|   | SIGNATURE OF CHIEF FINA | NCIAL OFFICER OR ADMINISTRATOR    | CHECKBOX | ELECTRONI C  |   |
|---|-------------------------|-----------------------------------|----------|--|---|
|   |                         | 1                                 | 2        | SI GNATURE STATEMENT   |   |
| 1 | Kev                     | in A. Stagg                       | т        | I have read and agree with the above certification<br>statement. I certify that I intend my electronic<br>signature on this certification be the legally<br>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       | -91, 390    | 25     | 0    | 0         | 1.00   |
| 2.00   | SUBPROVIDER - IPF             | 0       | 0           | 0      |      | 0         | 2.00   |
| 3.00   | SUBPROVIDER - IRF             | 0       | 0           | 0      |      | 0         | 3.00   |
| 5.00   | SWING BED - SNF               | 0       | 0           | 0      |      | 0         | 5.00   |
| 6.00   | SWING BED - NF                | 0       |             |        |      | 0         | 6.00   |
| 7.00   | SKILLED NURSING FACILITY      | 0       | 1           | 0      |      | 0         | 7.00   |
| 8.00   | NURSING FACILITY              | 0       |             |        |      | 0         | 8.00   |
| 200.00 | TOTAL                         | 0       | -91, 389    | 25     | 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.

| SPI  | AL AND HOSPITAL HEALTH CARE COMPLEX I  | DENTIFICATION DATA                                 | Provi c                | ier CCN:      |        | Period:<br>From 01/01/ |      | Part I           | et S-2  |             |
|------|--|--|------------------------|---------------|--------|------------------------|------|------------------|---------|-------------|
|      |  |  |                        |               |        | To 12/31/              | 2023 | Date/Ti          |         |             |
|      | 1.00   | 2.00   |                        | 3.00          |        |                        | 4.00 | 5/20/20          | 024 11: | <u>05 a</u> |
|      | Hospital and Hospital Health Care Co   |  |                        | 0.00          |        |                        |      |                  |         |             |
| 00   | Street: 301 SICOMAC AVENUE   | P0 Box:  |                        |               |        |                        |      |                  |         | 1.          |
| 00   | City: WYCKOFF  | State: NJ  | Zip Cod                |               |        | y: BERGEN              |      |                  | (5      | 2.          |
|      |  | Component Name                                     | CCN<br>Number          | CBSA<br>Numbe |        | Date<br>Certified      |      | nt Syst<br>0, or |         |             |
|      |  |  | Number                 | Numbe         | i iype | Certified              | V 1, |                  |         | 1           |
|      |  | 1.00   | 2.00                   | 3.00          | 4.00   | 5.00                   | 6.00 | 7.00             | 8.00    | 1           |
|      | Hospital and Hospital-Based Componen   |  |                        |               |        |                        |      |                  |         |             |
| 00   | Hospi tal  | RAMAPO RI DGE                                      | 314019                 | 35614         | 4 4    | 01/12/1990             | N    | P                | Т       | 3           |
| 00   | Subprovider - IPF  | PSYCHI ATRI C                                      |                        |               |        |                        |      |                  |         | 4           |
| 00   | Subprovider - IRF  |  |                        |               |        |                        |      |                  |         | 5           |
| 0    | Subprovider - (Other)  |  |                        |               |        |                        |      |                  |         | 6           |
| 0    | Swing Beds - SNF   |  |                        |               |        |                        |      |                  |         | 7           |
| 00   | Swing Beds - NF  |  |                        |               |        |                        |      |                  |         | 8           |
| 00   | Hospital-Based SNF   | HERI TAGE MANOR                                    | 315376                 | 35614         | 4      | 12/01/1997             | N    | P                | 0       | 9           |
| 00   | Hospital-Based NF  |  |                        |               |        |                        |      |                  |         | 10          |
| 00   | Hospital-Based OLTC  |  |                        |               |        |                        |      |                  |         | 11          |
| . 00 | Hospi tal -Based HHA   |  |                        |               |        |                        |      |                  |         | 12          |
|      | Separately Certified ASC   |  |                        |               |        |                        |      |                  |         | 13          |
|      | Hospital-Based Hospice<br>Hospital-Based Health Clinic - RHC                   |  |                        |               |        |                        |      |                  |         | 14          |
|      | Hospital-Based Health Clinic - FQHC  |  |                        |               |        |                        |      |                  |         | 16          |
| 00   | Hospital -Based (CMHC) I   |  |                        |               |        |                        |      |                  |         | 17          |
|      | Renal Dialysis   |  |                        |               |        |                        |      |                  |         | 18          |
| 00   | Other  |  |                        |               |        |                        |      |                  |         | 19          |
|      |  |  |                        |               |        | From:                  |      | To               |         |             |
| 00   | Cost Reporting Period (mm/dd/yyyy)   |  |                        |               |        | 1.00                   | 023  | 2.0              |         | 20          |
|      | Type of Control (see instructions)   |  |                        |               |        | 2                      | 023  | 12/31/           | 2023    | 20          |
| 55   |  |  |                        |               |        |                        |      |                  |         |             |
|      | L  |  |                        |               | 1.00   | 2.00                   |      | 3. (             | 00      |             |
|      | Inpatient PPS Information  |  |                        |               |        |                        |      |                  |         |             |
| . 00 | Does this facility qualify and is it<br>disproportionate share hospital adjust |  |                        |               | N      | N                      |      |                  |         | 22          |
|      | §412.106? In column 1, enter "Y" fo  |  |                        | `             |        |                        |      |                  |         |             |
|      | facility subject to 42 CFR Section §   |  |                        |               |        |                        |      |                  |         |             |
|      | hospital?) In column 2, enter "Y" fo   |  |                        |               |        |                        |      |                  |         |             |
| 01   | Did this hospital receive interim UC   | Ps, including supplemer                            |                        |               | Ν      | N                      |      |                  |         | 22          |
|      | this cost reporting period? Enter in   |  |                        |               |        |                        |      |                  |         |             |
|      | for the portion of the cost reporting  |  |                        |               |        |                        |      |                  |         |             |
|      | 1. Enter in column 2, "Y" for yes or   |  |                        | ie            |        |                        |      |                  |         |             |
|      | cost reporting period occurring on o instructions)                             | i aitei uctuber I. (See                            | 7                      |               |        |                        |      |                  |         |             |
| . 02 | Is this a newly merged hospital that   | requires a final UCP t                             | to be                  |               | Ν      | N                      |      |                  |         | 22          |
|      | determined at cost report settlement   |  |                        | umn           | -      |                        |      |                  |         | _           |
|      | 1, "Y" for yes or "N" for no, for the  | e portion of the cost r                            | reporting              |               |        |                        |      |                  |         |             |
|      | period prior to October 1. Enter in  |  |                        | no,           |        |                        |      |                  |         |             |
| ~~   | for the portion of the cost reporting  | 0 1  |                        |               |        |                        |      |                  |         |             |
| . 03 | Did this hospital receive a geograph<br>rural as a result of the OMB standard  |  |                        |               | N      | N                      |      | N                |         | 22          |
|      | adopted by CMS in FY2015? Enter in c   | 5  |                        |               |        |                        |      |                  |         |             |
|      | for the portion of the cost reporting  |  |                        |               |        |                        |      |                  |         |             |
|      | in column 2, "Y" for yes or "N" for  |  |                        |               |        |                        |      |                  |         |             |
|      | reporting period occurring on or after   | er October 1. (see inst                            | ructions)              |               |        |                        |      |                  |         |             |
|      | Does this hospital contain at least  |  |                        |               |        |                        |      |                  |         |             |
|      | counted in accordance with 42 CFR 41.  | 2.105)? Enter in column                            | 13, "Y" fo             | pr            |        |                        |      |                  |         |             |
| 04   | yes or "N" for no.<br>Did this hospital receive a geograph                     | ic reclassification fro                            | m urhan to             |               |        |                        |      |                  |         | 22          |
| 54   | rural as a result of the revised OMB   |  |                        |               |        |                        |      |                  |         | 22          |
|      | adopted by CMS in FY 2021? Enter in  |  |                        |               |        |                        |      |                  |         |             |
|      | for the portion of the cost reporting  |  |                        |               |        |                        |      |                  |         |             |
|      | in column 2, "Y" for yes or "N" for  | no for the portion of t                            | the cost               |               |        |                        |      |                  |         |             |
|      | reporting period occurring on or aft   |  |                        |               |        |                        |      |                  |         |             |
|      | Does this hospital contain at least  |  |                        |               |        |                        |      |                  |         |             |
|      | counted in accordance with 42 CFR 41.  | 2.105)? Enter in colur                             | nn 3, "Y" f            | or            |        |                        |      |                  |         |             |
|      | yes or "N" for no.<br>Which method is used to determine Me                     | dicaid days on lines 2                             | Land/or 25             | ,             |        | 2 N                    |      |                  |         | 23          |
| 00   | WINCH MELTION IS USED TO DELETING ME   |  |                        |               |        | ∠ N                    |      |                  |         | 23          |
| 00   |  | of admission 2 if cond                             | vis davs o             | or ≺ '        |        |                        |      |                  |         |             |
| 00   | below? In column 1, enter 1 if date  |  |                        |               |        |                        |      |                  |         |             |
| 00   |  | of identifying the days<br>method used in the pric | s in this o<br>or cost |               |        |                        |      |                  |         |             |

| IOSPI T | Financial Systems RAMAPO<br>AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA   | TA RIDGE PSYC   | Provider CC   | N: 31-4019  | Peri od:   | TH LIE               |               | rm CMS-<br>eet S-2        |        |
|---------|---|---|---|---|--|----------------------|---------------|---------------------------|--------|
|         |   |   |   |   |  | /01/2023<br>/31/2023 | Date/1        | ime Pre<br>024 11:        |        |
|         |   | In-State<br>Medicaid<br>paid days                                     | In-State<br>Medicaid<br>eligible<br>unpaid<br>days    | Out-of<br>State<br>Medicaid<br>paid days                  | Out-of<br>State<br>Medi cai d<br>el i gi bl e<br>unpai d |                      | ays Me        | Other<br>di cai d<br>days |        |
| 4.00    | If this provider is an IPPS hospital, enter the   | 1.00  | 2.00  | 3.00  | 4.00   | 5.00                 | 0             | 6.00                      | 24.0   |
| 5. 00   | in-state Medicaid paid days in column 1, in-state<br>Medicaid eligible unpaid days in column 1, in-state<br>Medicaid eligible unpaid days in column 2,<br>out-of-state Medicaid paid days in column 3,<br>out-of-state Medicaid eligible unpaid days in column<br>4, Medicaid HMO paid and eligible but unpaid days in<br>column 5, and other Medicaid days in column 6.<br>If this provider is an IRF, enter the in-state<br>Medicaid paid days in column 1, the in-state<br>Medicaid eligible unpaid days in column 2,<br>out-of-state Medicaid days in column 3, out-of-state<br>Medicaid eligible unpaid days in column 4, Medicaid | 0   |   |   |  | 0                    | 0             |                           | 25. 00 |
|         | HMO paid and eligible but unpaid days in column 4, medicaid<br>HMO paid and eligible but unpaid days in column 5.   |   |   |   |  |                      |               |                           |        |
|         |   |   |   |   |  | /Rural S<br>.00      |               | f Geogr<br>00             |        |
| 6.00    | Enter your standard geographic classification (not wa   |   | at the beg  | inning of t   | he   | 1                    |               |                           | 26.00  |
|         | cost reporting period. Enter "1" for urban or "2" for<br>Enter your standard geographic classification (not we<br>reporting period. Enter in column 1, "1" for urban or<br>enter the effective date of the geographic reclassifi<br>If this is a sole community hospital (SCH), enter the   | age) status<br>~ "2" for r<br>cation in                               | ural. If ap<br>column 2.                              | pl i cabl e,  |  | 1                    |               |                           | 27.00  |
| 5.00    | effect in the cost reporting period.  |   |   |   |  |                      |               |                           | 35.00  |
|         |   |   |   |   |  | nni ng:<br>. 00      |               | i ng:<br>00               | -      |
| 6.00    | Enter applicable beginning and ending dates of SCH st<br>of periods in excess of one and enter subsequent date  |   | cript line  | 36 for numb   | ber  |                      |               |                           | 36.0   |
| 7.00    | If this is a Medicare dependent hospital (MDH), enter   |   | r of period   | ls MDH statu  | ıs   | 0                    |               |                           | 37.0   |
| 7. 01   | is in effect in the cost reporting period.<br>Is this hospital a former MDH that is eligible for th<br>accordance with FY 2016 OPPS final rule? Enter "Y" fo  |   |   |   |  |                      |               |                           | 37.0   |
| 8. 00   | <pre>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.</pre>  |   |   |   |  |                      |               |                           | 38. C  |
|         |   |   |   |   |  | //N<br>. 00          |               | /N<br>00                  | -      |
|         | Does this facility qualify for the inpatient hospital<br>hospitals in accordance with 42 CFR §412.101(b)(2)(i)<br>1 "Y" for yes or "N" for no. Does the facility meet 1<br>accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii<br>or "N" for no. (see instructions)   | ), (İi), or<br>the mileage<br>i)? Enter                               | (iii)? Ent<br>requiremer<br>in column 2               | er in colum<br>nts in<br>? "Y" for ye                     | ime<br>in<br>es  | N                    |               | N                         | 39.0   |
| 0.00    | Is this hospital subject to the HAC program reduction<br>"N" for no in column 1, for discharges prior to Octob<br>no in column 2, for discharges on or after October 1.   | per 1. Ente   | r"Y" for y  |   |  | N                    |               | N                         | 40. C  |
|         |   |   |   |   |  | V<br>1.00            | XVIII<br>2.00 |                           | -      |
| 5.00    | Prospective Payment System (PPS)-Capital<br>Does this facility qualify and receive Capital paymer   | at for disp   | roporti opat  | o sharo in  | accordance   |                      | N             | N                         | 45. C  |
|         | with 42 CFR Section §412.320? (see instructions)<br>Is this facility eligible for additional payment exce<br>pursuant to 42 CFR §412.348(f)? If yes, complete Wkst  | eption for  | extraordi na  | ary circumst  | ances  | N                    | N             | N                         | 46. 0  |
| 7.00    | Pt. III.<br>Is this a new hospital under 42 CFR §412.300(b) PPS of  |   |   |   | 0  | N                    | N             | N                         | 47.0   |
|         | Is the facility electing full federal capital payment   |   |   |   |  | N                    | N             | N                         | 47.0   |
|         | Teaching Hospitals<br>Is this a hospital involved in training residents in<br>periods beginning prior to December 27, 2020, enter "<br>cost reporting periods beginning on or after December<br>the instructions. For column 2, if the response to co<br>involved in training residents in approved GME progra<br>and are you are impacted by CR 11642 (or applicable (   | 'Y' for yes<br>- 27, 2020,<br>olumn 1 is<br>ams in the<br>CRs) MA dir | or "N" for<br>under 42 (<br>"Y", or if<br>prior year  | no in colu<br>CFR 413.78(k<br>this hospit<br>or penultin  | umn 1. For<br>b)(2), see<br>al was<br>nate year,         |                      |               |                           | 56.0   |
| 7.00    | "Y" for yes; otherwise, enter "N" for no in column 2.<br>For cost reporting periods beginning prior to December<br>is this the first cost reporting period during which<br>at this facility? Enter "Y" for yes or "N" for no ir<br>residents start training in the first month of this of<br>"N" for no in column 2. If column 2 is "Y", complete<br>complete Wkst. D, Parts III & IV and D-2, Pt. II, if<br>beginning on or after December 27, 2020, under 42 CFF  | er 27, 2020<br>residents<br>n column 1.<br>cost report<br>e Worksheet | in approved<br>If column<br>ing period?<br>E-4. If co | IGME progra<br>1 is "Y", c<br>P Enter "Y'<br>Diumn 2 is ' | ams traine<br>lid<br>'for yes<br>'N",                    |                      |               |                           | 57.0   |

| IOSPI T.         | AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA  | TA                           | Provider C             | F                  | veriod:<br>rom 01/01/2023<br>o 12/31/2023 | B Date/Time Pre<br>5/20/2024 11:<br>XVIII XIX | pared:                  |
|------------------|--|------------------------------|------------------------|--------------------|---|---|-------------------------|
| 0.00             | Are costs claimed on line 100 of Worksheet A? If yes   | compl                        | ata Wkat D 2           | Pt. I.             | 1. C                                      |   | 59.0                    |
| 9.00             | Are costs channed on the too of worksheet A: Th yes  | <u>s, comp</u>               | ete wist. D-2,         | NAHE 413.85<br>Y/N | Worksheet A<br>Line #                     |   |                         |
|                  |  |                              |                        | 1.00               | 2.00                                      | 3.00  |                         |
|                  | Are you claiming nursing and allied health education<br>any programs that meet the criteria under 42 CFR 413.<br>instructions) Enter "Y" for yes or "N" for no in col<br>is "Y", are you impacted by CR 11642 (or subsequent C<br>adjustment? Enter "Y" for yes or "N" for no in colum   | 85? (s<br>umn 1.<br>CR) NAHE | see<br>If column 1     | N                  |   |   | 60. C                   |
|                  |  | Y/N                          | IME                    | Direct GME         | IME                                       | Direct GME                                    |                         |
|                  |  | 1.00                         | 2.00                   | 3.00               | 4.00                                      | 5.00  |                         |
| o1. 01<br>o1. 02 | Did your hospital receive FTE slots under ACA<br>section 5503? Enter "Y" for yes or "N" for no in<br>column 1. (see instructions)<br>Enter the average number of unweighted primary care<br>FTEs from the hospital's 3 most recent cost reports<br>ending and submitted before March 23, 2010. (see<br>instructions)<br>Enter the current year total unweighted primary care                             | N                            |                        |                    | 0.0                                       | 0.00  | 61. 0<br>61. 0<br>61. 0 |
|                  | FTE count (excluding OB/GYN, general surgery FTEs,<br>and primary care FTEs added under section 5503 of<br>ACA). (see instructions)<br>Enter the base line FTE count for primary care<br>and/or general surgery residents, which is used for<br>determining compliance with the 75% test. (see<br>instructions)  |                              |                        |                    |   |   | 61. (                   |
|                  | Enter the number of unweighted primary care/or<br>surgery allopathic and/or osteopathic FTEs in the<br>current cost reporting period. (see instructions).<br>Enter the difference between the baseline primary   |                              |                        |                    |   |   | 61.0                    |
| 1.06             | and/or general surgery FTEs and the current year's<br>primary care and/or general surgery FTE counts (line<br>61.04 minus line 61.03). (see instructions)<br>Enter the amount of ACA §5503 award that is being<br>used for cap relief and/or FTEs that are nonprimary<br>care or general surgery. (see instructions)   |                              |                        |                    |   |   | 61. (                   |
|                  |  | Pro                          | ogram Name             | Program Code       | Unweighted IM<br>FTE Count                | Direct GME FTE                                | -                       |
|                  |  |                              | 1.00                   | 2.00               | 3.00                                      | Count<br>4.00                                 | -                       |
|                  | Of the FTEs in line 61.05, specify each new program<br>specialty, if any, and the number of FTE residents<br>for each new program. (see instructions) Enter in<br>column 1, the program name. Enter in column 2, the<br>program code. Enter in column 3, the IME FTE<br>unweighted count. Enter in column 4, the direct GME<br>FTE unweighted count.<br>Of the FTEs in line 61.05, specify each expanded |                              |                        |                    | 0. 0                                      | 0 0. 00                                       | 61.1                    |
| 1. 20            | or the FIEs in fine 61.05, specify each expanded<br>program specialty, if any, and the number of FTE<br>residents for each expanded program. (see<br>instructions) Enter in column 1, the program name.<br>Enter in column 2, the program code. Enter in column<br>3, the IME FTE unweighted count. Enter in column 4,<br>the direct GME FTE unweighted count.   |                              |                        |                    | 0.0                                       |   | 01.2                    |
|                  |  |                              |                        |                    |   | 1.00  |                         |
| 2. 00            | ACA Provisions Affecting the Health Resources and Ser<br>Enter the number of FTE residents that your hospital  | trai neo                     |                        |                    | iod for which                             | 0.00  | 62.0                    |
| 2. 01            | your hospital received HRSA PCRE funding (see instruc<br>Enter the number of FTE residents that rotated from a<br>during in this cost reporting period of HRSA THC prog  | a Teachi                     |                        |                    | your hospital                             | 0.00  | 62.0                    |
| 3. 00            | Teaching Hospitals that Claim Residents in Nonprovide<br>Has your facility trained residents in nonprovider se<br>"Y" for yes or "N" for no in column 1. If yes, comple  | er Setti<br>ettings          | ings<br>during this co | ost reporting p    |   | N   | 63. 0                   |

| th Financial Systems<br>PITAL AND HOSPITAL HEALTH CARE COMPLE   |   | RIDGE PSYCHIATRIC   | CCN: 31-4019 P                              | eri od:  | u of Form CMS-<br>Worksheet S-2                     |         |
|---|---|---|---|--|---|---------|
| THE AND HOST THE HEALTH DARE COMPLE   |   |   | F   | rom 01/01/2023<br>o 12/31/2023                 | Part I  | epared: |
|   |   |   | Unwei ghted                                 | Unweighted                                     | Ratio (col. 1/                                      | /       |
|   |   |   | FTEs<br>Nonprovider                         | FTEs in<br>Hospital                            | (col. 1 + col.<br>2))                               |         |
|   |   |   | Si te                                       |  | 2))   |         |
|   |   |   | 1.00  | 2.00   | 3.00  |         |
| Section 5504 of the ACA Base Year   |   |   | -This base year                             | is your cost r                                 | reporting   |         |
| period that begins on or after Ju<br>Denter in column 1, if line 63 is<br>in the base year period, the numb<br>resident FTEs attributable to rot<br>settings. Enter in column 2 the<br>resident FTEs that trained in you  | yes, or your facilit<br>er of unweighted nor<br>ations occurring in<br>number of unweighted | ty trained residents<br>n-primary care<br>all nonprovider<br>d non-primary care |   | 0.00   | 0. 000000   | 64.0    |
| of (column 1 divided by (column 1   | + column 2)). (see  | instructions)   |   |  |   |         |
|   | Program Name  | Program Code  | Unweighted                                  | Unwei ghted                                    | Ratio (col. 3/                                      |         |
|   |   |   | FTEs<br>Nonprovider                         | FTEs in<br>Hospital                            | (col. 3 + col.<br>4))                               |         |
|   |   |   | Si te                                       | nospi tui                                      | .,,,  |         |
|   | 1.00  | 2.00  | 3.00  | 4.00   | 5.00  |         |
| 00 Enter in column 1, if line 63<br>is yes, or your facility<br>trained residents in the base<br>year period, the program name<br>associated with primary care<br>FTEs for each primary care<br>program in which you trained<br>residents. Enter in column 2,<br>the program code. Enter in<br>column 3, the number of<br>unweighted primary care FTE<br>residents attributable to<br>rotations occurring in all<br>non-provider settings. Enter in<br>column 4, the number of<br>unweighted primary care<br>resident FTEs that trained in<br>your hospital. Enter in column<br>5, the ratio of (column 3<br>divided by (column 3 + column<br>4)). (see instructions) |   |   | 0.00<br>Unwei ghted<br>FTEs<br>Nonprovi der | 0 0.00<br>Unwei ghted<br>FTEs i n<br>Hospi tal | 0.000000<br>Ratio (col. 1/<br>(col. 1 + col.<br>2)) |         |
|   |   |   | Si te<br>1.00                               | 2.00   | 3.00  | -       |
| Section 5504 of the ACA Current Y   | ear FTE Residents in  | n Nonprovider Settin  |   |  |   |         |
| beginning on or after July 1, 201<br>0 Enter in column 1 the number of u  | nweighted non-primar  |   | 0.00  | 0.00   | 0. 000000   | 66. C   |
| FTEs attributable to rotations oc<br>Enter in column 2 the number of u<br>FTEs that trained in your hospita<br>(column 1 divided by (column 1 +   | nweighted non-priman<br>L. Enter in column 3  | ry care resident<br>3 the ratio of  |   |  |   |         |
|   | Program Name  | Program Code  | Unwei ghted                                 | Unwei ghted                                    | Ratio (col. 3/                                      |         |
|   |   |   | FTEs  | FTEs in  | $(col \cdot 3 + col \cdot$                          |         |
|   |   |   | Nonprovider<br>Site                         | Hospi tal                                      | 4))   |         |
|   | 1.00  | 2.00  | 3.00  | 4.00   | 5.00  | 1       |
| 00 Enter in column 1, the program   |   |   | 0.00  |  |   | 67.0    |
| name associated with each of<br>your primary care programs in<br>which you trained residents.<br>Enter in column 2, the program<br>code. Enter in column 3, the<br>number of unweighted primary<br>care FTE residents attributable<br>to rotations occurring in all<br>non-provider settings. Enter in<br>column 4, the number of<br>unweighted primary care<br>resident FTEs that trained in<br>your hospital. Enter in column   |   |   |   |  |   |         |

| Heal th | Financial Systems RAMAPO RIDGE PSYCHIATRIC  |  | In   | Lieu | ı of Form   | CMS-2              | 2552-10          |
|---------|---|--|--|------|---|--------------------|------------------|
|         | AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO   | F  | eriod:<br>rom 01/01/2<br>o 12/31/2               | 2023 | Workshee<br>Part I<br>Date/Tim<br>5/20/202        | et S-2<br>Ne Prep  | pared:           |
|         |   | I  |  |      | 1.00  |                    |                  |
| 68.00   | Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49<br>For a cost reporting period beginning prior to October 1, 2022, did you of<br>MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Fina<br>(August 10, 2022)?   | otain permissio                                      | on from you                                      |      |   |                    | 68.00            |
|         |   |  |  | 1.00 | 2.00  | 3.00               |                  |
|         | Inpatient Psychiatric Facility PPS<br>Is this facility an Inpatient Psychiatric Facility (IPF), or does it conta  | ain an IPF subj                                      | provi der?                                       | Y    |   |                    | 70.00            |
| 71.00   | Enter "Y" for yes or "N" for no.<br>If line 70 is yes: Column 1: Did the facility have an approved GME teaching<br>recent cost report filed on or before November 15, 2004? Enter "Y" for ye<br>42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents<br>program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for ye<br>Column 3: If column 2 is Y, indicate which program year began during this<br>(see instructions)<br>Inpatient Rehabilitation Facility PPS | es or "N" for 1<br>in a new teach<br>es or "N" for 1 | וס. (see<br>ni ng<br>ס.                          | N    | N   | 0                  | 71.00            |
| 75.00   | Is this facility an Inpatient Rehabilitation Facility (IRF), or does it c   | ontain an IRF  |  | N    |   |                    | 75.00            |
| 76.00   | subprovider? Enter "Y" for yes and "N" for no.<br>If line 75 is yes: Column 1: Did the facility have an approved GME teachin<br>recent cost reporting period ending on or before November 15, 2004? Enter<br>no. Column 2: Did this facility train residents in a new teaching program<br>CFR 412.424 (d)(1)(ii)(D)? Enter "Y" for yes or "N" for no. Column 3: If<br>indicate which program year began during this cost reporting period. (see   | "Y" for yes of<br>in accordance<br>column 2 is Y,    | "N" for<br>with 42                               |      |   | 0                  | 76.00            |
|         |   |  |  | _    | 1.00  | )                  |                  |
| 80.00   | Long Term Care Hospital PPS<br>Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for y  | 20   |  |      | N   |                    | 80.00            |
| 81.00   | Is this a LTCH co-located within another hospital for part or all of the "<br>"Y" for yes and "N" for no.<br>TEFRA Providers  |  | period? En                                       | iter | N   |                    | 81.00            |
| 86.00   | Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter<br>Did this facility establish a new Other subprovider (excluded unit) under<br>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.  |  |  | no.  | Ν   |                    | 85. 00<br>86. 00 |
|         | Is this hospital an extended neoplastic disease care hospital classified (1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.   | under section  |  |      | Ν   |                    | 87.00            |
|         |   |  | Approved<br>Permane<br>Adjustme<br>(Y/N)<br>1.00 | nt   | Number<br>Approv<br>Permane<br>Adjustme<br>2.00   | ved<br>ent<br>ents |                  |
|         | Column 1: Is this hospital approved for a permanent adjustment to the TEF<br>amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete c<br>89. (see instructions)  |  | N  |      | 2.00  |                    | 88.00            |
|         | Column 2: Enter the number of approved permanent adjustments.   | Wkst. A Line<br>No.                                  | Effecti ve                                       | Date | Approv<br>Permane<br>Adjustm<br>Amount<br>Dischal | ent<br>nent<br>Per |                  |
| 00.00   | Column 4. If Line 00, column 4 is V, onton the Werkeheet A Line number  | 1.00   | 2.00   |      | 3.00  |                    | 00.00            |
|         | Column 1: If line 88, column 1 is Y, enter the Worksheet A line number<br>on which the per discharge permanent adjustment approval was based.<br>Column 2: Enter the effective date (i.e., the cost reporting period<br>beginning date) for the permanent adjustment to the TEFRA target amount<br>per discharge.   | 0.00   | ,  |      |   | U                  | 89.00            |
|         | Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.   |  |  |      |   |                    |                  |
|         |   |  | V<br>1.00  |      | XI X<br>2. 00                                     |                    |                  |
|         | Title V and XIX Services<br>Does this facility have title V and/or XIX inpatient hospital services? E   | nter "Y" for   | N  |      | N   |                    | 90.00            |
|         | yes or "N" for no in the applicable column.<br>Is this hospital reimbursed for title V and/or XIX through the cost repor  | t either in  | N  |      | Y   |                    | 91.00            |
| 92.00   | full or in part? Enter "Y" for yes or "N" for no in the applicable column<br>Are title XIX NF patients occupying title XVIII SNF beds (dual certificat<br>instructions) Enter "Y" for yes or "N" for no in the applicable column.   |  |  |      | Ŷ   |                    | 92.00            |
|         | Does this facility operate an ICF/IID facility for purposes of title V and<br>"Y" for yes or "N" for no in the applicable column.   | d XIX? Enter   | Ν  |      | Ν   |                    | 93.00            |
| 94.00   | Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for n<br>applicable column.   | o in the   | N  |      | Y   |                    | 94.00            |
| 96.00   | If line 94 is "Y", enter the reduction percentage in the applicable column<br>Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for n<br>applicable column.   |  | 0. 00<br>N                                       |      | 10. 00<br>Y                                       | 0                  | 95. 00<br>96. 00 |
|         | If line 96 is "Y", enter the reduction percentage in the applicable colum   | ٦.   | 0.00   |      | 5.80  | )                  | 97.00            |

