Description		Total Charges (from Wkst. C, Part I, col.	to Charges	Program	Capital Costs (column 3 x column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 288	272, 463	0.00472	27 0	0	54.00
60. 00 06000 LABORATORY	2, 240	466, 617	0.00480	01 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	1,080	195, 700	0.0055	19 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	249, 556	4, 592, 768	0.05433	37 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	12, 736	3, 532, 945	0.00360	05 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	2,979	826, 353	0.00360	05 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 247	686, 708	0.00472	28 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	11, 621	1, 895, 150	0.00613	32 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	445, 890	6, 627, 715	0.0672	77 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0.0000	0 00	0	92.00
200.00 Total (lines 50 through 199)	730, 637	19, 096, 419		0	0	200.00

Health Financial Systems	RAMAPO RIDGE F	PSYCHI ATRI C		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE O	THER PASS THROUGH COST			Period: From 01/01/2024 To 12/31/2024	Date/Time Pre 5/7/2025 3:54	epared: pm
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	6					
30. 00 03000 ADULTS & PEDIATRICS	0	0	1	0 0	0	30.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0		44.00
45.00 04500 NURSING FACILITY	0	0		0 0		45.00
200.00 Total (lines 30 through 199)	o	0		o o	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		í í	5 5	
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30. 00 03000 ADULTS & PEDIATRICS	0	0	16, 01	4 0.00	2, 199	30.00
44.00 04400 SKILLED NURSING FACILITY		0	86, 80	6 0.00	33, 821	44.00
45.00 04500 NURSING FACILITY		0	15, 54	4 0.00	10, 317	45.00
200.00 Total (lines 30 through 199)		0	118, 36	4	46, 337	200.00
Cost Center Description	Inpati ent					
· · · · ·	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
44.00 04400 SKILLED NURSING FACILITY	0					44.00
45.00 04500 NURSING FACILITY	0					45.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		S Provider CO	CN: 31-4019	Period: From 01/01/2024 To 12/31/2024			
		Ti tl	e XIX	Hospi tal	TEFRA		
Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments			
	1.00	2A	2.00	3A	3.00		
ANCI LLARY SERVICE COST CENTERS							
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1	0 0	0	54.00	
60. 00 06000 LABORATORY	0	0		0 0	0	60.00	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00	
OUTPATIENT SERVICE COST CENTERS			_				
90. 00 09000 CLINIC	0	0		0 0	0	90.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00	
200.00   Total (lines 50 through 199)	0	0		0 0	0	200. 00	

Health Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS			Period: From 01/01/2024 To 12/31/2024		
		Titl	e XIX	Hospi tal	TEFRA	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 272, 463	0. 000000	54.00
60. 00 06000 LABORATORY	0	0		0 466, 617	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 195, 700	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 4, 592, 768	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 532, 945	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 826, 353	0. 000000	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 686, 708	0. 000000	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 1, 895, 150	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	0		0 6, 627, 715	0.000000	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0. 000000	92.00
200.00 Total (lines 50 through 199)	0	0		0 19, 096, 419		200.00

Health Financial Systems	RAMAPO RIDGE P	SYCHI ATRI C		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 01/01/2024	Worksheet D Part IV	
				To 12/31/2024		
		Titl	e XIX	Hospi tal	TEFRA	piii
Cost Center Description	Outpatient	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	-	Costs (col.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0	1	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0		0 0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		0		0 0	0	200. 00
					•	•

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 31-4019	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Pre	pare
		Title XVIII	Hospi tal	5/7/2025 3: 54 PPS	pm
	Cost Center Description		nospitai	1 113	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed days			16, 014	
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day		ivate room davs	16, 014 0	
	do not complete this line.	,, , , , , , , , , , , , , , , , , , , ,	r varo r oom dago,	Ũ	
00	Semi-private room days (excluding swing-bed and observation be	5 /	- 01 - <del>C</del> the sect	16, 014	
00	Total swing-bed SNF type inpatient days (including private roo reporting period	om days) through becembe	and the cost	0	5
00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	m days) through December	31 of the cost	0	7
	reporting period			0	'
00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	8, 104	9
	newborn days) (see instructions)	0	Ŭ	0,101	'
00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	nly (including private r	room days)	0	10
00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom davs) after	0	11
	December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)	, , , , , , , , , , , , , , , , , , ,	-	
00	Swing-bed NF type inpatient days applicable to titles V or XLX through December 31 of the cost reporting period	( only (including privat	e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XIX	K only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar ye				
	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		<u> </u>		
00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	of the cost	0.00	17
00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19
	reporting period	<u> </u>			
00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	the cost	0.00	20
00	Total general inpatient routine service cost (see instructions	5)		18, 432, 109	21
00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22
00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line 6	0	23
	x line 18)			_	
00	Swing-bed cost applicable to NF type services through December $7 \times 1$ (ine 19)	r 31 of the cost reporti	ng period (line	0	24
00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25
00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		18, 432, 109	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed ch	narges)	0	28
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	
00	Average per diem private room cost differential (line 34 x lin			0.00	35
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (Line	0 18, 432, 109	36
	27 minus line 36)			10, 432, 109	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 151. 00	38
	Program general inpatient routine service cost (line 9 x line	-		9, 327, 704	
00	Medically necessary private room cost applicable to the Progra	am (line 14 x line 35)		0	40
00	Total Program general inpatient routine service cost (line 39	+ líne 40)		9, 327, 704	41