|                                      | AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  | Provider C  |  | Period:<br>From 01/01/2023                                    | Worksheet S<br>Part I          | -2  |
|--------------------------------------|--|---|--|---|--------------------------------|---|
|                                      |  |   |  | To 12/31/2023   | Date/Time P                    |   |
|                                      |  |   |  | V   | 5/20/2024 1<br>XI X            | <u>1:05 ar</u>                                |
|                                      |  |   |  | 1.00  | 2.00                           |   |
| 8. 00                                | Does title V or XIX follow Medicare (title XVIII) for the ir<br>stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f<br>column 1 for title V, and in column 2 for title XIX.   |   |  | N   | Y                              | 98.   |
| 8. 01                                | Does title V or XIX follow Medicare (title XVIII) for the re<br>C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti<br>title XIX.   |   |  | . N   | Y                              | 98.   |
| 8. 02                                | Does title V or XIX follow Medicare (title XVIII) for the ca<br>bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes c<br>for title V, and in column 2 for title XIX.  |   |  | Ν   | Y                              | 98.   |
| 8. 03                                | Does title V or XIX follow Medicare (title XVIII) for a crit<br>reimbursed 101% of inpatient services cost? Enter "Y" for ye<br>for title V, and in column 2 for title XIX.  |   |  |   | N                              | 98.   |
| 8. 04                                | Does title V or XIX follow Medicare (title XVIII) for a CAH<br>outpatient services cost? Enter "Y" for yes or "N" for no ir<br>in column 2 for title XIX.  |   |  | Ν   | N                              | 98.   |
| 8. 05                                | Does title V or XIX follow Medicare (title XVIII) and add ba<br>Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c<br>column 2 for title XIX.  |   |  |   | Y                              | 98.   |
| 8. 06                                | Does title V or XIX follow Medicare (title XVIII) when cost<br>Pts. I through IV? Enter "Y" for yes or "N" for no in columr<br>column 2 for title XIX.   |   |  | Ν   | Y                              | 98.   |
|                                      | Rural Providers  |   |  |   |                                |   |
|                                      | Does this hospital qualify as a CAH?<br>If this facility qualifies as a CAH, has it elected the all-<br>for outpatient services? (see instructions)  | inclusive met   | hod of paymen  | t   |                                | 105.<br>106.                                  |
| 07.00                                | Column 1: If line 105 is Y, is this facility eligible for co<br>training programs? Enter "Y" for yes or "N" for no in column<br>Column 2: If column 1 is Y and line 70 or line 75 is Y, do<br>approved medical education program in the CAH's excluded IF  | n 1. (see ins<br>you train I&R  | tructions)<br>s in an  |   |                                | 107   |
| 07.01                                | Enter "Y" for yes or "N" for no in column 2. (see instructi<br>If this facility is a REH (line 3, column 4, is "12"), is it<br>reimbursement for I&R training programs? Enter "Y" for yes c  | ons)<br>eligible for  | cost   |   |                                | 107   |
| 08. 00                               | instructions)<br>Is this a rural hospital qualifying for an exception to the<br>CFR Section §412.113(c). Enter "Y" for yes or "N" for no.  | CRNA fee sche   | dul e? See 42  | Ν   |                                | 108   |
|                                      |  |   |  |   |                                |   |
|                                      |  | Physi cal   | Occupationa  |   | Respiratory                    |   |
| 09.00                                | If this hospital qualifies as a CAH or a cost provider, are<br>therapy services provided by outside supplier? Enter "Y"<br>for ves or "N" for no for each therapy.   | Physical<br>1.00<br>N   | Occupationa<br>2.00<br>N   | I Speech<br>3.00<br>N   | 4.00<br>N                      |   |
| 09.00                                |  | 1.00  | 2.00   | 3.00  | 4.00<br>N                      |   |
|                                      | therapy services provided by outside supplier? Enter "Y"   | 1.00<br>N<br>al Demonstrati<br>Y" for yes or  | 2.00<br>N<br>on project (§:<br>"N" for no.   | 3.00<br>N<br>410A<br>If yes,                                  | 4.00                           | 109.  |
|                                      | therapy services provided by outside supplier? Enter "Y"<br>for yes or "N" for no for each therapy.<br>Did this hospital participate in the Rural Community Hospita<br>Demonstration)for the current cost reporting period? Enter "<br>complete Worksheet E, Part A, lines 200 through 218, and Wor  | 1.00<br>N<br>al Demonstrati<br>Y" for yes or  | 2.00<br>N<br>on project (§:<br>"N" for no.   | 3.00<br>N<br>410A<br>If yes,<br>ugh 215, as                   | 4.00<br>N<br>1.00<br>N         | 109.  |
| 10.00                                | therapy services provided by outside supplier? Enter "Y"<br>for yes or "N" for no for each therapy.<br>Did this hospital participate in the Rural Community Hospita<br>Demonstration) for the current cost reporting period? Enter "<br>complete Worksheet E, Part A, lines 200 through 218, and Wor<br>applicable.<br>If this facility qualifies as a CAH, did it participate in t<br>Health Integration Project (FCHIP) demonstration for this co<br>"Y" for yes or "N" for no in column 1. If the response to co<br>integration prong of the FCHIP demo in which this CAH is par<br>Enter all that apply: "A" for Ambulance services; "B" for ac  | 1.00<br>N<br>N<br>I Demonstrati<br>Y" for yes or<br>ksheet E-2, I<br>che Frontier C<br>ost reporting<br>Jumn 1 is Y,<br>ticipating in   | 2.00<br>N<br>on project (§<br>"N" for no.<br>i nes 200 throu<br>ommuni ty<br>peri od? Enter<br>enter the<br>col umn 2.                               | 3.00<br>N<br>410A<br>If yes,<br>ugh 215, as<br>1.00<br>N      | 4.00<br>N<br>1.00              | 109.<br>110.<br>1110.                         |
| 10.00                                | therapy services provided by outside supplier? Enter "Y"<br>for yes or "N" for no for each therapy.<br>Did this hospital participate in the Rural Community Hospita<br>Demonstration) for the current cost reporting period? Enter "<br>complete Worksheet E, Part A, lines 200 through 218, and Wor<br>applicable.<br>If this facility qualifies as a CAH, did it participate in t<br>Health Integration Project (FCHIP) demonstration for this co<br>"Y" for yes or "N" for no in column 1. If the response to co<br>integration prong of the FCHIP demo in which this CAH is par  | 1.00<br>N<br>N<br>I Demonstrati<br>Y" for yes or<br>ksheet E-2, I<br>che Frontier C<br>ost reporting<br>Jumn 1 is Y,<br>ticipating in   | 2.00<br>N<br>on project (§<br>"N" for no.<br>i nes 200 throu<br>ommuni ty<br>peri od? Enter<br>enter the<br>col umn 2.<br>; and/or "C"               | 3.00<br>N<br>N<br>410A<br>If yes,<br>ugh 215, as<br>1.00<br>N | 4.00<br>N<br>1.00<br>N<br>2.00 | 109.  |
| 0.00                                 | therapy services provided by outside supplier? Enter "Y"<br>for yes or "N" for no for each therapy.<br>Did this hospital participate in the Rural Community Hospita<br>Demonstration)for the current cost reporting period? Enter "<br>complete Worksheet E, Part A, lines 200 through 218, and Wor<br>applicable.<br>If this facility qualifies as a CAH, did it participate in t<br>Health Integration Project (FCHIP) demonstration for this co<br>"Y" for yes or "N" for no in column 1. If the response to co<br>integration prong of the FCHIP demo in which this CAH is par<br>Enter all that apply: "A" for Ambulance services; "B" for ac<br>for tele-health services.  | 1.00<br>N<br>N<br>Tor yes or<br>ksheet E-2, I<br>che Frontier C<br>ost reporting<br>Jumn 1 is Y,<br>ticipating in<br>Iditional beds   | 2.00<br>N<br>on project (§<br>"N" for no.<br>i nes 200 throu<br>ommuni ty<br>peri od? Enter<br>enter the<br>col umn 2.<br>; and/or "C"<br>1.00       | 3.00<br>N<br>410A<br>If yes,<br>ugh 215, as<br>1.00<br>N      | 4.00<br>N<br>1.00<br>N         | 109.  |
| 0.00                                 | therapy services provided by outside supplier? Enter "Y"<br>for yes or "N" for no for each therapy.<br>Did this hospital participate in the Rural Community Hospita<br>Demonstration) for the current cost reporting period? Enter "<br>complete Worksheet E, Part A, lines 200 through 218, and Wor<br>applicable.<br>If this facility qualifies as a CAH, did it participate in t<br>Health Integration Project (FCHIP) demonstration for this co<br>"Y" for yes or "N" for no in column 1. If the response to co<br>integration prong of the FCHIP demo in which this CAH is par<br>Enter all that apply: "A" for Ambulance services; "B" for ac<br>for tele-health services.<br>Did this hospital participate in the Pennsylvania Rural Heal<br>(PARHM) demonstration for any portion of the current cost re<br>period? Enter "Y" for yes or "N" for no in column 1. If co<br>"Y", enter in column 2, the date the hospital began particip<br>demonstration. In column 3, enter the date the hospital cea  | 1.00<br>N<br>N<br>Al Demonstrati<br>Y" for yes or<br>ksheet E-2, I<br>che Frontier C<br>st reporting<br>olumn 1 is Y,<br>cticipating in<br>Iditional beds<br>th Model<br>eporting<br>olumn 1 is<br>pating in the  | 2.00<br>N<br>on project (§<br>"N" for no.<br>i nes 200 throu<br>ommuni ty<br>peri od? Enter<br>enter the<br>col umn 2.<br>; and/or "C"               | 3.00<br>N<br>N<br>410A<br>If yes,<br>ugh 215, as<br>1.00<br>N | 4.00<br>N<br>1.00<br>N<br>2.00 | 109   |
| 10. 00                               | therapy services provided by outside supplier? Enter "Y"<br>for yes or "N" for no for each therapy.<br>Did this hospital participate in the Rural Community Hospita<br>Demonstration) for the current cost reporting period? Enter "<br>complete Worksheet E, Part A, lines 200 through 218, and Wor<br>applicable.<br>If this facility qualifies as a CAH, did it participate in t<br>Health Integration Project (FCHIP) demonstration for this co<br>"Y" for yes or "N" for no in column 1. If the response to co<br>integration prong of the FCHIP demo in which this CAH is par<br>Enter all that apply: "A" for Ambulance services; "B" for ac<br>for tele-health services.<br>Did this hospital participate in the Pennsylvania Rural Heal<br>(PARHM) demonstration for any portion of the current cost re<br>period? Enter "Y" for yes or "N" for no in column 1. If column 2, the date the hospital began particip<br>demonstration. In column 3, enter the date the hospital cea<br>participation in the demonstration, if applicable.  | 1.00<br>N<br>N<br>Al Demonstrati<br>Y" for yes or<br>ksheet E-2, I<br>che Frontier C<br>st reporting<br>olumn 1 is Y,<br>cticipating in<br>Iditional beds<br>th Model<br>eporting<br>olumn 1 is<br>pating in the  | 2.00<br>N<br>on project (§<br>"N" for no.<br>i nes 200 throu<br>ommuni ty<br>peri od? Enter<br>enter the<br>col umn 2.<br>; and/or "C"<br>1.00       | 3.00<br>N<br>N<br>410A<br>If yes,<br>ugh 215, as<br>1.00<br>N | 4.00<br>N<br>1.00<br>N<br>2.00 | 109.  |
| 10.00                                | <pre>therapy services provided by outside supplier? Enter "Y"<br/>for yes or "N" for no for each therapy.<br/>Did this hospital participate in the Rural Community Hospita<br/>Demonstration) for the current cost reporting period? Enter "<br/>complete Worksheet E, Part A, lines 200 through 218, and Wor<br/>applicable.<br/>If this facility qualifies as a CAH, did it participate in t<br/>Health Integration Project (FCHIP) demonstration for this co<br/>"Y" for yes or "N" for no in column 1. If the response to co<br/>integration prong of the FCHIP demo in which this CAH is par<br/>Enter all that apply: "A" for Ambulance services; "B" for ac<br/>for tele-health services.<br/>Did this hospital participate in the Pennsylvania Rural Heal<br/>(PARHM) demonstration for any portion of the current cost re<br/>period? Enter "Y" for yes or "N" for no in column 1. If co<br/>"Y", enter in column 2, the date the hospital began particip<br/>demonstration. In column 3, enter the date the hospital cee<br/>participation in the demonstration, if applicable.<br/>Miscel laneous Cost Reporting Information<br/>Is this an all-inclusive rate provider? Enter "Y" for yes or<br/>in column 1. If column 1 is yes, enter the method used (A, E<br/>in column 2. If column 2 is "E", enter in column 3 either "S<br/>for short term hospital or "98" percent for long term care (A)<br/>Did term for a service of the for long term care (A)<br/>Did this an all-inclusive or "98" percent for long term care (A)<br/>Did this an all or "98" percent for long term care (A)<br/>Did this term hospital or "98" percent for long term care (A)<br/>Did the period care the term column 2 term care (A)<br/>Did this an all or column 2 term care (A)<br/>Did this an all or column 2 term care (A)<br/>Did this an all or column 2 term care (A)<br/>Did this an all or column 2 term care (A)<br/>Did /pre> | 1.00<br>N<br>N<br>Al Demonstrati<br>Y" for yes or<br>ksheet E-2, I<br>che Frontier C<br>ost reporting<br>olumn 1 is Y,<br>ticipating in<br>Iditional beds<br>th Model<br>eporting<br>olumn 1 is<br>vating in the<br>ased<br>"N" for no<br>8, or E only)<br>V3" percent<br>(includes                               | 2.00<br>N<br>on project (§<br>"N" for no.<br>i nes 200 throu<br>ommuni ty<br>peri od? Enter<br>enter the<br>col umn 2.<br>; and/or "C"<br>1.00       | 3.00<br>N<br>N<br>410A<br>If yes,<br>ugh 215, as<br>1.00<br>N | 4.00<br>N<br>1.00<br>N<br>2.00 | 109.<br>110.<br>1110.<br>1111.<br>1112.       |
| 10. 00<br>11. 00<br>12. 00           | therapy services provided by outside supplier? Enter "Y"<br>for yes or "N" for no for each therapy.<br>Did this hospital participate in the Rural Community Hospita<br>Demonstration) for the current cost reporting period? Enter "<br>complete Worksheet E, Part A, lines 200 through 218, and Wor<br>applicable.<br>If this facility qualifies as a CAH, did it participate in t<br>Health Integration Project (FCHIP) demonstration for this co<br>"Y" for yes or "N" for no in column 1. If the response to co<br>integration prong of the FCHIP demo in which this CAH is par<br>Enter all that apply: "A" for Ambulance services; "B" for ac<br>for tele-health services.<br>Did this hospital participate in the Pennsylvania Rural Heal<br>(PARHM) demonstration for any portion of the current cost re<br>period? Enter "Y" for yes or "N" for no in column 1. If co<br>"Y", enter in column 2, the date the hospital began particip<br>demonstration. In column 3, enter the date the hospital cea<br>participation in the demonstration, if applicable.<br>Miscel aneous Cost Reporting Information<br>Is this an all-inclusive rate provider? Enter "Y" for yes or<br>in column 1. If column 1 is yes, enter the method used (A, E<br>in column 2. If column 2 is "E", enter in column 3 either "S<br>for short term hospital or "98" percent for long term care (<br>psychiatric, rehabilitation and long term hospitals provider<br>the definition in CMS Pub. 15-1, chapter 22, §2208.1.<br>Is this facility classified as a referral center? Enter "Y"  | 1.00<br>N<br>N<br>I Demonstrati<br>Y" for yes or<br>ksheet E-2, I<br>che Frontier C<br>st reporting<br>olumn 1 is Y,<br>ticipating in<br>dditional beds<br>th Model<br>porting<br>olumn 1 is<br>pating in the<br>ased<br>"N" for no<br>3, or E only)<br>23" percent<br>(includes<br>"s) based on                  | 2.00<br>N<br>on project (§-<br>"N" for no.<br>i nes 200 throu<br>ommuni ty<br>peri od? Enter<br>enter the<br>col umn 2.<br>; and/or "C"<br>1.00<br>N | 3.00<br>N<br>N<br>410A<br>If yes,<br>ugh 215, as<br>1.00<br>N | 4.00<br>N<br>1.00<br>N<br>2.00 | 109.<br>110.<br>111.<br>111.<br>111.<br>0115. |
| 10. 00<br>11. 00<br>12. 00<br>15. 00 | therapy services provided by outside supplier? Enter "Y"<br>for yes or "N" for no for each therapy.<br>Did this hospital participate in the Rural Community Hospita<br>Demonstration) for the current cost reporting period? Enter "<br>complete Worksheet E, Part A, lines 200 through 218, and Wor<br>applicable.<br>If this facility qualifies as a CAH, did it participate in t<br>Health Integration Project (FCHIP) demonstration for this co<br>"Y" for yes or "N" for no in column 1. If the response to co<br>integration prong of the FCHIP demo in which this CAH is par<br>Enter all that apply: "A" for Ambulance services; "B" for ac<br>for tele-health services.<br>Did this hospital participate in the Pennsylvania Rural Heal<br>(PARHM) demonstration for any portion of the current cost re<br>period? Enter "Y" for yes or "N" for no in column 1. If co<br>"Y", enter in column 2, the date the hospital began particip<br>demonstration. In column 3, enter the date the hospital cea<br>participation in the demonstration, if applicable.<br>Miscellaneous Cost Reporting Information<br>Is this an all-inclusive rate provider? Enter "Y" for yes or<br>in column 1. If column 1 is yes, enter the method used (A, E<br>in column 2. If column 2 is "E", enter in column 3 either "9<br>for short term hospital or "98" percent for long term care (<br>psychiatric, rehabilitation and long term hospitals provider<br>the definition in CMS Pub. 15-1, chapter 22, §2208.1.   | 1.00<br>N<br>N<br>Al Demonstrati<br>Y" for yes or<br>ksheet E-2, I<br>che Frontier C<br>st reporting<br>olumn 1 is Y,<br>ticipating in<br>Iditional beds<br>th Model<br>eporting<br>olumn 1 is<br>pating in the<br>ased<br>S "N" for no<br>8, or E only)<br>23" percent<br>includes<br>(s) based on<br>for yes or | 2.00<br>N<br>on project (§<br>"N" for no.<br>i nes 200 throu<br>ommuni ty<br>peri od? Enter<br>enter the<br>col umn 2.<br>; and/or "C"<br>1.00<br>N  | 3.00<br>N<br>N<br>410A<br>If yes,<br>ugh 215, as<br>1.00<br>N | 4.00<br>N<br>1.00<br>N<br>2.00 | 109.  |

| Ith Financial Systems RAMAPO RIDGE PSYCHIATRIC SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO                                       | CN: 31-4019 P    | eri od:                        | u of Form CM<br>Worksheet S |         |
|--|------------------|--------------------------------|-----------------------------|---------|
|  | F                | rom 01/01/2023<br>0 12/31/2023 |                             | roporod |
|  |                  |                                | Date/Time P<br>5/20/2024 1  |         |
|  | Premi ums        | Losses                         | Insurance                   |         |
|  |                  |                                |                             |         |
|  | 1.00             | 2.00                           | 3.00                        | _       |
| 3.01 List amounts of malpractice premiums and paid losses:   | 0                |                                |                             | 0118.   |
|  |                  | 1.00                           | 2.00                        | _       |
| 3.02 Are malpractice premiums and paid losses reported in a cost center other  | than the         | N                              |                             | 118.    |
| Administrative and General? If yes, submit supporting schedule listing co<br>and amounts contained therein.  | ost centers      |                                |                             |         |
| 9. OODO NOT USE THIS LINE  |                  |                                |                             | 119.    |
| 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro<br>\$3121 and applicable amendments? (see instructions) Enter in column 1, "Y |                  | N                              | N                           | 120.    |
| "N" for no. Is this a rural hospital with < 100 beds that qualifies for the  | he Outpatient    |                                |                             |         |
| Hold Harmless provision in ACA §3121 and applicable amendments? (see inst<br>Enter in column 2, "Y" for yes or "N" for no.                                   | ructions)        |                                |                             |         |
| 1.00 Did this facility incur and report costs for high cost implantable device:  | s charged to     | N                              |                             | 121.    |
| patients? Enter "Y" for yes or "N" for no.<br>2.00Does the cost report contain healthcare related taxes as defined in §1903                                  | (w)(3) of the    | N                              |                             | 122.    |
| Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter   |                  |                                |                             |         |
| the Worksheet A line number where these taxes are included.<br>3.00Did the facility and/or its subproviders (if applicable) purchase profess                 | i onal           | N                              |                             | 123.    |
| services, e.g., legal, accounting, tax preparation, bookkeeping, payroll,  | and/or           |                                |                             | 1201    |
| management/consulting services, from an unrelated organization? In column for yes or "N" for no.   | 1, enter "Y"     |                                |                             |         |
| If column 1 is "Y", were the majority of the expenses, i.e., greater than  | 50% of total     |                                |                             |         |
| professional services expenses, for services purchased from unrelated org  |                  |                                |                             |         |
| located in a CBSA outside of the main hospital CBSA? In column 2, enter "'<br>"N" for no.  | r for yes or     |                                |                             |         |
| Certified Transplant Center Information  |                  |                                |                             |         |
| 5.00 Does this facility operate a Medicare-certified transplant center? Enter<br>and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.     | "Y" for yes      | N                              |                             | 125.    |
| 5.00 If this is a Medicare-certified kidney transplant program, enter the cert   | ification date   |                                |                             | 126.    |
| in column 1 and termination date, if applicable, in column 2.<br>7.00 If this is a Medicare-certified heart transplant program, enter the certi              | fication date    |                                |                             | 127.    |
| in column 1 and termination date, if applicable, in column 2.  |                  |                                |                             |         |
| 3.00 If this is a Medicare-certified liver transplant program, enter the certiin column 1 and termination date, if applicable, in column 2.                  | rication date    |                                |                             | 128.    |
| 9.00 If this is a Medicare-certified lung transplant program, enter the certif   | ication date     |                                |                             | 129.    |
| in column 1 and termination date, if applicable, in column 2.<br>D. OO If this is a Medicare-certified pancreas transplant program, enter the ce             | rtification      |                                |                             | 130.    |
| date in column 1 and termination date, if applicable, in column 2.   |                  |                                |                             |         |
| 1.00 If this is a Medicare-certified intestinal transplant program, enter the<br>date in column 1 and termination date, if applicable, in column 2.          | certi fi cati on |                                |                             | 131.    |
| 2. 00 f this is a Medicare-certified islet transplant program, enter the certi   | fication date    |                                |                             | 132.    |
| in column 1 and termination date, if applicable, in column 2.<br>3.00Removed and reserved  |                  |                                |                             | 133.    |
| 4.00 If this is a hospital-based organ procurement organization (OPO), enter th  | he OPO number    |                                |                             | 133.    |
| in column 1 and termination date, if applicable, in column 2.  |                  |                                |                             | _       |
| All Providers<br>D. 00Are there any related organization or home office costs as defined in CMS  | Pub. 15-1.       | N                              |                             | 140.    |
| chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home  | office costs     |                                |                             |         |
| are claimed, enter in column 2 the home office chain number. (see instruction 1.00 2.00  | tions)           | 3.00                           |                             |         |
| If this facility is part of a chain organization, enter on lines 141 thro  |                  |                                | of the                      |         |
| home office and enter the home office contractor name and contractor numb<br>1.00Name: Contractor's Name:  | contractor       | 's Number:                     |                             | 141.    |
| 2. 00 Street: PO Box:  |                  |                                |                             | 142.    |
| 3. 00 Ci ty:  State:   | Zip Code:        |                                |                             | 143.    |
|  |                  |                                | 1.00                        |         |
| 4.00 Are provider based physicians' costs included in Worksheet A?   |                  |                                | Y                           | 144.    |
|  |                  | 1.00                           | 2.00                        | -       |
| 5.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs  |                  |                                |                             | 145.    |
| inpatient services only? Enter "Y" for yes or "N" for no in column 1. If no, does the dialysis facility include Medicare utilization for this cost           |                  |                                |                             |         |
| period? Enter "Y" for yes or "N" for no in column 2.   |                  |                                |                             |         |
| 5.00Has the cost allocation methodology changed from the previously filed cos  |                  | N                              |                             | 146.    |
| Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter   | 10 81020) IF     |                                |                             |         |

| HOSPITAL AND HOSPITAL HEALTH CARE COMPLE  | X IDENTIFICATION DATA                              | Provider C        | CN: 31-4019 |                   | 1/01/2023<br>2/31/2023 |            | epared:  |
|---|--|-------------------|-------------|-------------------|------------------------|------------|----------|
|   |  |                   |             |                   |                        | 1.00       | -        |
| 47.00 Was there a change in the statisti  | cal basis? Enter "Y" fo                            | or yes or "N" for | no.         |                   |                        | N          | 147.00   |
| 48.00 Was there a change in the order of  |  |                   |             |                   |                        | N          | 148. 0   |
| 49.00 Was there a change to the simplifi  | ed cost finding method?                            | 2                 |             |                   |                        | N          | 149.0    |
|   |  | Part A            | Part E      | 3 T               | itle V                 | Title XIX  | _        |
|   |  | 1.00              | 2.00        |                   | 3.00                   | 4.00       | _        |
| Does this facility contain a provi<br>or charges? Enter "Y" for yes or '  |  |                   |             |                   |                        |            |          |
| 55. 00 Hospi tal  |  |                   |             | <u>. (366 4</u> 2 | N                      | N          | 155.0    |
| 56.00 Subprovider - IPF   |  | N                 | N N         |                   | N                      | N          | 156.0    |
| 57.00 Subprovi der – I RF   |  | N                 | N           |                   | N                      | N          | 157. C   |
| 58. 00 SUBPROVI DER   |  |                   |             |                   |                        |            | 158. C   |
| 59. 00 SNF  |  | N                 | N           |                   | N                      | N          | 159. C   |
| 60.00 HOME HEALTH AGENCY  |  | N                 | N           |                   | Ν                      | N          | 160. C   |
| 61.00 CMHC  |  |                   | N           |                   | N                      | N          | 161. C   |
|   |  |                   |             |                   |                        | 1.00       | -        |
| Multicampus   |  |                   |             |                   |                        |            |          |
| 55.00 Is this hospital part of a Multica<br>Enter "Y" for yes or "N" for no.  | mpus hospital that has                             | one or more camp  | uses in dif | ferent CE         | ISAs?                  | N          | 165. 0   |
|   | Name   | County            |             | Zip Code          | CBSA                   | FTE/Campus |          |
|   | 0  | 1.00              | 2.00        | 3.00              | 4.00                   | 5.00       | 0 166. 0 |
| 66.00 If line 165 is yes, for each<br>campus enter the name in column<br>0, county in column 1, state in<br>column 2, zip code in column 3,<br>CBSA in column 4, FTE/Campus in<br>column 5 (see instructions) |  |                   |             |                   |                        | 0.0        |          |
|   |  |                   |             |                   |                        | 1.00       |          |
| Health Information Technology (HI   |  |                   |             |                   |                        | T          |          |
| 67.00 Is this provider a meaningful user<br>68.00 If this provider is a CAH (line 10  | 5 is "Y") and is a mean                            | ningful user (lin |             |                   | the                    | N          | 167. C   |
| reasonable cost incurred for the H  |  | ,                 |             |                   |                        |            |          |
| 68.01 If this provider is a CAH and is r  |  |                   |             |                   | lshi p                 |            | 168. C   |
| exception under §413.70(a)(6)(ii)?<br>69.00 If this provider is a meaningful u<br>transition factor. (see instructio  | ser (line 167 is "Y") a                            |                   |             |                   | enter the              | 0.0        | 00169. 0 |
|   | (13)   |                   |             | Be                | gi nni ng              | Endi ng    |          |
|   |  |                   |             |                   | 1.00                   | 2.00       | -        |
| 70.00 Enter in columns 1 and 2 the EHR b<br>period respectively (mm/dd/yyyy)  | eginning date and endin                            | ng date for the r | eporti ng   |                   |                        |            | 170. C   |
|   |  |                   |             |                   | 1 00                   | 2.00       | _        |
| 71.00 If line 167 is "Y", does this prov  | ider have any days for                             | individuals onco  | lledin      |                   | 1.00<br>N              | 2.00       | 0171.0   |
| section 1876 Medicare cost plans r<br>"Y" for yes and "N" for no in colu<br>1876 Medicare days in column 2. (s  | eported on Wkst. S-3, P<br>mn 1. If column 1 is ye | rt. I, line 2, co | I. 6? Enter |                   | IN I                   |            |          |

| SPI T.       | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE   | Provider C                                  |                | Period:<br>From 01/01/2023<br>To 12/31/2023 | Date/Time Pr         | epared   |
|--------------|---|---|----------------|---|----------------------|----------|
|              |   |   |                | Y/N   | 5/20/2024 11<br>Date | :05 ar   |
|              |   |   |                | 1.00  | 2.00                 | -        |
|              | PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE   |   |                |   |                      |          |
|              | General Instruction: Enter Y for all YES responses. Enter N<br>mm/dd/yyyy format.   | lfor all NO r€                              | esponses. Ente | r all dates in <sup>-</sup>                 | the                  |          |
|              | COMPLETED BY ALL HOSPITALS Provider Organization and Operation  |   |                |   |                      | _        |
| 00           | Has the provider changed ownership immediately prior to the   | e beginning of                              | the cost       | N   |                      | 1.       |
|              | reporting period? If yes, enter the date of the change in o   |   |                |   |                      |          |
|              |   | · · · ·                                     | Y/N            | Date  | V/I                  |          |
|              |   |   | 1.00           | 2.00  | 3.00                 |          |
| 00           | Has the provider terminated participation in the Medicare F<br>yes, enter in column 2 the date of termination and in colum<br>voluntary or "I" for involuntary.   |   | N              |   |                      | 2.       |
| 00           | Is the provider involved in business transactions, includir<br>contracts, with individuals or entities (e.g., chain home of<br>or medical supply companies) that are related to the provid<br>officers, medical staff, management personnel, or members of<br>of directors through ownership, control, or family and other<br>relationships? (see instructions) | offices, drug<br>der or its<br>of the board | N              |   |                      | 3.       |
|              |   |   | Y/N            | Туре  | Date                 |          |
|              |   |   | 1.00           | 2.00  | 3.00                 |          |
|              | Financial Data and Reports  |   |                |   | 1                    |          |
| 00           | Column 1: Were the financial statements prepared by a Cert<br>Accountant? Column 2: If yes, enter "A" for Audited, "C" f<br>or "R" for Reviewed. Submit complete copy or enter date ava<br>column 3. (see instructions) If no, see instructions.<br>Are the cost report total expenses and total revenues diffe   | for Compiled,<br>ailable in                 | Y<br>N         | A   |                      | 4.       |
|              | those on the filed financial statements? If yes, submit rec   |   |                |   |                      |          |
|              |   |   |                | Y/N   | Legal Oper.          |          |
|              |   |   |                | 1.00  | 2.00                 |          |
|              | Approved Educational Activities   |   |                |   |                      |          |
| 00           | Column 1: Are costs claimed for a nursing program? Column   | 2: If yes, is                               | s the provider | N   |                      | 6.       |
| ~~           | the legal operator of the program?  |   |                | N   |                      | -        |
| 00<br>00     | Are costs claimed for Allied Health Programs? If "Y" see in<br>Were nursing programs and/or allied health programs approve<br>cost reporting period? If yes, see instructions.  |   | wed during the | N<br>N                                      |                      | 7.<br>8. |
| 00           | Are costs claimed for Interns and Residents in an approved<br>program in the current cost report? If yes, see instruction   | is.   |                | N   |                      | 9.       |
| . 00<br>. 00 | Was an approved Intern and Resident GME program initiated c<br>cost reporting period? If yes, see instructions.<br>Are GME cost directly assigned to cost centers other than I  |   |                | N   |                      | 10.      |
|              | Teaching Program on Worksheet A? If yes, see instructions.  |   |                |   |                      |          |
|              |   |   |                |   | Y/N                  |          |
|              |   |   |                |   | 1.00                 | _        |
| 00           | Bad Debts<br>Is the provider seeking reimbursement for bad debts? If yes  |   | tions          |   | Y                    | 12       |
|              | If line 12 is yes, did the provider's bad debt collection p<br>period? If yes, submit copy.   |   |                | st reporting                                | N N                  | 13       |
| . 00         | If line 12 is yes, were patient deductibles and/or coinsura<br>instructions.  | ance amounts wa                             | aived? If yes, | see   | N                    | 14       |
| 00           | Bed Complement<br>Did total beds available change from the prior cost reporti   | ng period? If                               | Ves see inst   | ructions                                    | N                    | 15.      |
| 00           | bie total boas atalitable onango from the pirer coot report   |   | rt A           |   | rt B                 |          |
|              |   | Y/N   | Date           | Y/N   | Date                 |          |
|              |   | 1.00  | 2.00           | 3.00  | 4.00                 |          |
|              | PS&R Data   |   |                |   |                      |          |
| 00           | Was the cost report prepared using the PS&R Report only?<br>If either column 1 or 3 is yes, enter the paid-through<br>date of the PS&R Report used in columns 2 and 4. (see<br>instructions)  | Y   | 03/20/2024     | Y   | 03/20/2024           | 16       |
| 00           | Was the cost report prepared using the PS&R Report for<br>totals and the provider's records for allocation? If<br>either column 1 or 3 is yes, enter the paid-through date<br>in columns 2 and 4. (see instructions)  | N   |                | N   |                      | 17.      |
| . 00         | If line 16 or 17 is yes, were adjustments made to PS&R<br>Report data for additional claims that have been billed<br>but are not included on the PS&R Report used to file this  | N   |                | Ν   |                      | 18.      |
| . 00         | cost report? If yes, see instructions.<br>If line 16 or 17 is yes, were adjustments made to PS&R<br>Report data for corrections of other PS&R Report<br>information? If yes, see instructions.  | N   |                | Ν   |                      | 19.      |

Health Financial Systems

## RAMAPO RIDGE PSYCHIATRIC

In Lieu of Form CMS-2552-10

| 20.00       11 line 16 or 17 is yes, were adjustments made to PS&R<br>Report data for 0ther? Describe the other adjustments:       0       1.00       3.00         20.00       11 line 16 or 17 is yes, were adjustments made to PS&R<br>Report data for 0ther? Describe the other adjustments:       N       N       N         20.00       121.00       Was the cost report prepared only using the provider's records? If yes, see instructions.       N       N       N         21.00       Was the cost report prepared only using the provider's records? If yes, see instructions.       N       N       N         22.00       Have assets been relifed for Medicare purposes? If yes, see instructions       1.00       20.00       1.00         23.00       Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.       1.00       2.00       1.00         24.00       Were new leases and/or amendments to existing leases entered into during this cost reporting period?       1.90       1.90       1.90         25.00       Have there been new capitalized leases entered into during the cost reporting period? If yes, see       1.00       2.00       1.00  | ne Prepared:<br>24 11: 05 am<br>20. 00<br>20. 00<br>21. 00 |
|--|--|
| Description         Y/N         Y/N         Y/N           0         1.00         3.00           20.00         If line 16 or 17 is yes, were adjustments made to PS&R<br>Report data for Other? Describe the other adjustments:         N         N           20.00         If line 16 or 17 is yes, were adjustments made to PS&R<br>Report data for Other? Describe the other adjustments:         N         N         N           20.00         If line 16 or 17 is yes, were adjustments made to PS&R<br>Report data for Other? Describe the other adjustments:         N         N         N           21.00         Was the cost report prepared only using the provider's<br>records? If yes, see instructions.         N         N         N           21.00         Was the cost report prepared only using the provider's<br>records? If yes, see instructions.         N         N         N           22.00         Was the cost report prepared only using the provider's<br>reporting period? If yes, see instructions         N         N         N           22.00         Have assets been relifed for Medicare purposes? If yes, see instructions         N         N         N           23.00         Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost<br>reporting period? If yes, see instructions.         If yes, see instructions.         If yes, see instructions           24.00         Were new leases and/or amendments to existing l |  |
| 0       1.00       3.00         20.00       If line 16 or 17 is yes, were adjustments made to PS&R<br>Report data for Other? Describe the other adjustments:       N       N         1.00       20.00       N       N       N         1.00       2.00       3.00       4.00         21.00       Was the cost report prepared only using the provider's records? If yes, see instructions.       N       N         21.00       Was the Cost report prepared only using the provider's needed.       N       N       N         21.00       Was the cost report prepared only using the provider's needed.       N       N       N         21.00       Was the cost report prepared only using the provider's needed.       N       N       N         21.00       Was the cost report prepared only using the provider's needed.       N       N       N         21.00       Was the cost report prepared only using the provider's needed.       N       N       N         22.00       Have assets been relifed for Medicare purposes? If yes, see instructions       1.00       1.00         23.00       Have changes occurred in the Medicare depreciation expense due to appraisal s made during the cost reporting period? If yes, see instructions.       24.00       Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see  | 20.00  |
| Report data for 0ther? Describe the other adjustments:       Y/N       Date       Y/N       Date         21.00       Was the cost report prepared only using the provider's records? If yes, see instructions.       N       N       N         21.00       Was the cost report prepared only using the provider's records? If yes, see instructions.       N       N       N         22.00       Maxe assets been relifed for Medicare purposes? If yes, see instructions       23.00       Have assets been relifed for Medicare purposes? If yes, see instructions       23.00       Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.       24.00       Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see       11.00         25.00       Have there been new capitalized leases entered into during the cost reporting period? If yes, see       11.00  | 21.00  |
| 1.00       2.00       3.00       4.00         21.00       Was the cost report prepared only using the provider's       N       N         21.00       Was the cost report prepared only using the provider's       N       N         21.00       Was the cost report prepared only using the provider's       N       N         21.00       Was the cost report prepared only using the provider's       N       N         Completing the cost report prepared only using the provider's         Completing the cost report prepared only using the provider's         Completing the cost report prepared only using the provider's         Completing the cost report prepared only using the provider's         Completing the cost report prepared only using the provider's         Completing the cost         Completing period? If yes, see instructions.         24.00         Were new leases and/or amendments to existing leases entered into during this cost reporting period?         If yes, see instructions         25.00   | 21.00  |
| 21.00       Was the cost report prepared only using the provider's       N       N         records? If yes, see instructions.       N       N         COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)         Capital Related Cost         22.00         Have assets been relifed for Medicare purposes? If yes, see instructions         23.00         Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.         24.00         Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see         1.00         Use there been new capitalized leases entered into during the cost reporting period? If yes, see  | 21.00  |
| records? If yes, see instructions.       1.00         COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)       1.00         Capital Related Cost       22.00         Have assets been relifed for Medicare purposes? If yes, see instructions       1.00         23.00       Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.         24.00       Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see         11.00       1.00         12.00       Have there been new capitalized leases entered into during the cost reporting period? If yes, see   | 22.00  |
| COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)         Capital Related Cost         22.00       Have assets been relifed for Medicare purposes? If yes, see instructions         23.00       Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.         24.00       Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see         25.00       Have there been new capitalized leases entered into during the cost reporting period? If yes, see  | 22.00  |
| COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)         Capital Related Cost         22.00       Have assets been relifed for Medicare purposes? If yes, see instructions         23.00       Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.         24.00       Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see         25.00       Have there been new capitalized leases entered into during the cost reporting period? If yes, see  | 22.00  |
| <ul> <li>22.00 Have assets been relifed for Medicare purposes? If yes, see instructions</li> <li>23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.</li> <li>24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions</li> <li>25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see</li> </ul>  |  |
| <ul> <li>23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.</li> <li>24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions</li> <li>25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see</li> </ul>  |  |
| <ul> <li>reporting period? If yes, see instructions.</li> <li>24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions</li> <li>25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see</li> </ul>  | 23.00  |
| <ul> <li>24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions</li> <li>25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see</li> </ul>   |  |
| 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see  | 24.00  |
| i nstructi ons.  | 25.00  |
| 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.   | 26.00  |
| 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.  | 27.00  |
| Interest Expense           28.00         Were new Loans, mortgage agreements or Letters of credit entered into during the cost reporting   | 28.00  |
| period? If yes, see instructions.         29.00       Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)  | 29.00  |
| treated as a funded depreciation account? If yes, see instructions<br>30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see   | 30. 00   |
| instructions.<br>31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see  | 31.00  |
| i nstructi ons. Purchased Servi ces  |  |
| 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.  | 32.00  |
| 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.  | 33.00  |
| Provi der-Based Physi ci ans   |  |
| 34.00 Were services furnished at the provider facility under an arrangement with provider-based physicians?<br>If yes, see instructions.   | 34.00  |
| 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.   | 35.00  |
| Physicians during the cost reporting period? If yes, see instructions.   |  |
| 1.00 2.00  |  |
| Home Office Costs  |  |
| 36.00 Were home office costs claimed on the cost report?<br>37.00 [If line 36 is yes, has a home office cost statement been prepared by the home office?]  | 36.00  |
| If yes, see instructions.<br>38.00 If line 36 is yes, was the fiscal year end of the home office different from that of  | 38.00  |
| the provider? If yes, enter in column 2 the fiscal year end of the home office.<br>39.00 If line 36 is yes, did the provider render services to other chain components? If yes,  | 39.00  |
| see instructions.<br>40.00 If line 36 is yes, did the provider render services to the home office? If yes, see   | 40.00  |
| i nstructi ons.  |  |
| 1.00 2.00  |  |
| Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position KATHERINE BLISSIT bld by the cost report proparer in columns 1, 2, and 2   | 41.00  |
| <ul> <li>held by the cost report preparer in columns 1, 2, and 3, respectively.</li> <li>42.00 Enter the employer/company name of the cost report HEALTH CARE RESOURCES</li> </ul>   | 42.00  |
| 42.00 Enter the telephone number and email address of the cost 609-987-1440 KITTY. BLISSIT@HCRNJ. NET  | 43.00  |
| report preparer in columns 1 and 2, respectively.  | +3. 00   |

| Heal th | Financial Systems RAMAPO RID                             | GE PSYCHIATRIC      | In Lie                   | u of Form CMS-           | 2552-10         |
|---------|--|---------------------|--------------------------|--------------------------|-----------------|
| H0SPI T | AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE  | Provider CCN: 31-40 | eriod:<br>rom 01/01/2023 | Worksheet S-2<br>Part II |                 |
|         |  |                     | o 12/31/2023             |                          | pared:<br>05 am |
|         |  |                     |                          |                          |                 |
|         |  | 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, |                     |                          |                          |                 |
|         | 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 cost |                     |                          |                          | 43.00           |
|         | report preparer in columns 1 and 2, respectively.        |                     |                          |                          |                 |

|                | Financial Systems                               | RAMAPO RIDGE     |             |                   |                            | u of Form CMS-2         |                |
|----------------|---|------------------|-------------|-------------------|----------------------------|-------------------------|----------------|
| HOSPI T        | AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.  | AL DATA          | Provider C  | CN: 31-4019       | Period:<br>From 01/01/2023 | Worksheet S-3<br>Part I |                |
|                |   |                  |             |                   | To 12/31/2023              |                         | pared:         |
|                |   |                  |             |                   |                            | 5/20/2024 11:           | <u>05 am</u>   |
|                |   |                  |             |                   |                            | I/P Days / O/P          |                |
|                |   |                  |             |                   |                            | Visits / Trips          |                |
|                | Component                                       | Worksheet A      | No. of Beds | Bed Days          | CAH/REH Hours              | Title V                 |                |
|                |   | Line No.<br>1.00 | 2.00        | Available<br>3.00 | 4.00                       | 5.00                    |                |
|                | PART I – STATISTICAL DATA                       | 1.00             | 2.00        | 3.00              | 4.00                       | 5.00                    |                |
| 1.00           | Hospital Adults & Peds. (columns 5, 6, 7 and    | 30.00            | 58          | 21, 17            | 0.00                       | 0                       | 1.00           |
|                | 8 exclude Swing Bed, Observation Bed and        |                  |             |                   |                            |                         |                |
|                | Hospice days)(see instructions for col. 2       |                  |             |                   |                            |                         |                |
|                | for the portion of LDP room available beds)     |                  |             |                   |                            |                         |                |
| 2.00           | HMO and other (see instructions)                |                  |             |                   |                            |                         | 2.00           |
| 3.00           | HMO I PF Subprovi der                           |                  |             |                   |                            |                         | 3.00           |
| 4.00           | HMO I RF Subprovi der                           |                  |             |                   |                            |                         | 4.00           |
| 5.00           | Hospital Adults & Peds. Swing Bed SNF           |                  |             |                   |                            | 0                       | 5.00           |
| 6.00           | Hospital Adults & Peds. Swing Bed NF            |                  | 50          | 01.1-             | 0 00                       | 0                       | 6.00           |
| 7.00           | Total Adults and Peds. (exclude observation     |                  | 58          | 21, 17            | 0.00                       | 0                       | 7.00           |
| 8.00           | beds) (see instructions)<br>INTENSIVE CARE UNIT |                  |             |                   |                            |                         | 8.00           |
| 9.00           | CORONARY CARE UNIT                              |                  |             |                   |                            |                         | 9,00           |
| 10.00          | BURN INTENSIVE CARE UNIT                        |                  |             |                   |                            |                         | 10.00          |
| 11.00          | SURGICAL INTENSIVE CARE UNIT                    |                  |             |                   |                            |                         | 11.00          |
| 12.00          | OTHER SPECIAL CARE (SPECIFY)                    |                  |             |                   |                            |                         | 12.00          |
| 13.00          | NURSERY   |                  |             |                   |                            |                         | 13.00          |
| 14.00          | Total (see instructions)                        |                  | 58          | 21, 17            | 0.00                       | 0                       | 14.00          |
| 15.00          | CAH visits                                      |                  |             |                   |                            | 0                       | 15.00          |
| 15.10          | REH hours and visits                            |                  |             |                   | 0.00                       | 0                       | 15.10          |
| 16.00          | SUBPROVIDER - IPF                               |                  |             |                   |                            |                         | 16.00          |
| 17.00          | SUBPROVIDER - IRF                               |                  |             |                   |                            |                         | 17.00          |
| 18.00          | SUBPROVI DER                                    |                  |             |                   |                            |                         | 18.00          |
| 19.00          | SKILLED NURSING FACILITY                        | 44.00            | 254         |                   |                            | 0                       | 19.00          |
| 20.00          | NURSING FACILITY                                | 45.00            | 44          |                   |                            | 0                       | 20.00          |
| 21.00          | OTHER LONG TERM CARE                            | 46.00            | 134         | 48, 91            | 0                          |                         | 21.00          |
| 22.00          | HOME HEALTH AGENCY                              |                  |             |                   |                            |                         | 22.00          |
| 23.00<br>24.00 | AMBULATORY SURGICAL CENTER (D. P. )<br>HOSPICE  |                  |             |                   |                            |                         | 23.00<br>24.00 |
| 24.00          | HOSPICE<br>HOSPICE (non-distinct part)          | 30.00            |             |                   |                            |                         | 24.00          |
| 24.10          | CMHC - CMHC                                     | 30.00            |             |                   |                            |                         | 25.00          |
| 26.00          | RURAL HEALTH CLINIC                             |                  |             |                   |                            |                         | 26.00          |
| 26.25          | FEDERALLY QUALIFIED HEALTH CENTER               | 89.00            |             |                   |                            | 0                       | 26.25          |
| 27.00          | Total (sum of lines 14-26)                      | 07.00            | 490         |                   |                            | 0                       | 27.00          |
| 28.00          | Observation Bed Days                            |                  |             |                   |                            | 0                       | 28.00          |
| 29.00          | Ambul ance Trips                                |                  |             |                   |                            |                         | 29.00          |
| 30.00          | Employee discount days (see instruction)        |                  |             |                   |                            |                         | 30.00          |
| 31.00          | Employee discount days - IRF                    |                  |             |                   |                            |                         | 31.00          |
| 32.00          | Labor & delivery days (see instructions)        |                  | 0           |                   | 0                          |                         | 32.00          |
| 32.01          | Total ancillary labor & delivery room           |                  |             |                   |                            |                         | 32.01          |
|                | outpatient days (see instructions)              |                  |             |                   |                            |                         |                |
| 33.00          | LTCH non-covered days                           |                  |             |                   |                            |                         | 33.00          |
| 33.01          | LTCH site neutral days and discharges           |                  | _           |                   |                            |                         | 33.01          |
| 34.00          | Temporary Expansion COVID-19 PHE Acute Care     | 30.00            | 0           |                   | 0                          | 0                       | 34.00          |

| To         12/31/2023         Date/Time<br>S/20/2024           Full Time Equivalents           Full Time Equivalents           Component         Full Time Equivalents           Title XVIII         Title XIX         Total All<br>Total All<br>Abspited Abduts & Peds. (columes 5, 6, 7 and<br>Hospital Adults & Peds. (columes 5, 6, 7 and<br>Hospital Adults & Peds. (columes 5, 6, 7 and<br>Hospited absylice instructions for col. 2<br>for the portion of LDP room available beds)         0         0         0         0         0         0         0           2.00         HM0 and other (see instructions)         0  |        | Financial Systems<br>AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC. | RAMAPO RIDGE P<br>AL DATA | Provider CC  | CN: 31-4019 | Period:   | eu of Form CMS-<br>Worksheet S-3 |                  |
|--|--------|---|---------------------------|--------------|-------------|-----------|----------------------------------|------------------|
| Full Time Equivalents           Full Time Equivalents           Total All Total All Total Interns Employees           PART I - STATISTICAL DATA           1111e XVIII         Title XVII         Title XVII           Note of the portion of the portion of LDP room available beds)         0         Ref the portion of LDP room available beds)           2.00         HW0 and other (see instructions)         0 <t< th=""><th></th><th></th><th></th><th></th><th></th><th></th><th></th><th>epared:<br/>05 am</th></t<>  |        |   |                           |              |             |           |                                  | epared:<br>05 am |
| PART I - STATISTICAL DATA         Partients         & Residents         Payroll           1.00         Hospital Adults & Peds. (columns 5, 6, 7 and<br>Hospited ays) (see instructions for col. 2<br>for the portion of LDP room available beds)         7,546         1,497         15,068         9,00         9,00           2.00         H00 adother (see instructions)         0 <td></td> <td></td> <td>I/P Days</td> <td>/ O/P Visits</td> <td>/ Trips</td> <td>Full Time</td> <td></td> <td></td>  |        |   | I/P Days                  | / O/P Visits | / Trips     | Full Time |                                  |                  |
| PART I - STATISTICAL DATA           1.00         Hospital Adults & Peds. (columns 5, 6, 7 and<br>B exclude \$wing Bed, Observation Bed and<br>Hospite days) (see instructions for col. 2<br>for the portion of LDP room available beds)         1, 497           0.00         MMO IPF Subprovider         0         0           3.00         HMO IPF Subprovider         0         0           3.00         HMO IPF Subprovider         0         0           0.01         Hospital Adults & Peds. Swing Bed NF         0         0           0.01         Hospital Adults & Peds. Swing Bed NF         0         0           0.01         NENSIVE CARE UNIT         0         0           9.00         COROMARY CARE UNIT         0         0           10.00         BUBR INTENSIVE CARE UNIT         0         0           11.00         SUBPROVIDER - IFF         0         0           12.00         OTHER SPECIAL CARE (SPECIFY)         0         0           13.00         NUBRSIVE CARE UNIT         0         0         0           14.00         Total (see instructions)         7,546         1,497         15,068         0.00           15.00         SUBPROVIDER - IFF         0         0         0         0           15.00         SUBPROVIDER -   |        | Component   | Title XVIII               |              | Patients    |           | Payrol I                         |                  |
| 1.00         Hospital Adults & Peds. (columns 5. 6, 7 and<br>8 excludes Wing Bed, Observation Bed and<br>Hospice days)(see instructions for col. 2<br>for the portion of LDP room avail able beds)         0         0           2.00         HMO and other (see instructions)         0         0           3.00         HMO IRF Subprovider         0         0           4.00         Hospital Adults & Peds. Swing Bed NF         0         0           7.00         Total Adults & Peds. Swing Bed NF         0         0           7.00         Total Adults & Peds. Swing Bed NF         0         0           0.0         UNTENSIVE CARE UNIT         0         0           0.0         DORNAY CARE UNIT         0         0           11.00         SURGICAL INTENSIVE CARE UNIT         0         0           12.00         DIRKERY         0         0         0           13.00         NURSERY         0         0         0           15.00         CAR Visits         0         0         0           15.00         SUBPROVIDER - IFF         0         0         0           16.00         SUBPROVIDER - IFF         0         0         0           17.00         SUBROVIDER - IFF         0         0         0  |        |   | 6.00                      | 7.00         | 8.00        | 9.00      | 10.00                            |                  |
| 8         exclude.Swing.Bed, Observation Bed and<br>Hospice days) (see instructions for col. 2<br>for the portion of LDP room available beds)           00         HMO IPF Subprovider         0           3.00         HMO IPF Subprovider         0           7.00         Hospital Adults & Peds. Swing Bed NF         0         0           7.00         Total Adults and Peds. (exclude observation<br>beds) (see instructions)         7,546         1,497         15,068           8.00         INTENSIVE CARE UNIT         0         0         0         0           9.00         COROMARY CARE UNIT         0         0         0         0           11.00         BURS VE CARE UNIT         0         0         0         0           12.00         OTHER SPECH AL CARE (SPECIFY)         0         0         0         0           13.00         NURSERY         0         0         0         0         0           14.00         Total (see instructions)         7,546         1,497         15,068         0.00         165           15.00         CAH visits         0         0         0         0         0           13.00         NURSERY         19,928         36,281         82,145         0.00         48  | 1 00   |   | 7 544                     | 1 407        | 15 04       | 20        |                                  | 1 1.00           |
| 2.00         HM0 and other (see Instructions)         0         0           3.00         HM0 IPF Subprovider         0         0           4.00         HSpital Adults & Peds. Swing Bed SNF         0         0           5.00         Hospital Adults & Peds. Swing Bed SNF         0         0           6.00         Hospital Adults & Peds. Swing Bed NF         0         0           7.00         Total Adults and Peds. (exclude observation beds) (see instructions)         7,546         1,497         15,068           8.00         INTENSIVE CARE UNIT         0         0         0         0           10.00         BURN INTENSIVE CARE UNIT         0         0         0         0           10.00         BURN INTENSIVE CARE UNIT         0         0         0         0           10.00         BURN INTENSIVE CARE UNIT         0         0         0         0           12.00         OTHER SPECIAL CARE (SPECIFY)         0         0         0         0           13.00         NURSERY         0         0         0         0         0           14.00         Total (see instructions)         7,546         1,497         15,068         0.00         333           15.00         S   | 1.00   | 8 exclude Swing Bed, Observation Bed and                            | 7, 340                    | 1,477        | 15, 00      | 00        |                                  | 1.00             |
| 3.00         HM0 IPF Subprovider         0         0           4.00         HM0 IFF Subprovider         0         0           5.01         Hospital Adults & Peds. Swing Bed SNF         0         0           6.00         Hospital Adults & Peds. Swing Bed NF         0         0           7.00         Total Adults & Peds. Ceclude observation         7,546         1,497         15,068           8.00         INTENSIVE CARE UNIT         0         0         0         0           9.00         CORONARY CARE UNIT         0         0         0         0           10.00         BURN INTENSIVE CARE UNIT         0         0         0         0           11.00         SURGICAL INTENSIVE CARE UNIT         0         0         0         0           12.00         OTHER SPECIAL CARE (SPECIFY)         13.00         NURSERY         0         0         0           13.00         NURSERY         0         0         0         0         0           14.00         Total (see Instructions)         7,546         1,497         15,068         0.00         165           15.00         CAH visits         0         0         0         0         0         0  |        |   |                           |              |             |           |                                  |                  |
| 4.00         HMO IRF Subprovider         0         0           5.00         Hospital Adults & Peds. Swing Bed SNF         0         0         0           6.00         Hospital Adults & Peds. Swing Bed SNF         0         0         0           7.00         Total Adults & Peds. Swing Bed NF         0         0         0           7.00         Total Adults & Peds. (exclude observation beds) (see instructions)         7,546         1,497         15,068           8.00         INTENSIVE CARE UNIT         0         0         0         0           9.00         CORONARY CARE UNIT         0         0         0         0           11.00         SURGICAL INTENSIVE CARE UNIT         0         0         0         0           12.00         OTHER SPECIAL CARE (SPECIFY)         0         0         0         0           13.00         NURSERY         0         0         0         0         0           15.00 SUBPROVIDER - IPF         0         0         0         0         0         0           15.00         SUBPROVIDER - IRF         19,928         36,281         82,145         0.00         333           15.00         SUBPROVIDER         IRF         0         0<   |        |   |                           |              |             |           |                                  | 2.00             |
| 5.00         Hospital Adults & Peds. Swing Bed SNF         0         0         0           6.00         Hospital Adults and Peds. (exclude observation beds) (see instructions)         7,546         1,497         15,068           0.01         NTENSIVE CARE UNIT         7,546         1,497         15,068           0.01         NTENSIVE CARE UNIT         7,546         1,497         15,068           0.00         BURN INTENSIVE CARE UNIT         7,546         1,497         15,068         0.00           11.00         SURGICAL INTENSIVE CARE UNIT         0         0         0         0         0           12.00         OTHER SPECIAL CARE (SPECIFY)         13,00         NURSERY         0   |        |   | -                         | -            |             |           |                                  | 3.00             |
| 6.00         Hospital Adults & Peds. Swing Bed NF         0         0           7.00         Total Adults and Peds. (exclude observation beds) (see instructions)         7,546         1,497         15,068           8.00         INTENSIVE CARE UNIT         15,068         1,497         15,068           9.00         CORNARY CARE UNIT         10,00         BURN INTENSIVE CARE UNIT         10,00         NURSERY         11,497         15,068         0,00           11.00         SURGICAL INTENSIVE CARE UNIT         0         0         0         0         0           12.00         OTHER SPECIAL CARE (SPECIFY)         0         0         0         0         0         0           13.00         NURSERY         0         <   |        |   | -                         | -            |             |           |                                  | 4.00             |
| 7.00         Total Adults and Peds. (exclude observation beds) (see instructions)         7,546         1,497         15,068           8.00         INTENSIVE CARE UNIT         9.00         CORONARY CARE UNIT         10.00           9.00         CORONARY CARE UNIT         11.00         0.00         SUBROVI DER         15.068           10.00         BURN INTENSIVE CARE UNIT         0         0         15.00         6.0           13.00         NURSERY         0         0         0         0           14.00         Total (see instructions)         7,546         1,497         15.068         0.00           15.00         REH hours and visits         0         0         0         0         0           10.00         SUBPROVI DER - 1 PF         0         0         0         0         0           10.00         SUBPROVI DER - 1 RF         19,928         36,281         82,145         0.00         48           21.00         ONKE HEALTH AGENCY         19,928         36,281         82,145         0.00         84           21.00         OHME HALTH AGENCY         19,928         36,281         82,145         0.00         84           21.00         OHME HEALTH AGENCY         19,928 <td< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td></td><td>5.00</td></td<>  |        |   | 0                         |              |             |           |                                  | 5.00             |
| beds) (see instructions)         beds) (see instructions)           8.00         INTENSIVE CARE UNIT           9.00         CORONARY CARE UNIT           10.00         BURN INTENSIVE CARE UNIT           11.00         SURGICAL INTENSIVE CARE UNIT           12.00         OTHER SPECIAL CARE (SPECIFY)           13.00         NURSERY           14.00         Total (see instructions)           15.10         REH hours and visits           0         0           15.00         SUBPROVIDER - IPF           17.00         SUBPROVIDER - IPF           17.00         SUBPROVIDER - IRF           18.00         SUBPROVIDER - R           19.00         SKILLED NURSING FACILITY           19.00         SKILLED NURSING FACILITY           10.00         OTHER LONG TERM CARE           21.00         OTHER LONG TERM CARE           22.00         HOME HEALTH AGENCY           23.00         AMBULATORY SURGICAL CENTER (D.P.)           24.00         HOSPICE (non-distinct part)           25.00         CMC - CMMC           26.00         RIVAL HEALTH CLINIC           26.00         BROW JORES           26.00         BROW JORES           20.00         DHOK - CMMC </td <td></td> <td></td> <td>7 544</td> <td>-</td> <td>15 0/</td> <td>-</td> <td></td> <td>6.00</td>   |        |   | 7 544                     | -            | 15 0/       | -         |                                  | 6.00             |
| 8.00       INTENSIVE CARE UNIT         9.00       CORONARY CARE UNIT         9.00       CORONARY CARE UNIT         10.00       BURN INTENSIVE CARE UNIT         11.00       SURGICAL INTENSIVE CARE UNIT         12.00       OTHER SPECIAL CARE (SPECIFY)         13.00       NURSERY         14.00       Total (see instructions)       7,546         15.00       CAR visits       0         10.00       SUBPROVIDER - IPF         17.00       SUBPROVIDER - IFF         18.00       SUBPROVIDER - IRF         18.00       SUBPROVIDER - IRF         18.00       SUBPROVIDER         19.00       SKILLED NURSING FACILITY         19.00       SKILLED NURSING FACILITY         10.00       SUBPROVIDER         10.00       SUBPROVIDER         10.00       SUBPROVIDER         12.00       HEL LONG TERM CARE         20.00       NURSING FACILITY         19.928       36,281         8,309       12,634         10.00       SUBPROVIDER         20.00       HOME HEALTH AGENCY         21.00       OHME HEALTH AGENCY         23.00       AMBULATORY SURCICAL CENTER (D.P.)         24.10   | 7.00   |   | 7, 540                    | 1,497        | 15, 00      | 08        |                                  | 7.00             |
| 9.00 CORONARY CARE UNIT<br>10.00 BURN INTENSIVE CARE UNIT<br>11.00 SURGICAL INTENSIVE CARE UNIT<br>12.00 OTHER SPECIAL CARE (SPECIFY)<br>13.00 NURSERY<br>14.00 Total (see instructions) 7,546 1,497 15,068 0.00 165<br>15.00 CAH visits 0 0 0 0<br>15.10 REH hours and visits 0 0 0<br>16.00 SUBPROVIDER - IPF<br>17.00 SUBPROVIDER - IPF<br>17.00 SUBPROVIDER - IRF<br>18.00 SUBPROVIDER - IRF<br>19.00 SKILLED NURSING FACILITY 19,928 36,281 82,145 0.00 333<br>20.00 NURSING FACILITY 19,928 8,309 12,634 0.00 48<br>21.00 OTHER LONG TERM CARE<br>23.00 ANURSING FACILITY 19,928 8,309 12,634 0.00 48<br>23.00 ANULATORY SURGICAL CENTER (D.P.)<br>24.00 HOME HEALTH ACENCY<br>23.00 ANULATORY SURGICAL CENTER (D.P.)<br>24.00 HOSPICE (non-distinct part)<br>25.00 CMHC - CMHC<br>26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 03<br>27.00 Total (sum of lines 14-26) 0<br>28.00 Observation Bed Days<br>29.00 Ambulance Trips 0<br>30.00 Employee discount days (see instruction) 0<br>31.00 Employee discount days (see instruction) 0<br>32.01 Total ancill ary labor & delivery room 0<br>outpatient days (see instructions) 0<br>32.00 Lich on-covered days 0<br>30.00 L | 8 00   |   |                           |              |             |           |                                  | 8.00             |
| 10.00       BURN INTENSIVE CARE UNIT         11.00       SURGICAL INTENSIVE CARE UNIT         12.00       OTHER SPECIAL CARE (SPECIFY)         13.00       NURSERY         14.00       Total (see instructions)       7,546       1,497       15,068       0.00         15.00       CAH visits       0       0       0       0         15.00       REH hours and visits       0       0       0       0         16.00       SUBPROVIDER - IPF       0       0       0       0         17.00       SUBPROVIDER - IRF       0       0       0       333         19.00       SKILLED NURSING FACILITY       19,928       36,281       82,145       0.00       333         20.00       MURSING FACILITY       19,928       36,281       82,145       0.00       48         21.00       OHTER LONG TERM CARE       44,376       0.00       48         22.00       HOME HEALTH AGENCY       0       0       0       0         24.00       HOSPICE       0       0       0       0       0         25.00       CMHC - CMHC       0       0       0       0       0       0       0       0       0  |        |   |                           |              |             |           |                                  | 9.00             |
| 11.00       SURGICAL INTENSIVE CARE UNIT         12.00       OTHER SPECIAL CARE (SPECIFY)         13.00       NURSERY         14.00       Total (see instructions)       7,546         15.00       CAH visits       0         0       0         15.00       CAH visits       0         0       0       0         15.00       REH hours and visits       0         00       SUBPROVIDER - IPF       0         17.00       SUBROVIDER - IFF       0         18.00       SUBPROVIDER       12,634       0.00         19.00       SKILLED NURSING FACILITY       19,928       36,281       82,145       0.00         20.00       NURSING FACILITY       19,928       36,281       82,00       333         20.00       NURSING FACILITY       19,928       36,281       82,00       344,376       0.00         23.00       MBULATORY SURGICAL CENTER (D.P.)       44,376       0.00       84         23.00       AMBULATORY SURGICAL CENTER (D.P.)       0       0       0         24.10       HOSPICE       0       0       0.00       0         25.00       CMRC - CMMC       0       0       0.00  |        |   |                           |              |             |           |                                  | 10.00            |
| 12.00       OTHER SPECIAL CARE (SPECIFY)       13.00       NURSERY         13.00       NURSERY       15.00       AH visits       0       0       0         15.00       CAH visits       0       0       0       0       0         15.00       REH hours and visits       0       0       0       0       0       0         15.00       SUBPROVIDER - IPF       0       0       0       0       0       0         17.00       SUBPROVIDER - IRF       0       0       0       0       333         18.00       SUBPROVIDER - IRF       19,928       36,281       82,145       0.00       333         19.00       SKILLED NURSING FACILITY       19,928       36,281       82,145       0.00       48         21.00       OHRER LONG TERM CARE       8,309       12,634       0.00       44       376       0.00       84         21.00       OHME HEALTH AGENCY       19,928       8,309       12,634       0.00       84         22.00       HOME HEALTH AGENCY       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0   |        |   |                           |              |             |           |                                  | 11.00            |
| 13.00       NURSERY       7,546       1,497       15,068       0.00       165         14.00       Total (see instructions)       7,546       1,497       15,068       0.00       165         15.00       CAH visits       0       0       0       0       0       165         15.00       SUBPROVIDER - IPF       0       0       0       0       0       333         17.00       SUBPROVIDER - IRF       19,928       36,281       82,145       0.00       333         19.00       SKILLED NURSING FACILITY       19,928       36,281       82,145       0.00       348         20.00       NURSING FACILITY       19,928       36,281       82,145       0.00       348         21.00       OTHER LONG TERM CARE       8,309       12,634       0.00       44       376       0.00       44         22.00       HOME HEALTH AGENCY       44,376       0.00       60   |        |   |                           |              |             |           |                                  | 12.00            |
| 15.00       CAH visits       0       0       0         15.10       REH hours and visits       0       0       0         15.00       SUBPROVIDER - IPF       0       0       0         17.00       SUBPROVIDER - IPF       19.00       SKILED NURSING FACILITY       19,928       36,281       82,145       0.00       333         19.00       SKILED NURSING FACILITY       19,928       36,281       82,145       0.00       384         20.00       NURSING FACILITY       19,928       36,281       82,145       0.00       384         21.00       OTHER LONG TERM CARE       8,309       12,634       0.00       48         22.00       HOME HEALTH AGENCY       23.00       AMBULATORY SURGICAL CENTER (D.P.)       44,376       0.00       84         23.00       AMBULATORY SURGICAL CENTER (D.P.)       0       0       0       0       0         24.00       HOSPICE       0   | 13.00  | · ·   |                           |              |             |           |                                  | 13.00            |
| 15.10       REH hours and visits       0       0       0       0         16.00       SUBPROVI DER - IPF       1       <  | 14.00  | Total (see instructions)  | 7, 546                    | 1, 497       | 15, 06      | 58 0.00   | 165.00                           | 14.00            |
| 16.00       SUBPROVIDER - IPF         17.00       SUBPROVIDER - IRF         18.00       SUBPROVIDER         18.00       SUBPROVIDER         19.00       SKILLED NURSING FACILITY         19.00       SKILLED NURSING FACILITY         19.00       SKILLED NURSING FACILITY         19.00       SKILLED NURSING FACILITY         10.00       OHRE HEALTH AGENCY         21.00       OMME HEALTH AGENCY         23.00       AMBULATORY SURGICAL CENTER (D.P.)         44, 376       0         24.00       HOSPICE         25.00       CMHC         26.00       RURAL HEALTH CLINIC         26.00       RURAL HEALTH CLINIC         26.00       Observation Bed Days         0       0         27.00       Observation Bed Days         0       0         29.00       Ambulance Trips         0       0         100       Employee discount days (see instruction)         101.00       Employee discount days (see instructions)         100       Employee discount days (see instructions)         100       Labor & delivery days (see instructions)         101       Total ncillary labor & delivery room   | 15.00  | CAH visits  | 0                         | 0            |             | 0         |                                  | 15.00            |
| 17.00       SUBPROVIDER - IRF         18.00       SUBPROVIDER         19.00       SKILLED NURSING FACILITY       19,928       36,281       82,145       0.00       333         20.00       NURSING FACILITY       19,928       36,281       82,145       0.00       338         21.00       OTHER LONG TERM CARE       8,309       12,634       0.00       44         22.00       HOME HEALTH AGENCY       44,376       0.00       84         23.00       AMBULATORY SURGICAL CENTER (D. P.)       0       0       0         24.00       HOSPICE (non-distinct part)       0       0       0         25.00       CMHC - CMHC       0       0       0       0       0         26.20       RURAL HEALTH CLINIC       0       0       0       0       0       0         26.25       FEDERALLY QUALIFIED HEALTH CENTER       0       0       0       0       0       0       0       0         27.00       Total (sum of lines 14-26)       0  | 15. 10 | REH hours and visits  | 0                         | 0            |             | 0         |                                  | 15.10            |
| 18.00       SUBPROVIDER       19.00       SKILLED NURSING FACILITY       19,928       36,281       82,145       0.00       333         20.00       NURSING FACILITY       19,928       36,281       82,145       0.00       48         20.00       OTHER LONG TERM CARE       44,376       0.00       48         22.00       HOME HEALTH AGENCY       44,376       0.00       84         23.00       AMBULATORY SURGICAL CENTER (D.P.)   |        |   |                           |              |             |           |                                  | 16.00            |
| 19.00       SKILLED NURSING FACILITY       19,928       36,281       82,145       0.00       333         20.00       NURSING FACILITY       19,928       36,281       82,145       0.00       48         21.00       OTHER LONG TERM CARE       44,376       0.00       84         22.00       HOME HEALTH AGENCY       44,376       0.00       84         23.00       AMBULATORY SURGICAL CENTER (D.P.)       0       0       84         24.00       HOSPICE       0       0       0       0         24.01       HOSPICE (non-distinct part)       0       0       0       0       0         25.00       CMHC - CMHC       0  |        |   |                           |              |             |           |                                  | 17.00            |
| 20.00       NURSING FACILITY       8,309       12,634       0.00       48         21.00       OTHER LONG TERM CARE       44,376       0.00       84         22.00       HOME HEALTH AGENCY       44,376       0.00       84         23.00       AMBULATORY SURGICAL CENTER (D. P.)       0       44,376       0.00       84         24.00       HOSPICE       0       0       0       0       8,309       12,634       0.00       84         24.00       HOME HEALTH AGENCY       0       44,376       0.00       84       0.00       84         24.00       HOSPICE       0   |        |   |                           |              |             |           |                                  | 18.00            |
| 21.00OTHER LONG TERM CARE44,3760.008422.00HOME HEALTH AGENCY23.00AMBULATORY SURGICAL CENTER (D.P.)008424.00HOSPICE000024.00HOSPICE (non-distinct part)000025.00CMHC - CMHC0000026.25FEDERALLY QUALIFIED HEALTH CENTER0000027.00Total (sum of lines 14-26)000063028.00Observation Bed Days0000029.00Ambulance Trips0000031.00Employee discount days (see instruction)000032.01Total ancillary labor & delivery room<br>outpatient days (see instructions)000033.00LTCH non-covered days00000  |        |   | 19, 928                   |              |             |           |                                  |                  |
| 22.00HOME HEALTH AGENCY23.00AMBULATORY SURGICAL CENTER (D.P.)24.00HOSPICE24.10HOSPICE (non-distinct part)25.00CMHC - CMHC26.00RURAL HEALTH CLINIC26.25FEDERALLY QUALIFIED HEALTH CENTER27.00Total (sum of lines 14-26)28.00Observation Bed Days29.00Ambulance Trips31.00Employee discount days (see instruction)32.00Labor & delivery days (see instructions)33.00LTCH non-covered days33.00LTCH non-covered days  |        |   |                           | 8, 309       |             |           |                                  |                  |
| 23.00AMBULATORY SURGICAL CENTER (D. P. )24.00HOSPICE24.10HOSPICE (non-distinct part)25.00CMHC - CMHC26.00RURAL HEALTH CLINIC26.25FEDERALLY QUALIFIED HEALTH CENTER0000001Total (sum of lines 14-26)28.00Observation Bed Days29.00Ambulance Trips30.00Employee discount days (see instruction)31.00Employee discount days - IRF0000000000000000000000000010010010011012013014csei instructions)150160171018019101910100100111014101501601710181019101910191019101910191019101910191019101010 </td <td></td> <td></td> <td></td> <td></td> <td>44, 37</td> <td>0.00</td> <td>84.00</td> <td></td>  |        |   |                           |              | 44, 37      | 0.00      | 84.00                            |                  |
| 24.00HOSPICE24.10HOSPICE (non-distinct part)25.00CMHC - CMHC26.00RURAL HEALTH CLINIC26.25FEDERALLY QUALIFIED HEALTH CENTER000027.00Total (sum of lines 14-26)000028.00Observation Bed Days0029.00Ambulance Trips31.00Employee discount days (see instructions)0020.01Labor & delivery days (see instructions)0032.01Total ancillary labor & delivery room0033.00LTCH non-covered days00  |        |   |                           |              |             |           |                                  | 22.00            |
| 24.10HOSPICE (non-distinct part)025.00CMHC - CMHC26.00RURAL HEALTH CLINIC26.25FEDERALLY QUALIFIED HEALTH CENTER026.25FEDERALLY QUALIFIED HEALTH CENTER028.00Observation Bed Days029.00Ambulance Trips030.00Employee discount days (see instruction)031.00Employee discount days (see instructions)032.01Total ancillary labor & delivery room00UtCH non-covered days0  |        |   |                           |              |             |           |                                  | 23.00            |
| 25.00CMHC - CMHC26.00RURAL HEALTH CLINIC26.25FEDERALLY QUALIFIED HEALTH CENTER26.25FEDERALLY QUALIFIED HEALTH CENTER27.00Total (sum of lines 14-26)28.00Observation Bed Days29.00Ambulance Trips30.00Employee discount days (see instruction)31.00Employee discount days (see instructions)32.00Labor & delivery days (see instructions)000022.01Total ancillary labor & delivery room000033.00LTCH non-covered days00   |        |   |                           |              |             | 0         |                                  | 24.0             |
| 226.00RURAL HEALTH CLINIC26.25FEDERALLY QUALIFIED HEALTH CENTER0000027.00Total (sum of lines 14-26)00000028.00Observation Bed Days00006300029.00Ambulance Trips000 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td> <td>25.00</td>  |        |   |                           |              |             | 0         |                                  | 25.00            |
| 26.25FEDERALLY QUALIFIED HEALTH CENTER0000.00027.00Total (sum of lines 14-26)00063028.00Observation Bed Days00063029.00Ambulance Trips000030.00Employee discount days (see instruction)00031.00Employee discount days - IRF00022.01Labor & delivery days (see instructions)00032.01Total ancillary labor & delivery room<br>outpatient days (see instructions)00033.00LTCH non-covered days0000  |        |   |                           |              |             |           |                                  | 26.00            |
| 27.00Total (sum of lines 14-26)0.0063028.00Observation Bed Days0029.00Ambulance Trips0030.00Employee discount days (see instruction)0031.00Employee discount days - IRF0032.00Labor & delivery days (see instructions)0032.01Total ancillary labor & delivery room00000033.00LTCH non-covered days00   |        |   | О                         | 0            |             | 0 0.00    | 0.00                             |                  |
| 28.00Observation Bed Days0029.00Ambulance Trips0030.00Employee discount days (see instruction)031.00Employee discount days - IRF032.00Labor & delivery days (see instructions)032.01Total ancillary labor & delivery room0outpatient days (see instructions)0033.00LTCH non-covered days0  |        |   |                           |              |             |           |                                  |                  |
| 30.00Employee discount days (see instruction)031.00Employee discount days - IRF032.00Labor & delivery days (see instructions)0032.01Total ancillary labor & delivery room<br>outpatient days (see instructions)0033.00LTCH non-covered days00  | 28.00  | Observation Bed Days  |                           | 0            |             | 0         |                                  | 28.00            |
| 31.00       Employee discount days - IRF       0         32.00       Labor & delivery days (see instructions)       0       0         32.01       Total ancillary labor & delivery room outpatient days (see instructions)       0       0         33.00       LTCH non-covered days       0       0   | 29.00  | Ambulance Trips   | 0                         |              |             |           |                                  | 29.00            |
| 32.00       Labor & delivery days (see instructions)       0       0       0         32.01       Total ancillary labor & delivery room outpatient days (see instructions)       0       0       0         33.00       LTCH non-covered days       0       0       0       0  | 30. 00 | Employee discount days (see instruction)                            |                           |              |             | 0         |                                  | 30.00            |
| 32.01       Total ancillary labor & delivery room outpatient days (see instructions)       0         33.00       LTCH non-covered days       0   |        |   |                           |              |             |           |                                  | 31.00            |
| outpatient days (see instructions)       33.00       LTCH non-covered days   |        |   | 0                         | 0            |             |           |                                  | 32.00            |
| 33.00 LTCH non-covered days 0  | 32.01  |   |                           |              |             | 0         |                                  | 32.01            |
| 5  |        |   |                           |              |             |           |                                  |                  |
| 33. UT LITCH SITE DEUTRAL GAVS AND DISCHARGES 1 01 1   |        |   | -                         |              |             |           |                                  | 33.00            |
| 34.00 Temporary Expansion COVID-19 PHE Acute Care 0 0 0  |        |   |                           | ~            |             | 0         |                                  | 33.01<br>34.00   |

| OSPI T       | AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC  | AL DATA                                     | Provider CO |             | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet S-3<br>Part I<br>Date/Time Pre<br>5/20/2024 11:0 | pared |
|--------------|--|---|-------------|-------------|---|--|-------|
|              |  | Full Time                                   |             | Di so       | charges                                     |  |       |
|              | Component  | <u>Equi val ents</u><br>Nonpai d<br>Workers | Title V     | Title XVIII | Title XIX                                   | Total All<br>Patients                                      |       |
|              |  | 11.00                                       | 12.00       | 13.00       | 14.00                                       | 15.00  |       |
|              | PART I - STATISTICAL DATA  |   |             |             | .1  |  |       |
| . 00         | Hospital Adults & Peds. (columns 5, 6, 7 and<br>8 exclude Swing Bed, Observation Bed and<br>Hospice days)(see instructions for col. 2<br>for the portion of LDP room available beds) |   | 0           | 32          | 9 108                                       | 848  | 1.0   |
| . 00         | HMO and other (see instructions)   |   |             |             | 0 0   |  | 2.0   |
| . 00         | HMO I PF Subprovi der  |   |             |             | 0   |  | 3.0   |
| . 00         | HMO IRF Subprovider  |   |             |             | 0   |  | 4.0   |
| . 00         | Hospital Adults & Peds. Swing Bed SNF  |   |             |             |   |  | 5.0   |
| . 00         | Hospital Adults & Peds. Swing Bed NF   |   |             |             |   |  | 6. (  |
| . 00         | Total Adults and Peds. (exclude observation beds) (see instructions)   |   |             |             |   |  | 7.    |
| . 00         | INTENSIVE CARE UNIT  |   |             |             |   |  | 8.    |
| 00           | CORONARY CARE UNIT   |   |             |             |   |  | 9.    |
| ). 00        | BURN INTENSIVE CARE UNIT   |   |             |             |   |  | 10.   |
| . 00         | SURGI CAL I NTENSI VE CARE UNI T   |   |             |             |   |  | 11.   |
| 2.00         | OTHER SPECIAL CARE (SPECIFY)<br>NURSERY  |   |             |             |   |  | 12.   |
| 1.00         | Total (see instructions)   | 0.00  | 0           | 32          | 9 108                                       | 848  |       |
| 5.00         | CAH visits   | 0.00  | 0           |             | 7 100                                       | 040  | 14.   |
| . 10         | REH hours and visits   |   |             |             |   |  | 15.   |
| b. 00        | SUBPROVI DER – I PF  |   |             |             |   |  | 16.   |
| . 00         | SUBPROVI DER – I RF  |   |             |             |   |  | 17.   |
| 8. 00        | SUBPROVI DER   |   |             |             |   |  | 18.   |
| . 00         | SKILLED NURSING FACILITY   | 0.00  |             |             |   |  | 19.   |
| . 00         | NURSING FACILITY   | 0.00  |             |             |   |  | 20.   |
|              | OTHER LONG TERM CARE   | 0.00  |             |             |   | 20   |       |
| . 00         | HOME HEALTH AGENCY   |   |             |             |   |  | 22    |
| 3. 00        | AMBULATORY SURGICAL CENTER (D. P. )  |   |             |             |   |  | 23.   |
| . 00         |  |   |             |             |   |  | 24.   |
| . 10<br>. 00 | HOSPICE (non-distinct part)  |   |             |             |   |  | 24    |
| . 00         | CMHC - CMHC<br>RURAL HEALTH CLINIC   |   |             |             |   |  | 25    |
| . 25         | FEDERALLY QUALIFIED HEALTH CENTER  | 0.00  |             |             |   |  | 26    |
| . 23         | Total (sum of lines 14-26)   | 0.00  |             |             |   |  | 27    |
| . 00         | Observation Bed Days   | 0.00  |             |             |   |  | 28    |
| . 00         | Ambul ance Trips   |   |             |             |   |  | 29    |
| . 00         | Employee discount days (see instruction)   |   |             |             |   |  | 30.   |
| . 00         | Employee discount days - IRF   |   |             |             |   |  | 31.   |
| . 00         | Labor & delivery days (see instructions)   |   |             |             |   |  | 32.   |
| 2. 01        | Total ancillary labor & delivery room<br>outpatient days (see instructions)  |   |             |             |   |  | 32.   |
| 8.00         | LTCH non-covered days  |   |             |             | 0   |  | 33.   |
| 3. 01        | LTCH site neutral days and discharges  |   |             |             | 0   |  | 33.   |
| ł. 00        | Temporary Expansion COVID-19 PHE Acute Care  |   |             |             |   |  | 34.   |