	Financial Systems ATLON OF INPATIENT OPERATING COST		Provider C	CN: 31-4019	Period: From 01/01/2024	Worksheet D-1	
					To 12/31/2024	Date/Time Pre 5/7/2025 3:54	
	Cost Costor Description	Tatal		XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
2.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.0
2.00	Intensive Care Type Inpatient Hospital Units						42.0
3.00	INTENSIVE CARE UNIT						43.0
4.00	CORONARY CARE UNIT						44.0
5.00 6.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.0
	OTHER SPECIAL CARE (SPECIFY)						40.0
	Cost Center Description					1.00	
8.00	Program inpatient ancillary service cost (Wi	st. D-3, col. 3,	line 200)			167, 635	48.
8. 01	Program inpatient cellular therapy acquisiti				column 1)	0	
9.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.01	)(see instruc	tions)		9, 495, 339	49.
0.00	Pass through costs applicable to Program in	atient routine s	ervices (from	Wkst. D. sur	m of Parts I and	428, 864	50.0
1.00	Pass through costs applicable to Program inp and IV)	batient ancillary	services (fr	om Wkst. D, s	sum of Parts II	1, 026	51.0
2.00	Total Program excludable cost (sum of lines					429, 890	52.
53.00	Total Program inpatient operating cost exclu		ated, non-phy	sician anestl	netist, and	9, 065, 449	53.0
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
4.00						0	54.
5.00	Target amount per discharge					0.00	
5.01	Permanent adjustment amount per discharge					0.00	
5.02 5.03	Adjustment amount per discharge (contractor CAR T-cell amount paid as an interim payment	J .				0.00	
5. 03 5. 00	Target amount ((line 54 x sum of lines 55, 5		plus line 55	03)		0	
7.00	Difference between adjusted inpatient operation				line 53)	0	
3. 00	Bonus payment (see instructions)	5	<u>j</u>			0	58.
9.00	Trended costs (lesser of line 53 ÷ line 54,		the cost repo	rting period	endi ng 1996,	0.00	59.
0. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		prior year o	ost report i	indated by the	0.00	60.
1. 00	market basket) Continuous improvement bonus payment (if lin		. ,	•		0.00	
1.00	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of th	e amount by w	hich operati	ng costs (İine		01.
2.00	Relief payment (see instructions)					0	
3.00	Allowable Inpatient cost plus incentive payr	nent (see instruc	tions)			0	63.
4.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	sts through Decem	ber 31 of the	cost reporti	ng period (See	0	64.
	instructions) (title XVIII only)	Ū			0 1		
5.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decembe	r 31 of the c	ost reporting	g period (See	0	65.
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVI	ll only); for	0	66.
7.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost re	eporting period	0	67.
8.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	0				0	
9.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient				si ting period	0	
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID	ONLY			
0. 00 1. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of				)		70.
2.00	Program routine service cost (line 9 x line		ne 70 ÷ Trne	2)			72.
3.00	Medically necessary private room cost applic	,	(line 14 x li	ne 35)			73.
4.00	Total Program general inpatient routine serv	vice costs (line	72 + line 73)				74.
5.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from W	lorksheet B, I	Part II, column		75.
	Per diem capital-related costs (line 75 ÷ li						76.
	Program capital-related costs (line 9 x line	· · · · · · · · · · · · · · · · · · ·					77.
. 00	Inpatient routine service cost (line 74 minu		ovider rocorr	le)			78.
7.00 3.00	Addregate charges to bonoficiaries for ever				nus line 79)		80.
7.00 3.00 9.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for com	parison to the co	ST LIMITATION				,
7.00 3.00 9.00 0.00	Total Program routine service costs for comp		st limitation	(			81.
7.00 8.00 9.00 0.00 1.00	Total Program routine service costs for comp	tation		(			
6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I Reasonable inpatient routine service costs	tation ine 9 x line 81) (see instructions					82. 83.
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I Reasonable inpatient routine service costs Program inpatient ancillary services (see in	tation ine 9 x line 81) (see instructions nstructions)	)				82. 83. 84.
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I Reasonable inpatient routine service costs Program inpatient ancillary services (see in Utilization review - physician compensation	tation ine 9 x line 81) (see instructions) (see instruction	) s)				82. 83. 84. 85.
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I Reasonable inpatient routine service costs Program inpatient ancillary services (see in Utilization review - physician compensation	tation ine 9 x line 81) (see instructions) (see instruction n of lines 83 thr	) s)				81. 82. 83. 84. 85. 86.

Health Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lie	u of Form CMS-2	2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provider CC	CN: 31-4019	Period:	Worksheet D-1			
				From 01/01/2024 To 12/31/2024	Date/Time Pre 5/7/2025 3:54	pared: pm		
		Title	XVIII	Hospi tal	PPS			
Cost Center Description								
					1.00			
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)	)			0	89.00		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on			
		(from line 21)	column 2	Observati on	Bed Pass			
				Bed Cost (from				
				line 89)	(col. 3 x col.			
					4) (see			
					instructions)			
	1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH C	COST							
90.00 Capital-related cost	847, 410	18, 432, 109	0.0459	75 0	0	90.00		
91.00 Nursing Program cost	0	18, 432, 109	0.0000	0 00	0	91.00		
92.00 Allied health cost	0	18, 432, 109	0.0000	0 00	0	92.00		
93.00 All other Medical Education	0	18, 432, 109	0.0000	0 0	0	93.00		

MPUL	ATION OF INPATIENT OPERATING COST	Provider CCN: 31-4019 Component CCN: 31-5376	Period: From 01/01/2024 To 12/31/2024	Worksheet D-1 Date/Time Pre	pare
		Title XVIII	Skilled Nursing Facility	5/7/2025 3: 54 PPS	pm
	Cost Center Description		Facility	1.00	
	PART I - ALL PROVIDER COMPONENTS		1		
00	INPATIENT DAYS			04 004	1 1
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing			86, 806 86, 806	
	Private room days (excluding swing-bed and observation bed da do not complete this line.		ivate room days,	00,000	3.
00	Semi-private room days (excluding swing-bed and observation l	bed days)		86, 806	4.
00	Total swing-bed SNF type inpatient days (including private reporting period		er 31 of the cost	0	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (excluding	swing-bed and	20, 219	9
	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII (	5	5	0	
	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII of the total sector applicable total sector ap	ctions)	5,	-	
	December 31 of the cost reporting period (if calendar year, e	enter 0 on this line)	3 /	0	
00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	IX only (including privat	e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendary			0	13
	Medically necessary private room days applicable to the Prog			0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT			-	
00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces through December 31 c	of the cost	0.00	17
00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after December 31 of	the cost	0.00	18
00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	0.00	19
00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of t	he cost	0.00	20
00	Total general inpatient routine service cost (see instruction	ns)		35, 789, 281	21
. 00	Swing-bed cost applicable to SNF type services through Deceml 5 x line 17)	ber 31 of the cost report	ing period (line	0	22
00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	ng period (line 6	0	23
00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24
. 00	/xline 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		35, 789, 281	27
00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		5 /	0	
00	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
	Average per diem private room charge differential (line 32 mi		tions)	0.00	
	Average per diem private room cost differential (line 34 x li	ine 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	
	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	fferential (line	35, 789, 281	37
	PART II - HOSPITÁL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			
. 00	Adjusted general inpatient routine service cost per diem (see				38
	Program general inpatient routine service cost (line 9 x line				39
. 00					
	Medically necessary private room cost applicable to the Progr				40