| PLIA | AL WAGE INDEX INFORMATION                                     |                        |                    | Provider CO   | F   | Period:<br>From 01/01/2023<br>Fo 12/31/2023       |   | pare  |
|------|---|------------------------|--------------------|---|---|---|---|-------|
|      |   | Wkst. A Line<br>Number | Amount<br>Reported | Reclassificati<br>on of Salaries<br>(from Wkst.<br>A-6) | Adj usted<br>Sal ari es<br>(col . 2 ± col .<br>3) | Paid Hours<br>Related to<br>Salaries in<br>col. 4 | Average Hourly<br>Wage (col. 4 ÷<br>col. 5) |       |
|      | PART II - WAGE DATA   | 1.00                   | 2.00               | 3.00  | 4.00  | 5.00  | 6.00  |       |
|      | SALARIES  |                        |                    |   |   |   |   |       |
| o [  | Total salaries (see   | 200. 00                | 56, 738, 214       | 0   | 56, 738, 214                                      | 1, 388, 530. 00                                   | 40.86                                       | 1     |
|      | instructions)   |                        |                    |   |   |   | 0.00  |       |
| 0    | Non-physician anesthetist Part<br>A                           |                        | C                  | 0   | (   | 0.00  | 0.00  | 2     |
| 0    | Non-physician anesthetist Part                                |                        | C                  | 0   | (   | 0.00  | 0.00  | 3     |
|      | В   |                        |                    | _   |   |   |   |       |
| 0    | Physician-Part A -<br>Administrative                          |                        | C                  | 0   | (   | 0.00  | 0.00  | 4     |
| 1    | Physicians - Part A - Teaching                                |                        | C                  | 0   | (   | 0.00  | 0.00  | 4     |
|      | Physician and Non   |                        | C                  | 0   | (   | 0.00  |   |       |
| _    | Physician-Part B  |                        | ~                  |   | ,   |   | 0.00  |       |
| 0    | Non-physician-Part B for<br>hospital-based RHC and FQHC       |                        | C                  | 0   |   | 0.00  | 0.00  | 6     |
|      | servi ces   |                        |                    |   |   |   |   |       |
| 0    | Interns & residents (in an                                    | 21.00                  | C                  | 0   | (   | 0.00  | 0.00  | 7     |
| 1    | approved program)   |                        | C                  | 0   |   |   | 0.00  |       |
| 1    | Contracted interns and residents (in an approved              |                        | Ĺ                  | 0   |   | 0.00  | 0.00  | 7     |
|      | programs)   |                        |                    |   |   |   |   |       |
| 0    | Home office and/or related                                    |                        | C                  | 0   | (   | 0.00  | 0.00  | 8     |
| o    | organization personnel<br>SNF                                 | 44.00                  | 16, 163, 358       | 0   | 16, 163, 358                                      | 405, 927. 00                                      | 39. 82                                      | 9     |
|      | Excluded area salaries (see                                   | 11.00                  | 11, 446, 892       |   |   |   |   |       |
| ļ    | instructions)   |                        |                    |   |   |   |   |       |
|      | OTHER WAGES & RELATED COSTS<br>Contract Labor: Direct Patient |                        | (                  | 0   | · · · · · · · · · · · · · · · · · · ·             | 0.00  | 0.00  | 1 1 1 |
| 00   | Care  |                        | Ĺ                  | 0   |   | 0.00  | 0.00  |       |
| 00   | Contract Labor: Top Level                                     |                        | C                  | 0   | (   | 0.00  | 0.00  | 12    |
|      | management and other  |                        |                    |   |   |   |   |       |
|      | management and administrative services                        |                        |                    |   |   |   |   |       |
| 00   | Contract Labor: Physician-Part                                |                        | C                  | 0   | (   | 0.00  | 0.00  | 13    |
|      | A - Administrative  |                        |                    | _   |   |   |   |       |
| 00   | Home office and/or related organization salaries and          |                        | C                  | 0   | (   | 0.00  | 0.00  | 14    |
|      | wage-related costs  |                        |                    |   |   |   |   |       |
|      | Home office salaries  |                        | C                  | 0   | (   | 0.00  |   |       |
|      | Related organization salaries                                 |                        | C                  | -   | (   | 0.00  |   |       |
| 00   | Home office: Physician Part A<br>- Administrative             |                        | Ĺ                  | 0   |   | 0.00  | 0.00  |       |
| 00   | Home office and Contract                                      |                        | C                  | 0   | (   | 0.00  | 0.00  | 16    |
|      | Physicians Part A - Teaching                                  |                        |                    |   |   |   | 0.00  |       |
| 01   | Home office Physicians Part A<br>- Teaching                   |                        | C                  | 0   |   | 0.00  | 0.00  |       |
| 02   | Home office contract  |                        | C                  | 0   | (   | 0.00  | 0.00  | 16    |
|      | Physicians Part A - Teaching                                  |                        |                    |   |   |   |   |       |
|      | WAGE-RELATED COSTS<br>Wage-related costs (core) (see          |                        | 10, 234, 574       | 0   | 10, 234, 574                                      | 1   |   | 1 17  |
|      | instructions)   |                        | 10, 204, 074       |   | 10, 234, 374                                      | `   |   | ''    |
| 00   | Wage-related costs (other)                                    |                        |                    |   |   |   |   | 18    |
| 00   | (see instructions)  |                        | 2 100 700          | 0   | 2 100 700   | 2   |   | 19    |
|      | Excluded areas<br>Non-physician anesthetist Part              |                        | 2, 109, 708<br>C   |   | 2, 109, 708                                       |   |   | 20    |
| -    | A   |                        |                    |   |   |   |   | _ `   |
| 00   | Non-physician anesthetist Part                                |                        | C                  | 0   | (   | ס   |   | 21    |
| 00   | B<br>Physician Part A -                                       |                        | C                  |   | (   |   |   | 22    |
|      | Admi ni strati ve   |                        | C                  |   |   | -   |   |       |
|      | Physician Part A - Teaching                                   |                        | C                  | 0   | (   | D   |   | 22    |
|      | Physician Part B  |                        | 0                  | 0   |   |   |   | 23    |
|      | Wage-related costs (RHC/FQHC)<br>Interns & residents (in an   |                        | ſ                  |   |   |   |   | 22    |
|      | approved program)   |                        |                    |   |   |   |   | _``   |
| 50   | Home office wage-related                                      |                        | C                  | 0   | (   | ס   |   | 25    |
| 51   | (core)<br>Related organization                                |                        | C                  | 0   |   |   |   | 25    |
|      | wage-related (core)   |                        | Ĺ                  | , 0   |   |   |   | 20    |
|      | Home office: Physician Part A                                 |                        | C                  | 0   |   | ס   |   | 25    |
|      | - Administrative -  |                        |                    |   |   |   |   | 1     |

| Heal th | Financial Systems                            |              | RAMAPO RIDGE | PSYCHI ATRI C    |               | In Lie                                      | eu of Form CMS-2         | 2552-10 |
|---------|--|--------------|--------------|------------------|---------------|---|--------------------------|---------|
|         | AL WAGE INDEX INFORMATION                    |              |              | Provider C       |               | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet S-3<br>Part II | pared:  |
|         |  | Wkst. A Line | Amount       | Reclassi fi cati | Adj usted     | Paid Hours                                  | Average Hourly           |         |
|         |  | Number       | Reported     | on of Salaries   | Sal ari es    | Related to                                  | Wage (col. 4 ÷           |         |
|         |  |              |              | (from Wkst.      | (col.2 ± col. | Salaries in                                 | col. 5)                  |         |
|         |  |              |              | A-6)             | 3)            | col. 4                                      |                          |         |
|         |  | 1.00         | 2.00         | 3.00             | 4.00          | 5.00  | 6.00                     |         |
| 25.53   | Home office: Physicians Part A               |              | 0            | 0                |               | 0   |                          | 25.53   |
|         | - Teaching - wage-related                    |              |              |                  |               |   |                          |         |
|         | (core)                                       |              |              |                  |               |   |                          |         |
|         | OVERHEAD COSTS - DIRECT SALARII              |              |              |                  |               |   | 1                        |         |
| 26.00   | Employee Benefits Department                 | 4.00         |              | 0                |               | 0 0.00                                      |                          |         |
| 27.00   | Administrative & General                     | 5.00         | 7,084,723    | 0                | 7, 084, 72    |   |                          |         |
| 28.00   | Administrative & General under               |              | 0            | 0                |               | 0 0.00                                      | 0.00                     | 28.00   |
|         | contract (see inst.)                         |              |              |                  |               |   |                          |         |
| 29.00   | Maintenance & Repairs                        | 6.00         | 0            | 0                |               | 0 0.00                                      |                          | 29.00   |
| 30.00   | Operation of Plant                           | 7.00         | 1, 375, 440  | 0                | 1, 375, 44    | 0 61, 126. 00                               | 22.50                    | 30.00   |
| 31.00   | Laundry & Linen Service                      | 8.00         | 616, 296     | 0                | 616, 29       |   |                          |         |
| 32.00   | Housekeepi ng                                | 9.00         | 1, 482, 525  | 0                | 1, 482, 52    | 5 76, 327. 00                               | 19. 42                   | 32.00   |
| 33.00   | Housekeeping under contract                  |              | 0            | 0                |               | 0 0.00                                      | 0.00                     | 33.00   |
|         | (see instructions)                           |              |              |                  |               |   |                          |         |
| 34.00   | Dietary                                      | 10.00        | 4, 544, 126  | 0                | 4, 544, 12    | 6 151, 085. 00                              | 30.08                    | 34.00   |
| 35.00   | Dietary under contract (see                  |              | 0            | 0                |               | 0 0.00                                      | 0.00                     | 35.00   |
| 36.00   | i nstructi ons)<br>Cafeteri a                | 11.00        | 0            | 0                |               | 0 0.00                                      | 0.00                     | 36, 00  |
| 37.00   | Maintenance of Personnel                     | 12.00        | 0            | 0                |               | 0 0.00                                      |                          |         |
| 37.00   | Nursing Administration                       | 12.00        | 0            | 0                |               | 0 0.00                                      |                          |         |
|         | 5  |              | 0            | 0                |               |   |                          |         |
| 39.00   | Central Services and Supply                  | 14.00        | 0            | 0                |               | 0 0.00                                      |                          |         |
| 40.00   | Pharmacy                                     | 15.00        | 0            | 0                |               | 0 0.00                                      |                          | 40.00   |
| 41.00   | Medical Records & Medical<br>Records Library | 16.00        | 0            | 0                |               | 0 0.00                                      | 0.00                     | 41.00   |
| 42.00   | Soci al Servi ce                             | 17.00        | Ο            | 0                |               | 0 0.00                                      | 0.00                     | 42.00   |
| 43.00   | Other General Service                        | 18.00        |              |                  |               |   |                          | 43.00   |
|         |  | 1 10.00      | 000,217      |                  | 1 000,21      | . 1, 020.00                                 | 1 00.01                  | 1.0.00  |

| 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 CO       |               | Period:<br>From 01/01/2023<br>To 12/31/2023 |                  |         |
|         |                                | Worksheet A | Amount       | Recl assi fi cati | Adj usted     | Paid Hours                                  | Average Hourly   |         |
|         |                                | Line Number |              | on of Salaries    | , J           |   | Wage (col. 4 ÷   |         |
|         |                                |             | ·            | (from             | (col.2 ± col. |   | 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              |             | 56, 738, 214 | 0                 | 56, 738, 21   | 4 1, 388, 530. 00                           | 40. 86           | 1.00    |
|         | instructions)                  |             |              |                   |               |   |                  |         |
| 2.00    | Excluded area salaries (see    |             | 27, 610, 250 | 0                 | 27, 610, 25   | 0 552, 117. 00                              | 50. 01           | 2.00    |
|         | instructions)                  |             |              |                   |               |   |                  |         |
| 3.00    | Subtotal salaries (line 1      |             | 29, 127, 964 | 0                 | 29, 127, 96   | 4 836, 413. 00                              | 34. 82           | 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                                      | 35.14            | 5.00    |
|         | (see inst.)                    |             |              |                   |               |   |                  |         |
| 6.00    | Total (sum of lines 3 thru 5)  |             | 39, 362, 538 |                   | 39, 362, 53   |   |                  |         |
| 7.00    | Total overhead cost (see       |             | 15, 609, 327 | 0                 | 15, 609, 32   | 7 464, 383. 00                              | 33. 61           | 7.00    |
|         | instructions)                  |             |              |                   | I             |   |                  |         |

| Heal th | Financial Systems  | RAMAPO RIDGE PS    | YCHI ATRI C            | In Lie                | eu of Form CMS-:               | 2552-10 |
|---------|--|--------------------|------------------------|-----------------------|--------------------------------|---------|
| HOSPI T | AL WAGE RELATED COSTS  |                    | Provider CCN: 31-40    | From 01/01/2023       |                                |         |
|         |  |                    |                        | To 12/31/2023         | Date/Time Pre<br>5/20/2024 11: |         |
|         |  |                    |                        |                       | Amount                         |         |
|         |  |                    |                        |                       | Reported                       |         |
|         |  |                    |                        |                       | 1.00                           |         |
|         | PART IV - WAGE RELATED COSTS   |                    |                        |                       |                                |         |
|         | Part A - Core List   |                    |                        |                       |                                |         |
|         | RETI REMENT COST   |                    |                        |                       |                                |         |
| 1.00    | 401K Employer Contributions  |                    |                        |                       | 622, 832                       | 1.00    |
| 2.00    | Tax Sheltered Annuity (TSA) Employer Contribu                                      |                    |                        |                       | 0                              |         |
| 3.00    | Nonqualified Defined Benefit Plan Cost (see  |                    |                        |                       | 0                              |         |
| 4.00    | Qualified Defined Benefit Plan Cost (see ins                                       |                    |                        |                       | 218, 971                       | 4.00    |
| 5.00    | PLAN ADMINISTRATIVE COSTS (Paid to External (<br>401K/TSA Plan Administration fees | urgani zati on)    |                        |                       | 0                              | 5.00    |
| 6.00    | Legal /Accounting/Management Fees-Pension Plan                                     | n                  |                        |                       | 0                              | 6,00    |
| 7.00    | Employee Managed Care Program Administration                                       |                    |                        |                       | 0                              |         |
| 7.00    | HEALTH AND INSURANCE COST  | 1 665              |                        |                       | 0                              | 7.00    |
| 8.00    | Heal th Insurance (Purchased or Self Funded)                                       |                    |                        |                       | 0                              | 8.00    |
| 8.01    | Heal th Insurance (Self Funded without a Third                                     | d Party Administr  | rator)                 |                       | 0                              |         |
| 8.02    | Health Insurance (Self Funded with a Third Pa                                      |                    |                        |                       | 0                              |         |
| 8.03    | Heal th Insurance (Purchased)  | ar eg nam moera ee | . ,                    |                       | 4, 753, 535                    |         |
| 9.00    | Prescription Drug Plan   |                    |                        |                       | 0                              |         |
| 10.00   | Dental, Hearing and Vision Plan  |                    |                        |                       | 0                              |         |
| 11.00   | Life Insurance (If employee is owner or bene                                       | fi ci ary)         |                        |                       | 54, 127                        | 11.00   |
| 12.00   | Accident Insurance (If employee is owner or I                                      |                    |                        |                       | 0                              | 12.00   |
| 13.00   | Disability Insurance (If employee is owner o                                       | r beneficiary)     |                        |                       | 40, 399                        | 13.00   |
| 14.00   | Long-Term Care Insurance (If employee is own                                       | er or beneficiary  | ')                     |                       | 0                              | 14.00   |
| 15.00   | 'Workers' Compensation Insurance   |                    |                        |                       | 842, 289                       | 15.00   |
| 16.00   | Retirement Health Care Cost (Only current year                                     | ar, not the extra  | ordinary accrual req   | uired by FASB 106.    | 0                              | 16.00   |
|         | Noncumulative portion)   |                    |                        |                       |                                |         |
|         | TAXES  |                    |                        |                       | 1                              |         |
|         | FICA-Employers Portion Only  |                    |                        |                       | 3, 477, 286                    |         |
| 18.00   | Medicare Taxes - Employers Portion Only  |                    |                        |                       |                                | 18.00   |
| 19.00   | Unemployment Insurance   |                    |                        |                       | 110,000                        |         |
| 20.00   | State or Federal Unemployment Taxes  |                    |                        |                       | 299, 122                       | 20.00   |
| 21 00   | OTHER<br>Executive Deferred Compensation (Other Than )                             | Dati rement Cost D | concreted on Lines 1 t | brough 4 above (coo   | 0                              | 21.00   |
| 21.00   | instructions))   | RELITEMENT COST R  | eporteu un rines i t   | in ough 4 above. (See |                                | 21.00   |
| 22.00   | Day Care Cost and Allowances   |                    |                        |                       | 3 312                          | 22.00   |
| 23.00   | Tuition Reimbursement  |                    |                        |                       | 0,312                          |         |
|         | Total Wage Related cost (Sum of lines 1 -23)                                       |                    |                        |                       | 10, 421, 873                   |         |
|         | Part B - Other than Core Related Cost  |                    |                        |                       | ,,                             | 1       |
| 25.00   | OTHER WAGE RELATED COSTS (SPECIFY)   |                    |                        |                       |                                | 25.00   |
|         |  |                    |                        |                       |                                |         |

| Heal th | Financial Systems                            | RAMAPO RIDGE PSY | CHI ATRI C            | In Lie                           | u of Form CMS-2 | 2552-10 |
|---------|--|------------------|-----------------------|----------------------------------|-----------------|---------|
| HOSPI T | AL CONTRACT LABOR AND BENEFIT COST           |                  | Provider CCN: 31-4019 | Peri od:                         | Worksheet S-3   |         |
|         |  |                  |                       | From 01/01/2023<br>To 12/31/2023 |                 | narodi  |
|         |  |                  |                       | 10 12/31/2023                    | 5/20/2024 11:0  | 05 am   |
|         | Cost Center Description                      |                  |                       | Contract Labor                   |                 |         |
|         | · .  |                  |                       | 1.00                             | 2.00            |         |
|         | PART V - Contract Labor and Benefit Cost     |                  |                       |                                  |                 |         |
|         | Hospital and Hospital-Based Component Identi |                  |                       |                                  |                 |         |
| 1.00    | Total facility's contract labor and benefit  | cost             |                       | 0                                | 11, 037, 708    | 1.00    |
| 2.00    | Hospi tal                                    |                  |                       | 0                                | 2, 083, 876     | 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                                | 2, 962, 239     | 8.00    |
| 9.00    | NURSING FACILITY                             |                  |                       | 0                                | 0               | 9.00    |
| 10.00   | OTHER LONG TERM CARE I                       |                  |                       |                                  |                 | 10.00   |
| 11.00   | Hospital-Based HHA                           |                  |                       |                                  |                 | 11.00   |
| 12.00   | AMBULATORY SURGICAL CENTER (D. P.) I         |                  |                       |                                  |                 | 12.00   |
| 13.00   | Hospital-Based Hospice                       |                  |                       |                                  |                 | 13.00   |
| 14.00   | Hospital-Based Health Clinic RHC             |                  |                       |                                  |                 | 14.00   |
| 15.00   | Hospital-Based Health Clinic FQHC            |                  |                       |                                  |                 | 15.00   |
| 16.00   | Hospital-Based-CMHC                          |                  |                       |                                  |                 | 16.00   |
| 17.00   | RENAL DIALYSIS I                             |                  |                       |                                  |                 | 17.00   |
| 18.00   | Other  |                  |                       | 0                                | 5, 991, 593     | 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 OF         | F EXPENSES                  | Provider CO       |               | Period:                          | Worksheet A                    |                 |
|         |   |                             |                   |               | From 01/01/2023<br>To 12/31/2023 | Data /Tima Dra                 | norod.          |
|         |   |                             |                   |               | 10 12/31/2023                    | Date/Time Pre<br>5/20/2024 11: | pareu:<br>05 am |
|         | Cost Center Description                                 | Sal ari es                  | Other             | Total (col 1  | Recl assi fi cati                | Recl assi fi ed                |                 |
|         |   | our ur roo                  | othor             | + 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, 721, 845       | 6, 721, 845   | 5 0                              | 6, 721, 845                    | 1.00            |
| 2.00    | 00200 CAP REL COSTS-MVBLE EQUIP                         |                             | 0                 | (             | -                                |                                | 2.00            |
| 4.00    | 00400 EMPLOYEE BENEFITS DEPARTMENT                      | 0                           | 12, 675, 392      | 12, 675, 392  | 2 0                              | 12, 675, 392                   | 4.00            |
| 5.00    | 00500 ADMI NI STRATI VE & GENERAL                       | 7,084,723                   | 4, 438, 663       | 11, 523, 386  | 5 0                              | 11, 523, 386                   | 5.00            |
| 6.00    | 00600 MAI NTENANCE & REPAI RS                           | 0                           | 0                 | (             | 0 0                              | 0                              | 6.00            |
| 7.00    | 00700 OPERATION OF PLANT                                | 1, 375, 440                 | 3, 790, 322       | 5, 165, 762   | 2 0                              | 5, 165, 762                    | 7.00            |
| 8.00    | 00800 LAUNDRY & LINEN SERVICE                           | 616, 296                    | 241, 083          | 857, 379      | 9 0                              | 857, 379                       | 8.00            |
| 9.00    | 00900 HOUSEKEEPI NG                                     | 1, 482, 525                 | 726, 962          | 2, 209, 487   | 7 0                              | 2, 209, 487                    | 9.00            |
| 10.00   | 01000 DI ETARY  | 4, 544, 126                 | 2, 306, 329       | 6, 850, 455   | 5 0                              | 6, 850, 455                    | 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                                     | 506, 217                    | 6, 645            | 512, 862      | 2 0                              | 512, 862                       | 18.00           |
|         | INPATIENT ROUTINE SERVICE COST CENTERS                  |                             |                   |               |                                  |                                |                 |
| 30.00   |   | 9, 696, 883                 | 159, 940          | 9, 856, 823   | 3 0                              | 9, 856, 823                    | 30.00           |
| 44.00   | 04400 SKILLED NURSING FACILITY                          | 16, 163, 358                | 752, 481          |               |                                  |                                |                 |
| 45.00   |   | 2, 055, 745                 | 90, 949           |               |                                  |                                |                 |
| 46.00   |   | 3, 204, 754                 | 110, 811          | 3, 315, 565   | 5 0                              | 3, 315, 565                    | 46.00           |
|         | ANCI LLARY SERVI CE COST CENTERS                        |                             |                   |               | 1                                |                                |                 |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C                           | 0                           | 184, 828          |               |                                  |                                |                 |
| 60.00   | 06000 LABORATORY  | 0                           | 325, 593          |               |                                  | 325, 593                       | •               |
| 65.00   | 06500 RESPI RATORY THERAPY                              | 0                           | 144, 871          |               |                                  | 144, 871                       |                 |
| 66.00   | 06600 PHYSI CAL THERAPY                                 | 0                           | 2,037,942         |               |                                  |                                |                 |
| 67.00   | 06700 OCCUPATI ONAL THERAPY                             | 0                           | 1, 611, 423       |               |                                  | 1, 611, 423                    |                 |
| 68.00   | 06800 SPEECH PATHOLOGY                                  | 0                           | 394, 517          | 394, 517      |                                  | 394, 517                       | •               |
| 71.00   | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT               | 0                           | 360, 344          |               |                                  | 360, 344                       | •               |
| 73.00   | 07300 DRUGS CHARGED TO PATIENTS                         | 0                           | 1, 269, 946       | 1, 269, 946   | 5 0                              | 1, 269, 946                    | 73.00           |
| ~~ ~~   | OUTPATIENT SERVICE COST CENTERS                         | 0.001.754                   | 510               | 0.000.07      |                                  | 0.000.044                      |                 |
| 90.00   |   | 3, 821, 754                 | 512               | 3, 822, 266   | 5 0                              | 3, 822, 266                    |                 |
| 92.00   |   |                             |                   |               |                                  |                                | 92.00           |
| 110 0   | SPECIAL PURPOSE COST CENTERS                            | 50 554 004                  | 00.054.000        | 00.000.01/    |                                  | 00.000.010                     | 110 00          |
| 118.00  |   | 50, 551, 821                | 38, 351, 398      | 88, 903, 219  | 9 0                              | 88, 903, 219                   | 118.00          |
| 100.00  | NONREI MBURSABLE COST CENTERS                           | 0                           | 240 424           | 240,42        | 4                                | 240,424                        | 100.00          |
|         | D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN             | 0                           | 240, 424          |               |                                  |                                |                 |
|         | 19200 PHYSI CLANS' PRI VATE OFFICES                     | 0                           | 0                 |               | 0                                |                                | 192.00          |
|         | 19202 OTHER NONREI MBURSABLE<br>19201 MEDI CAL DAY CARE | 0                           | 0                 |               |                                  |                                | 192.10          |
|         | 019201 MEDICAL DAY CARE<br>007950 MARKETI NG/GROUP      | °,                          | 2 024 242         |               |                                  |                                | 192.50          |
|         | 107950 MARKETTNG/GROUP                                  | 1, 053, 537<br>2, 357, 957  | 3, 934, 263       |               |                                  |                                |                 |
|         | 207952 HOME HEALTH SERVICES                             | 2, 357, 957<br>2, 774, 899  | 14, 250, 478<br>0 |               |                                  |                                |                 |
| 200.00  |   | 2, 774, 899<br>56, 738, 214 | 56, 776, 563      |               |                                  |                                |                 |
| 200.00  |   | 50, 750, 214                | 50, 770, 505      | 113, 514, 777 | 0                                | 113, 314, 777                  | 1200. 00        |

| Health Financial Systems                            | RAMAPO RIDGE | PSYCHI ATRI C         | In Lieu of Form CMS-25           |   |  |
|---|--------------|-----------------------|----------------------------------|---|--|
| RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C | F EXPENSES   | Provider CCN: 31-4019 | Peri od:                         | Worksheet A                               |  |
|   |              |                       | From 01/01/2023<br>To 12/31/2023 | Data /Tima Dranaradi                      |  |
|   |              |                       | 10 12/31/2023                    | Date/Time Prepared:<br>5/20/2024 11:05 am |  |
| Cost Center Description                             | Adjustments  | Net Expenses          | _l .                             | 0, 20, 2021 111 00 am                     |  |
|   |              | For Allocation        |                                  |   |  |
|   | 6.00         | 7.00                  |                                  |   |  |
| GENERAL SERVICE COST CENTERS                        |              |                       |                                  |   |  |
| 1.00 00100 CAP REL COSTS-BLDG & FIXT                | -323, 551    | 6, 398, 294           |                                  | 1.00                                      |  |
| 2.00 00200 CAP REL COSTS-MVBLE EQUIP                | 0            | 0                     |                                  | 2.00                                      |  |
| 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT             | 0            | 12, 675, 392          |                                  | 4.00                                      |  |
| 5. 00 00500 ADMI NI STRATI VE & GENERAL             | -736, 787    | 10, 786, 599          |                                  | 5.00                                      |  |
| 6. 00 00600 MAI NTENANCE & REPAI RS                 | 0            | 0                     |                                  | 6.00                                      |  |
| 7.00 00700 OPERATION OF PLANT                       | 0            | 5, 165, 762           |                                  | 7.00                                      |  |
| 8.00 00800 LAUNDRY & LINEN SERVICE                  | 0            | 857, 379              |                                  | 8.00                                      |  |
| 9. 00 00900 HOUSEKEEPI NG                           | 0            | 2, 209, 487           |                                  | 9.00                                      |  |
| 10. 00 01000 DI ETARY                               | -21, 674     | 6, 828, 781           |                                  | 10.00                                     |  |
| 11. 00 01100 CAFETERI A                             | 0            | 0                     |                                  | 11.00                                     |  |
| 13.00 01300 NURSING ADMINISTRATION                  | 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            | 512, 862              |                                  | 18.00                                     |  |
| INPATIENT ROUTINE SERVICE COST CENTERS              |              |                       |                                  |   |  |
| 30. 00 03000 ADULTS & PEDI ATRI CS                  | -798, 686    | 9, 058, 137           |                                  | 30.00                                     |  |
| 44.00 04400 SKILLED NURSING FACILITY                | -590, 574    | 16, 325, 265          |                                  | 44.00                                     |  |
| 45.00 04500 NURSING FACILITY                        | -53, 082     | 2, 093, 612           |                                  | 45.00                                     |  |
| 46.00 04600 OTHER LONG TERM CARE                    | 0            | 3, 315, 565           |                                  | 46.00                                     |  |
| ANCI LLARY SERVI CE COST CENTERS                    | 11           | 1                     |                                  |   |  |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                | 0            | 184, 828              |                                  | 54.00                                     |  |
| 60. 00 06000 LABORATORY                             | 0            | 325, 593              |                                  | 60.00                                     |  |
| 65.00 06500 RESPI RATORY THERAPY                    | 0            | 144, 871              |                                  | 65.00                                     |  |
| 66. 00 06600 PHYSI CAL THERAPY                      | 0            | 2, 037, 942           |                                  | 66.00                                     |  |
| 67.00 06700 OCCUPATIONAL THERAPY                    | 0            | 1, 611, 423           |                                  | 67.00                                     |  |
| 68.00 06800 SPEECH PATHOLOGY                        | 0            | 394, 517              |                                  | 68.00                                     |  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 0            | 360, 344              |                                  | 71.00                                     |  |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS              | 0            | 1, 269, 946           |                                  | 73.00                                     |  |
| OUTPATIENT SERVICE COST CENTERS                     | 1 150 0//    | 0.070.000             |                                  |   |  |
|   | -1, 450, 066 | 2, 372, 200           |                                  | 90.00                                     |  |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART |              |                       |                                  | 92.00                                     |  |
| SPECIAL PURPOSE COST CENTERS                        | 0.074.400    | 04.000.700            |                                  |   |  |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)       | -3, 974, 420 | 84, 928, 799          |                                  | 118.00                                    |  |
|   |              | 240,424               |                                  | 100.00                                    |  |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN    | 0            | 240, 424              |                                  | 190.00                                    |  |
| 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES         | 0            | 0                     |                                  | 192.00                                    |  |
| 192. 10 19202 OTHER NONRELIMBURSABLE                | 0            | U                     |                                  | 192.10                                    |  |
| 192. 50 19201 MEDI CAL DAY CARE                     | 0            |                       |                                  | 192.50                                    |  |
| 194. 00 07950 MARKETI NG/GROUP                      | 0            | 4, 987, 800           |                                  | 194.00                                    |  |
| 194. 01 07951 VI LLAGE                              | -636, 400    | 15, 972, 035          |                                  | 194.01                                    |  |
| 194. 02 07952 HOME HEALTH SERVICES                  | 0            | 2, 774, 899           |                                  | 194.02                                    |  |
| 200.00   TOTAL (SUM OF LINES 118 through 199)       | -4, 610, 820 | 108, 903, 957         |                                  | 200.00                                    |  |

| Heal th | Financial Systems      |           | RAMAPO RIDGE | PSYCHI ATRI C |              | In Lieu                    | u of Form CMS-                 | 2552-10          |
|---------|------------------------|-----------|--------------|---------------|--------------|----------------------------|--------------------------------|------------------|
| RECLAS  | SEFECATIONS            |           |              | Provider (    | CCN: 31-4019 | Period:<br>From 01/01/2023 | Worksheet A-                   | 6                |
|         |                        |           |              |               |              |                            | Date/Time Pre<br>5/20/2024 11: | epared:<br>05 am |
|         |                        | Increases |              |               |              |                            |                                |                  |
|         | Cost Center            | Line #    | Sal ary      | 0ther         |              |                            |                                |                  |
|         | 2.00                   | 3.00      | 4.00         | 5.00          |              |                            |                                |                  |
|         | A – DEFAULT            |           |              |               |              |                            |                                |                  |
| 1.00    |                        | 0.00      | 0            | 0             |              |                            |                                | 1.00             |
|         | 0                      |           | 0            | 0             |              |                            |                                |                  |
| 500.00  | Grand Total: Increases |           | 0            | 0             |              |                            |                                | 500.00           |

| Heal th | Financial Systems      |           | RAMAPO RIDGE | PSYCHI ATRI C |               | In Lieu                    | u of Form CMS-                 | -2552-10         |
|---------|------------------------|-----------|--------------|---------------|---------------|----------------------------|--------------------------------|------------------|
| RECLASS | SEFECATIONS            |           |              | Provi der (   | CCN: 31-4019  | Period:<br>From 01/01/2023 | Worksheet A-                   | 6                |
|         |                        |           |              |               |               |                            | Date/Time Pre<br>5/20/2024 11: | epared:<br>05 am |
|         |                        | 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           |

|        | Financial Systems                             | RAMAPO RIDGE I | PSYCHI ATRI C |                |   | In Lie                             | u of Form CMS-2 | 2552-10 |
|--------|---|----------------|---------------|----------------|---|------------------------------------|-----------------|---------|
| RECONC | ILIATION OF CAPITAL COSTS CENTERS             |                | Provider CC   | CN: 31-4019    |   | iod:<br>m 01/01/2023<br>12/31/2023 |                 | pared:  |
|        |   |                |               | Acqui si ti on | s |                                    |                 |         |
|        |   | 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       | 0             |                | 0 | 0                                  | 0               | 1.00    |
| 2.00   | Land Improvements                             | 4, 202, 816    | 770, 421      |                | 0 | 770, 421                           | 0               | 2.00    |
| 3.00   | Buildings and Fixtures                        | 246, 818, 612  | 13, 670, 615  |                | 0 | 13, 670, 615                       | 0               | 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                             | 38, 715, 357   | 2, 049, 735   |                | 0 | 2, 049, 735                        | 0               | 6.00    |
| 7.00   | HIT designated Assets                         | 0              | 0             |                | 0 | 0                                  | 0               | 7.00    |
| 8.00   | Subtotal (sum of lines 1-7)                   | 290, 728, 818  | 16, 490, 771  |                | 0 | 16, 490, 771                       | 0               | 8.00    |
| 9.00   | Reconciling Items                             | 0              | 0             |                | 0 | 0                                  | 0               | 9.00    |
| 10.00  | Total (line 8 minus line 9)                   | 290, 728, 818  | 16, 490, 771  |                | 0 | 16, 490, 771                       | 0               | 10.00   |
|        |   | Ending Balance | Fully         |                |   |                                    |                 |         |
|        |   | Ũ              | Depreciated   |                |   |                                    |                 |         |
|        |   |                | Assets        |                |   |                                    |                 |         |
|        |   | 6.00           | 7.00          |                |   |                                    |                 |         |
|        | PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET | BALANCES       |               |                |   |                                    |                 |         |
| 1.00   | Land  | 992, 033       | 0             |                |   |                                    |                 | 1.00    |
| 2.00   | Land Improvements                             | 4, 973, 237    | 0             |                |   |                                    |                 | 2.00    |
| 3.00   | Buildings and Fixtures                        | 260, 489, 227  | 0             |                |   |                                    |                 | 3.00    |
| 4.00   | Building Improvements                         | 0              | 0             |                |   |                                    |                 | 4.00    |
| 5.00   | Fixed Equipment                               | 0              | 0             |                |   |                                    |                 | 5.00    |
| 6.00   | Movable Equipment                             | 40, 765, 092   | 0             |                |   |                                    |                 | 6.00    |
| 7.00   | HIT designated Assets                         | 0              | 0             |                |   |                                    |                 | 7.00    |
| 8.00   | Subtotal (sum of lines 1-7)                   | 307, 219, 589  | 0             |                |   |                                    |                 | 8.00    |
| 9.00   | Reconciling Items                             | 0              | 0             |                |   |                                    |                 | 9.00    |
| 10.00  | Total (line 8 minus line 9)                   | 307, 219, 589  | 0             |                |   |                                    |                 | 10.00   |

| Heal th | Financial Systems                             | RAMAPO RIDGE      | PSYCHI ATRI C  |                | In Lie                           | u of Form CMS-2 | 2552-10 |
|---------|---|-------------------|----------------|----------------|----------------------------------|-----------------|---------|
| RECON   | CILIATION OF CAPITAL COSTS CENTERS            |                   | Provider CO    |                | Peri od:                         | Worksheet A-7   |         |
|         |   |                   |                |                | From 01/01/2023<br>To 12/31/2023 |                 | narod   |
|         |   |                   |                |                | 10 12/31/2023                    | 5/20/2024 11:0  |         |
|         |   |                   | SL             | JMMARY OF CAPI | TAL                              |                 |         |
|         |   |                   |                |                |                                  |                 |         |
|         | Cost Center Description                       | Depreciation      | Lease          | Interest       | Insurance (see                   |                 |         |
|         |   |                   |                |                |                                  | instructions)   |         |
|         | 1   | 9.00              | 10.00          | 11.00          | 12.00                            | 13.00           |         |
|         | PART II - RECONCILIATION OF AMOUNTS FROM WOR  |                   |                |                | _                                |                 |         |
| 1.00    | CAP REL COSTS-BLDG & FIXT                     | 4, 725, 668       | 253, 228       | 1, 581, 98     | 0 160, 969                       | 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)                      | 4, 725, 668       | 253, 228       | 1, 581, 98     | 0 160, 969                       | 0               | 3.00    |
|         |   | SUMMARY O         | F CAPI TAL     |                |                                  |                 |         |
|         |   |                   |                |                |                                  |                 |         |
|         | Cost Center Description                       |                   | Total (1) (sum |                |                                  |                 |         |
|         |   | Capi tal -Rel ate |                |                |                                  |                 |         |
|         |   | d Costs (see      | through 14)    |                |                                  |                 |         |
|         |   | instructions)     |                |                |                                  |                 |         |
|         |   | 14.00             | 15.00          |                |                                  |                 |         |
|         | PART II - RECONCILIATION OF AMOUNTS FROM WORK | KSHEET A, COLUM   |                |                |                                  |                 |         |
| 1.00    | CAP REL COSTS-BLDG & FIXT                     | 0                 | 6, 721, 845    |                |                                  |                 | 1.00    |
| 2.00    | CAP REL COSTS-MVBLE EQUIP                     | 0                 | 0              |                |                                  |                 | 2.00    |
| 3.00    | Total (sum of lines 1-2)                      | 0                 | 6, 721, 845    |                |                                  |                 | 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                            | I   | Period:<br>From 01/01/2023<br>Fo 12/31/2023              | Worksheet A-7<br>Part III<br>Date/Time Prep<br>5/20/2024 11:0 |                      |
|   | COM                                 | PUTATION OF RAT                       | -1 0S   | ALLOCATION OF  | OTHER CAPITAL   |                      |
| Cost Center Description   | Gross Assets                        | Capi tal i zed<br>Leases              | Gross Assets<br>for Ratio<br>(col. 1 - col.<br>2) |  | Insurance   |                      |
| PART III - RECONCILIATION OF CAPITAL COSTS CE   | 1.00                                | 2.00                                  | 3.00  | 4.00   | 5.00  |                      |
| 1.00 CAP REL COSTS-BLDG & FIXT<br>2.00 CAP REL COSTS-MVBLE EQUIP<br>3.00 Total (sum of lines 1-2) | 290, 728, 819<br>0<br>290, 728, 819 | 0                                     | 290, 728, 81                                      | 0.000000<br>7.000000                                     | 0<br>0<br>0   | 1.00<br>2.00<br>3.00 |
|   | ALLUCA                              | ITON OF OTHER (                       | APITAL  | SUMMARY O  | F CAPITAL   |                      |
| Cost Center Description   | Taxes                               | Other<br>Capi tal -Rel ate<br>d Costs | Total (sum of<br>cols. 5<br>through 7)            | Depreciation   | Lease   |                      |
|   | 6.00                                | 7.00                                  | 8.00  | 9.00   | 10.00   |                      |
| PART III - RECONCILIATION OF CAPITAL COSTS CE   |                                     |                                       |   |  |   |                      |
| 1.00 CAP REL COSTS-BLDG & FIXT<br>2.00 CAP REL COSTS-MVBLE EQUIP<br>3.00 Total (sum of lines 1-2) | 0                                   | 0                                     |   | 0 4, 572, 852<br>0 0<br>0 4, 572, 852                    | 253, 228<br>0<br>253, 228                                     | 1.00<br>2.00<br>3.00 |
|   | 0                                   | SL                                    | IMMARY OF CAPI                                    |  | 233, 220  | 3.00                 |
| Cost Center Description   | Interest                            | Insurance (see<br>instructions)       |   | Other<br>Capital-Relate<br>d Costs (see<br>instructions) | Total (2) (sum<br>of cols. 9<br>through 14)                   |                      |
|   | 11.00                               | 12.00                                 | 13.00   | 14.00  | 15.00   |                      |
| PART III - RECONCILIATION OF CAPITAL COSTS CE   |                                     |                                       |   |  |   |                      |
| 1.00 CAP REL COSTS-BLDG & FIXT<br>2.00 CAP REL COSTS-MVBLE EQUIP                                  | 1, 411, 245<br>0                    |                                       |   |  | 6, 398, 294<br>0  | 1.00<br>2.00         |
| 3.00 Total (sum of lines 1-2)   | 1, 411, 245                         | e e e e e e e e e e e e e e e e e e e |   |  | 6, 398, 294   | 3.00                 |

| un | i i nanci ai | Systems | KAWAFU | KIDGL |   |
|----|--------------|---------|--------|-------|---|
| th | Fi nanci al  | Suctome | RAMAPO |       | D |

## PSYCHI ATRI C

|              | Financial Systems<br>MENTS TO EXPENSES                           |   | RAMAPO RIDGE | Provi der CCN: 31-4019                                | Peri od:                         | u of Form CMS-2<br>Worksheet A-8 |                |
|--------------|--|---|--------------|---|----------------------------------|----------------------------------|----------------|
|              |  |   |              |   | From 01/01/2023<br>To 12/31/2023 |                                  | pared:         |
|              |  |   |              | Expense Classification of To/From Which the Amount is |                                  | 5/20/2024 11:0                   | <u>05 am</u>   |
|              |  |   |              |   | s to be Aujusted                 |                                  |                |
|              | Cost Center Description  | Basis/Code (2)                          | Amount       | Cost Center   | Line #                           | Wkst. A-7 Ref.                   |                |
|              | cost center bescription  | 1.00                                    | 2.00         | 3.00  | 4.00                             | 5. 00                            |                |
| 1.00         | Investment income - CAP REL<br>COSTS-BLDG & FIXT (chapter 2)     | В                                       | -170, 735    | CAP REL COSTS-BLDG & FIXT                             | 1.00                             | 11                               | 1.0            |
| 2.00         | Investment income - CAP REL                                      |   | C            | CAP REL COSTS-MVBLE EQUIP                             | 2.00                             | 0                                | 2.0            |
| 3.00         | COSTS-MVBLE EQUIP (chapter 2)<br>Investment income - other       |   | C            |   | 0.00                             | 0                                | 3.0            |
| 1.00         | (chapter 2)<br>Trade, quantity, and time                         |   | C            | ADMI NI STRATI VE & GENERAL                           | 5.00                             | 0                                | 4.0            |
| 5.00         | discounts (chapter 8)<br>Refunds and rebates of                  | В                                       | -2.865       | ADMI NI STRATI VE & GENERAL                           | 5.00                             | 0                                | 5.0            |
|              | expenses (chapter 8)   | D                                       | -2,000       |   |                                  |                                  |                |
| 5.00         | Rental of provider space by suppliers (chapter 8)                |   | C            |   | 0.00                             | 0                                | 6.0            |
| 7.00         | Telephone services (pay<br>stations excluded) (chapter<br>21)    | В                                       | C            | ADMI NI STRATI VE & GENERAL                           | 5.00                             | 0                                | 7. C           |
| 8. 00        | Television and radio service                                     | В                                       | C            | OPERATION OF PLANT                                    | 7.00                             | 0                                | 8. C           |
| 9.00         | (chapter 21)<br>Parking lot (chapter 21)                         |   | C            |   | 0.00                             |                                  |                |
| 10. 00       | Provider-based physician<br>adjustment                           | A-8-2                                   | -2, 892, 408 | 3   |                                  | 0                                | 10.0           |
| 11.00        | Sale of scrap, waste, etc.<br>(chapter 23)                       |   | C            |   | 0.00                             | 0                                | 11. C          |
| 2.00         | Related organization   | A-8-1                                   | C            |   |                                  | 0                                | 12.0           |
| 3.00         | transactions (chapter 10)<br>Laundry and linen service           |   | C            |   | 0.00                             |                                  |                |
| 4.00<br>5.00 | Cafeteria-employees and guests<br>Rental of quarters to employee | BB                                      |              | DIETARY<br>CAP REL COSTS-BLDG & FIXT                  | 10.00<br>1.00                    |                                  | 14. (<br>15. ( |
|              | and others   | D                                       |              |   |                                  |                                  |                |
| 6. 00        | Sale of medical and surgical supplies to other than              |   | C            | )   | 0.00                             | 0                                | 16.0           |
| 7.00         | patients<br>Sale of drugs to other than                          |   | C            |   | 0.00                             | 0                                | 17.0           |
| 8.00         | patients<br>Sale of medical records and                          |   | C            |   | 0.00                             | 0                                | 18.0           |
|              | abstracts<br>Nursing and allied health                           |   | -            |   | 0.00                             |                                  |                |
| 9.00         | education (tuition, fees,  |   | Ĺ            |   | 0.00                             | 0                                | 19.0           |
| 20.00        | books, etc.)<br>Vending machines                                 |   | C            |   | 0.00                             | 0                                | 20.0           |
|              | Income from imposition of interest, finance or penalty           | В                                       | -1, 909      | ADMI NI STRATI VE & GENERAL                           | 5.00                             | 0                                | 21. (          |
|              | charges (chapter 21)   |   |              |   |                                  | _                                |                |
| 22.00        | Interest expense on Medicare<br>overpayments and borrowings to   |   | C            |   | 0.00                             | 0                                | 22.0           |
| 23.00        | repay Medicare overpayments<br>Adjustment for respiratory        | A-8-3                                   | ſ            | RESPI RATORY THERAPY                                  | 65.00                            |                                  | 23.0           |
|              | therapy costs in excess of                                       |   |              |   |                                  |                                  | 2010           |
| 24.00        | limitation (chapter 14)<br>Adjustment for physical               | A-8-3                                   | C            | PHYSICAL THERAPY                                      | 66.00                            |                                  | 24.0           |
|              | therapy costs in excess of<br>limitation (chapter 14)            |   |              |   |                                  |                                  |                |
| 25.00        | Utilization review -<br>physicians' compensation                 |   | C            | *** Cost Center Deleted ***                           | * 114.00                         |                                  | 25.0           |
| 04 00        | (chapter 21)   |   | ~            |   | 1.00                             |                                  | 24             |
|              | Depreciation - CAP REL<br>COSTS-BLDG & FIXT                      |   |              | CAP REL COSTS-BLDG & FIXT                             | 1.00                             |                                  |                |
| 27.00        | Depreciation - CAP REL<br>COSTS-MVBLE EQUIP                      |   | C            | CAP REL COSTS-MVBLE EQUIP                             | 2.00                             | 0                                | 27.0           |
| 28.00        | Non-physician Anesthetist<br>Physicians'assistant                |   | 0            | *** Cost Center Deleted ***                           | * 19.00<br>0.00                  |                                  | 28. C          |
|              | Adjustment for occupational therapy costs in excess of           | A-8-3                                   | C            | OCCUPATI ONAL THERAPY                                 | 67.00                            |                                  | 30. C          |
| 0. 99        | limitation (chapter 14)<br>Hospice (non-distinct) (see           |   | C            | ADULTS & PEDIATRICS                                   | 30.00                            |                                  | 30. 9          |
| 31.00        | instructions)<br>Adjustment for speech                           | A-8-3                                   |              | SPEECH PATHOLOGY                                      | 68.00                            |                                  | 31.0           |
|              | pathology costs in excess of<br>limitation (chapter 14)          | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, |              |   |                                  |                                  |                |
| 32.00        | CAH HIT Adjustment for<br>Depreciation and Interest              |   | C            |   | 0.00                             | 0                                | 32.0           |
| 33.00        | CONSULTING FEES  | В                                       | -369, 421    | ADMI NI STRATI VE & GENERAL                           | 5.00                             | 0                                | 33. (          |

| Health Financial Systems             |                | RAMAPO RIDGE | PSYCHI ATRI C               | In Lie                           | u of Form CMS-2 | 2552-10 |
|--------------------------------------|----------------|--------------|-----------------------------|----------------------------------|-----------------|---------|
| ADJUSTMENTS TO EXPENSES              |                |              | Provider CCN: 31-4019       | Peri od:                         | Worksheet A-8   |         |
|                                      |                |              |                             | From 01/01/2023<br>To 12/31/2023 | Date/Time Pre   | nared   |
|                                      |                |              |                             | 10 12/31/2023                    | 5/20/2024 11:0  |         |
|                                      |                |              | Expense Classification o    |                                  |                 |         |
|                                      |                |              | To/From Which the Amount is | s to be Adjusted                 |                 |         |
|                                      |                |              |                             |                                  |                 |         |
|                                      |                |              |                             |                                  |                 |         |
|                                      |                |              |                             |                                  |                 |         |
| Cost Center Description B            | Basis/Code (2) | Amount       | Cost Center                 | Line #                           | Wkst. A-7 Ref.  |         |
| · F                                  | 1.00           | 2.00         | 3.00                        | 4.00                             | 5.00            |         |
| 34.00 JURY DUTY                      | В              | -115         | ADMI NI STRATI VE & GENERAL | 5.00                             | 0               | 34.00   |
| 36.00 SALE OF MEDICAL RECORDS        | В              | -8,044       | ADMINISTRATIVE & GENERAL    | 5.00                             | 0               | 36.00   |
| 37.00 MEMBERSHIP DUES                | A              | -873         | ADMINISTRATIVE & GENERAL    | 5.00                             | 0               | 37.00   |
| 38.00 RETURNED CHECK CHARGE          | В              | -250         | ADMINISTRATIVE & GENERAL    | 5.00                             | 0               | 38.00   |
| 39.00 OTHER REVENUE                  | В              | -1, 583      | ADMINISTRATIVE & GENERAL    | 5.00                             | 0               | 39.00   |
| 40.00 SALE OF NEWSPAPERS             | В              | -256         | ADMINISTRATIVE & GENERAL    | 5.00                             | 0               | 40.00   |
| 41.00 INTERNAL MGMT FEES             | A              | -636, 400    | VI LLAGE                    | 194.01                           | 0               | 41.00   |
| 42.00 REFUND BED TAX                 | В              | -326, 186    | ADMINISTRATIVE & GENERAL    | 5.00                             | 0               | 42.00   |
| 42.01 BADGE REPLACEMENT              | В              | -285         | ADMINISTRATIVE & GENERAL    | 5.00                             | 0               | 42.01   |
| 42.02 BAD DEBTS                      | A              | -25,000      | ADMINISTRATIVE & 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) |                | -4, 610, 820 |                             |                                  |                 | 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.

| Heal th       | Financial Syste | ems                                   | RAMAPO RIDGE                     | PSYCHI ATRI C             |                       | In Lie                                      | eu of Form CMS-  | 2552-10 |
|---------------|-----------------|---------------------------------------|----------------------------------|---------------------------|-----------------------|---|--|---------|
| PROVI DE      | R BASED PHYSIC  | I AN ADJUSTMENT                       |                                  | Provider (                |                       | Period:<br>From 01/01/2023<br>To 12/31/2023 | Date/Time Pre  | epared: |
|               | Wkst. A Line #  | Cost Center/Physician<br>Identifier   | Total<br>Remuneration            | Professional<br>Component | Provider<br>Component | RCE Amount                                  | 5/20/2024 11:<br>Physician/Prov<br>ider Component<br>Hours |         |
|               | 1.00            | 2.00                                  | 3.00                             | 4.00                      | 5.00                  | 6.00  | 7.00   |         |
| 1.00          | 30.00           | AGGREGATE-ADULTS &<br>PEDI ATRI CS    | 1, 043, 695                      | 630, 385                  | 413, 310              | 181, 300                                    | 2, 799   | 1.00    |
| 2.00          | 44.00           | AGGREGATE-SKILLED NURSING<br>FACILITY | 656, 193                         | 590, 574                  | 65, 619               | 7 181, 300                                  | 3, 233   | 2.00    |
| 3.00          | 45.00           | AGGREGATE-NURSING FACILITY            | 53, 082                          | 53, 082                   | (                     | 181, 300                                    | 0  | 3.00    |
| 4.00          | 90.00           | AGGREGATE-CLI NI C                    | 1, 611, 184                      | 1, 450, 066               | 161, 118              | 3 181, 300                                  | 6, 960   | 4.00    |
| 5.00          | 0.00            |                                       | 0                                | 0                         | (                     | 0 0   | 0  | 5.00    |
| 6.00          | 0.00            |                                       | 0                                | 0                         | (                     | 0 0   | 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                         | (                     | 0 0   | 0  | 9.00    |
| 10.00         | 0.00            |                                       | 0                                | 0                         | (                     |   | 0  | 10.00   |
| 200.00        |                 |                                       | 3, 364, 154                      | 2, 724, 107               | 640,04                | 7   | 12, 992  |         |
|               | Wkst. A Line #  | Cost Center/Physician                 | Unadjusted RCE                   |                           | Cost of               |   | Physician Cost   |         |
|               |                 | I denti fi er                         | Limit                            | Unadjusted RCE            |                       |   | of Malpractice   |         |
|               |                 |                                       |                                  | Limit                     | Conti nui ng          | Share of col.                               | Insurance  |         |
|               |                 |                                       |                                  |                           | Educati on            | 12  |  |         |
|               | 1.00            | 2.00                                  | 8.00                             | 9.00                      | 12.00                 | 13.00                                       | 14.00  |         |
| 1.00          | 30.00           | AGGREGATE-ADULTS &<br>PEDI ATRI CS    | 243, 971                         | 12, 199                   | (                     | 0 0   | 2, 620   | 1.00    |
| 2.00          | 44.00           | AGGREGATE-SKILLED NURSING             | 281, 799                         | 14, 090                   | (                     | 0 0   | 0  | 2.00    |
| 3.00          | 45.00           | AGGREGATE-NURSING FACILITY            | 0                                | 0                         | (                     | 0 0   | 0  | 3.00    |
| 4.00          |                 | AGGREGATE-CLINIC                      | 606, 658                         | 30, 333                   |                       |   | 0  | 4.00    |
| 5.00          | 0.00            |                                       | 000,000                          | 0,000                     |                       |   | 0  | 5.00    |
| 6.00          | 0.00            |                                       | 0                                | Ŭ                         |                       |   | 0  | 6.00    |
| 7.00          | 0.00            |                                       | 0                                | -                         | (                     |   | 0  | 7.00    |
| 8.00          | 0.00            |                                       | 0                                | -                         |                       |   | 0  | 8.00    |
| 8.00<br>9.00  | 0.00            |                                       | 0                                | , s                       | (                     |   | 0  | 9,00    |
| 9.00<br>10.00 | 0.00            |                                       | 0                                | 0                         |                       |   | 0  | 10.00   |
| 200.00        | 0.00            |                                       | 1, 132, 428                      | 56, 622                   |                       |   | -  | 200.00  |
|               | Wkst. A Line #  | Cost Center/Physician                 | Provi der                        | Adjusted RCE              | RCE                   | Adjustment                                  | 2,020  | 200.00  |
|               | WRSt. A Effic # | I denti fi er                         | Component<br>Share of col.<br>14 | Limit                     | Di sal I owance       | Ag us there                                 |  |         |
|               | 1.00            | 2.00                                  | 15.00                            | 16.00                     | 17.00                 | 18.00                                       |  |         |
| 1.00          |                 | AGGREGATE-ADULTS &<br>PEDIATRICS      | 1, 038                           | 245, 009                  | 168, 30 <sup>-</sup>  | 1 798, 686                                  |  | 1.00    |
| 2.00          | 44.00           | AGGREGATE-SKILLED NURSING             | 0                                | 281, 799                  | (                     | 590, 574                                    |  | 2.00    |
| 3.00          | 45.00           | AGGREGATE-NURSING FACILITY            | 0                                | 0                         | (                     | 53, 082                                     |  | 3.00    |
| 4.00          |                 | AGGREGATE-CLI NI C                    | 0                                | 606, 658                  | (                     | 1, 450, 066                                 |  | 4.00    |
| 5.00          | 0.00            |                                       | 0                                |                           | (                     |   |  | 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                                | -                         |                       |   |  | 8.00    |
| 9.00          | 0.00            |                                       | 0                                | -                         | (                     | -   |  | 9,00    |
| 10.00         | 0.00            |                                       | 0                                | -                         | (                     |   |  | 10.00   |
| 200.00        | 0.00            |                                       | 1,038                            | -                         | 168, 30 <sup>°</sup>  | -   |  | 200.00  |
|               | I               | 1                                     | ., 500                           | ,,                        | , 00                  | , ,   | 1  |         |

|                  | Financial Systems   | RAMAPO RIDGE   |              |             |   | u of Form CMS-  | 2552-10 |
|------------------|---|--|--------------|-------------|---|-----------------|---------|
| COST A           | ALLOCATION - GENERAL SERVICE COSTS                                  |  | Provider C   | CN: 31-4019 | Period:<br>From 01/01/2023<br>To 12/31/2023 |                 |         |
|                  |   |  | CAPI TAL REL | ATED COSTS  |   | 572072024 11.   |         |
|                  |   |  |              |             |   |                 |         |
|                  | Cost Center Description   | Net Expenses<br>for Cost<br>Allocation<br>(from Wkst A | BLDG & FIXT  | MVBLE EQUIP | EMPLOYEE<br>BENEFI TS<br>DEPARTMENT         | Subtotal        |         |
|                  |   | <u>col. 7)</u><br>0                                    | 1.00         | 2.00        | 4.00  | 4A              |         |
|                  | GENERAL SERVICE COST CENTERS  | 0  | 1.00         | 2.00        | 4.00  | 47              |         |
| 1.00             | 00100 CAP REL COSTS-BLDG & FIXT                                     | 6, 398, 294  | 6, 398, 294  |             |   |                 | 1.00    |
| 2.00             | 00200 CAP REL COSTS-MVBLE EQUIP                                     | 0,010,010  | -,           |             | 0   |                 | 2.00    |
| 4.00             | 00400 EMPLOYEE BENEFITS DEPARTMENT                                  | 12, 675, 392   | 59, 440      |             | 0 12, 734, 832                              |                 | 4.00    |
| 5.00             | 00500 ADMINI STRATI VE & GENERAL                                    | 10, 786, 599   |              |             | 0 1, 590, 159                               |                 |         |
| 6.00             | 00600 MAI NTENANCE & REPAI RS                                       | 0  | 0            |             | 0 0   | 0               | 1       |
| 7.00             | 00700 OPERATION OF PLANT  | 5, 165, 762  | 219, 140     |             | 0 308, 716                                  | 5, 693, 618     | 7.00    |
| 8.00             | 00800 LAUNDRY & LINEN SERVICE                                       | 857, 379   | 98, 443      |             | 0 138, 327                                  | 1, 094, 149     | 8.00    |
| 9.00             | 00900 HOUSEKEEPI NG   | 2, 209, 487  | 12, 742      |             | 0 332, 751                                  | 2, 554, 980     |         |
| 10.00            | 01000 DI ETARY  | 6, 828, 781  | 0            |             | 0 1, 019, 925                               |                 |         |
| 11.00            | 01100 CAFETERI A  | 0  | 0            |             | 0 0   | 0               |         |
| 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 SOCI AL SERVI CE  | 0  | 0            |             | 0 0   | 0               | 17.00   |
| 18.00            | 01850 PASTORAL CARE   | 512, 862   | 0            |             | 0 113, 620                                  | 626, 482        | 18.00   |
|                  | INPATIENT ROUTINE SERVICE COST CENTERS                              |  |              |             |   |                 |         |
| 30.00            | 03000 ADULTS & PEDI ATRI CS   | 9, 058, 137  | 732, 496     |             | 0 2, 176, 456                               | 11, 967, 089    | 30.00   |
| 44.00            | 04400 SKILLED NURSING FACILITY                                      | 16, 325, 265   |              |             | 0 3, 627, 846                               | 21, 380, 811    | 44.00   |
| 45.00            | 04500 NURSING FACILITY  | 2, 093, 612  | 379, 952     |             | 0 461, 410                                  | 2, 934, 974     | 45.00   |
| 46.00            | 04600 OTHER LONG TERM CARE  | 3, 315, 565  | 1, 912, 535  |             | 0 719, 304                                  | 5, 947, 404     | 46.00   |
|                  | ANCILLARY SERVICE COST CENTERS                                      |  |              | -           |   |                 |         |
| 54.00            | 05400 RADI OLOGY-DI AGNOSTI C                                       | 184, 828   |              |             | 0 0   | 184, 828        |         |
| 60.00            | 06000 LABORATORY  | 325, 593   | 0            |             | 0 0   | 325, 593        | 60.00   |
| 65.00            | 06500 RESPI RATORY THERAPY  | 144, 871   | 0            |             | 0 0   | 144, 871        |         |
| 66.00            | 06600 PHYSI CAL THERAPY   | 2, 037, 942  |              |             | 0 0   | 2, 275, 048     |         |
| 67.00            | 06700 OCCUPATI ONAL THERAPY   | 1, 611, 423  |              |             | 0 0   |                 |         |
| 68.00            | 06800 SPEECH PATHOLOGY  | 394, 517   | 0            |             | 0 0   |                 |         |
| 71.00            | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                           | 360, 344   |              |             | 0 0   |                 |         |
| 73.00            | 07300 DRUGS CHARGED TO PATIENTS                                     | 1, 269, 946  | 0            |             | 0 0   | 1, 269, 946     | 73.00   |
|                  | OUTPATIENT SERVICE COST CENTERS                                     |  |              | 1           |   |                 |         |
| 90.00            | 09000 CLI NI C  | 2, 372, 200  | 423, 367     |             | 0 857, 789                                  |                 |         |
| 92.00            | 09200 OBSERVATION BEDS (NON-DISTINCT PART                           |  |              |             |   | 0               | 92.00   |
| 440.00           | SPECIAL PURPOSE COST CENTERS  | 04 000 700   | ( 100 00(    |             | 0 44 044 000                                | 00.000.070      | 1110 00 |
| 118.00           |   | 84, 928, 799   | 6, 190, 096  |             | 0 11, 346, 303                              | 83, 332, 072    | 118.00  |
| 100.00           | NONREI MBURSABLE COST CENTERS                                       | 240 424  | 10 105       | 1           |   | 250 (10         | 100.00  |
|                  | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                           | 240, 424   | 18, 195      |             | 0 0   |                 |         |
|                  | 19200 PHYSI CLANS' PRI VATE OFFICES<br>19202 OTHER NONREI MBURSABLE | 0  |              |             | 0 0   |                 | 192.00  |
|                  | 19202 OTHER NONREIMBURSABLE   | 0  | -            |             |   |                 | 192.10  |
|                  | 07950 MARKETI NG/GROUP  | 0<br>4, 987, 800                                       | 100,007      |             | 0 236, 465                                  | 100/00/         |         |
|                  | 07950 MARKETTNG/GROUP   | 4, 987, 800<br>15, 972, 035                            |              |             | 0 236, 465                                  | 16, 501, 276    |         |
|                  | 207951 VILLAGE  | 2, 774, 899  |              |             | 0 529, 241                                  |                 |         |
| 194.0₂<br>200.00 |   | 2, 774, 899  | 0            |             | 022, 823                                    |                 | 200.00  |
| 200.00           |   |  | _            |             | 0 0   |                 | 200.00  |
| 201.00           |   | 108, 903, 957  | 6, 398, 294  |             | 0 12, 734, 832                              |                 |         |
| 202.00           |   | 100, 703, 737  | 0, 370, 294  | I           | 12, 134, 032                                | 1 100, 703, 737 | 1202.00 |

| Heal th | 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                             | Peri od:        | Worksheet B    |         |
|         |  |                     |              |   | From 01/01/2023 | Part I         |         |
|         |  |                     |              |   | To 12/31/2023   | Date/Time Pre  |         |
|         |  |                     |              |   |                 | 5/20/2024 11:  | 05 am   |
|         | Cost Center Description                    | ADMI NI STRATI VE I |              |   |                 | HOUSEKEEPI NG  |         |
|         |  | & GENERAL           | REPAI RS     | PLANT                                   | LINEN SERVICE   |                |         |
|         |  | 5.00                | 6.00         | 7.00                                    | 8.00            | 9.00           |         |
|         | GENERAL SERVICE COST CENTERS               | T T                 |              | 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 ADMINI STRATI VE & GENERAL           | 13, 063, 933        |              |   |                 |                | 5.00    |
| 6.00    | 00600 MAI NTENANCE & REPAI RS              | 0                   | C            |   |                 |                | 6.00    |
| 7.00    | 00700 OPERATION OF PLANT                   | 776, 097            | C            | 6, 469, 71                              | 5               |                | 7.00    |
| 8.00    | 00800 LAUNDRY & LINEN SERVICE              | 149, 143            | C            | 181, 61                                 | 3 1, 424, 905   |                | 8.00    |
| 9.00    | 00900 HOUSEKEEPI NG                        | 348, 269            | C            | 23, 50                                  | 07 0            | 2, 926, 756    | 9.00    |
| 10.00   | 01000 DI ETARY                             | 1, 069, 857         | C            |   | 0 0             | 0              | 10.00   |
| 11.00   | 01100 CAFETERI A                           | 0                   | C            |   | 0 0             | 0              | 11.00   |
| 13.00   | 01300 NURSING ADMINISTRATION               | 0                   | C            |   | 0 0             | 0              | 13.00   |
| 16.00   | 01600 MEDI CAL RECORDS & LI BRARY          | 0                   | C            |   | 0 0             | 0              | 16.00   |
| 17.00   | 01700 SOCIAL SERVICE                       | 0                   | C            |   | 0 0             | 0              | 17.00   |
| 18.00   | 01850 PASTORAL CARE                        | 85, 396             | C            |   | 0 0             | 0              | •       |
| 101.00  | I NPATI ENT ROUTI NE SERVI CE COST CENTERS | 00,070              |              |   | <u> </u>        |                | 10100   |
| 30.00   | 03000 ADULTS & PEDIATRICS                  | 1, 631, 234         | C            | 1, 149, 48                              | 6 270, 731      | 537, 029       | 30.00   |
| 44.00   | 04400 SKI LLED NURSI NG FACI LI TY         | 2, 914, 398         | C            |   |                 | 1, 230, 534    |         |
| 45.00   | 04500 NURSING FACILITY                     | 400, 066            | C            |   |                 | 327, 480       | •       |
| 46.00   | 04600 OTHER LONG TERM CARE                 | 810, 691            | C            |   |                 | 451, 861       |         |
| 40.00   | ANCI LLARY SERVICE COST CENTERS            | 010,071             | C.           | , | 120, 242        | 431,001        | 40.00   |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C              | 25, 194             | C            |   | 0 0             | 0              | 54.00   |
| 60.00   | 06000 LABORATORY                           | 44, 382             | C            |   | 0 0             | 0              | 60.00   |
| 65.00   | 06500 RESPIRATORY THERAPY                  | 19, 747             | 0            |   | 0 0             | 0              | 65.00   |
| 66.00   | 06600 PHYSI CAL THERAPY                    | 310, 112            |              | 65,37                                   | 0               | 30, 544        | 66.00   |
| 67.00   | 06700 OCCUPATI ONAL THERAPY                | 219, 653            |              | 05, 57                                  | 0 0             | 30, 344        | 67.00   |
| 68.00   | 06800 SPEECH PATHOLOGY                     | 53, 777             |              |   | 0 0             | 0              |         |
| 71.00   | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT  | 49, 118             | 0            |   | 0 0             | 0              | 71.00   |
|         |  |                     | C            |   | 0 0             | 0              |         |
| 73.00   | 07300 DRUGS CHARGED TO PATIENTS            | 173, 106            | Ĺ            | /                                       | 0 0             | 0              | 73.00   |
| 00.00   | OUTPATI ENT SERVICE COST CENTERS           | 407.000             | 0            | E00.72                                  | 2               | 270 717        |         |
| 90.00   |  | 497, 989            | Ĺ            | 598, 72                                 | .3 0            | 279, 717       | 90.00   |
| 92.00   | 09200 OBSERVATION BEDS (NON-DISTINCT PART  |                     |              |   |                 |                | 92.00   |
| 110 0   | SPECIAL PURPOSE COST CENTERS               | 0 570 000           |              | ( 000 75                                | 0 4 40 4 005    | 0.057.4/5      | 110 00  |
| 118.00  |  | 9, 578, 229         | C            | 6, 320, 75                              | 9 1, 424, 905   | 2, 857, 165    | 118.00  |
| 100.0   | NONREI MBURSABLE COST CENTERS              | 05.050              |              |   |                 | 15 (00         | 1.00.00 |
|         | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN  | 35, 252             | C            |   |                 |                | 190.00  |
|         | 19200 PHYSI CLANS' PRI VATE OFFI CES       | 1, 528              | C            |   |                 |                | 192.00  |
|         | 19202 OTHER NONREI MBURSABLE               | 0                   | C            |   | 0 0             |                | 192. 10 |
|         | 19201 MEDICAL DAY CARE                     | 22, 231             | C            | 00,70                                   |                 |                | 192. 50 |
|         | 07950 MARKETI NG/GROUP                     | 714, 261            | C            | 28, 97                                  | 7 0             |                | 194.00  |
|         | 07951 VI LLAGE                             | 2, 249, 289         | C            |   | 0 0             |                | 194. 01 |
|         | 207952 HOME HEALTH SERVICES                | 463, 143            | C            |   | 0 0             | 0              | 194. 02 |
| 200.00  |  |                     |              |   |                 |                | 200. 00 |
| 201.00  |  | 0                   | C            |   | 0 0             | 0              | 201.00  |
| 202.00  | ) TOTAL (sum lines 118 through 201)        | 13, 063, 933        | C            | 6, 469, 71                              | 5 1, 424, 905   | 2, 926, 756    | 202.00  |
|         |  |                     |              |   |                 |                |         |

| Health Financial Systems   | RAMAPO RIDGE P   | SYCHI ATRI C |                              | In Lie                                      | u of Form CMS-  | 2552-10          |
|--|------------------|--------------|------------------------------|---|---|------------------|
| COST ALLOCATION - GENERAL SERVICE COSTS                            |                  | Provider C   |                              | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet B<br>Part I<br>Date/Time Pre<br>5/20/2024 11: | pared:           |
| Cost Center Description  | DI ETARY         | CAFETERI A   | NURSI NG<br>ADMI NI STRATI C |   | 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 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  | 8, 918, 563      |              |                              |   |   | 10.00            |
| 11. 00 01100 CAFETERI A  | 2, 922, 431      | 2, 922, 431  |                              |   |   | 11.00            |
| 13.00 01300 NURSI NG ADMI NI STRATI ON                             | 0                | C            |                              | 0   |   | 13.00            |
| 16.00 01600 MEDICAL RECORDS & LIBRARY                              | 0                | C            |                              | 0 0   |   | 16.00            |
| 17.00 01700 SOCIAL SERVICE   | 0                | 0            |                              | 0 0   | 0   | 17.00            |
| 18.00 01850 PASTORAL CARE  | 0                | 41, 343      |                              | 0 0   | 0   | 18.00            |
| INPATIENT ROUTINE SERVICE COST CENTERS                             | - F              |              | -                            | - F   |   |                  |
| 30. 00 03000 ADULTS & PEDI ATRI CS                                 | 679, 639         | 757, 408     |                              | 0 0   | 0   |                  |
| 44.00 04400 SKILLED NURSING FACILITY                               | 3, 482, 994      | 1, 292, 305  | 1                            | 0 0   | 0   |                  |
| 45.00 04500 NURSING FACILITY                                       | 517, 343         | 186, 237     |                              | 0 0   | 0   | •                |
| 46.00 O4600 OTHER LONG TERM CARE                                   | 1, 316, 156      | 329, 390     |                              | 0 0   | 0   | 46.00            |
| ANCI LLARY SERVI CE COST CENTERS                                   |                  |              |                              | 0   | 0   | 54.00            |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                               | 0                | 0            | 1                            | 0 0   | 0   |                  |
| 60. 00 06000 LABORATORY<br>65. 00 06500 RESPI RATORY THERAPY       | 0                | 0            |                              | 0 0   | 0   |                  |
| 66. 00 06600 PHYSI CAL THERAPY                                     | 0                | 0            |                              | 0 0   | 0   |                  |
| 67. 00 06700 0CCUPATI 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 07300 DRUGS CHARGED TO PATIENTS                              | 0                | 0            |                              | 0 0   | 0   |                  |
| OUTPATIENT SERVICE COST CENTERS                                    |                  |              | 1                            | <u> </u>                                    |   |                  |
| 90. 00 09000 CLI NI C  | 0                | 20, 126      |                              | 0 0   | 0   | 90.00            |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART                    |                  |              |                              |   |   | 92.00            |
| SPECIAL PURPOSE COST CENTERS                                       |                  |              |                              |   |   |                  |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)                      | 8, 918, 563      | 2, 626, 809  |                              | 0 0   | 0   | 118.00           |
| NONREI MBURSABLE COST CENTERS                                      |                  |              |                              | -   | -   |                  |
| 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                   | 0                | 0            |                              | 0 0   |   | 190.00           |
| 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES                        | 0                | 0            |                              | 0 0   |   | 192.00           |
| 192. 10 19202 OTHER NONREI MBURSABLE                               | 0                | 235, 895     |                              | 0 0   |   | 192.10           |
| 192. 50 19201 MEDI CAL DAY CARE                                    | 0                | 0            |                              | 0 0   |   | 192.50           |
| 194. 00 07950 MARKETI NG/GROUP                                     | 0                | 59, 727      | 1                            | 0 0   |   | 194.00           |
| 194. 01 07951 VI LLAGE   | 0                | 0            |                              | 0 0   |   | 194.01           |
| 194. 02 07952 HOME HEALTH SERVICES                                 | 0                | C            |                              | 0 0   | 0   | 194.02           |
| 200.00 Cross Foot Adjustments                                      |                  | ~            |                              | 0   | _   | 200.00           |
| 201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201) | 0<br>8, 918, 563 | 2, 922, 431  |                              | 0 0   |   | 201.00<br>202.00 |
| 202.00   TOTAL (Sum TIMES TTO UN OUGH 201)                         | 0, 910, 003      | 2, 722, 431  | I                            | U U   | 0   | 1202.00          |