	Financial Systems TION OF INPATIENT OPERATING COST	RAMAPO RIDGE			CN: 31-4019	Po	In Lie riod:	u of Form CMS- Worksheet D-1	
50111 0174						Fr	om 01/01/2024		
			Compone	ent C	CCN: 31-5376	То	12/31/2024	Date/Time Pre 5/7/2025 3:54	
			Ti	itle	XVIII	Sk	illed Nursing	PPS	
	Cost Center Description	Total	Total		Average Per	-	Facility Program Days	Program Cost	
	·	Inpatient Cost	Inpatient [	Days	•	÷		(col. 3 x col.	
		1.00	2.00		<u>col.2)</u> 3.00		4.00	<u>4)</u> 5.00	
42.00	NURSERY (title V & XIX only)	1.00	2.00		5.00		1.00	0.00	42.00
	ntensive Care Type Inpatient Hospital Units								1 10 00
	INTENSIVE CARE UNIT CORONARY CARE UNIT								43.00
	BURN INTENSIVE CARE UNIT								45.00
	SURGICAL INTENSIVE CARE UNIT								46.00
17.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description								47.00
	cost center bescription							1.00	
	Program inpatient ancillary service cost (Wks								48.00
	Program inpatient cellular therapy acquisitio					, C	olumn 1)		48.0
	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	i through 48.C	I)(see Insi	truc	tions)				49.00
	Pass through costs applicable to Program inpa	atient routine	services (1	from	Wkst. D, su	mо	f Parts I and		50.00
	111)								
	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services	(fr	om Wkst. D, s	sum	of Parts II		51.00
	Total Program excludable cost (sum of lines !	50 and 51)							52.00
53.00	Total Program inpatient operating cost exclud	ding capital re	lated, non-	-phy	sician anest	het	ist, and		53.00
	medical education costs (line 49 minus line 5 FARGET AMOUNT AND LIMIT COMPUTATION	52)							-
	Program discharges								54.00
5.00	Target amount per discharge								55.0
	Permanent adjustment amount per discharge								55.0
	Adjustment amount per discharge (contractor ι CAR T-cell amount paid as an interim payment	ise on y)							55. C
	Target amount ((line 54 x sum of lines 55, 55	5.01, and 55.02	) plus line	e 55	. 03)				56.0
									57. C
	Bonus payment (see instructions)						-line 100/		58.0
	Trended costs (lesser of line 53 ÷ line 54, or updated and compounded by the market basket)	Dr line 55 trom	the cost r	геро	rting period	en	ai ng 1996,		59.0
0. 00 I	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior yea	ar c	ost report, i	upd	ated by the		60.0
	market basket)			+-					1 (1 0)
	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less								61.0
	53) are less than expected costs (lines 54 x								
	enter zero. (see instructions)								
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)						62. 0 63. 0
	PROGRAM INPATIENT ROUTINE SWING BED COST		0110110)						
	Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of	the	cost report	i ng	period (See		64.0
	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of th	he c	ost reportin	ар	eriod (See		65.0
	instructions)(title XVIII only)					9 P			00.0
	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus lir	ne 6	5)(title XVI		only); for		66.0
	CAH, see instructions Title V or XIX swing-bed NF inpatient routine	e costs through	December ?	31 oʻ	f the cost r	eno	rting period		67.0
	(line 12 x line 19)		2000/1001	0		200			
	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31	of	the cost rep	ort	ing period		68.0
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	routine costs (	line 67 + I	line	68)				69.0
	PART III - SKILLED NURSING FACILITY, OTHER NU								1
	Skilled nursing facility/other nursing facili	2				)		35, 789, 281	1
1	Adjusted general inpatient routine service co Program routine service cost (line 9 x line )		ine 70 ÷ li	i ne :	2)			412. 29 8, 336, 092	
	Program routine service cost (line 9 x line 1 Medically necessary private room cost applica		(line 14)	x li	ne 35)			8, 336, 092	
4.00	Total Program general inpatient routine servi	0	•					8, 336, 092	74.0
	Capital-related cost allocated to inpatient (	routine service	costs (fro	om W	orksheet B, I	Par	t II, column	0	75.0
1	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)						0 00	76.0
	Program capital -related costs (line 9 x line							0.00	
	Inpatient routine service cost (line 74 minus							0	
	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	• •			· · ·	ทกร	line 70)	0	
	Inpatient routine service costs for compa		ost i i illi tăl			iiuS	1116 /7)	0.00	
	Inpatient routine service cost limitation (li		)					0.00	
	Reasonable inpatient routine service costs (s		s)					8, 336, 092	
	Program inpatient ancillary services (see ins Utilization review – physician compensation (		ns)					3, 110, 650 0	1
	Total Program inpatient operating costs (sum							11, 446, 742	
F	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST	· · · /						
7.00	Total observation bed days (see instructions)	)						0	87.0

Health Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC	CN: 31-4019	Period:	Worksheet D-1	
		Component (	CCN: 31-5376	From 01/01/2024 To 12/31/2024		pared: pm
		Title	Title XVIII Ski		PPS	
		Facility				
Cost Center Description						
	1.00					
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) (se	0	89.00				
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
		` í		Bed Cost (from	Through Cost	
					(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	0	0	0.0000	00 00	0	90.00
91.00 Nursing Program cost	0	0	0.0000		0	91.00
92.00 Allied health cost	0	0	0, 00000		0	92.00
	0	0				
93.00 All other Medical Education	0		0.0000	0 וטנ	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 31-4019	Period: From 01/01/2024	Worksheet D-1	
			To 12/31/2024	Date/Time Pre 5/7/2025 3:54	pare pm
	Cost Center Description	Title XIX	Hospi tal	TEFRA	
	· · · · · · · · · · · · · · · · · · ·			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		16, 014	1
	Inpatient days (including private room days, excluding swing-			16, 014	2
00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	rivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation be	ed days)		16, 014	4
00	Total swing-bed SNF type inpatient days (including private row	om days) through Decembe	er 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private ro	om davc) after December	21 of the cost	0	6
50	reporting period (if calendar year, enter 0 on this line)	un days) arter becember	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line)	in days) arter becember a	of the cost	0	
00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	2, 199	9
.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	ave)	0	10
. 00	through December 31 of the cost reporting period (see instruct	tions)	oom days)	0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, end Swing-bed NF type inpatient days applicable to titles V or XI.		e room days)	0	12
. 00	through December 31 of the cost reporting period			Ũ	'2
. 00	Swing-bed NF type inpatient days applicable to titles V or XI.			0	13
. 00	after December 31 of the cost reporting period (if calendar yo Medically necessary private room days applicable to the Progra			0	14
	Total nursery days (title V or XIX only)	am (exer during swring bed	uuys)	0	
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 c	of the cost	0.00	1 1 7
. 00	reporting period	es thi dugh becember 31 t	in the cost	0.00	''
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service:	s after December 31 of t	he cost	0.00	20
	reporting period			0.00	
	Total general inpatient routine service cost (see instruction	·		18, 225, 429	
. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ (ine 17)	er 31 of the cost report	ing period (iine	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23
00	x line 18)	n 21 of the east monorti	ng paried (line	0	
. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ (ine 19)	r 31 of the cost report	ng period (inne	0	24
. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		18, 225, 429	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	· · · ·			
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)		28
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus lina 33)(saa instruc	tions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x lin			0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	-		0	36
. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	18, 225, 429	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				1
	Adjusted general inpatient routine service cost per diem (see	-		1, 138. 09	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra	-		2, 502, 660 0	40
	Total Program general inpatient routine service cost (line 39			2, 502, 660	