|        | Financial Systems                         | RAMAPO RIDGE P                             |               |   |                    |                                 | u of Form CMS-  | -2552-10         |
|--------|---|--|---------------|---|--------------------|---------------------------------|---|------------------|
| COST A | LLOCATION - GENERAL SERVICE COSTS         |  | Provider C    | CN: 31-4019   | Peri<br>From<br>To | od:<br>01/01/2023<br>12/31/2023 | Worksheet B<br>Part I<br>Date/Time Pre<br>5/20/2024 11: | epared:<br>05 am |
|        | Cost Center Description                   | OTHER GENERAL<br>SERVI CE<br>PASTORAL CARE | Subtotal      | Intern &<br>Residents Co<br>& Post<br>Stepdown<br>Adjustments |                    | Total                           |   |                  |
|        |   | 18.00                                      | 24.00         | 25.00   | >                  | 26.00                           |   |                  |
|        | 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          |  |               |   |                    |                                 |   | 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                            |  |               |   |                    |                                 |   | 10.00            |
| 10.00  | 01100 CAFETERI A                          |  |               |   |                    |                                 |   | 11.00            |
|        |   |  |               |   |                    |                                 |   |                  |
| 13.00  | 01300 NURSI NG ADMI NI STRATI ON          |  |               |   |                    |                                 |   | 13.00            |
| 16.00  | 01600 MEDICAL RECORDS & LIBRARY           |  |               |   |                    |                                 |   | 16.00            |
| 17.00  | 01700 SOCIAL SERVICE                      | 750.004                                    |               |   |                    |                                 |   | 17.00            |
| 18.00  | 01850 PASTORAL CARE                       | 753, 221                                   |               |   |                    |                                 |   | 18.00            |
|        | INPATIENT ROUTINE SERVICE COST CENTERS    | (00, (00)                                  | 17 101 105    |   |                    | 17 101 105                      |   |                  |
| 30.00  | 03000 ADULTS & PEDIATRICS                 | 408, 489                                   | 17, 401, 105  |   | 0                  | 17, 401, 105                    |   | 30.00            |
| 44.00  | 04400 SKI LLED NURSI NG FACI LI TY        | 276, 884                                   | 33, 952, 782  |   | 0                  | 33, 952, 782                    |   | 44.00            |
| 45.00  | 04500 NURSI NG FACI LI TY                 | 67, 848                                    | 5, 419, 886   |   | 0                  | 5, 419, 886                     |   | 45.00            |
| 46.00  | 04600 OTHER LONG TERM CARE                | 0  | 9, 950, 934   |   | 0                  | 9, 950, 934                     |   | 46.00            |
|        | ANCI LLARY SERVI CE COST CENTERS          | L  |               | 1   |                    |                                 |   |                  |
| 54.00  | 05400 RADI OLOGY-DI AGNOSTI C             | 0  | 210, 022      |   | 0                  | 210, 022                        |   | 54.00            |
| 60.00  | 06000 LABORATORY                          | 0  | 369, 975      |   | 0                  | 369, 975                        |   | 60.00            |
| 65.00  | 06500 RESPI RATORY THERAPY                | 0  | 164, 618      |   | 0                  | 164, 618                        |   | 65.00            |
| 66.00  | 06600 PHYSI CAL THERAPY                   | 0  | 2, 681, 082   |   | 0                  | 2, 681, 082                     |   | 66.00            |
| 67.00  | 06700 OCCUPATI ONAL THERAPY               | 0  | 1, 831, 076   |   | 0                  | 1, 831, 076                     |   | 67.00            |
| 68.00  | 06800 SPEECH PATHOLOGY                    | 0  | 448, 294      | Ļ   | 0                  | 448, 294                        |   | 68.00            |
| 71.00  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0  | 409, 462      |   | 0                  | 409, 462                        |   | 71.00            |
| 73.00  | 07300 DRUGS CHARGED TO PATIENTS           | 0  | 1, 443, 052   | 2   | 0                  | 1, 443, 052                     |   | 73.00            |
|        | OUTPATIENT SERVICE COST CENTERS           |  |               |   |                    |                                 |   |                  |
| 90.00  | 09000 CLI NI C                            | 0  | 5, 049, 911   |   | 0                  | 5, 049, 911                     |   | 90.00            |
| 92.00  | 09200 OBSERVATION BEDS (NON-DISTINCT PART |  |               |   | 0                  |                                 |   | 92.00            |
|        | SPECIAL PURPOSE COST CENTERS              |  |               |   |                    |                                 |   |                  |
| 118.00 | SUBTOTALS (SUM OF LINES 1 through 117)    | 753, 221                                   | 79, 332, 199  | )   | 0                  | 79, 332, 199                    |   | 118.00           |
|        | NONREI MBURSABLE COST CENTERS             |  |               |   | · ·                |                                 |   |                  |
| 190.00 | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 0  | 343, 122      |   | 0                  | 343, 122                        |   | 190.00           |
|        | 19200 PHYSI CLANS' PRI VATE OFFI CES      | 0  | 43,069        |   | 0                  | 43,069                          |   | 192.00           |
|        | 19202 OTHER NONREI MBURSABLE              | l o  | 235, 895      | •   | 0                  | 235, 895                        |   | 192.10           |
|        | 19201 MEDICAL DAY CARE                    | 0  | 281, 767      |   | 0                  | 281, 767                        |   | 192.50           |
|        | 07950 MARKETI NG/GROUP                    | 0  | 6, 056, 475   |   | 0                  | 6, 056, 475                     |   | 194.00           |
|        | 07951 VI LLAGE                            | 0  | 18, 750, 565  |   | 0                  | 18, 750, 565                    |   | 194.00           |
|        | 07952 HOME HEALTH SERVICES                | 0  | 3, 860, 865   |   | 0                  | 3, 860, 865                     |   | 194.02           |
| 200.00 |   | U U  | 3, 000, 003   | 1   | 0                  | 3, 000, 003                     |   | 200.00           |
| 200.00 |   |  |               |   | 0                  | 0                               |   | 200.00           |
| 201.00 |   | 753, 221                                   | 108, 903, 957 |   | 0                  | 108, 903, 957                   |   | 201.00           |
| 202.00 | I I I I I I I I I I I I I I I I I I I     | / 55, 221                                  | 100, 703, 937 | 1   | 9                  | 100, 703, 737                   |   | 1202.00          |

| Health Financial Systems                                | RAMAPO RIDGE   | PSYCHI ATRI C |             | In Lie                                      | u of Form CMS-   | 2552-10 |  |  |  |  |  |
|---|--|---------------|-------------|---|--|---------|--|--|--|--|--|
| ALLOCATION OF CAPITAL RELATED COSTS                     |  | Provider CO   |             | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet B<br>Part II<br>Date/Time Pre<br>5/20/2024 11: | pared:  |  |  |  |  |  |
|   |  | 572072024 11. |             |   |  |         |  |  |  |  |  |
|   | CAPI TAL RELATED COSTS                               |               |             |   |  |         |  |  |  |  |  |
| Cost Center Description                                 | Directly<br>Assigned New<br>Capital<br>Related Costs | BLDG & FIXT   | MVBLE EQUIP | Subtotal                                    | EMPLOYEE<br>BENEFI TS<br>DEPARTMENT                      |         |  |  |  |  |  |
|   | 0  | 1.00          | 2.00        | 2A  | 4.00   |         |  |  |  |  |  |
| GENERAL SERVICE COST CENTERS                            |  |               |             |   |  |         |  |  |  |  |  |
| 1.00 00100 CAP REL COSTS-BLDG & FIXT                    |  |               |             |   |  | 1 1.00  |  |  |  |  |  |
| 2.00 00200 CAP REL COSTS-MVBLE EQUIP                    |  |               |             |   |  | 2.00    |  |  |  |  |  |
| 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT                | 0  | 59, 440       |             | 59, 440                                     | 59, 440  |         |  |  |  |  |  |
| 5. 00 00500 ADMI NI STRATI VE & GENERAL                 | 0  | 687, 175      |             | 687, 175                                    | 7, 425   | 1       |  |  |  |  |  |
| 6.00 00600 MAI NTENANCE & REPAI RS                      | 0  | 0             |             | 0 0   | 0  | 1       |  |  |  |  |  |
| 7.00 00700 OPERATION OF PLANT                           | 0  | 219, 140      |             | 219, 140                                    | 1, 441   | 7.00    |  |  |  |  |  |
| 8.00 00800 LAUNDRY & LINEN SERVICE                      | 0  | 98, 443       |             | 98, 443                                     | 646  | 1       |  |  |  |  |  |
| 9.00 00900 HOUSEKEEPING                                 | 0  | 12, 742       |             | 0 12, 742                                   | 1, 554   |         |  |  |  |  |  |
| 10. 00 01000 DI ETARY                                   | 0  | 0             |             | 0   | 4, 762   | 1       |  |  |  |  |  |
| 11. 00 01100 CAFETERI A                                 | 0  | 0             |             | 0 0   | 0  | 1       |  |  |  |  |  |
| 13.00 01300 NURSI NG ADMI NI STRATI ON                  | 0  | 0             |             | 0 0   | 0  | 13.00   |  |  |  |  |  |
| 16.00 01600 MEDICAL RECORDS & LIBRARY                   | 0  | 0             |             | o o   | 0  | 16.00   |  |  |  |  |  |
| 17.00 01700 SOCIAL SERVICE                              | 0  | 0             |             | o o   | 0  | 17.00   |  |  |  |  |  |
| 18.00 01850 PASTORAL CARE                               | 0  | 0             |             | o o   | 531  | 18.00   |  |  |  |  |  |
| INPATIENT ROUTINE SERVICE COST CENTERS                  |  |               |             |   |  |         |  |  |  |  |  |
| 30. 00 03000 ADULTS & PEDIATRICS                        | 0  | 732, 496      |             | 0 732, 496                                  | 10, 162  | 30.00   |  |  |  |  |  |
| 44.00 04400 SKILLED NURSING FACILITY                    | 0  | 1, 427, 700   |             | 0 1, 427, 700                               | 16, 918  | 44.00   |  |  |  |  |  |
| 45.00 04500 NURSING FACILITY                            | 0  | 379, 952      |             | 379, 952                                    | 2, 154   | 45.00   |  |  |  |  |  |
| 46.00 04600 OTHER LONG TERM CARE                        | 0  | 1, 912, 535   |             | 0 1, 912, 535                               | 3, 359   | 46.00   |  |  |  |  |  |
| ANCILLARY SERVICE COST CENTERS                          | 1  | 1             | 1           |   |  |         |  |  |  |  |  |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                    | 0  |               |             | 0 0   | 0  |         |  |  |  |  |  |
| 60. 00 06000 LABORATORY                                 | 0  | 0             |             | 0 0   | 0  |         |  |  |  |  |  |
| 65. 00 06500 RESPI RATORY THERAPY                       | 0  | 0             |             | 0 0   | 0  |         |  |  |  |  |  |
| 66. 00 06600 PHYSI CAL THERAPY                          | 0  | 237, 106      |             | 237, 106                                    | 0  |         |  |  |  |  |  |
| 67.00 06700 OCCUPATI ONAL THERAPY                       | 0  | 0             |             | 0 0   | 0  |         |  |  |  |  |  |
| 68. 00 06800 SPEECH PATHOLOGY                           | 0  | 0             |             | 0 0   | 0  |         |  |  |  |  |  |
| 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT     | 0  | 0             |             | 0 0   | 0  |         |  |  |  |  |  |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS                  | 0  | 0             |             | 0 0   | 0  | 73.00   |  |  |  |  |  |
| 0UTPATI ENT SERVICE COST CENTERS<br>90. 00 09000 CLINIC | 0  | 423, 367      |             | 423, 367                                    | 4, 005   | 90.00   |  |  |  |  |  |
| 90.00 09200 OBSERVATION BEDS (NON-DISTINCT PART         | 0  | 423, 307      |             | J 423, 367<br>0                             | 4,005  | 90.00   |  |  |  |  |  |
| SPECIAL PURPOSE COST CENTERS                            |  |               |             | 0   |  | 92.00   |  |  |  |  |  |
| 118.00 SUBTOTALS (SUM OF LINES 1 through 117)           | 0  | 6, 190, 096   |             | 6, 190, 096                                 | 52 057   | 118.00  |  |  |  |  |  |
| NONREI MBURSABLE COST CENTERS                           | 0  | 0, 190, 090   |             | 0, 190, 090                                 | 52, 757  | 1110.00 |  |  |  |  |  |
| 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN       | 0  | 18, 195       |             | 0 18, 195                                   | 0  | 190.00  |  |  |  |  |  |
| 192. 00 19200 PHYSI CLANS' PRI VATE OFFICES             | 0  |               |             | 11, 207                                     |  | 192.00  |  |  |  |  |  |
| 192. 10 19202 OTHER NONREI MBURSABLE                    | 0  | 0             |             | 0   |  | 192.10  |  |  |  |  |  |
| 192. 50 19201 MEDI CAL DAY CARE                         | 0  | 163, 089      |             | 163,089                                     |  | 192.50  |  |  |  |  |  |
| 194. 00 07950 MARKETI NG/GROUP                          | 0  | 15, 707       |             | 15, 707                                     |  | 194.00  |  |  |  |  |  |
| 194. 01 07951 VI LLAGE                                  | 0  | 0             |             | 0 0   |  | 194.01  |  |  |  |  |  |
| 194. 02 07952 HOME HEALTH SERVICES                      | 0  | 0             |             | 0 0   |  | 194.02  |  |  |  |  |  |
| 200.00 Cross Foot Adjustments                           |  | -             |             | 0   | ,  | 200.00  |  |  |  |  |  |
| 201.00 Negative Cost Centers                            | 1  | 0             |             | 0 0   | 0  | 201.00  |  |  |  |  |  |
| 202.00 TOTAL (sum lines 118 through 201)                | 0  | 6, 398, 294   |             | 6, 398, 294                                 | 59, 440  | 202.00  |  |  |  |  |  |
|   |  |               |             |   |  |         |  |  |  |  |  |

| Heal th | Financial Systems                           | RAMAPO RIDGE      | PSYCHI ATRI C |              |             | In Lie         | u of Form CMS-2                       | 2552-10 |
|---------|---|-------------------|---------------|--------------|-------------|----------------|---------------------------------------|---------|
| ALLOC   | ATION OF CAPITAL RELATED COSTS              |                   | Provider (    | CCN:         |             | eriod:         | Worksheet B                           |         |
|         |   |                   |               |              |             | rom 01/01/2023 | Part II                               |         |
|         |   |                   |               |              | T           | o 12/31/2023   | Date/Time Pre                         | pared:  |
|         |   |                   |               |              |             |                | 5/20/2024 11:                         | 05 am   |
|         | Cost Center Description                     | ADMI NI STRATI VE |               | <u>s</u>   0 | PERATION OF | LAUNDRY &      | HOUSEKEEPI NG                         |         |
|         |   | & GENERAL         | REPAI RS      | _            | PLANT       | LINEN SERVICE  | 0.00                                  |         |
|         |   | 5.00              | 6.00          |              | 7.00        | 8.00           | 9.00                                  |         |
| 1 00    | GENERAL SERVICE COST CENTERS                | 1                 |               |              |             | I              |                                       | 1 00    |
| 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              | 694, 600          |               |              |             |                |                                       | 5.00    |
| 6.00    | 00600 MAI NTENANCE & REPAI RS               | 0                 |               | 0            |             |                |                                       | 6.00    |
| 7.00    | 00700 OPERATION OF PLANT                    | 41, 262           |               | 0            | 261, 843    |                |                                       | 7.00    |
| 8.00    | 00800 LAUNDRY & LINEN SERVICE               | 7, 929            |               | 0            | 7, 350      | 114, 368       |                                       | 8.00    |
| 9.00    | 00900 HOUSEKEEPI NG                         | 18, 516           |               | 0            | 951         | 0              | 33, 763                               | 9.00    |
| 10.00   | 01000 DI ETARY                              | 56, 880           |               | 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              | 0                                     | 16.00   |
| 17.00   | 01700 SOCIAL SERVICE                        | 0                 |               | 0            | 0           | 0              | 0                                     | 17.00   |
| 18.00   | 01850 PASTORAL CARE                         | 4, 540            |               | 0            | 0           |                | 0                                     | 18.00   |
|         | INPATIENT ROUTINE SERVICE COST CENTERS      | .,                |               | -            |             | -1             | -                                     |         |
| 30.00   | 03000 ADULTS & PEDI ATRI CS                 | 86, 725           |               | 0            | 46, 522     | 21, 730        | 6, 195                                | 30.00   |
| 44.00   | 04400 SKILLED NURSING FACILITY              | 154, 995          |               | 0            | 106, 600    |                | 14, 196                               |         |
| 45.00   | 04500 NURSING FACILITY                      | 21, 270           |               | o            | 28, 369     |                | 3, 778                                |         |
| 46.00   | 04600 OTHER LONG TERM CARE                  | 43, 101           |               | 0            | 39, 144     |                | 5, 213                                |         |
| 40.00   | ANCI LLARY SERVICE COST CENTERS             | 43, 101           |               | 9            | 57, 144     | 10, 273        | 5,215                                 | 40.00   |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C               | 1, 339            |               | 0            | 0           | 0              | 0                                     | 54.00   |
| 60.00   | 06000 LABORATORY                            | 2, 360            |               | 0            | 0           |                | 0                                     | 60.00   |
| 65.00   | 06500 RESPIRATORY THERAPY                   | 1,050             |               | 0            | 0           | -              | 0                                     | 65.00   |
| 66.00   | 06600 PHYSI CAL THERAPY                     | 16, 487           |               |              | 2, 646      | -              | 352                                   | 66.00   |
| 67.00   | 06700 OCCUPATIONAL THERAPY                  | 10, 487           |               |              | 2, 040      | 0              | 352<br>0                              | 67.00   |
|         | 068000 SPEECH PATHOLOGY                     |                   |               | 0            | 0           | J J            | 0                                     |         |
| 68.00   |   | 2,859             |               | 0            | 0           |                |                                       | 68.00   |
| 71.00   | 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT | 2,611             |               | -            | 0           | -              | 0                                     | 71.00   |
| 73.00   |   | 9, 203            |               | 0            | 0           | 0              | 0                                     | 73.00   |
| ~~~~~   | OUTPATIENT SERVICE COST CENTERS             | 0( 17(            |               |              | 04.000      |                | 0.007                                 | 00.00   |
| 90.00   | 09000 CLINIC                                | 26, 476           |               | 0            | 24, 232     | 0              | 3, 227                                | 90.00   |
| 92.00   |   |                   |               |              |             |                |                                       | 92.00   |
|         | SPECIAL PURPOSE COST CENTERS                |                   |               | -            |             |                |                                       |         |
| 118.00  |   | 509, 281          |               | 0            | 255, 814    | 114, 368       | 32, 961                               | 118.00  |
|         | NONREI MBURSABLE COST CENTERS               |                   |               |              |             |                |                                       |         |
|         | 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN | 1, 874            |               | 0            | 1, 359      |                |                                       | 190.00  |
|         | 0 19200 PHYSI CLANS' PRI VATE OFFI CES      | 81                |               | 0            | 837         | 0              | 111                                   | 192.00  |
| 192.10  | 0 19202 OTHER NONREI MBURSABLE              | 0                 |               | 0            | 0           | 0              | 0                                     | 192.10  |
| 192.50  | 0 19201 MEDI CAL DAY CARE                   | 1, 182            |               | 0            | 2, 660      | 0              | 354                                   | 192.50  |
| 194.00  | 07950 MARKETI NG/GROUP                      | 37, 974           |               | 0            | 1, 173      | 0              | 156                                   | 194.00  |
| 194. O  | 1 07951 VI LLAGE                            | 119, 585          |               | 0            | 0           | 0              | 0                                     | 194.01  |
| 194.02  | 2 07952 HOME HEALTH SERVICES                | 24, 623           |               | 0            | 0           | 0              | 0                                     | 194. 02 |
| 200.00  |   |                   |               |              |             |                |                                       | 200.00  |
| 201.00  |   | 0                 |               | о            | 0           | 0              | 0                                     | 201.00  |
| 202.00  | 5   | 694, 600          |               | 0            | 261, 843    | 114, 368       | 33, 763                               | 1       |
|         | · · · · · · · · · · · · · · · · · · ·       |                   | 1             | -1           |             |                | , , , , , , , , , , , , , , , , , , , |         |

| ALLOCATION OF CAPITAL RELATED COSTS         Provider CCK: 31-010         Port of:<br>From 07/07/2023         Worksheet B<br>From 07/07/2023         Worksheet B<br>Prot of:<br>To 12/21/2023         Worksheet B<br>Prot of:<br>Prot of: | Health Financial Systems                  | RAMAPO RIDGE I  | PSYCHI ATRI C |         | In Lie  | u of Form CMS- | 2552-10 |
|---|---|-----------------|---------------|---------|---------|----------------|---------|
| To         12/37/2023         Date/Time         Prepared:<br>5/20/2024           Cost Center Description         DIETARY         CAFETERIA<br>ADMINISTRATION         NURSING<br>MECONDS<br>LIBRARY         SOCIAL SERVICE           10:00         01000 (CAP REL COST-SHUGE A FIXT<br>001000 (CAP REL COST-SHUGE A FIXT<br>000000 (CAP REL COST-SHUGE COUP P<br>4.00         10:00         13:00         16:00         17:00           0:00         00400 (EMPLOYTE BENETITS DEPARTMENT<br>5.00         5.00         5.00         5.00         6.00   |   |                 |               |         | Period: | Worksheet B    |         |
| Cost Center Description         DI ETARY         CAFETERIA<br>ADMINISTRATION<br>ADMINISTRATION<br>DI OCO         MEDICAL<br>SERVICE         SOCIAL SERVICE           BENERAL SERVICE COST CENTERS         10.00         13.00         16.00         17.00           00000 CAP REL COSTS-MUDE & FINT         2.00         2.00         0.200         18.00         16.00         17.00           0.0000 CAP REL COSTS-MUDE & FINT         2.01         0.000         13.00         16.00         17.00           0.0000 CAP REL COSTS-MUDE & COUP         2.01         2.00         0.0000         4.00         5.00         0.0000         4.00           5.00         0.0000 AMINIESMACE REPAIRS         -         -         -         -         2.00           0.0000 OPELOVEE ENERGING         -         -         -         -         -         0.00         -         0.00         0.00         -         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         0.00         10.00         110.00         110.00         110.00         110.00         110.00         110.00         110.00         110.00         110.00         110.00         110.00         10.00         11.00         110.00  |   |                 |               |         |         | Date/Time Pre  |         |
| Image: Control of the service cost centers         Internation         Proceeding         Internation         Proceeding         Internation         Internation <thinternation< th=""> <thinternation< th=""></thinternation<></thinternation<>  | Cost Center Description                   | DIFTARY         |               | NURSING | MEDICAL |                |         |
| ENERGY         10.00         11.00         13.00         16.00         17.00           0         00100 CAP REL COSTS -MUGE E COIL FERS         1 <td>obst center bescription</td> <td>DIETARI</td> <td>OALETERIA</td> <td></td> <td></td> <td>SUCIAL SERVICE</td> <td></td>   | obst center bescription                   | DIETARI         | OALETERIA     |         |         | SUCIAL SERVICE |         |
| ERREPAL SERVICE COST CENTERS         1.00           1.00         00700 CAP REL COSTS-RUDG & FIXT         2.00           2.00         00200 CAP REL COSTS-MUBE EQUIP         4.00           4.00         00400 DEPLOYEE EDENETTS DEPARTINENT         4.00           5.00         00500 AUM INTENNET VE & GEMERAL         5.00           6.00         00500 AUM INTENNET REPT IS DEPARTINENT         7.00           7.00         00700 OPERATION OF PLANT         8.00           8.00         000000 DIETARY         61,642           11.00         01100 CAFETERIA         20.199         10.00           11.00         01100 CAFETERIA         20.199         10.00           11.00         01400 CAFETERIA         0         0         0           11.00         01400 CAFETERIA         20.199         11.00         11.00           11.00         01400 CAFETERIA         20.199         10.00         10.00           11.00         01500 PASTORAL CARE         0         0         0         10.00           11.00         01400 CAFETERIA         8.02         0         0         10.00           11.00         01400 CAFETERIA         0         0         0         0         0         0         0  |   |                 |               |         |         |                |         |
| 1.00 00700 CAP REL COSTS-BUDG & FIXT 0.0 00700 CAP REL COSTS-WULE COUP 0.0 0.0 00000 AMI INTERNATURE & REPAILING 0.0 00000 AMI INTERNATURE & CONTRATION 0.0 00 00000 AMI INTERNATURE & CONTRATION 0.0 00 00000 AMI INTERNATURE & CONTRATION 0.0 00 000 00 00 00 00 00 00 00 00 00 0   |   | 10.00           | 11.00         | 13.00   | 16.00   | 17.00          |         |
| 2: 00         00200 [AP REL COSTS-WURLE EQUIP         2: 00           4: 00         00400 [MHRLOVE EREPTITS DEPARIMENT         2: 00           5: 00         00500 ADM IN STRATIVE & GENERAL         5: 00           6: 00         00000 [MAINTENATOR & REPAIRS         5: 00           0: 00000 [MAINTENATOR & REPAIRS         7: 00           0: 00000 [MAINTENATOR & REPAIRS         7: 00           0: 00000 [MAINTENATOR         8: 00           0: 00000 [MAINTENATOR         9: 00           0: 00000 [DETARY         61, 642           0: 00100 [DETARY         0: 0           0: 00100 [DETARY         0: 0           0: 00100 [DETARY         0: 0           0: 000 [DETARY         0: 0  | GENERAL SERVICE COST CENTERS              | · · · ·         |               |         |         |                |         |
| 4.00         00400         EMPLOYEE BENEFITS DEPARTMENT         4.00           5.00         00500         ADMIN ISTRATIVE & GENERAL         5.00           7.00         00700         OPERATION OF PLANT         6.00           8.00         00800         MAININENANCE & REPAIRS         7.00           8.00         00800         LINENTERANCE & REPAIRS         8.00           9.00         00800         LINENTERANCE & REPAIRS         8.00           11.00         01000         DETARY         61.642         10.00           11.00         DIOLOR HETERIA         20.199         11.00           13.00         DISING ADMIN ISTRATION         0         0         0           14.00         DIOLOR LEDICAL REFORDS & LI BRARY         0         0         0           10.00         DIOLOR DETARY         A.697         5.235         0         0           10.00         DIALISS A FUNICE COST CENTERS         3.00         46.00         44.00         45.00           10.00         DIALISS A FUNICE COST CENTERS         -         -         -         -           30.00         DAGO DAULTS A FUNICE COST CENTERS         -         -         -         -           30.00         DAGO DAULASINNINTY A L   | 1.00 00100 CAP REL COSTS-BLDG & FIXT      |                 |               |         |         |                | 1.00    |
| 5. 00         00500         ADMIN STRATIVE & GENERAL         5. 00           00         00500         AMIN TENANCE & REPAIRS         5. 00           0.00         00700         OPERATION OF PLANT         6. 00           0.00         00000         AMIN TENANCE & REPAIRS         9. 00           0.00         00000         HURSKEEPING         9. 00           1.00         01000         DIETARY         61, 642         11. 00           1.00         01000         DIETARY         61, 642         11. 00           1.00         01000         DIETARY         0         0         0           1.00         01000         DIETARY         0         0         0         11. 00           1.00         DIETARY         0         0         0         0         11. 00           1.00         DISONUBLICAL SERVICE         0         0         0         0         0           1.00         DISONUBLICAL SERVICE         0  | 2.00 00200 CAP REL COSTS-MVBLE EQUIP      |                 |               |         |         |                | 2.00    |
| 6.00         00600         MAINTENANCE & REPAIRS         6.00           7.00         00700         OPERATION OF PLANT         7.00           9.00         00000         HUNDRY & LINEN SERVICE         9.00           9.00         00000         HUNDRY & LINEN SERVICE         9.00           9.00         00000         HUNDRY & LINEN SERVICE         9.00           10.00         10100         LETRY         61.642         10.00           11.00         DISON (MRSING ADMINISTRATION         0         0         0           11.00         DISON (MRSING ADMINISTRATION         0         0         0         0           11.00         DISON (MRSING ADMINISTRATION         0         0         0         0         0           11.00         DISON (MRSING FACILITY         22.0199         0         0         0         0           11.00         DISON (MRSING FACILITY         24.073         8.932         0         0         44.00           0         0.00         OSIGON OPADULTS & PEDIATRICS         4.697         5.235         0         0         45.00           4.00         04000         NELLED NURSING FACILITY         3.576         1.287         0         0         0   | 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT   |                 |               |         |         |                | 4.00    |
| 7. 00         00700 (PERATION OF PLANT         7. 00           80.00         00800 (LAUNDER & LINEN SERVICE         8. 00           9. 00         00900 (LAUNDER & LINEN SERVICE         9. 00           10.00         01000 (LAUNDER & LINEN SERVICE         9. 00           11. 00         01100 (AFETERI A         20. 199         20. 199           13. 00         01300 NURSI MG ADMINISTRATION         0         0         10. 00           16. 00         01500 ADETARY         0         0         0         13. 00           16. 00         1050 CAL SERVICE         0         0         0         0         17.00           17.00         01700 SOCIAL SERVICE COST CENTERS         0         0         0         0         18. 00           18.00         10850 PASTORAL CARE         9.097         2.277         0         0         44. 00           45.00         04000 TAULTS & PEDIATRICS         4. 697         5. 235         0         0         0         45. 00           60.00         04000 TAULTS & PEDIATRICS         4. 697         5. 235         0         0         0         44. 00           45.00         04000 OLUSTS MERACILITY         2.3. 576         1.287         0         0         45. 00 </td <td>5. 00 00500 ADMINI STRATI VE &amp; GENERAL</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>5.00</td>  | 5. 00 00500 ADMINI STRATI VE & GENERAL    |                 |               |         |         |                | 5.00    |
| 8. 00         00800         LAUNDRY & LINEN SERVICE         8. 00           9.00         00900         HUSEXEEPING         10.00           11.00         01100         CAFETERIA         20, 199         20, 199           11.00         01100         CAFETERIA         20, 199         20, 199         11.00           11.00         01100         CAFETERIA         20, 199         20, 199         11.00           11.00         01100         SERVICE         0         0         0         0           11.00         01100         SERVICE         0         0         0         0         0           11.00         01100         SERVICE         0  | 6. 00 00600 MAI NTENANCE & REPAI RS       |                 |               |         |         |                | 6.00    |
| 9, 00         00900 HOUSEKEEPING         9, 00           10.00         01000 DI ETARY         61, 642         10, 00           13.00         01300 NURSI NG ABINI NI STRATI ON         0         0         0           13.00         01300 NURSI NG ABINI NI STRATI ON         0         0         0         11, 00           13.00         01300 NURSI NG ABINI NI STRATI ON         0         0         0         0         11, 00           13.00         01300 NURSI NG ABINI NI STRATI ON         0         0         0         0         0         0         0         0         11, 00         13, 00           14.00         01700 SOCI AL SERVICE         0  | 7.00 00700 OPERATION OF PLANT             |                 |               |         |         |                | 7.00    |
| 10.000       01000       CAFETERIA       20, 199       10.00       11.00         11.00       01100       CAFETERIA       20, 199       0       11.00         11.00       01100       CAFETERIA       20, 199       0       0       11.00         11.00       01000       NURSING ADMINISTRATION       0       0       0       0       0       11.00         11.00       01000       SOLIAL SERVICE       0       0       0       0       0       11.00         11.00       SOLIAL SERVICE       0       0       0       0       0       0       11.00         11.00       SOLIAL SERVICE COST CENTERS       0   | 8.00 00800 LAUNDRY & LINEN SERVICE        |                 |               |         |         |                | 8.00    |
| 11.00       01100       CAFETERIA       20, 199       20, 199       11.00         13.00       01300       0030 NURSING ADMINISTATION       0       0       13.00         13.00       01500 NURSING ADMINISTATION       0       0       0       16.00       16.00         17.00       0170.05 OCI AL SERVICE       0       0       0       0       0       16.00         18.00       01500 ADULTS & SERVICE COST CENTERS       0       0       0       0       0       0       30.00         18.00       04400 SKILLED NURSING FACILITY       24,073       8,932       0       0       0       45.00         45.00       046000 OHER LONG TERM CARE       9,097       2,277       0       0       0       46.00         46.00       06000 ADULTS & ROTLER COST CENTES  |   |                 |               |         |         |                | 9.00    |
| 13.00       OI3300       NURSING ADMI NI STRATI ON       0       0       0       13.00         16.00       OFOOD MEDICAL RECORDS & LIBRARY       0 <td>10. 00 01000 DI ETARY</td> <td>61, 642</td> <td></td> <td></td> <td></td> <td></td> <td>10.00</td>   | 10. 00 01000 DI ETARY                     | 61, 642         |               |         |         |                | 10.00   |
| 16.00       01600       MEDI CAL RECORDS & LIBRARY       0       0       0       16.00         17.00       SOCIAL SERVICE       0       0       0       0       0       17.00         18.00       O1850 PASTORAL CARE       0       286       0   | 11. 00 01100 CAFETERI A                   | 20, 199         | 20, 199       | 1       |         |                | 11.00   |
| 17.00       01700       SOCIAL SERVICE       0 <td>13.00 01300 NURSING ADMINISTRATION</td> <td>0</td> <td>0</td> <td>(</td> <td>C</td> <td></td> <td>13.00</td>   | 13.00 01300 NURSING ADMINISTRATION        | 0               | 0             | (       | C       |                | 13.00   |
| 18.00         1950         PASTORAL CARE         0         286         0         0         0         18.00           INPATIENT ROUTINE SERVICE COST CENTERS   | 16.00 01600 MEDICAL RECORDS & LIBRARY     | 0               | 0             | (       | 0 0     |                | 16.00   |
| INPATI ENT ROUTI NE SERVICE COST CENTERS         0  | 17.00 01700 SOCIAL SERVICE                | 0               | 0             | (       | o o     | 0              | 17.00   |
| 30.00       03000       ADULTS & PEDIATRICS       4,697       5,235       0       0       0       30.00         44.00       SKILLED NURSING FACILITY       24,073       8,932       0       0       0       44.00         45.00       04500       NURSING FACILITY       3,576       1,287       0       0       0       45.00         46.00       D4600       OTHER LONG TERM CARE       9,097       2,277       0       0       0       60.00         ANCILLARY SERVICE COST CENTERS       0       0       0       0       0       0       0       60.00         65.00       05500       RSPIRATORY THERAPY       0       0       0       0       0       66.00         66.00       06600       PHYSICAL THERAPY       0       0       0       0       0       66.00         66.00       06600       SPECHARDER THERAPY       0       0       0       0       66.00         67.00       06700       0       0       0       0       0       0       67.00         68.00       06800       SPECHATRORY THERAPY       0       0       0       0       71.00       71.00       71.00       71.00   | 18.00 01850 PASTORAL CARE                 | 0               | 286           | (       | o o     | 0              | 18.00   |
| 30.00       03000       ADULTS & PEDIATRICS       4,697       5,235       0       0       0       30.00         44.00       SKILLED NURSING FACILITY       24,073       8,932       0       0       0       44.00         45.00       04500       NURSING FACILITY       3,576       1,287       0       0       0       45.00         46.00       D4600       OTHER LONG TERM CARE       9,097       2,277       0       0       0       60.00         ANCILLARY SERVICE COST CENTERS       0       0       0       0       0       0       0       60.00         65.00       05500       RSPIRATORY THERAPY       0       0       0       0       0       66.00         66.00       06600       PHYSICAL THERAPY       0       0       0       0       0       66.00         66.00       06600       SPECHARDER THERAPY       0       0       0       0       66.00         67.00       06700       0       0       0       0       0       0       67.00         68.00       06800       SPECHATRORY THERAPY       0       0       0       0       71.00       71.00       71.00       71.00   | INPATIENT ROUTINE SERVICE COST CENTER     | S               |               |         |         |                | 1       |
| 45.00       04500       NURSI NG FACI LI TY       3,576       1,287       0       0       0       45.00         46.00       046000       DHER LONG TERM CARE       9,097       2,277       0       0       0       46.00         ANCI LLARY SERVICE COST CENTERS       0       0       0       0       0       0       60.00         54.00       05400 RADI OLOGY-DI AGNOSTI C       0       0       0       0       0       66.00         65.00       06500 RESPI RATORY THERAPY       0       0       0       0       66.00       67.00       68.00       71.00       0       0       0       67.00       68.00       71.00       0       0       0       0       71.00       73.00       73.00       73.00       73.00       73.00 <t< td=""><td></td><td></td><td>5, 235</td><td>(</td><td>0 0</td><td>0</td><td>30.00</td></t<>  |   |                 | 5, 235        | (       | 0 0     | 0              | 30.00   |
| 46.00         OHER LONG TERM CARE         9,097         2,277         0         0         46.00           ANCILLARY SERVICE COST CENTERS  | 44.00 04400 SKILLED NURSING FACILITY      | 24,073          | 8, 932        | (       | o o     | 0              | 44.00   |
| ANCILLARY SERVICE COST CENTERS           54.00         05400         RADIOLOGY-DIAGNOSTIC         0   | 45.00 04500 NURSING FACILITY              | 3, 576          | 1, 287        | (       | 0 0     | 0              | 45.00   |
| 54. 00         OS400         RADIOLOGY-DIAGNOSTIC         0   | 46.00 04600 OTHER LONG TERM CARE          | 9, 097          | 2, 277        | (       | 0 0     | 0              | 46.00   |
| 60.00         CABORATORY         0  | ANCI LLARY SERVI CE COST CENTERS          |                 |               |         |         |                |         |
| 65.00         06500         RESPIRATORY THERAPY         0         0         0         0         66.00         71.00         73.00         70.00         71.00         73.00         70.00         71.00         73.00         00         0         0         0         0         0         90.00         92.00         92.00         92.00         92.00         92.00         92.00         92.00         9  | 54.00 05400 RADI OLOGY-DI AGNOSTI C       | 0               | C             | (       | 0 0     | 0              | 54.00   |
| 66.00       06600       PHYSI CAL THERAPY       0       0       0       0       0       66.00         67.00       06700       0CUPATI ONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       68.00         71.00       07100       MEDI CAL, SUPPLI ES CHARGED TO PATI ENT       0       0       0       0       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       73.00         001700       VEDICAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       0       73.00         001700       DUTPATI ENT SERVI CE COST CENTERS       0       0       0       90.00       90.00         22.00       09200       DSERVATI ON BEDS (NON-DI STI NCT PART       92.00   | 60. 00 06000 LABORATORY                   | 0               | C             | (       | 0 0     | 0              | 60.00   |
| 67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       68.00         71.00       OTIOO       MEDI CAL SUPPLIES CHARGED TO PATIENT       0       0       0       0       0       71.00         73.00       DRUGS CHARGED TO PATIENTS       0       0       0       0       0       73.00         00000       CLINIC       O       0       0       0       0       0       90.00         90.00       09000       CLINIC       0       139       0       0       0       90.00         92.00       OSDERVATION BEDS (NON-DISTINCT PART       0       139       0       0       0       92.00         SPECIAL PURPOSE COST CENTERS       118.00       SUBTOTALS (SUM OF LINES 1 through 117)       61,642       18,156       0       0       0       118.00         192.00       19200       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.00       192.01       192.00       0       0  | 65. 00 06500 RESPI RATORY THERAPY         | 0               | C             | (       | 0 0     | 0              | 65.00   |
| 68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0       0       0       0       0       0       0       71.00       73.00          | 66. 00 06600 PHYSI CAL THERAPY            | 0               | C             | (       | 0 0     | 0              | 66.00   |
| 71.00       07100       MEDI CAL 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         0UTPATIENT SERVICE COST CENTERS       0  | 67.00 06700 OCCUPATI ONAL THERAPY         | 0               | C             | (       | 0 0     | 0              | 67.00   |
| 73.00       ORUGS CHARGED TO PATIENTS       O       O       O       O       O       73.00         OUTPATIENT SERVICE COST CENTERS   | 68.00 06800 SPEECH PATHOLOGY              | 0               | C             | (       | 0 0     | 0              | 68.00   |
| OUTPATI ENT SERVICE COST CENTERS           90.00         09000         CLINIC         0         139         0         0         90.00         90.00         92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART         0         139         0         0         92.00         90.00         0         0         0         0         92.00         92.00         92.00         92.00         92.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00         90.00   |   | I ENT O         | C             | (       | 0 0     | 0              | 71.00   |
| 90. 00         09000         CLINIC         0         139         0         0         90. 00         92  | 73.00 07300 DRUGS CHARGED TO PATIENTS     | 0               | C             | (       | 0 0     | 0              | 73.00   |
| 92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART         92.00           SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         61,642         18,156         0         0         0         118.00           NONRET MBURSABLE COST CENTERS           190.00         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         190.00         192.00         192.00         0         0         0         190.00         192.00         192.00         0         0         0         190.00         192.00         192.00         192.00         192.00         192.00         192.00         0         0         0         192.00         192.00         192.00         192.00         192.00         192.00         192.00         192.00         192.00         192.00         192.00         0         0         0         192.00           192.10         19202         OTHER NONREI MBURSABLE         0         1,630         0         0         192.00         192.10           192.50         19201         MEDI CAL DAY CARE         0         0         0         0         192.50           194.00         07955         MARKETI NG/G   |   |                 |               |         |         |                |         |
| SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         61,642         18,156         0         0         0         118.00           NONREI MBURSABLE COST CENTERS         NONREI MBURSABLE COST CENTERS         0         0         0         0         0         190.00         190.00         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00         192.00         192.00         192.01         192.00         192.02         OTHER NONREI MBURSABLE         0         1,630         0         0         192.10           192.10         19202         OTHER NONREI MBURSABLE         0         1,630         0         0         192.10           192.50         19201         MEDI CAL DAY CARE         0         0         0         192.50           194.00         07950         MARKETI NG/GROUP         0         413         0         0         194.01           194.02         07952         HOME HEALTH SERVI CES         0         0         0         0         194.02           200.00         Cross Foot Adj ustments         0         0         0         0         0         0         200.00           201.00  | 90. 00 09000 CLINIC                       | 0               | 139           | (       | 0 0     | 0              | 90.00   |
| SUBTOTALS         SUB OF LINES 1 through 117)         61,642         18,156         0         0         0         118.00           NORREI MBURSABLE         COST CENTERS         0         0         0         0         190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00         192.00         192.00         192.00         192.00         0         0         0         0         192.00         192.00         192.00         192.00         0         0         0         0         192.00         0         0         0         192.00         0         192.00         0         192.00         0         0         0         0         192.00         0         192.00         0         0         0         192.00         0         192.00         192.00         0         0         0         192.00         0         192.00         0         192.00         0         192.00         0         192.00         0         0         0         192.00         0         192.00         0         192.10         192.00         0         192.10         192.10         192.50         192.10         192.50         194.00         0         0  |   | PART            |               |         |         |                | 92.00   |
| NORREI MBURSABLE COST CENTERS           190.00         0 IFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         0         0         0         0         192.00           192.10         19200         OTHER NONREI MBURSABLE         0         1,630         0         0         192.10           192.50         19201         MEDI CAL DAY CARE         0         1,630         0         0         192.50           194.00         07950         MARKETI NG/GROUP         0         413         0         0         194.00           194.01         07955         HOME HEALTH SERVI CES         0         0         0         194.01           194.02         07952         HOME HEALTH SERVI CES         0         0         0         0         194.02           200.00         Cross Foot Adj ustments         200.00         0         0         0         0         0         201.00   | SPECIAL PURPOSE COST CENTERS              |                 |               |         |         |                |         |
| 190.00       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       190.00         192.00       19200       PHYSI CLANS' PRI VATE OFFICES       0       0       0       0       192.00         192.10       19202       OTHER NONREI MBURSABLE       0       1,630       0       0       192.10         192.50       19201       MEDI CAL DAY CARE       0       0       0       0       192.50         194.00       07950       MARKETI NG/GROUP       0       413       0       0       0       194.00         194.01       07951       VI LLAGE       0       0       0       0       0       194.01         194.02       07952       HOME HEALTH SERVICES       0       0       0       0       194.02         200.00       Cross Foot Adj ustments  | 118.00 SUBTOTALS (SUM OF LINES 1 throug   | gh 117) 61, 642 | 18, 156       | (       | 0 0     | 0              | 118.00  |
| 192.00       19200       PHYSI CLANS' PRI VATE OFFICES       0       0       0       192.00         192.10       19202       OTHER NONREI MBURSABLE       0       1,630       0       0       192.10         192.50       19201       MEDI CAL DAY CARE       0       0       0       0       192.50         194.00       07950       MARKETI NG/GROUP       0       413       0       0       194.01         194.01       07952       VI LLAGE       0       0       0       194.01         194.02       07952       HOME HEALTH SERVICES       0       0       0       0       194.02         200.00       Cross Foot Adjustments   |   |                 |               |         |         |                |         |
| 192.10       19202       OTHER NONREI MBURSABLE       0       1,630       0       0       192.10         192.50       19201       MEDI CAL DAY CARE       0       0       0       0       192.50         194.00       07950       MARKETI NG/GROUP       0       413       0       0       194.00         194.01       07951       VI LLAGE       0       0       0       194.01         194.02       07952       HOME HEALTH SERVICES       0       0       0       194.01         200.00       Cross Foot Adjustments       200.00       200.00       0       0       0       201.00  |   | TEEN O          | C             |         |         | 0              | 190.00  |
| 192.50       19201       MEDI CAL DAY CARE       0       0       0       192.50         194.00       07950       MARKETI NG/GROUP       0       413       0       0       194.00         194.01       07951       VI LLAGE       0       0       0       194.01         194.02       07952       HOME HEALTH SERVICES       0       0       0       194.02         200.00       Cross Foot Adjustments       -       -       200.00       201.00       0       0       0       0       201.00   |   | 0               | C             |         |         | 0              | 192.00  |
| 194.00       07950       MARKETI NG/GROUP       0       413       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       194.02         200.00       Cross Foot Adjustments       0       0       0       0       200.00         201.00       Negative Cost Centers       0       0       0       0       0       201.00   |   | 0               | 1, 630        | (       | 0 0     |                |         |
| 194. 01       07951       VI LLAGE       0       0       0       194. 01         194. 02       07952       HOME HEALTH SERVICES       0       0       0       0       194. 02         200. 00       Cross Foot Adjustments       0       0       0       0       200. 00         201. 00       Negative Cost Centers       0       0       0       0       0       0  | 192. 50 19201 MEDI CAL DAY CARE           | 0               | C             | (       | 0 0     | 0              | 192.50  |
| 194. 02       07952       HOME HEALTH SERVICES       0       0       0       194. 02         200. 00       Cross Foot Adjustments       200. 00       200. 00       200. 00       200. 00         201. 00       Negative Cost Centers       0       0       0       0       0       0   |   | 0               | 413           |         |         |                | •       |
| 200.00         Cross Foot Adjustments         200.00   |   | 0               | C             |         |         |                |         |
| 201.00         Negative Cost Centers         0         0         0         0         0         0         201.00   |   | 0               | C             | (       | 0 0     | 0              |         |
| 5   | 200.00 Cross Foot Adjustments             |                 |               |         |         |                | 200. 00 |
|   | 5   | 0               | 0             | (       | 0 0     |                |         |
| 202.00   TOTAL (sum lines 118 through 201)   61,642 20,199 0  0  0 202.00   | 202.00   TOTAL (sum lines 118 through 207 | 1) 61,642       | 20, 199       | (       | 0  0    | 0              | 202.00  |

| ALLOCAT | ION OF CAPITAL RELATED COSTS  |               | Provider C          | CN: 31-4019          | Peri od:                         | Worksheet B                                 |                  |
|---------|---|---------------|---------------------|----------------------|----------------------------------|---|------------------|
|         |   |               |                     |                      | From 01/01/2023<br>To 12/31/2023 | Part II<br>Date/Time Prep<br>5/20/2024 11:0 |                  |
|         |   | OTHER GENERAL |                     |                      |                                  | 572072024 11:0                              | <u>15 am</u>     |
|         |   | SERVI CE      |                     |                      |                                  |   |                  |
|         | Cost Center Description   | PASTORAL CARE | Subtotal            | Intern &             | Total                            |   |                  |
|         |   |               |                     | Residents Cos        | st                               |   |                  |
|         |   |               |                     | & Post               |                                  |   |                  |
|         |   |               |                     | Stepdown             |                                  |   |                  |
|         |   | 18.00         | 24.00               | Adjustments<br>25.00 | 26.00                            |   |                  |
| C       | GENERAL SERVICE COST CENTERS  | 18.00         | 24.00               | 25.00                | 20.00                            |   |                  |
|         | DO100 CAP REL COSTS-BLDG & FIXT                                       |               |                     |                      |                                  |   | 1.0              |
|         | DO200 CAP REL COSTS-MVBLE EQUIP                                       |               |                     |                      |                                  |   | 2.0              |
| 4.00 0  | DO400 EMPLOYEE BENEFITS DEPARTMENT                                    |               |                     |                      |                                  |   | 4.0              |
| 5.00 0  | DO500 ADMINISTRATIVE & GENERAL  |               |                     |                      |                                  |   | 5.0              |
| 5.00 0  | DO6OO MAI NTENANCE & REPAI RS   |               |                     |                      |                                  |   | 6.0              |
|         | DO700 OPERATION OF PLANT  |               |                     |                      |                                  |   | 7.0              |
|         | DO800 LAUNDRY & LINEN SERVICE   |               |                     |                      |                                  |   | 8. C             |
|         | DO900 HOUSEKEEPI NG   |               |                     |                      |                                  |   | 9. 0             |
|         | D1000 DI ETARY  |               |                     |                      |                                  |   | 10. (            |
|         |   |               |                     |                      |                                  |   | 11. (            |
|         | D1300 NURSI NG ADMI NI STRATI ON                                      |               |                     |                      |                                  |   | 13. (<br>16. (   |
|         | D1600 MEDI CAL RECORDS & LI BRARY<br>D1700 SOCI AL SERVI CE           |               |                     |                      |                                  |   | 16.0             |
|         | D1850 PASTORAL CARE   | 5, 357        |                     |                      |                                  |   | 17.0             |
|         | NPATIENT ROUTINE SERVICE COST CENTERS                                 | 5,357         |                     |                      |                                  |   | 10.0             |
|         | D3000 ADULTS & PEDI ATRI CS   | 2, 905        | 916, 667            | 7                    | 0 916, 667                       |   | 30. 0            |
|         | 04400 SKILLED NURSING FACILITY  | 1,969         | 1, 814, 854         |                      | 0 1, 814, 854                    |   | 44.0             |
| 5.00 0  | D4500 NURSING FACILITY  | 483           | 463, 743            | 3                    | 0 463, 743                       |   | 45.0             |
|         | D4600 OTHER LONG TERM CARE  | 0             | 2, 025, 019         |                      | 0 2, 025, 019                    |   | 46.0             |
|         | ANCI LLARY SERVI CE COST CENTERS                                      |               |                     | 1                    |                                  |   |                  |
|         | D5400 RADI OLOGY-DI AGNOSTI C   | 0             | 1, 339              |                      | 0 1, 339                         |   | 54.0             |
|         |   | 0             | 2, 360              |                      | 0 2, 360                         |   | 60.0             |
|         | 06500 RESPI RATORY THERAPY  | 0             | 1,050               |                      | 0 1,050<br>0 256,591             |   | 65.0             |
|         | D6600 PHYSI CAL THERAPY<br>D6700 OCCUPATI ONAL THERAPY                | 0             | 256, 591<br>11, 678 |                      | 0 256, 591<br>0 11, 678          |   | 66. (<br>67. (   |
|         | D6800 SPEECH PATHOLOGY  | 0             | 2, 859              |                      | 0 2,859                          |   | 68.0             |
|         | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                             | 0             | 2,637               |                      | 0 2,611                          |   | 71. (            |
|         | D7300 DRUGS CHARGED TO PATIENTS                                       | 0             | 9, 203              |                      | 0 9, 203                         |   | 73. (            |
|         | DUTPATIENT SERVICE COST CENTERS                                       |               |                     | 1                    | .,                               |   |                  |
|         | 09000 CLI NI C  | 0             | 481, 446            | þ                    | 0 481, 446                       |   | 90. (            |
|         | 09200 OBSERVATION BEDS (NON-DISTINCT PART                             |               |                     |                      | 0                                |   | 92. (            |
|         | SPECIAL PURPOSE COST CENTERS  |               |                     | 1                    |                                  |   |                  |
| 18.00   | SUBTOTALS (SUM OF LINES 1 through 117)                                | 5, 357        | 5, 989, 420         | )                    | 0 5, 989, 420                    | ŕ   | 118. (           |
|         | NONREI MBURSABLE COST CENTERS   |               | 04 (00              | 1                    | 0 01 (00                         |   | 100              |
|         | 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                             | 0             | 21,609              |                      | 0 21,609                         |   | 190. (           |
|         | 19200 PHYSI CI ANS' PRI VATE OFFI CES<br>19202 OTHER NONREI MBURSABLE | 0             | 12, 236<br>1, 630   |                      | 0 12, 236<br>0 1, 630            |   | 192. (<br>192. ( |
|         | 19202 OTHER NONREIMBURSABLE   |               | 1, 030              |                      | 0 167, 285                       |   | 192.<br>192. §   |
|         | D7950 MARKETI NG/GROUP  |               | 56, 527             | 1                    | 0 56, 527                        |   | 192. (           |
|         | D7951 VI LLAGE  | 0             | 122, 056            |                      | 0 122,056                        |   | 194.             |
|         | 07952 HOME HEALTH SERVICES  | 0             | 27, 531             |                      | 0 27, 531                        |   | 194. (           |
| 00.00   | Cross Foot Adjustments  |               | 27,001              |                      | 0 0                              |   | 200. (           |
| 01.00   | Negative Cost Centers   | 0             | 0                   | þ                    | 0 0                              |   | 201. (           |
| 02.00   | TOTAL (sum lines 118 through 201)                                     | 5, 357        | 6, 398, 294         | 1                    | 0 6, 398, 294                    |   | 202. (           |

| <u>Heal th</u> F     | inancial Systems   | RAMAPO RIDGE       | PSYCHI ATRI C  |                     | In_Lie                           | eu of Form CMS-:           | <u>2552-1</u> 0  |
|----------------------|--|--------------------|----------------|---------------------|----------------------------------|----------------------------|------------------|
| COST ALL             | OCATION - STATISTICAL BASIS  |                    | Provider C     | CN: 31-4019         | Peri od:                         | Worksheet B-1              |                  |
|                      |  |                    |                |                     | From 01/01/2023<br>To 12/31/2023 | Date/Time Pre              | pared:           |
|                      |  |                    |                |                     |                                  | 5/20/2024 11:              |                  |
|                      |  | CAPITAL REI        | LATED COSTS    |                     |                                  |                            |                  |
|                      | Cost Center Description  | BLDG & FIXT        | MVBLE EQUIP    | EMPLOYEE            | Reconciliation                   | ADMI NI STRATI VE          |                  |
|                      |  | ((SQUARE           | (DOLLAR VALUE) | BENEFITS            |                                  | & GENERAL                  |                  |
|                      |  | FEET))             |                | DEPARTMENT          |                                  | (ACCUM COST)               |                  |
|                      |  |                    |                | (GROSS              |                                  |                            |                  |
|                      |  | 1.00               | 2.00           | SALARI ES)<br>4. 00 | 5A                               | 5.00                       |                  |
| G                    | ENERAL SERVICE COST CENTERS  | 1.00               | 2.00           | 4.00                | 54                               | 5.00                       |                  |
|                      | 0100 CAP REL COSTS-BLDG & FIXT   | 362, 543           |                |                     |                                  |                            | 1.00             |
|                      | 0200 CAP REL COSTS-MVBLE EQUIP   |                    | 0              |                     |                                  |                            | 2.00             |
|                      | 0400 EMPLOYEE BENEFITS DEPARTMENT  | 3, 368             | -              |                     |                                  |                            | 4.00             |
|                      | 0500 ADMI NI STRATI VE & GENERAL   | 38, 937            |                | 7, 084, 7           | 23 -13, 063, 933                 |                            |                  |
|                      | 0600 MAINTENANCE & REPAIRS   | 0                  | -              | 1 075 4             | 0 0                              | 0                          |                  |
|                      | 0700 OPERATION OF PLANT<br>0800 LAUNDRY & LINEN SERVICE                      | 12, 417<br>5, 578  |                | 1, 375, 4<br>616, 2 |                                  | 5, 693, 618<br>1, 094, 149 |                  |
|                      | 0900 HOUSEKEEPING  | 722                |                | 1, 482, 5           |                                  | 2, 554, 980                | 1                |
|                      | 1000 DI ETARY  | 0                  |                | 4, 544, 1           |                                  | 7, 848, 706                |                  |
|                      | 1100 CAFETERIA   | 0                  | 0              | 1,011,1             | 0 0                              | 0                          | 1                |
|                      | 1300 NURSI NG ADMI NI STRATI ON  | 0                  | 0              |                     | 0 0                              | 0                          | 1                |
| 16.00 0 <sup>-</sup> | 1600 MEDI CAL RECORDS & LI BRARY   | 0                  | 0              |                     | 0 0                              | 0                          | 16.00            |
|                      | 1700 SOCIAL SERVICE  | 0                  | 0              |                     | 0 0                              | 0                          | 17.00            |
|                      | 1850 PASTORAL CARE   | 0                  | 0              | 506, 2              | 17 0                             | 626, 482                   | 18.00            |
|                      | NPATIENT ROUTINE SERVICE COST CENTERS  | 44 505             |                | 0 (0( 0             |                                  | 11.0(7.000                 | 1                |
|                      | 3000 ADULTS & PEDIATRICS   | 41, 505            |                |                     |                                  |                            |                  |
|                      | 4400 SKILLED NURSING FACILITY<br>4500 NURSING FACILITY                       | 80, 897<br>21, 529 |                |                     |                                  |                            |                  |
|                      | 4600 OTHER LONG TERM CARE  | 108, 369           |                |                     |                                  |                            | 1                |
|                      | VCI LLARY SERVICE COST CENTERS   | 100,007            |                | 0,201,7             | 0                                | 0,717,101                  | 10.00            |
|                      | 5400 RADI OLOGY-DI AGNOSTI C   | 0                  | 0              |                     | 0 0                              | 184, 828                   | 54.00            |
| 60.00 00             | 6000 LABORATORY  | 0                  | 0              |                     | 0 0                              | 325, 593                   | 60.00            |
| 65.00 00             | 6500 RESPI RATORY THERAPY  | 0                  | 0              |                     | 0 0                              | 144, 871                   | 65.00            |
|                      | 6600 PHYSI CAL THERAPY   | 13, 435            |                |                     | 0 0                              | 2, 275, 048                | 1                |
|                      | 6700 OCCUPATIONAL THERAPY  | 0                  | -              |                     | 0 0                              | 1, 611, 423                |                  |
|                      | 6800 SPEECH PATHOLOGY  | 0                  | 0              |                     | 0 0                              | 394, 517                   | 1                |
|                      | 7100 MEDICAL SUPPLIES CHARGED TO PATIENT<br>7300 DRUGS CHARGED TO PATIENTS   | 0                  | 0              |                     | 0 0                              | 360, 344<br>1, 269, 946    |                  |
|                      | JTPATIENT SERVICE COST CENTERS   | 0                  | 0              |                     | 0 0                              | 1, 209, 940                | 1 / 3. 00        |
|                      | 9000 CLINIC  | 23, 989            | 0              | 3, 821, 7           | 54 0                             | 3, 653, 356                | 90.00            |
|                      | 9200 OBSERVATION BEDS (NON-DISTINCT PART                                     |                    |                | -, - ,              |                                  |                            | 92.00            |
| SF                   | PECIAL PURPOSE COST CENTERS  |                    |                |                     |                                  |                            |                  |
| 118.00               | SUBTOTALS (SUM OF LINES 1 through 117)                                       | 350, 746           | 0              | 50, 551, 8          | 21 -13, 063, 933                 | 70, 268, 139               | 118.00           |
|                      | ONREI MBURSABLE COST CENTERS   | 1.001              |                |                     |                                  | 050 (10                    | 1.00.00          |
|                      | 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN                                     | 1,031              |                |                     | 0 0                              |                            |                  |
|                      | 9200 PHYSICIANS' PRIVATE OFFICES<br>9202 OTHER NONREIMBURSABLE               | 635<br>0           |                |                     | 0 0                              |                            | 192.00<br>192.10 |
|                      | 9201 MEDICAL DAY CARE  | 9, 241             |                |                     | 0 0                              |                            |                  |
|                      | 7950 MARKETI NG/GROUP  | 890                | -              | 1, 053, 5           |                                  |                            |                  |
|                      | 7951 VI LLAGE  | 0                  |                |                     |                                  |                            |                  |
| 194.020              | 7952 HOME HEALTH SERVICES  | 0                  | 0              | 2, 774, 8           |                                  | 3, 397, 722                | 194.02           |
| 200.00               | Cross Foot Adjustments   |                    |                |                     |                                  |                            | 200.00           |
| 201.00               | Negative Cost Centers  |                    |                |                     |                                  |                            | 201.00           |
| 202.00               | Cost to be allocated (per Wkst. B,   | 6, 398, 294        | 0              | 12, 734, 8          | 32                               | 13, 063, 933               | 202.00           |
| 203.00               | Part I)  | 17. 648373         | 0. 000000      | 0. 2244             | 10                               | 0. 136310                  | 202 00           |
| 203.00               | Unit cost multiplier (Wkst. B, Part I)<br>Cost to be allocated (per Wkst. B, | 17.0403/3          | 0.00000        | 59, 4               |                                  | 694, 600                   |                  |
| 207.00               | Part II)   |                    |                | 57,4                |                                  | 074,000                    | 207.00           |
| 205.00               | Unit cost multiplier (Wkst. B, Part  |                    |                | 0.0010              | 48                               | 0.007247                   | 205.00           |
|                      | 11)  |                    |                |                     |                                  |                            |                  |
| 206.00               | NAHE adjustment amount to be allocated                                       |                    |                |                     |                                  |                            | 206.00           |
| 207 00               | (per Wkst. B-2)  |                    |                |                     |                                  |                            | 207 00           |
| 207.00               | NAHE unit cost multiplier (Wkst. D,<br>Parts III and IV)                     |                    |                |                     |                                  |                            | 207.00           |
| 1                    |  | I                  | I              | I                   | I.                               | I                          | 1                |
|                      |  |                    |                |                     |                                  |                            |                  |

| OST ALLOCA              | ncial Systems<br>TION - STATISTICAL BASIS       | RAMAPO RIDGE  | Provider C   |               | Period:                          | u of Form CMS-:<br>Worksheet B-1 |            |
|-------------------------|---|---------------|--------------|---------------|----------------------------------|----------------------------------|------------|
|                         |   |               |              |               | From 01/01/2023<br>To 12/31/2023 | Date/Time Pre                    | naro       |
|                         |   |               |              |               | 10 12/31/2023                    | 5/20/2024 11:                    |            |
|                         | Cost Center Description                         | MAINTENANCE & | OPERATION OF | LAUNDRY &     | HOUSEKEEPI NG                    | DI ETARY                         |            |
|                         |   | REPAI RS      | PLANT        | LINEN SERVICE | E ((SQUARE                       | ((MEALS                          |            |
|                         |   | (SQUARE FEET) | ((SQUARE     | ((POUNDS OF   | FEET))                           | SERVED))                         |            |
|                         |   |               | FEET))       | LAUNDRY))     |                                  |                                  |            |
| OFNER                   |   | 6.00          | 7.00         | 8.00          | 9.00                             | 10.00                            | -          |
|                         | AL SERVICE COST CENTERS                         | 1             |              | 1             |                                  |                                  | 1 1        |
|                         | CAP REL COSTS-BLDG & FIXT                       |               |              |               |                                  |                                  | 1.         |
|                         | EMPLOYEE BENEFITS DEPARTMENT                    |               |              |               |                                  |                                  | 4.         |
|                         | ADMINISTRATIVE & GENERAL                        |               |              |               |                                  |                                  | 5.         |
|                         | MAINTENANCE & REPAIRS                           | 0             |              |               |                                  |                                  | 6.         |
|                         | OPERATION OF PLANT                              | 0             | 198, 709     |               |                                  |                                  | 7.         |
|                         | LAUNDRY & LINEN SERVICE                         | 0             | 5, 578       | 1             | 5                                |                                  | 8.         |
|                         | HOUSEKEEPING                                    | 0             | 722          |               | 0 192, 409                       |                                  | 9.         |
|                         | DIETARY   | 0             | ,22          |               | 0 192, 409                       | 631, 022                         |            |
|                         | CAFETERIA                                       | 0             |              |               | 0 0                              | 206, 773                         |            |
|                         | NURSING ADMINISTRATION                          | 0             |              |               | 0 0                              | 200, 779                         |            |
|                         | MEDICAL RECORDS & LIBRARY                       | 0             | 0            |               | 0 0                              | 0                                |            |
|                         | SOCIAL SERVICE                                  | 0             | 0            |               | 0 0                              | 0                                |            |
|                         | PASTORAL CARE                                   | 0             | 0            |               | 0 0                              | 0                                |            |
|                         | TENT ROUTINE SERVICE COST CENTERS               |               |              |               | <u> </u>                         |                                  |            |
|                         | ADULTS & PEDIATRICS                             | 0             | 35, 305      | 231, 39       | 2 35, 305                        | 48, 087                          | 30.        |
|                         | SKILLED NURSING FACILITY                        | 0             | 80, 897      |               |                                  | 246, 435                         |            |
|                         | NURSING FACILITY                                | 0             | 21, 529      |               |                                  |                                  |            |
|                         | OTHER LONG TERM CARE                            | 0             |              |               |                                  | 93, 123                          |            |
|                         | LARY SERVICE COST CENTERS                       |               |              |               |                                  |                                  |            |
| 4.00 05400              | RADI OLOGY-DI AGNOSTI C                         | 0             | 0            | )             | 0 0                              | 0                                | 54         |
| 0.00 06000              | LABORATORY                                      | 0             | 0            |               | o o                              | 0                                | 60         |
| 5.00 06500              | RESPI RATORY THERAPY                            | 0             | 0            |               | 0 0                              | 0                                | 65.        |
| 6.00 06600              | PHYSI CAL THERAPY                               | 0             | 2, 008       |               | 0 2, 008                         | 0                                | 66.        |
| 7.00 06700              | OCCUPATIONAL THERAPY                            | 0             | 0            |               | 0 0                              | 0                                | 67.        |
| 8.00 06800              | SPEECH PATHOLOGY                                | 0             | 0            | )             | 0 0                              | 0                                | 68.        |
| 1.00 07100              | MEDICAL SUPPLIES CHARGED TO PATIENT             | 0             | 0            | )             | 0 0                              | 0                                | 71.        |
| 3.00 07300              | DRUGS CHARGED TO PATIENTS                       | 0             | 0            |               | 0 0                              | 0                                | 73.        |
|                         | TIENT SERVICE COST CENTERS                      | i             |              | 1             |                                  |                                  |            |
|                         |   | 0             | 18, 389      |               | 0 18, 389                        | 0                                |            |
|                         | OBSERVATION BEDS (NON-DISTINCT PART             |               |              |               |                                  |                                  | 92         |
|                         | AL PURPOSE COST CENTERS                         | 1             |              | 1             |                                  |                                  |            |
| 18.00                   | SUBTOTALS (SUM OF LINES 1 through 117)          | 0             | 194, 134     | 1, 217, 85    | 5 187, 834                       | 631, 022                         | 118        |
|                         | I MBURSABLE COST CENTERS                        | -             |              | 1             |                                  | -                                | 1          |
|                         | GIFT, FLOWER, COFFEE SHOP & CANTEEN             | 0             | 1, 031       |               | 0 1,031                          |                                  | 190        |
|                         | PHYSICIANS' PRIVATE OFFICES                     | 0             | 635          |               | 0 635                            |                                  | 192        |
|                         |   | 0             | 0            |               | 0 0                              |                                  | 192        |
|                         | MEDICAL DAY CARE                                | 0             | 2,019        |               | 0 2,019                          |                                  | 192        |
| 74.0007950<br>74.010795 | MARKETI NG/GROUP                                | 0             | 890          |               | 0 890<br>0 0                     |                                  | 194        |
|                         | PORT HEALTH SERVICES                            | 0             | 0            |               | 0 0                              |                                  | 194<br>194 |
|                         |   | 0             | 0            |               | 0 0                              | 0                                | 200        |
| 0.00<br>1.00            | Cross Foot Adjustments<br>Negative Cost Centers |               |              |               |                                  |                                  | 200        |
|                         | Cost to be allocated (per Wkst. B,              | 0             | 6, 469, 715  | 1, 424, 90    | 5 2, 926, 756                    | 8, 918, 563                      |            |
| 2.00                    | Part I)   | 0             | 0,409,715    | 1, 424, 90    | 2, 720, 730                      | 0, 910, 003                      | 202        |
| 03.00                   | Unit cost multiplier (Wkst. B, Part I)          | 0. 000000     | 32. 558742   | 1. 17001      | 2 15. 211118                     | 14. 133521                       | 202        |
| )4.00                   | Cost to be allocated (per Wkst. B,              | 0.00000       | 261, 843     |               |                                  |                                  |            |
| · <del>·</del> ·····    | Part II)  |               | 201, 643     | 114, 30       | 33, 703                          | 01,042                           | 204        |
| 5.00                    | Unit cost multiplier (Wkst. B, Part             | 0. 000000     | 1. 317721    | 0. 09390      | 9 0. 175475                      | 0. 097686                        | 205        |
|                         | II)   | 0.00000       | 1. 31//21    | 0.07390       | 0.175475                         | 0.077000                         | 200        |
| 06.00                   | NAHE adjustment amount to be allocated          |               |              |               |                                  |                                  | 206        |
|                         | (per Wkst. B-2)                                 |               |              |               |                                  |                                  | 200        |
| 07.00                   | NAHE unit cost multiplier (Wkst. D,             |               |              |               |                                  |                                  | 207        |
|                         |   |               |              |               |                                  |                                  |            |

| Health F         | -<br>Financial Systems   | RAMAPO RIDGE | PSYCHI ATRI C     |   | In Lie                           | u of Form CMS-: | 2552-10            |
|------------------|--|--------------|-------------------|---|----------------------------------|-----------------|--------------------|
|                  | LOCATION - STATISTICAL BASIS   |              | Provider CO       |   | Peri od:                         | Worksheet B-1   |                    |
|                  |  |              |                   |   | From 01/01/2023<br>To 12/31/2023 | Date/Time Pre   | nared              |
|                  |  |              |                   |   |                                  | 5/20/2024 11:   |                    |
|                  |  |              |                   |   |                                  | OTHER GENERAL   |                    |
|                  | Cost Center Description  | CAFETERI A   | NURSING           | MEDI CAL                                | SOCI AL SERVI CE                 | SERVICE         |                    |
|                  | cost center bescription  |              | ADMI NI STRATI ON |   | SUCIAL SERVICE                   | (TIME SPENT)    |                    |
|                  |  |              |                   | LIBRARY                                 | (TIME SPENT)                     | (               |                    |
|                  |  |              | (DIRECT NRSING    | (TIME SPENT)                            |                                  |                 |                    |
|                  |  | 11.00        | HRS)              | 1/ 00                                   | 17.00                            | 10.00           |                    |
| 6                | ENERAL SERVICE COST CENTERS  | 11.00        | 13.00             | 16.00                                   | 17.00                            | 18.00           |                    |
|                  | 00100 CAP REL COSTS-BLDG & FIXT  |              |                   |   |                                  |                 | 1.00               |
|                  | 00200 CAP REL COSTS-MVBLE EQUIP  |              |                   |   |                                  |                 | 2.00               |
| 4.00 0           | 00400 EMPLOYEE BENEFITS DEPARTMENT   |              |                   |   |                                  |                 | 4.00               |
|                  | 00500 ADMINISTRATIVE & GENERAL   |              |                   |   |                                  |                 | 5.00               |
|                  | 00600 MAINTENANCE & REPAIRS  |              |                   |   |                                  |                 | 6.00               |
|                  | 00700 OPERATION OF PLANT<br>00800 LAUNDRY & LINEN SERVICE                    |              |                   |   |                                  |                 | 7.00<br>8.00       |
|                  | 00900 HOUSEKEEPING   |              |                   |   |                                  |                 | 9.00               |
|                  | 01000 DI ETARY   |              |                   |   |                                  |                 | 10.00              |
|                  | 01100 CAFETERIA  | 224, 929     |                   |   |                                  |                 | 11.00              |
|                  | 01300 NURSI NG ADMI NI STRATI ON   | 0            |                   |   |                                  |                 | 13.00              |
|                  | 01600 MEDICAL RECORDS & LIBRARY  | 0            |                   | (                                       |                                  |                 | 16.00              |
|                  | 01700 SOCIAL SERVICE<br>01850 PASTORAL CARE                                  | 3, 182       | 0                 |   |                                  | 12, 889         | 17.00<br>18.00     |
|                  | NPATIENT ROUTINE SERVICE COST CENTERS  | 5, 102       | 0                 |   |                                  | 12,007          | 10.00              |
| -                | 03000 ADULTS & PEDIATRICS  | 58, 295      | 226, 179          | (                                       | 0 0                              | 6, 990          | 30.00              |
| 44.00 0          | 04400 SKILLED NURSING FACILITY   | 99, 464      | 405, 927          | (                                       | 0 0                              | 4, 738          | 44.00              |
|                  | 04500 NURSING FACILITY   | 14, 334      |                   |   | 0 0                              | 1, 161          | 45.00              |
| -                | 04600 OTHER LONG TERM CARE   | 25, 352      | 102, 714          | (                                       | 0 0                              | 0               | 46.00              |
|                  | INCI LLARY SERVI CE COST CENTERS<br>05400 RADI OLOGY-DI AGNOSTI C            | 0            | 0                 | ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) | 0 0                              | 0               | 54.00              |
|                  | 06000 LABORATORY   |              | 0                 |   |                                  | 0               | 60.00              |
|                  | 06500 RESPI RATORY THERAPY   | 0            | 0                 |   |                                  | 0               | 65.00              |
| 66. 00 C         | 06600 PHYSI CAL THERAPY  | 0            | 0                 | (                                       | 0 0                              | 0               | 66.00              |
|                  | 06700 OCCUPATIONAL THERAPY   | 0            | 0                 | 0                                       | 0 0                              | 0               | 67.00              |
|                  | 06800 SPEECH PATHOLOGY   | 0            | 0                 |   | 0 0                              | 0               | 68.00              |
|                  | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT<br>07300 DRUGS CHARGED TO PATIENTS | 0            | 0                 |   |                                  | 0               | 71.00<br>73.00     |
|                  | DUTPATIENT SERVICE COST CENTERS  | 0            | 0                 |   |                                  | 0               | /3.00              |
|                  | 09000 CLINIC   | 1, 549       | 0                 | (                                       | 0 0                              | 0               | 90.00              |
|                  | 09200 OBSERVATION BEDS (NON-DISTINCT PART                                    |              |                   |   |                                  |                 | 92.00              |
|                  | SPECIAL PURPOSE COST CENTERS   | 1            | 1                 | 1                                       |                                  |                 |                    |
| 118.00           | SUBTOTALS (SUM OF LINES 1 through 117)                                       | 202, 176     | 792, 894          | (                                       | 0 0                              | 12, 889         | 118.00             |
|                  | IONREI MBURSABLE COST CENTERS  | 0            | 0                 | (                                       | 0 0                              | 0               | 190.00             |
|                  | 9200 PHYSICIANS' PRIVATE OFFICES   | 0            |                   |   |                                  |                 | 190.00             |
|                  | 9202 OTHER NONRELMBURSABLE   | 18, 156      |                   |   | 0                                |                 | 192.10             |
|                  | 9201 MEDI CAL DAY CARE   | 0            |                   |   | 0 0                              |                 | 192.50             |
|                  | 07950 MARKETI NG/GROUP   | 4, 597       | 0                 | (                                       | 0 0                              |                 | 194.00             |
|                  | 07951 VI LLAGE   | 0            | 0                 | (                                       | 0 0                              |                 | 194.01             |
|                  | 07952 HOME HEALTH SERVICES   | 0            | 0                 | (                                       | 0 0                              | 0               | 194.02             |
| 200.00<br>201.00 | Cross Foot Adjustments<br>Negative Cost Centers                              |              |                   |   |                                  |                 | 200. 00<br>201. 00 |
| 201.00           | Cost to be allocated (per Wkst. B,   | 2, 922, 431  | 0                 | (                                       | 0                                | 753, 221        |                    |
| 202.00           | Part I)  | 2,722,101    |                   |   |                                  | 100,221         | 202.00             |
| 203.00           | Unit cost multiplier (Wkst. B, Part I)                                       | 12. 992682   | 0. 000000         | 0. 000000                               | 0. 000000                        | 58. 439057      | 203.00             |
| 204.00           | Cost to be allocated (per Wkst. B,   | 20, 199      | 0                 | (                                       | 0 0                              | 5, 357          | 204. 00            |
| 205 00           | Part II)   | 0.000000     | 0 000000          | 0.00000                                 | 0 000000                         | 0 445/07        | 205 00             |
| 205.00           | Unit cost multiplier (Wkst. B, Part  | 0. 089802    | 0. 000000         | 0.00000                                 | 0. 000000                        | 0. 415626       | 205.00             |
| 206.00           | NAHE adjustment amount to be allocated                                       |              |                   |   |                                  |                 | 206.00             |
| 200.00           | (per Wkst. B-2)  |              |                   |   |                                  |                 |                    |
| 207.00           | NAHE unit cost multiplier (Wkst. D,  |              |                   |   |                                  |                 | 207.00             |
|                  | Parts III and IV)  |              | l                 | l                                       |                                  | l               | I                  |
|                  |  |              |                   |   |                                  |                 |                    |