	ATION OF INPATIENT OPERATING COST		Provider C	CN: 31-4019	Period: From 01/01/2024	Worksheet D-1	
					To 12/31/2024	Date/Time Pre 5/7/2025 3:54	
				e XIX	Hospi tal	TEFRA	1
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
12 00	NURSERY (title V & VIX only)	1.00	2.00	3.00	4.00	5.00	42.0
2.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	<u> </u>					42.0
3. 00	INTENSIVE CARE UNIT						43.0
4.00	CORONARY CARE UNIT						44.0
15.00 16.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.0
	OTHER SPECIAL CARE (SPECIFY)						47.0
	Cost Center Description					1.00	
8.00	Program inpatient ancillary service cost (W					0	
8.01 9.00	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				column 1)	0 2, 502, 660	
17.00	PASS THROUGH COST ADJUSTMENTS	41 thi bugit 48.01				2, 502, 600	49.0
50.00	Pass through costs applicable to Program in	patient routine s	ervices (from	Wkst. D, sun	of Parts I and	116, 371	50.0
51.00	III) Pass through costs applicable to Program inp	natient ancillary	services (fr	om Wkst D s	um of Parts II	0	51.0
1.00	and IV)		301 11 003 (11				
2.00	Total Program excludable cost (sum of lines					116, 371	
53.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phy	sician anestr	netist, and	2, 386, 289	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
4.00	5 5					109	
5.00 5.01	Target amount per discharge Permanent adjustment amount per discharge					0.00 0.00	
5.02	Adjustment amount per discharge (contractor	use only)				0.00	
5.03	CAR T-cell amount paid as an interim paymen	5.				0	55.0
6.00	Target amount ((line 54 x sum of lines 55, 1					0	
7.00 8.00	Difference between adjusted inpatient opera Bonus payment (see instructions)	ting cost and tar	get amount (I	ine 56 minus	line 53)	-2, 386, 289 0	1
9.00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	rting period	endi ng 1996,	0.00	
	updated and compounded by the market basket						
0. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	n prior year c	ost report, ι	ipdated by the	0.00	60. C
51.00	Continuous improvement bonus payment (iflin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	sser of 50% of th	ne amount by w	hich operatir	ng costs (İine	0	61.0
2.00	Relief payment (see instructions)					0	62.0
3.00	Allowable Inpatient cost plus incentive payr	ment (see instruc	tions)			116, 371	63. C
4.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Decem	ber 31 of the	cost reporti	ng period (See	0	64. C
	instructions)(title XVIII only)	0					
5.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decembe	er 31 of the c	ost reporting	period (See	0	65. C
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	4 plus line 6	5)(title XVII	l only); for	0	66.0
7 00	CAH, see instructions						
7.00	(line 12 x line 19)	0				0	67.0
8. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	ne costs after De	ecember 31 of	the cost repo	orting period	0	68.0
9.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N			,		0	69.0
0. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rout	ine service c	ost (line 37)			70.0
1.00	Adjusted general inpatient routine service of		ne 70 ÷ line	2)			71.0
2.00 3.00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	(line 14 v li	ne 35)			72.0
4.00	Total Program general inpatient routine serv						74.0
5.00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, F	Part II, column		75.0
6. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.0
7.00	Program capital -related costs (line 9 x line						77.0
8. 00	Inpatient routine service cost (line 74 minu	us line 77)					78.0
9.00	Aggregate charges to beneficiaries for exces				un line 70)		79.0
0.00	Total Program routine service costs for com Inpatient routine service cost per diem limi		st limitation	(IINE /8 mir	ius line /9)		80.0
2.00	Inpatient routine service cost per drem frim						82.0
3.00	Reasonable inpatient routine service costs	(see instructions					83. (
4.00	Program inpatient ancillary services (see in						84.0
	Utilization review - physician compensation	(see instruction	15)			1	85.0
5.00	Total Program inpatient operating costs (sur	n of lines 83 thr	ough 85)				86.0
	Total Program inpatient operating costs (sur PART IV - COMPUTATION OF OBSERVATION BED PAS		ough 85)				86. 0 87. 0

Health Financial Systems	RAMAPO RIDGE	PSYCHI ATRI C		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC	CN: 31-4019	Period:	Worksheet D-1	
				From 01/01/2024 To 12/31/2024	Date/Time Pre 5/7/2025 3:54	
		Ti tl	e XIX	Hospi tal	TEFRA	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from		
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	847, 410	18, 225, 429	0. 04649	96 0	0	90.00
91.00 Nursing Program cost	0	18, 225, 429	0.0000	0 0	0	91.00
92.00 Allied health cost	0	18, 225, 429	0.0000	0 0	0	92.00
93.00 All other Medical Education	0	18, 225, 429	0.0000	0 0	0	93.00

Health Financial Systems RAMAPO RIDGE PS	YCHI ATRI C		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 31-4019	Peri od:	Worksheet D-3	
			From 01/01/2024 To 12/31/2024	Date/Time Pre 5/7/2025 3:54	
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	1		
30. 00 03000 ADULTS & PEDI ATRI CS			12, 553, 600		30.00
ANCI LLARY SERVI CE COST CENTERS		1			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 7723			54.00
60. 00 06000 LABORATORY		0. 78420		17, 813	
65. 00 06500 RESPI RATORY THERAPY		0. 9010		0	65.00
66. 00 06600 PHYSI CAL THERAPY		0.74280		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 5888		0	67.00
68.00 06800 SPEECH PATHOLOGY		0. 5888		0	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 7723		0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS		1.0016	53 144, 349	144, 588	73.00
OUTPATIENT SERVICE COST CENTERS		1			
90. 00 09000 CLINIC		0.8354		0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.0000		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			173, 840		
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			173, 840		202.00

Health Financial Systems	RAMAPO RIDGE PSYCHIATRIC		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC		Peri od:	Worksheet D-3	
			From 01/01/2024		
	Component	CCN: 31-5376	To 12/31/2024	Date/Time Pre 5/7/2025 3:54	
	Title	2 XVIII	Skilled Nursing		piii
			Facility		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCILLARY SERVICE COST CENTERS					
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 77235			
60. 00 06000 LABORATORY		0. 78420		79, 011	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 90109		45	65.00
66. 00 06600 PHYSI CAL THERAPY		0.74280	5 1, 714, 226	1, 273, 336	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 58884	7 1, 789, 974	1, 054, 021	67.00
68.00 06800 SPEECH PATHOLOGY		0. 58884	6 456, 923	269, 057	68.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 77235	0 88, 636	68, 458	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS		1.00165	3 339, 513	340, 074	73.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 83549	9 0	0	90.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 00000	0 0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96	through 98)		4, 524, 578	3, 110, 650	200.00
201.00 Less PBP Clinic Laboratory Services-Progr	ram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			4, 524, 578		202.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-4019	Peri od: From 01/01/2024 To 12/31/2024	Worksheet E Part B Date/Time Pre 5/7/2025 3:54	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
00	Medical and other services (see instructions)			0	1.0
00	Medical and other services reimbursed under OPPS (see instruc OPPS or REH payments	tions)		2, 266, 446 2, 515, 546	
00	Outlier payment (see instructions)			2, 515, 546	
01	Outlier reconciliation amount (see instructions)			0	
00	Enter the hospital specific payment to cost ratio (see instru-	ctions)		0.000	
00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	6.0 7.0
00	Transitional corridor payment (see instructions)			0.00	8.0
00	Ancillary service other pass through costs including REH dire	ct graduate medical educ	cation costs from	0	9.0
D. 00	Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions			0	10.0
1.00	Total cost (sum of lines 1 and 10) (see instructions)			0	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges			0	1 1 2 0
2.00 3.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	12.0 13.0
4.00	Total reasonable charges (sum of lines 12 and 13)			0	
- 00	Customary charges			-	4
5.00 5.00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable for			0	
	had such payment been made in accordance with 42 CFR §413.13(		a chai gobasi s		
7.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
3.00 9.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	Ly if line 18 exceeds li	no 11) (soo	0	
7.00	instructions)	Ty IT The To exceeds IT	ne n) (see	0	17.0
0. 00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20.0
1.00	instructions) Lesser of cost or charges (see instructions)			0	21.0
2.00	Interns and residents (see instructions)			0	
3.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
4.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			2, 515, 546	24.0
5.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction:	s)		0	25.0
5.00	Deductibles and Coinsurance amounts relating to amount on line	e 24 (for CAH, see instr		588, 987	
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)   instructions)	plus the sum of lines 22	2 and 23] (see	1, 926, 559	27.0
3. 00	Direct graduate medical education payments (from Wkst. E-4, 1	ine 50)		0	28.0
8.50	REH facility payment amount (see instructions)				28.5
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
D. 00 1. 00	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments			1, 926, 559 0	
2.00	Subtotal (line 30 minus line 31)			1, 926, 559	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)		0	
3.00 4.00	Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions)			0	
5.00	Adjusted reimbursable bad debts (see instructions)			0	
5.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	36.0
7.00 3.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			1, 926, 559 0	37. ( 38. (
7.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. (
9.50	Pioneer ACO demonstration payment adjustment (see instruction	s)			39. !
9.75 9.97	N95 respirator payment adjustment amount (see instructions)			0	
7.97 7.98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	ced devices (see instruc	ctions)	0	39.
9. 99	RECOVERY OF ACCELERATED DEPRECIATION		/	0	39.
0.00	Subtotal (see instructions)			1, 926, 559	
D. 01 D. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			38, 531 0	40. 40.
D. 02	Sequestration adjustment-PARHM pass-throughs			0	40.
1.00	Interim payments			1, 888, 004	
1.01 2.00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41. 42.
2.00	Tentative settlement-PARHM (for contractor use only)			0	42.
3.00	Balance due provider/program (see instructions)			24	43.
3.01	Balance due provider/program-PARHM (see instructions)	noo with OVC Dut 15 C	abanta: 1	_	43.
4. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	cnapter 1,	0	44.0
	TO BE COMPLETED BY CONTRACTOR				1
0.00	Original outlier amount (see instructions)			0	
1.00 2.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	
	Time Value of Money (see instructions)				93. (

Health Financial Systems	RAMAPO RIDGE PSYCHIATRIC	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-4019	Peri od:	Worksheet E	
		From 01/01/2024 To 12/31/2024	Part B Date/Time Pre	epared:
			5/7/2025 3:54	1 pm
	Title XVIII	Hospi tal	PPS	
			1.00	
94.00 Total (sum of lines 91 and 93)			C	94.00
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			C	200. 00

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 31-4019	Period: From 01/01/2024 To 12/31/2024		pared
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 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		10, 249, 9	00	1, 888, 004 0	1. 2. 3.
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					1
01 02 03 04 05	ADJUSTMENTS TO PROVIDER			0 0 0 0	0 0 0 0	3. 3. 3. 3. 3.
00	Provider to Program				0	J J.
50 51 52 53 54 99	ADJUSTMENTS TO PROGRAM Subtotal (sum of lines 3.01-3.49 minus sum of lines	10/31/2024	73, 0 -73, 0	0 0 0 0	0 0 0 0 0	3. 3. 3. 3. 3. 3.
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		10, 176, 8	36	1, 888, 004	4
00	List separately each tentative settlement payment after					5
50	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	5
)2				0	0	
)3				0	0	5
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5
50 51				0	0	
52				0	0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	
00 01	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER		38, 0	58	24	6
)2	SETTLEMENT TO PROGRAM		50,0	0	24	6
00	Total Medicare program liability (see instructions)		10, 214, 8	94	1, 888, 028	
				Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	(	)	1.00	2.00	8

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component (	CN: 31-4019 CCN: 31-5376	Period: From 01/01/20 To 12/31/20		repare
		Title	XVIII	Skilled Nursi Facility		r4 pili
		Inpatien	t Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy		
		1.00	2.00	3.00	4.00	
00 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		15, 819, 1	67 0		0 1.
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.
)1	ADJUSTMENTS TO PROVIDER			0		0 3
)2				0		0 3
)3				0		0 3
)4				0		0 3
)5	Provider to Program			0		0 3
0	ADJUSTMENTS TO PROGRAM			0		0 3
1				0		0 3
52				0		0 3
53				0		0 3
54				0		0 3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		0 3
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		15, 819, 1	67		0 4
	TO BE COMPLETED BY CONTRACTOR					
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
	Program to Provider			_	-	
)1 )2	TENTATI VE TO PROVI DER			0		0 5
)2 )3				0		0 5
,5	Provider to Program			0		-
0	TENTATI VE TO PROGRAM			0		0 5
i1				0		0 5
52				0		0 5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0		0 5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
)1 )2	SETTLEMENT TO PROVIDER			0		0 6
)2 )0	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		15, 819, 1	-		0 6 0 7
.0	Total meaneare program traditity (see thistractions)		13, 017, 1	Contractor		<u> </u>
				Number	(Mo/Day/Yr)	
		(	)	1.00	2.00	

			From 01/01/2024 To 12/31/2024		nared
			10 12/31/2024	5/7/2025 3:54	
		Title XVIII	Hospi tal	PPS	
				1.00	
1 00	PART II - MEDICARE PART A SERVICES - IPF PPS	dical education noumente	<u>,</u>	11 175 220	1 00
1.00 2.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and me Net IPF PPS Outlier Payments	edical education payments	)	11, 175, 229 0	
3.00	Net IPF PPS ECT Payments			0	
4.00	Unweighted intern and resident FTE count in the most recent	cost report filed on or	pefore November	0.00	4.00
4.01	15, 2004. (see instructions) Cap increases for the unweighted intern and resident FTE cou	int for residents that we	co di col acod by	0.00	4.01
4.01	program or hospital closure, that would not be counted with $CFR$ §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	
6.00	Current year's unweighted FTE count of I&R excluding FTEs in	n the new program growth	period of a "new	0.00	6.00
7.00	teaching program" (see instuctions) Current year's unweighted I&R FTE count for residents withir	the new program growth	period of a "new	0.00	7.00
	teaching program" (see instuctions)			0100	
8.00	Intern and resident count for IPF PPS medical education adju	ustment (see instructions	)	0.00	1
9.00 10.00	Average Daily Census (see instructions) Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	a the newer of E1EO 1		43. 754098 0. 000000	
11.00	Teaching Adjustment (line 1 multiplied by line 10).	5 the power of . 5150 -1}.		0.000000	
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	)		11, 175, 229	
13.00	Nursing and Allied Health Managed Care payment (see instruct			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 ins Subtotal (see instructions)	structions)		0	
16.00 17.00	Primary payer payments			11, 175, 229 0	
18.00	Subtotal (line 16 less line 17).			11, 175, 229	
19.00	Deducti bl es			309, 536	
20.00	Subtotal (line 18 minus line 19)			10, 865, 693	
21.00 22.00	Coinsurance			549, 600	
	Subtotal (line 20 minus line 21) Allowable bad debts (exclude bad debts for professional serv	vices) (see instructions)		10, 316, 093 165, 027	
	Adjusted reimbursable bad debts (see instructions)			107, 268	
25.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		100, 163	25.00
	Subtotal (sum of lines 22 and 24)			10, 423, 361	
27.00 28.00	Direct graduate medical education payments (see instructions	5)		0	
28.00	Other pass through costs (see instructions) Outlier payments reconciliation			0	
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			Ő	1
30. 50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	
30.98	Recovery of accelerated depreciation.			0	
30.99 31.00	Demonstration payment adjustment amount before sequestration Total amount payable to the provider (see instructions)	1		0 10, 423, 361	
31.00	Sequestration adjustment (see instructions)			208, 467	1
	Demonstration payment adjustment amount after sequestration			0	
32.00	Interim payments			10, 176, 836	
33.00	Tentative settlement (for contractor use only)			0	
34.00 35.00	Balance due provider/program (line 31 minus lines 31.01, 31.		chaptor 1	38, 058	
35.00	Protested amounts (nonallowable cost report items) in accord §115.2	dance with the spub. 15-2,	chapter I,	0	35.00
	TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0	1
51.00 52.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	51.00 52.00
52.00 53.00	Time Value of Money (see instructions)			0.00	1
-0.00	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AN THE COVID-19 PHE)				
99.00	Teaching Adjustment Factor for the cost reporting period imm Calculated Teaching Adjustment Factor for the current year.		ary 29, 2020.	0. 000000	99.00 99.01

Heal th	Financial Systems RAMAPO RIDG	E PSYCHIATRI C	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-4019 Component CCN: 31-5376	Period: From 01/01/2024 To 12/31/2024	Worksheet E-3 Part VI Date/Time Prep 5/7/2025 3:54	pared:
		Title XVIII	Skilled Nursing Facility	PPS	-p
				1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL SERVICES	OTHER HEALTH SERVICES FOR T	IILE XVIII PARI A	PPS SNF	
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			17, 847, 039	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)			17, 847, 039	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vacci	ne costs are included in lin	e 1 of W/S E,		5.00
	Part B. This line is now shaded.)				
6.00	Deducti bl e			0	6.00
7.00	Coinsurance			1, 705, 032	
8.00	Allowable bad debts (see instructions)			0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (s	ee instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)			0	10.00
11.00	Utilization review			0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lin	es 10 and 11)(see instructio	ns)	16, 142, 007	
13.00	Inpatient primary payer payments			0	
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instruc	tions)		0	14.50
14.98	Recovery of accel erated depreciation.			0	
14.99	Demonstration payment adjustment amount before sequestrat	I ON			
15.00	Subtotal (see instructions			16, 142, 007	
15.01	Sequestration adjustment (see instructions)			322, 840	
15.02 15.75	Demonstration payment adjustment amount after sequestrati Sequestration for non-claims based amounts (see instructi			0	15. 02 15. 75
15.75	Interim payments	015)		15, 819, 167	
17.00	Tentative settlement (for contractor use only)				17.00
18.00	Balance due provider/program (line 15 minus lines 15.01,	15 02 15 75 16 and 17		0	18.00
19.00	Protested amounts (nonallowable cost report items) in acc		2 chanter 1	0	18.00
17.00	Frotested amounts (nonarrowable cost report ritems) in acc	UTUATICE WITH CWS 19 PUD. 13-		0	17.00

	Financial Systems RAMAPO RIDGE PSY( ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-4019	Peri od:	Worksheet E-3	
			From 01/01/2024 To 12/31/2024	Part VII Date/Time Pre 5/7/2025 3:54	pared:
		Title XIX	Hospi tal	TEFRA	Piii
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	VICES FOR TITLES V OR X	X SERVICES		-
1.00	COMPUTATION OF NET COST OF COVERED SERVICES		116, 371		1.00
2.00	Medical and other services		110, 371	0	2.00
3.00	Organ acquisition (certified transplant programs only)		0	-	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		116, 371	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments		11/ 071	0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		116, 371	0	7.00
	Reasonable Charges				-
8.00	Routi ne servi ce 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
13.00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for	convisor on a charge	0	0	13.00
13.00	basis	services on a charge	0	0	13.00
14.00	Amounts that would have been realized from patients liable for	payment for services o	n o	0	14.00
	a charge basis had such payment been made in accordance with 4				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only line 4) (see instructions)	y if line 16 exceeds	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only	vifline 4 exceeds lin	e 116, 371	0	18.00
	16) (see instructions)			Ũ	
19.00	Interns and Residents (see instructions)		0	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see instru		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 1)		0	0	21.00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be a	completed for PPS provid	ders.	0	222.00
22.00 23.00	Other than outlier payments Outlier payments		0	0	22.00 23.00
24.00	Program capital payments		0	0	23.00
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
30.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		116, 371	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	Deducti bl es		0	0	
	Coinsurance		0	0	33.00
33.00	Allowable bad debts (see instructions)		0	0	1
34.00			0		35.00
34. 00 35. 00	Utilization review	00)	_		
34. 00 35. 00 36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0	36.00
34.00 35.00 36.00 37.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	0	0	37.00
34.00 35.00 36.00 37.00 38.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 $\pm$ line 37)	33)	0		37.00 38.00
34.00 35.00 36.00 37.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	0	0	37.00 38.00 39.00
34.00 35.00 36.00 37.00 38.00 39.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4)	33)	0 0 0	0 0	37.00 38.00 39.00
<ol> <li>34.00</li> <li>35.00</li> <li>36.00</li> <li>37.00</li> <li>38.00</li> <li>39.00</li> <li>40.00</li> </ol>	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		0 0 0	0 0 0	37.00 38.00 39.00 40.00 41.00 42.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 31-4019	Period: From 01/01/2024	Worksheet E-3 Part VII	
		Component CCN: 31-5376	To 12/31/2024	Date/Time Pre 5/7/2025 3:54	par pm
		Title XIX	Skilled Nursing Facility	Cost	
			I npati ent	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR X	1.00	2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES				1
00	Inpatient hospital/SNF/NF services		0		] 1
00	Medical and other services			0	
00	Organ acquisition (certified transplant programs only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		0	0	
00	Inpatient primary payer payments		0	0	5
00	Outpatient primary payer payments		0	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	
	COMPUTATION OF LESSER OF COST OR CHARGES				1
00	Reasonable Charges Routine service charges		0		1
00 00	Ancillary service charges		0	0	
. 00	Organ acquisition charges, net of revenue		0	0	1
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		0	0	
	CUSTOMARY CHARGES				1
. 00	Amount actually collected from patients liable for payment fo	or services on a charge	0	0	1:
	basi s	-			
. 00	Amounts that would have been realized from patients liable fo	or payment for services o	n 0	0	1
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)	0. 000000		
. 00				0.00000	
. 00	Total customary charges (see instructions)		0	0	
. 00	Excess of customary charges over reasonable cost (complete on	nly if line 16 exceeds	0	0	1
. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds lin		0	18
. 00	16) (see instructions)	ily il ille 4 exceeds illi	0	0	
. 00	Interns and Residents (see instructions)		0	0	1
	Cost of physicians' services in a teaching hospital (see inst	tructions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		0	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				
. 00	Other than outlier payments		0	0	22
. 00	Outlier payments		0	0	2
. 00	Program capital payments		0		2
. 00	Capital exception payments (see instructions)		0		2
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
. 00	Titles V or XIX (sum of lines 21 and 27)		0	0	20
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 ~
. 00	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6 Deductibles	,	0	0	
. 00	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	0	3
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	nd 33)	0	0	
. 00				0	
. 00				0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		3
.00	Total amount payable to the provider (sum of lines 38 and 39)	1	0	0	
.00	Interim payments		0	0	
. 00	Balance due provider/program (line 40 minus line 41)		0	0	
	0 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub 15-2,				

Health Financial Systems         RAMAPO RIDGE PSYCHIATRIC           CALCULATION OF REIMBURSEMENT SETTLEMENT         Provider CCN: 31-4019         Peter CCN: 31-4019				u of Form CMS-2 Worksheet E-3	
SALCUL			Period: From 01/01/2024	Part VII	
		Component CCN: 31-5376	To 12/31/2024	Date/Time Pre 5/7/2025 3:54	pared:
		Title XIX	Nursing Facility		
			Inpatient	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI	X SERVICES		-
1.00	COMPUTATION OF NET COST OF COVERED SERVICES		0		1.00
2.00	Medical and other services		0	0	•
3.00	Organ acquisition (certified transplant programs only)		0	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	
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	•
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	0	0	13.00
14.00	basis Amounts that would have been realized from patients liable for	navment for services or	n 0	0	14.00
14.00	a charge basis had such payment been made in accordance with 4		1 0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	2 0111 31101 10(0)	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 onl	y if line 16 exceeds	0	0	17.00
	line 4) (see instructions)				10.00
18.00	Excess of reasonable cost over customary charges (complete onl)	y if line 4 exceeds line	e 0	0	18.00
19.00	16) (see instructions) Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instr	uctions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 1		0	0	•
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be o	completed for PPS provid	ders.		
22.00	Other than outlier payments		0	0	
	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00 27.00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		0	0	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	
	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	
	Deducti bl es		0	0	
32.00	Coi nsurance		0	0	
33.00			0	0	34.00
33. 00 34. 00	Allowable bad debts (see instructions)		0		25 00
33. 00 34. 00 35. 00	Utilization review	33)	0	0	35.00
33.00 34.00 35.00 36.00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	0	0	36.00
33. 00 34. 00 35. 00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	0 0 0		36.00 37.00
33.00 34.00 35.00 36.00 37.00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)		0	36.00 37.00
33.00 34.00 35.00 36.00 37.00 38.00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 $\pm$ line 37)	33)		0	36.00 37.00 38.00 39.00
$\begin{array}{c} 33.\ 00\\ 34.\ 00\\ 35.\ 00\\ 36.\ 00\\ 37.\ 00\\ 38.\ 00\\ 39.\ 00\\ 40.\ 00\\ 41.\ 00\\ \end{array}$	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39) Interim payments	33)		0 0 0 0	36.00 37.00 38.00 39.00 40.00 41.00
$\begin{array}{c} 33.\ 00\\ 34.\ 00\\ 35.\ 00\\ 36.\ 00\\ 37.\ 00\\ 38.\ 00\\ 39.\ 00\\ 40.\ 00\\ \end{array}$	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)			0 0 0	36.00 37.00 38.00 39.00 40.00 41.00 42.00

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	F	Period: From 01/01/2024 To 12/31/2024	Worksheet G Date/Time Pre	pare
		General Fund	Specific Purpose Fund	Endowment Fund	5/7/2025 3:54 Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	2, 366, 146		0 0	0	1.
00	Temporary investments	998			0	2.
00	Notes receivable	0 700 005	(	-	0	3.
00 00	Accounts receivable Other receivable	9, 780, 995 7, 701, 919		-	0	4. 5.
00	Allowances for uncollectible notes and accounts receivable	-116, 103		-	0	6
00	Inventory	371, 167		o o	0	7
00	Prepaid expenses	1, 033, 690	0	0 0	0	8
00	Other current assets	894, 813		-	0	9
. 00	Due from other funds	0	(	-	0	10
. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	22, 033, 625	(	0 0	0	11
00	Land	1, 017, 368		0	0	12
. 00	Land improvements	4, 752, 200			0	13
00	Accumulated depreciation	-2, 778, 095		0 0	0	14
00	Bui I di ngs	166, 106, 361	0	0 0	0	15
00	Accumulated depreciation	-56, 456, 311	(	-	0	16
00	Leasehold improvements	0	(	-	0	17
00	Accumulated depreciation Fixed equipment			, i i i i i i i i i i i i i i i i i i i	0	18   19
00	Accumulated depreciation	0		-	0	20
	Automobiles and trucks	3, 105, 433	-	-	0	21
. 00	Accumulated depreciation	-2, 933, 932	0	0 0	0	22
	Major movable equipment	33, 433, 557		-	0	23
	Accumulated depreciation	-35, 589, 133		-	0	24
	Minor equipment depreciable Accumulated depreciation	0		, ,	0	25 26
	HIT designated Assets			, i	0	20
	Accumulated depreciation	0			0	28
	Mi nor equi pment-nondepreci abl e	0	0	0 0	0	29
. 00	Total fixed assets (sum of lines 12-29)	110, 657, 448	(	0 0	0	30
~ ~	OTHER ASSETS					
. 00 . 00	Investments	23, 901, 798			0	31
00	Deposits on leases Due from owners/officers				0	33
. 00	Other assets	-201, 016		, i i i i i i i i i i i i i i i i i i i	0	34
. 00	Total other assets (sum of lines 31-34)	23, 700, 782		0	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	156, 391, 855	0	0 0	0	36
	CURRENT LIABILITIES		1	1		
	Accounts payable	6, 715, 951			0	37
00	Salaries, wages, and fees payable Payroll taxes payable	6, 778, 937 3, 704, 652			0	38
	Notes and Loans payable (short term)	2, 100, 900		0	0	40
	Deferred income	17, 895, 440	(	0	0	
. 00	Accelerated payments	0				42
00	Due to other funds	0	(	-	0	
. 00	Other current liabilities	3, 373, 056			0	
00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	40, 568, 936	(	0 0	0	45
. 00	Mortgage payable	55, 532, 745	0	0	0	46
00	Notes payable	8, 700, 000			0	47
00	Unsecured Loans	0	(	0 0	0	48
. 00	Other long term liabilities	0	0	-	0	49
00	Total long term liabilities (sum of lines 46 thru 49)	64, 232, 745			0	50
00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	104, 801, 681		0 0	0	51
00	General fund balance	51, 590, 174				52
00	Specific purpose fund		0			53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0	-	56
. 00	Plant fund balance - invested in plant				0	57
. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58
. 00	Total fund balances (sum of lines 52 thru 58)	51, 590, 174	0	0	0	59
00	Total liabilities and fund balances (sum of lines 51 and	156, 391, 855			0	60

Health Financial Systems	RAMAPO RIDGE P	SYCHI ATRI C			In Lie	u of Form CMS-:	2552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 31-4019		riod: om 01/01/2024 12/31/2024	Worksheet G-1 Date/Time Pre 5/7/2025 3:54	
	General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
	1.00	2.00	2.00		4.00	F 00	
1.00 Fund balances at beginning of period	1.00	2.00	3.00		4.00	5.00	1.00
2.00 Net income (loss) (from Wkst. G-3, line 29)		-1, 182, 774					2.00
3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify)	0	48, 093, 723		0	0	0	3.00 4.00
5. 00 ADJUSTMENTS TO OPENING BALANCE	3, 496, 451			0		0	4.00 5.00
6.00	0			0		0	6.00
7.00 8.00	0			0		0	7.00 8.00
9.00	0			0		0	9.00
10.00 Total additions (sum of line 4-9)		3, 496, 451			0		10.00
11.00 Subtotal (line 3 plus line 10)		51, 590, 174		~	0	0	11.00
12.00 Deductions (debit adjustments) (specify) 13.00 ROUNDING	0			0 0		0	12.00 13.00
14.00	0			0		0	14.00
15.00	0			0		0	15.00
16.00 17.00	0			0		0	16.00 17.00
18.00 Total deductions (sum of lines 12-17)		о		Ũ	о	0	18.00
19.00 Fund balance at end of period per balance		51, 590, 174			0		19.00
sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
	( 00	7.00	0.00				
1.00 Fund balances at beginning of period	6.00	7.00	8.00	0			1.00
2.00 Net income (loss) (from Wkst. G-3, line 29)				Ũ			2.00
3.00 Total (sum of line 1 and line 2)	0			0			3.00
4.00 Additions (credit adjustments) (specify) 5.00 ADJUSTMENTS TO OPENING BALANCE		0					4.00 5.00
6. 00		0					6.00
7.00		0					7.00
8.00 9.00		0					8.00 9.00
10.00 Total additions (sum of line 4-9)	0	0		0			10.00
11.00 Subtotal (line 3 plus line 10)	0			0			11.00
12.00   Deductions (debit adjustments) (specify) 13.00   ROUNDING		0					12.00 13.00
14.00		0					14.00
15. 00		0					15.00
16.00 17.00		0					16. 00 17. 00
18.00 Total deductions (sum of lines 12-17)	0	0		0			18.00
19.00 Fund balance at end of period per balance	0			0			19. 00
sheet (line 11 minus line 18)		I		I			l

	Financial Systems RAMAPO RIDGE PS MENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der C	CNI 21 4010	Peri od:	eu of Form CMS-: Worksheet G-2	
STATEN	IENT OF PATTENT REVENUES AND OPERATING EAPENSES	Provider C	UN: 31-4019	From 01/01/2024 To 12/31/2024	Parts I & II	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	-
	PART I - PATIENT REVENUES					-
1 00	General Inpatient Routine Services		07.014.4	10	07.014.440	1 1 00
1.00	Hospi tal		27, 211, 1	19	27, 211, 119	
2.00	SUBPROVIDER - IPF					2.00
3.00 4.00	SUBPROVI DER – I RF SUBPROVI DER					4.00
4.00 5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY		42, 823, 8		42, 823, 889	
8.00	NURSING FACILITY		10, 455, 0		10, 455, 062	
9.00	OTHER LONG TERM CARE		8, 549, 1		8, 549, 147	
10.00	Total general inpatient care services (sum of lines 1-9)		89, 039, 2		89, 039, 217	
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT					111.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines		0	0	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16	)	89, 039, 2		89, 039, 217	
18.00	Ancillary services		12, 468, 7			
19.00	Outpatient services			0 (	°	
20.00					0 0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0 0	
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00 25.00	AMBULATORY SURGICAL CENTER (D. P. )					24.00
26.00	HOSPICE					26.00
27.00	OTHER PATIENT REVENUE		3, 158, 3	36 (	3, 158, 336	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	104, 666, 2			
20.00	G-3, line 1)	to more.	104,000,2	0,027,71	111,273,773	20.00
	PART II - OPERATING EXPENSES		1			
29.00	Operating expenses (per Wkst. A, column 3, line 200)			110, 504, 200		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)			(		36.00
37.00	DEDUCT (SPECI FY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.0
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			(		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		110, 504, 200	י	43.00
	to Wkst. G-3, line 4)					1

Heal th	Ith Financial Systems RAMAPO RIDGE PSYCHIATRIC In Lieu			u of Form CMS-2	2552-10	
STATEM	ENT OF REVENUES AND EXPENSES		Provider CCN: 31-4019	Peri od:	Worksheet G-3	
				From 01/01/2024		
				To 12/31/2024	Date/Time Pre 5/7/2025 3:54	
					37772023 3.34	piii
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part	, column 3, line	e 28)		111, 293, 973	1.00
2.00	Less contractual allowances and discounts on	patients' account	ts		18, 667, 599	2.00
3.00	Net patient revenues (line 1 minus line 2)				92, 626, 374	3.00
4.00	Less total operating expenses (from Wkst. G-2,	Part II, line 4	43)		110, 504, 200	4.00
5.00	Net income from service to patients (line 3 mi	nus line 4)			-17, 877, 826	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				1, 839, 803	
7.00	Income from investments				957, 158	
8.00	Revenues from telephone and other miscellaneou	us communication	servi ces		0	
9.00	Revenue from television and radio service				14, 077	
10.00	Purchase di scounts				0	
11.00	Rebates and refunds of expenses				30, 806	
12.00	Parking lot receipts				0	
13.00	Revenue from laundry and linen service				0	13.00
14.00	Revenue from meals sold to employees and gues	ts			30, 542	
15.00	Revenue from rental of living quarters					15.00
16.00	Revenue from sale of medical and surgical supp	olies to other th	nan patients			16.00
17.00	Revenue from sale of drugs to other than pation					17.00
18.00	Revenue from sale of medical records and abstr					18.00
19.00	Tuition (fees, sale of textbooks, uniforms, e	,			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and	d canteen			321, 124	
21.00	Rental of vending machines					21.00
22.00	Rental of hospital space				65, 500	
23.00	Governmental appropriations				0	23.00
24.00	BARBER BEAUTY				167, 643	
24.01	MISCELLANEOUS				9, 665, 547	
24.02	INDEPENDENT LIVING				3, 594, 849	
	COVI D-19 PHE Funding				0	
	Total other income (sum of lines 6-24)				16, 695, 052	
26.00	Total (line 5 plus line 25)				-1, 182, 774	
	OTHER EXPENSES (SPECIFY)				0	
28.00	Total other expenses (sum of line 27 and subset				0	28.00
29.00	Net income (or loss) for the period (line 26 m	minus line 28)		ļ	-1, 182, 774	29.00