| Health Financial Systems   | RAMAPO RIDGE            | PSYCHI ATRI C |             | In Lie                                      | u of Form CMS-2            | 2552-10         |
|--|-------------------------|---------------|-------------|---|----------------------------|-----------------|
| COMPUTATION OF RATIO OF COSTS TO CHARGES                               |                         | Provider C    | CN: 31-4019 | Period:<br>From 01/01/2023<br>To 12/31/2023 |                            | pared:<br>05 am |
|  |                         | Title         | XVIII       | Hospi tal                                   | PPS                        |                 |
|  |                         |               |             | Costs                                       |                            |                 |
| Cost Center Description  | Total Cost              | Therapy Limit | Total Costs |   | Total Costs                |                 |
|  | (from Wkst. B,          | Adj.          |             | Di sal I owance                             |                            |                 |
|  | Part I, col.            |               |             |   |                            |                 |
|  | 26)                     | 0.00          |             |   | 5.00                       |                 |
|  | 1.00                    | 2.00          | 3.00        | 4.00  | 5.00                       |                 |
| INPATIENT ROUTINE SERVICE COST CENTERS                                 | 17 404 405              |               | 17 101 1    | 1/0.001                                     | 47 5 (0, 40)               | 0.00            |
| 30. 00 03000 ADULTS & PEDIATRICS                                       | 17, 401, 105            |               | 17, 401, 1  |   |                            |                 |
| 44. 00 04400 SKILLED NURSING FACILITY<br>45. 00 04500 NURSING FACILITY | 33, 952, 782            |               | 33, 952, 7  |   | 33, 952, 782               |                 |
| 46. 00 04600 OTHER LONG TERM CARE                                      | 5, 419, 886 9, 950, 934 |               | 5, 419, 8   |   | 5, 419, 886<br>9, 950, 934 |                 |
| ANCI LLARY SERVICE COST CENTERS  | 9,930,934               |               | 9, 950, 9   | 04  | 9, 900, 934                | 40.00           |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                                   | 210, 022                |               | 210, 0      | 22 0  | 210, 022                   | 54.00           |
| 60. 00 06000 LABORATORY  | 369, 975                |               | 369, 9      |   | 369, 975                   |                 |
| 65. 00 06500 RESPIRATORY THERAPY                                       | 164, 618                |               | 164, 6      |   | 164, 618                   |                 |
| 66. 00 06600 PHYSI CAL THERAPY   | 2, 681, 082             |               | 2, 681, 0   |   | 2, 681, 082                |                 |
| 67. 00 06700 OCCUPATI ONAL THERAPY                                     | 1, 831, 076             |               | 1, 831, 0   |   | 1, 831, 076                |                 |
| 68. 00 06800 SPEECH PATHOLOGY  | 448, 294                |               | 448, 2      |   | 448, 294                   |                 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                        | 409, 462                |               | 409, 4      |   | 409, 462                   |                 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS                                  | 1, 443, 052             |               | 1, 443, 0   |   | 1, 443, 052                |                 |
| OUTPATIENT SERVICE COST CENTERS  |                         |               |             |   |                            |                 |
| 90. 00 09000 CLINIC  | 5, 049, 911             |               | 5, 049, 9   | 11 0  | 5, 049, 911                | 90.00           |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART                        | 0                       |               |             | 0   | 0                          |                 |
| 200.00 Subtotal (see instructions)                                     | 79, 332, 199            | 0             | 79, 332, 1  | 99 168, 301                                 | 79, 500, 500               | 200.00          |
| 201.00 Less Observation Beds   | 0                       |               |             | 0   |                            | 201.00          |
| 202.00 Total (see instructions)  | 79, 332, 199            | 0             | 79, 332, 1  | 99 168, 301                                 | 79, 500, 500               | 202.00          |

| Heal th | Financial Systems                         | RAMAPO RIDGE I | PSYCHI ATRI C         |                          |   | u of Form CMS-  | 2552-10 |
|---------|---|----------------|-----------------------|--------------------------|---|---|---------|
| COMPUT  | ATION OF RATIO OF COSTS TO CHARGES        |                | Provider CO           | CN: 31-4019              | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet C<br>Part I<br>Date/Time Pre<br>5/20/2024 11: |         |
|         |   |                |                       | XVIII                    | Hospi tal                                   | PPS   |         |
|         | Cost Center Description                   | I npati ent    | Charges<br>Outpatient | Total (col.<br>+ col. 7) | 6 Cost or Other<br>Ratio                    | TEFRA<br>I npati ent<br>Rati o                          |         |
|         |   | 6.00           | 7.00                  | 8.00                     | 9.00  | 10.00   |         |
|         | INPATIENT ROUTINE SERVICE COST CENTERS    |                |                       |                          |   |   |         |
| 30.00   | 03000 ADULTS & PEDIATRICS                 | 25, 614, 503   |                       | 25, 614, 50              |   |   | 30.00   |
| 44.00   | 04400 SKILLED NURSING FACILITY            | 39, 230, 219   |                       | 39, 230, 21              |   |   | 44.00   |
| 45.00   | 04500 NURSING FACILITY                    | 8, 597, 574    |                       | 8, 597, 57               |   |   | 45.00   |
| 46.00   | 04600 OTHER LONG TERM CARE                | 1, 198, 506    |                       | 1, 198, 50               | 06  |   | 46.00   |
|         | ANCILLARY SERVICE COST CENTERS            |                |                       |                          |   |   | -       |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C             | 275, 689       | 0                     | 275, 68                  |   |   | 1       |
| 60.00   | 06000 LABORATORY                          | 517, 445       | 0                     | 517, 44                  |   |   |         |
| 65.00   | 06500 RESPI RATORY THERAPY                | 196, 700       | 0                     | 196, 70                  |   |   |         |
| 66.00   | 06600 PHYSI CAL THERAPY                   | 4, 017, 231    | 0                     | 4, 017, 23               |   |   | 1       |
| 67.00   | 06700 OCCUPATIONAL THERAPY                | 3, 176, 469    | 0                     | 3, 176, 46               |   |   |         |
| 68.00   | 06800 SPEECH PATHOLOGY                    | 777, 679       | 0                     | 777, 67                  |   |   | 1       |
| 71.00   | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 537, 488       | 0                     | 537, 48                  |   |   | 1       |
| 73.00   | 07300 DRUGS CHARGED TO PATIENTS           | 1, 500, 139    | 0                     | 1, 500, 13               | 0. 961946                                   | 0.00000   | 73.00   |
|         | OUTPATIENT SERVICE COST CENTERS           | ,              |                       |                          | 1   | -   |         |
|         | 09000 CLI NI C                            | 0              | 6, 089, 788           | 6, 089, 78               |   |   | 1       |
| 92.00   | 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0              | 0                     |                          | 0 0.000000                                  | 0. 000000   |         |
| 200.00  |   | 85, 639, 642   | 6, 089, 788           | 91, 729, 43              | 0   |   | 200.00  |
| 201.00  |   |                |                       |                          |   |   | 201.00  |
| 202.00  | Total (see instructions)                  | 85, 639, 642   | 6, 089, 788           | 91, 729, 43              | 0   |   | 202.00  |

| Heal th Financial  | Systems   | RAMAPO RIDGE P                  | SYCHI ATRI C          | In Lie                                      | u of Form CMS-2552-10  |
|--------------------|---|---------------------------------|-----------------------|---|--|
| COMPUTATION OF RA  | ATIO OF COSTS TO CHARGES                                |                                 | Provider CCN: 31-4019 | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet C<br>Part I<br>Date/Time Prepared:<br>5/20/2024 11:05 am |
|                    |   |                                 | Title XVIII           | Hospi tal                                   | PPS  |
| Cost               | Center Description                                      | PPS Inpatient<br>Ratio<br>11.00 |                       |   |  |
| I NPATI ENT        | ROUTINE SERVICE COST CENTERS                            | · · ·                           |                       |   |  |
| 44.00 04400 SKI LI | TS & PEDIATRICS<br>LED NURSING FACILITY<br>ING FACILITY |                                 |                       |   | 30. 00<br>44. 00<br>45. 00   |
|                    | R LONG TERM CARE  |                                 |                       |   | 45.00  |
|                    | SERVICE COST CENTERS                                    |                                 |                       |   | 10.00  |
|                    | OLOGY-DI AGNOSTI C                                      | 0. 761808                       |                       |   | 54.00  |
| 60.00 06000 LABO   |   | 0. 715004                       |                       |   | 60.00  |
| 65.00 06500 RESP   | I RATORY THERAPY  | 0. 836899                       |                       |   | 65.00  |
| 66.00 06600 PHYS   | I CAL THERAPY   | 0. 667396                       |                       |   | 66.00  |
| 67.00 06700 0CCUI  | PATIONAL THERAPY  | 0. 576450                       |                       |   | 67.00  |
|                    | CH PATHOLOGY  | 0. 576451                       |                       |   | 68.00  |
|                    | CAL SUPPLIES CHARGED TO PATIENT                         | 0. 761807                       |                       |   | 71.00  |
|                    | S CHARGED TO PATIENTS                                   | 0. 961946                       |                       |   | 73.00  |
|                    | SERVICE COST CENTERS                                    |                                 |                       |   |  |
| 90.00 09000 CLI N  |   | 0. 829242                       |                       |   | 90.00  |
|                    | RVATION BEDS (NON-DISTINCT PART                         | 0. 000000                       |                       |   | 92.00  |
|                    | otal (see instructions)                                 |                                 |                       |   | 200.00   |
|                    | Observation Beds  |                                 |                       |   | 201.00   |
| 202.00   Tota      | l (see instructions)                                    |                                 |                       |   | 202.00   |

| 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:<br>From 01/01/2023<br>To 12/31/2023 |                 | pared:<br>05 am |
|   |                | Ti tl         | e XIX       | Hospi tal                                   | TEFRA           |                 |
|   |                |               |             | Costs                                       |                 |                 |
| Cost Center Description                         |                | Therapy Limit | Total Costs |   | 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              | 17, 401, 105   |               | 17, 401, 1  |   |                 | •               |
| 44.00 04400 SKILLED NURSING FACILITY            | 33, 952, 782   |               | 33, 952, 7  |   | 33, 952, 782    | •               |
| 45.00 04500 NURSING FACILITY                    | 5, 419, 886    |               | 5, 419, 8   |   | 5, 419, 886     |                 |
| 46.00 04600 OTHER LONG TERM CARE                | 9, 950, 934    |               | 9, 950, 9   | 34 0  | 9, 950, 934     | 46.00           |
| ANCI LLARY SERVI CE COST CENTERS                |                |               |             |   |                 |                 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C            | 210, 022       |               | 210, 0      |   | 210, 022        | •               |
| 60. 00 06000 LABORATORY                         | 369, 975       |               | 369, 9      |   | 369, 975        | •               |
| 65. 00 06500 RESPI RATORY THERAPY               | 164, 618       | 0             | 164, 6      |   | 164, 618        |                 |
| 66. 00 06600 PHYSI CAL THERAPY                  | 2, 681, 082    | 0             | 2, 681, 0   |   | 2, 681, 082     |                 |
| 67.00 06700 OCCUPATI ONAL THERAPY               | 1, 831, 076    | 0             | 1, 831, 0   |   | 1, 831, 076     | •               |
| 68.00 06800 SPEECH PATHOLOGY                    | 448, 294       | 0             | 448, 2      |   | 448, 294        | •               |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 409, 462       |               | 409, 4      |   | 409, 462        | •               |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           | 1, 443, 052    |               | 1, 443, 0   | 52 0  | 1, 443, 052     | 73.00           |
| OUTPATIENT SERVICE COST CENTERS                 |                |               |             |   |                 |                 |
| 90. 00 09000 CLINIC                             | 5, 049, 911    |               | 5, 049, 9   | 11 0  | 5, 049, 911     | 90.00           |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0              |               |             | 0   | 0               | 92.00           |
| 200.00 Subtotal (see instructions)              | 79, 332, 199   | 0             | 79, 332, 1  | 99 168, 301                                 |                 | •               |
| 201.00 Less Observation Beds                    | 0              |               |             | 0   |                 | 201.00          |
| 202.00   Total (see instructions)               | 79, 332, 199   | 0             | 79, 332, 1  | 99 168, 301                                 | 79, 500, 500    | 202.00          |

| Heal th | Financial Systems                         | RAMAPO RIDGE I                        | PSYCHI ATRI C         |                          |   | u of Form CMS-  | 2552-10 |
|---------|---|---------------------------------------|-----------------------|--------------------------|---|---|---------|
| COMPUT  | ATION OF RATIO OF COSTS TO CHARGES        |                                       | Provider C            | CN: 31-4019              | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet C<br>Part I<br>Date/Time Pre<br>5/20/2024 11: |         |
|         |   |                                       |                       | e XIX                    | Hospi tal                                   | TEFRA   |         |
|         | Cost Center Description                   | I npati ent                           | Charges<br>Outpatient | Total (col.<br>+ col. 7) | 6 Cost or Other<br>Ratio                    | TEFRA<br>I npati ent<br>Rati o                          |         |
|         |   | 6.00                                  | 7.00                  | 8.00                     | 9.00  | 10.00   |         |
|         | INPATIENT ROUTINE SERVICE COST CENTERS    |                                       |                       |                          | -   |   |         |
| 30.00   | 03000 ADULTS & PEDIATRICS                 | 25, 614, 503                          |                       | 25, 614, 50              |   |   | 30.00   |
| 44.00   | 04400 SKILLED NURSING FACILITY            | 39, 230, 219                          |                       | 39, 230, 2               |   |   | 44.00   |
| 45.00   | 04500 NURSING FACILITY                    | 8, 597, 574                           |                       | 8, 597, 5                |   |   | 45.00   |
| 46.00   | 04600 OTHER LONG TERM CARE                | 1, 198, 506                           |                       | 1, 198, 50               | )6  |   | 46.00   |
|         | ANCI LLARY SERVI CE COST CENTERS          | · · · · · · · · · · · · · · · · · · · |                       |                          |   |   |         |
| 54.00   | 05400 RADI OLOGY-DI AGNOSTI C             | 275, 689                              | 0                     | 275, 6                   |   |   |         |
| 60.00   | 06000 LABORATORY                          | 517, 445                              | 0                     | 517, 4                   |   |   |         |
| 65.00   | 06500 RESPI RATORY THERAPY                | 196, 700                              | 0                     | 196, 70                  |   |   |         |
| 66.00   | 06600 PHYSI CAL THERAPY                   | 4, 017, 231                           | 0                     | 4, 017, 2                |   |   | •       |
| 67.00   | 06700 OCCUPATIONAL THERAPY                | 3, 176, 469                           | 0                     | 3, 176, 4                |   |   |         |
| 68.00   | 06800 SPEECH PATHOLOGY                    | 777, 679                              | 0                     | 777, 6                   |   |   | •       |
| 71.00   | 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 537, 488                              | 0                     | 537, 4                   |   |   | 71.00   |
| 73.00   | 07300 DRUGS CHARGED TO PATIENTS           | 1, 500, 139                           | 0                     | 1, 500, 1                | <u> </u>                                    | 0. 961946   | 73.00   |
|         | OUTPATIENT SERVICE COST CENTERS           | ,                                     |                       | 1                        | - 1   | -   |         |
|         | 09000 CLI NI C                            | 0                                     | 6, 089, 788           | 6, 089, 7                |   |   |         |
| 92.00   | 09200 OBSERVATION BEDS (NON-DISTINCT PART | 0                                     | 0                     |                          | 0 0. 000000                                 | 0. 000000   |         |
| 200.00  |   | 85, 639, 642                          | 6, 089, 788           | 91, 729, 43              | 30  |   | 200.00  |
| 201.00  |   |                                       |                       |                          |   |   | 201.00  |
| 202.00  | Total (see instructions)                  | 85, 639, 642                          | 6, 089, 788           | 91, 729, 43              | 30  |   | 202.00  |

| Health Financial Systems                        | RAMAPO RIDGE P                  | SYCHI ATRI C          | In Lie                                      | u of Form CMS-2552-1   | 10 |
|---|---------------------------------|-----------------------|---|--|----|
| COMPUTATION OF RATIO OF COSTS TO CHARGES        |                                 | Provider CCN: 31-4019 | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet C<br>Part I<br>Date/Time Prepared:<br>5/20/2024 11:05 am |    |
|   |                                 | Title XIX             | Hospi tal                                   | TEFRA  |    |
| Cost Center Description                         | PPS Inpatient<br>Ratio<br>11.00 |                       |   |  |    |
| INPATIENT ROUTINE SERVICE COST CENTERS          | <u>.</u>                        |                       |   |  |    |
| 30. 00 03000 ADULTS & PEDI ATRI CS              |                                 |                       |   | 30. 0  | 00 |
| 44.00 04400 SKILLED NURSING FACILITY            |                                 |                       |   | 44.0   | )0 |
| 45.00 04500 NURSING FACILITY                    |                                 |                       |   | 45.0   | )0 |
| 46.00 04600 OTHER LONG TERM CARE                |                                 |                       |   | 46. 0  | )0 |
| ANCILLARY SERVICE COST CENTERS                  | 1                               |                       |   |  |    |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C            | 0. 000000                       |                       |   | 54.0   |    |
| 60. 00 06000 LABORATORY                         | 0. 000000                       |                       |   | 60. 0  |    |
| 65. 00 06500 RESPI RATORY THERAPY               | 0. 000000                       |                       |   | 65. 0  |    |
| 66. 00 06600 PHYSI CAL THERAPY                  | 0. 000000                       |                       |   | 66. 0  |    |
| 67.00 06700 OCCUPATI ONAL THERAPY               | 0. 000000                       |                       |   | 67.0   |    |
| 68.00 06800 SPEECH PATHOLOGY                    | 0. 000000                       |                       |   | 68.0   |    |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT | 0. 000000                       |                       |   | 71.0   |    |
| 73.00 07300 DRUGS CHARGED TO PATIENTS           | 0. 000000                       |                       |   | 73.0   | )0 |
| OUTPATIENT SERVICE COST CENTERS                 |                                 |                       |   |  |    |
| 90. 00 09000 CLINIC                             | 0. 000000                       |                       |   | 90.0   |    |
| 92.00 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  | )0 |

| Health Financial Systems  | Health Financial Systems RAMAPO RIDGE PSYCHIATRIC In Lieu of Form CMS-25 |              |               |                            |                                |                 |
|---|--|--------------|---------------|----------------------------|--------------------------------|-----------------|
| CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA<br>REDUCTIONS FOR MEDICAID ONLY | TIOS NET OF  | Provider C   | CN: 31-4019   | Period:<br>From 01/01/2023 |                                |                 |
|   |  |              |               | To 12/31/2023              | Date/Time Pre<br>5/20/2024 11: | pared:<br>05 am |
|   |  | Titl         | e XIX         | Hospi tal                  | TEFRA                          |                 |
| Cost Center Description   | Total Cost   | Capital Cost | Operating Cos | st Capital                 | 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  | I  |              |               | - 1                        | -                              |                 |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C  | 210, 022   |              |               |                            |                                | 54.00           |
| 60. 00 06000 LABORATORY   | 369, 975   |              |               |                            |                                | 60.00           |
| 65. 00 06500 RESPI RATORY THERAPY   | 164, 618   |              |               | 58 105                     | 9, 487                         | 65.00           |
| 66. 00 06600 PHYSI CAL THERAPY  | 2, 681, 082  | 256, 591     | 2, 424, 49    | 25, 659                    | 140, 620                       | 66.00           |
| 67.00 06700 OCCUPATI ONAL THERAPY   | 1, 831, 076  | 11, 678      | 1, 819, 39    | 98 1, 168                  | 105, 525                       | 67.00           |
| 68.00 06800 SPEECH PATHOLOGY  | 448, 294   | 2, 859       | 445, 43       | 35 286                     | 25, 835                        | 68.00           |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                                     | 409, 462   | 2, 611       | 406, 85       | 51 261                     | 23, 597                        | 71.00           |
| 73.00 07300 DRUGS CHARGED TO PATIENTS   | 1, 443, 052  | 9, 203       | 1, 433, 84    | 920                        | 83, 163                        | 73.00           |
| OUTPATIENT SERVICE COST CENTERS   |  |              |               |                            |                                |                 |
| 90. 00 09000 CLINIC   | 5, 049, 911  | 481, 446     | 4, 568, 46    | 48, 145                    | 264, 971                       | 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)  | 12, 607, 492   | 769, 137     | 11, 838, 35   | 5 76, 914                  | 686, 624                       | 200.00          |
| 201.00 Less Observation Beds  | 0  | C            |               | 0 0                        | 0                              | 201.00          |
| 202.00 Total (line 200 minus line 201)  | 12, 607, 492   | 769, 137     | 11, 838, 35   | 5 76, 914                  | 686, 624                       | 202.00          |
|   |  |              |               |                            |                                |                 |

| Health Financial Systems                            | inancial Systems RAMAPO RIDGE PSYCHIATRIC |               |             |                 |                                | 2552-10 |
|---|---|---------------|-------------|-----------------|--------------------------------|---------|
| CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA | ATIOS NET OF                              | Provider C    | CN: 31-4019 | Peri od:        | Worksheet C                    |         |
| REDUCTIONS FOR MEDICALD ONLY                        |   |               |             | From 01/01/2023 | Part II                        |         |
|   |   |               |             | To 12/31/2023   | Date/Time Pre<br>5/20/2024 11: | pared:  |
|   |   | Ti +1         | e XIX       | Hospi tal       | TEFRA                          |         |
| Cost Center Description                             | Cost Net of                               | Total Charges |             |                 |                                |         |
| Cost Center Description                             |   | (Worksheet C, |             | 10              |                                |         |
|   | Operating Cost                            |               |             |                 |                                |         |
|   | Reduction                                 |               | / col. 7)   | 0               |                                |         |
|   | 6.00                                      | 7,00          | 8.00        | _               |                                |         |
| ANCI LLARY SERVICE COST CENTERS                     | 0.00                                      | 7.00          | 0.00        |                 |                                |         |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                | 197, 784                                  | 275, 689      | 0. 7174     | 7               |                                | 54.00   |
| 60. 00 06000 LABORATORY                             | 348, 417                                  |               |             |                 |                                | 60.00   |
| 65. 00 06500 RESPIRATORY THERAPY                    |   |               |             |                 |                                | 65.00   |
|   | 155, 026                                  |               |             |                 |                                |         |
| 66. 00 06600 PHYSI CAL THERAPY                      | 2, 514, 803                               |               |             |                 |                                | 66.00   |
| 67. 00 06700 OCCUPATI ONAL THERAPY                  | 1, 724, 383                               |               |             |                 |                                | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY                        | 422, 173                                  |               |             |                 |                                | 68.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 385, 604                                  |               | 1           |                 |                                | 71.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 1, 358, 969                               | 1, 500, 139   | 0. 9058     | 95              |                                | 73.00   |
| OUTPATIENT SERVICE COST CENTERS                     | 1   |               | <b>T</b>    |                 |                                |         |
| 90. 00 09000 CLINIC                                 | 4, 736, 795                               | 6, 089, 788   | 0. 77782    | 26              |                                | 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)          | 11, 843, 954                              | 17, 088, 628  |             |                 |                                | 200.00  |
| 201.00 Less Observation Beds                        | 0   | 0             |             |                 |                                | 201.00  |
| 202.00   Total (line 200 minus line 201)            | 11, 843, 954                              | 17, 088, 628  |             |                 |                                | 202.00  |

| Health Financial Systems                          | RAMAPO RIDGE   | PSYCHI ATRI C  |               | In Lie                                      | u of Form CMS- | 2552-10 |
|---|----------------|----------------|---------------|---|----------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITA | _ COSTS        | Provider C     |               | Period:<br>From 01/01/2023<br>To 12/31/2023 | Date/Time Pre  | epared: |
|   |                |                |               |   | 5/20/2024 11:  | 05 am   |
|   |                |                | e XVIII       | Hospi tal                                   | PPS            |         |
| 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            |                | 1              |               | -1  | -              |         |
| 30. 00 ADULTS & PEDIATRICS                        | 916, 667       | C              | 916, 66       | 7 15, 068                                   | 60.84          | 30.00   |
| 44.00 SKILLED NURSING FACILITY                    | 1, 814, 854    |                | 1, 814, 85    | 4 82, 145                                   | 22.09          | 44.00   |
| 45.00 NURSING FACILITY                            | 463, 743       |                | 463, 74       | 3 12, 634                                   | 36.71          | 45.00   |
| 200.00 Total (lines 30 through 199)               | 3, 195, 264    |                | 3, 195, 26    | 4 109, 847                                  |                | 200.00  |
| Cost Center Description                           | I npati ent    | Inpati ent     |               |   |                |         |
|   | Program days   | Program        |               |   |                |         |
|   |                | Capital Cost   |               |   |                |         |
|   |                | (col. 5 x col. |               |   |                |         |
|   |                | 6)             |               |   |                |         |
|   | 6.00           | 7.00           |               |   |                |         |
| INPATIENT ROUTINE SERVICE COST CENTERS            |                |                |               |   | -              |         |
| 30. 00 ADULTS & PEDIATRICS                        | 7, 546         | 459, 099       |               |   |                | 30.00   |
| 44.00 SKILLED NURSING FACILITY                    | 19, 928        | 440, 210       |               |   |                | 44.00   |
| 45.00 NURSING FACILITY                            | 0              | c c            |               |   |                | 45.00   |
| 200.00 Total (lines 30 through 199)               | 27, 474        | 899, 309       |               |   |                | 200.00  |

| Health Financial Systems                            | RAMAPO RIDGE         | PSYCHI ATRI C                                   |             | In Lie                                      | u of Form CMS-2                           | 2552-10 |
|---|----------------------|---|-------------|---|---|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | AL COSTS             | Provider C                                      | CN: 31-4019 | Period:<br>From 01/01/2023<br>To 12/31/2023 |   |         |
|   | _                    | Title   | XVIII       | Hospi tal                                   | PPS                                       |         |
| Cost Center Description                             |                      | Total Charges<br>(from Wkst. C,<br>Part I, col. | to Charges  | Program                                     | Capital Costs<br>(column 3 x<br>column 4) |         |
|   | Part II, col.<br>26) | 8)  | 2)          | Ŭ   |   |         |
|   | 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, 339               | 275, 689  | 0. 00485    | 57 11, 120                                  | 54  | 54.00   |
| 60. 00 06000 LABORATORY                             | 2,360                | 517, 445  | 0. 00456    | 25, 218                                     | 115                                       | 60.00   |
| 65. 00 06500 RESPI RATORY THERAPY                   | 1,050                | 196, 700  | 0.00533     | 8 0   | 0   | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY                      | 256, 591             | 4, 017, 231                                     | 0. 06387    | 3 0   | 0   | 66.00   |
| 67.00 06700 OCCUPATI ONAL THERAPY                   | 11,678               | 3, 176, 469                                     | 0.00367     | 6 0   | 0   | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY                        | 2,859                | 777, 679  | 0.00367     | 6 0   | 0   | 68.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 2,611                | 537, 488  | 0. 00485    | 68 0  | 0   | 71.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 9, 203               | 1, 500, 139                                     | 0. 00613    | 102, 674                                    | 630                                       | 73.00   |
| OUTPATIENT SERVICE COST CENTERS                     |                      |   |             |   |   | 1       |
| 90. 00 09000 CLI NI C                               | 481, 446             | 6, 089, 788                                     | 0. 07905    | 68 0  | 0   | 90.00   |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART     | 0                    | 0   | 0. 00000    | 0 0   | 0   | 92.00   |
| 200.00 Total (lines 50 through 199)                 | 769, 137             | 17, 088, 628                                    |             | 139, 012                                    | 799                                       | 200. 00 |
|   |                      |   |             |   |   |         |

| Health Financial Systems                      | RAMAPO RIDGE F        | PSYCHI ATRI C |              | In Lie                                      | u of Form CMS- | 2552-10 |
|---|-----------------------|---------------|--------------|---|----------------|---------|
| APPORTIONMENT OF INPATIENT ROUTINE SERVICE OT | HER PASS THROUGH COST | S Provider C  |              | Period:<br>From 01/01/2023<br>To 12/31/2023 |                |         |
|   |                       | Title         | XVIII        | Hospi tal                                   | PPS            |         |
| Cost Center Description                       | Nursi ng              | Nursi ng      | Allied Healt | Allied Health                               | All Other      |         |
|   | Program               | Program       | Post-Stepdow | 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 & PEDIATRICS              | 0                     | 0             |              | 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 Patien | Per Diem (col.                              | Inpati ent     |         |
|   | Adjustment            | (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        | <b>I</b>              |               |              |   |                |         |
| 30. 00 03000 ADULTS & PEDIATRICS              | 0                     | 0             | 15, 06       | 8 0.00                                      | 7, 546         | 30.00   |
| 44.00 04400 SKILLED NURSING FACILITY          |                       | 0             | 82, 14       | 5 0.00                                      | 19, 928        | 44.00   |
| 45.00 04500 NURSING FACILITY                  |                       | 0             | 12,63        | 4 0.00                                      | 0              | 45.00   |
| 200.00 Total (lines 30 through 199)           |                       | 0             | 109, 84      | 7   | 27, 474        | 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 04400 SKILLED NURSING FACILITY          | 0                     |               |              |   |                | 44. OC  |
| 45. 00 04500 NURSING FACILITY                 | 0                     |               |              |   |                | 45.00   |
| 200.00 Total (lines 30 through 199)           | o                     |               |              |   |                | 200.00  |

| Health Financial Systems RAMAPO RIDGE PSYCHIATRIC In Lieu of Form CMS-2552 |                                      |  |                    |   |      |         |
|--|--------------------------------------|--|--------------------|---|------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER<br>THROUGH COSTS       | VICE OTHER PASS                      | S Provider CO                                      | CN: 31-4019        | Period:<br>From 01/01/2023<br>To 12/31/2023   |      |         |
|  |                                      | Title  | XVIII              | Hospi tal                                     | PPS  |         |
| Cost Center Description  | Non Physician<br>Anesthetist<br>Cost | Nursing<br>Program<br>Post-Stepdown<br>Adjustments | Nursing<br>Program | Allied Health<br>Post-Stepdown<br>Adjustments |      |         |
|  | 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     | PSYCHI ATRI C |              | In Lieu of Form CMS-2552-10      |                |         |  |
|---|------------------|---------------|--------------|----------------------------------|----------------|---------|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI | RVICE OTHER PASS | S Provider C  |              | Peri od:                         | Worksheet D    |         |  |
| THROUGH COSTS                                       |                  |               |              | From 01/01/2023<br>To 12/31/2023 |                | nared   |  |
|   |                  |               |              | 10 12/01/2020                    | 5/20/2024 11:  |         |  |
|   |                  | Title         | XVIII        | Hospi tal                        | PPS            |         |  |
| Cost Center Description                             | All Other        | Total Cost    | Total        |                                  | Ratio of Cost  |         |  |
|   | Medi cal         | (sum of cols. | Outpati ent  | (from Wkst. C,                   |                |         |  |
|   | Education Cost   |               | Cost (sum of |                                  | (col. 5 ÷ col. |         |  |
|   |                  | 4)            | cols. 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             |              | 0 275, 689                       |                | •       |  |
| 60. 00 06000 LABORATORY                             | 0                | 0             |              | 0 517, 445                       |                |         |  |
| 65. 00 06500 RESPI RATORY THERAPY                   | 0                | 0             |              | 0 196, 700                       | 0. 000000      | 65.00   |  |
| 66. 00 06600 PHYSI CAL THERAPY                      | 0                | 0             |              | 0 4, 017, 231                    | 0. 000000      | 66.00   |  |
| 67.00 06700 OCCUPATI ONAL THERAPY                   | 0                | 0             |              | 0 3, 176, 469                    | 0.000000       | 67.00   |  |
| 68.00 06800 SPEECH PATHOLOGY                        | 0                | 0             |              | 0 777, 679                       | 0.000000       | 68.00   |  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 0                | 0             |              | 0 537, 488                       | 0.000000       | 71.00   |  |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 0                | 0             |              | 0 1, 500, 139                    | 0.000000       | 73.00   |  |
| OUTPATIENT SERVICE COST CENTERS                     |                  |               |              |                                  |                |         |  |
| 90. 00 09000 CLI NI C                               | 0                | 0             |              | 0 6, 089, 788                    | 0.00000        | 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 17, 088, 628                   | 1              | 200. 00 |  |
|   |                  |               |              |                                  |                |         |  |

| Health Financial Systems                            | RAMAPO RIDGE P  | SYCHI ATRI C |              | In Lieu of Form CMS-2552-1       |                |         |
|---|-----------------|--------------|--------------|----------------------------------|----------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER | VICE OTHER PASS | Provider CO  |              | Period:                          | Worksheet D    |         |
| THROUGH COSTS                                       |                 |              |              | From 01/01/2023<br>To 12/31/2023 |                | narod   |
|   |                 |              |              | 10 12/31/2023                    | 5/20/2024 11:0 | 05 am   |
|   |                 | 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 | 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          |         |
| ANCILLARY SERVICE COST CENTERS                      |                 |              |              |                                  |                |         |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                | 0. 000000       | 11, 120      |              | 0 0                              | 0              | 54.00   |
| 60. 00 06000 LABORATORY                             | 0. 000000       | 25, 218      |              | 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            | 1            | 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       | 102, 674     |              | 0 0                              | 0              | 73.00   |
| OUTPATIENT SERVICE COST CENTERS                     | · · ·           |              |              |                                  |                |         |
| 90. 00 09000 CLINIC                                 | 0.000000        | 0            |              | 0 2, 522, 564                    | 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)                 | 1               | 139, 012     |              | 0 2, 522, 564                    | 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  | Peri od:                         | Worksheet D     |         |
|   |                |                |              | From 01/01/2023<br>To 12/31/2023 |                 | narod   |
|   |                |                |              | 10 12/31/2023                    | 5/20/2024 11:   |         |
|   |                | Title          | e XVIII      | Hospi tal                        | PPS             |         |
|   |                |                | Charges      |                                  | Costs           |         |
| Cost Center Description                                   | Cost to Charge | PPS Reimbursec | l Cost       | Cost                             | PPS Services    |         |
|   |                | Services (see  | Rei mbursed  | Reimbursed                       | (see inst.)     |         |
|   | Worksheet C,   | inst.)         | Servi ces    | Services Not                     |                 |         |
|   | Part I, col. 9 |                | Subject To   |                                  |                 |         |
|   |                |                | Ded. & Coins |                                  |                 |         |
|   |                |                | (see inst.)  | (see inst.)                      |                 |         |
|   | 1.00           | 2.00           | 3.00         | 4.00                             | 5.00            |         |
| ANCI LLARY SERVI CE COST CENTERS                          | 0.7(4000       |                |              |                                  |                 | 54.00   |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                      | 0. 761808      |                |              | 0 0                              | 0               | 0.1.00  |
|   | 0. 715004      |                |              | 0 0                              | 0               | 60.00   |
| 65. 00 06500 RESPI RATORY THERAPY                         | 0. 836899      |                |              | 0 0                              | 0               | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY                            | 0. 667396      |                |              | 0 0                              | 0               | 66.00   |
| 67. 00 06700 OCCUPATI ONAL THERAPY                        | 0. 576450      |                |              | 0 0                              | 0               | 67.00   |
| 68. 00 06800 SPEECH PATHOLOGY                             | 0. 576451      |                |              | 0 0                              | 0               | 68.00   |
| 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT       | 0. 761807      |                |              | 0 0                              | 0               | 71.00   |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS                    | 0. 961946      | (              | <u>и</u>     | 0 0                              | 0               | 73.00   |
|   | 0,000040       |                |              | 0                                | 2 001 01/       | 00.00   |
| 90. 00 09000 CLINIC                                       | 0. 829242      |                | ł            | 0 0                              | 2, 091, 816     |         |
| 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART          | 0. 000000      |                |              | 0 0                              | 0               | 92.00   |
| 200.00 Subtotal (see instructions)                        |                | 2, 522, 564    | ł            | 0 0                              | 2, 091, 816     |         |
| 201.00 Less PBP Clinic Lab. Services-Program              |                |                |              | 0 0                              |                 | 201.00  |
| 0nl y Charges<br>202.00 Net Charges (line 200 - line 201) |                | 2, 522, 564    |              | 0 0                              | 2, 091, 816     | 202 00  |
| 202.00   met charges (TTHE 200 - TTHE 201)                | I              | 2, 322, 304    | 1            | u u                              | 2,091,010       | 202.00  |

| Health Financial Systems                            | RAMAPO RIDGE                   | PSYCHI ATRI C                      |       | In Lie                                       | u of Form CMS-2552  | 2-10 |
|---|--------------------------------|------------------------------------|-------|--|---|------|
| APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND | VACCINE COST                   | Provider C                         |       | Peri od:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet D<br>Part V<br>Date/Time Prepare<br>5/20/2024 11:05 |      |
|   |                                |                                    | XVIII | Hospi tal                                    | PPS   |      |
|   |                                | sts                                |       |  |   |      |
| Cost Center Description                             | Cost<br>Reimbursed<br>Services | Cost<br>Reimbursed<br>Services Not |       |  |   |      |
|   | Subject To                     | Subject To                         |       |  |   |      |
|   |                                | Ded. & Coi ns.                     |       |  |   |      |
|   | (see inst.)                    | (see inst.)                        |       |  |   |      |
|   | 6.00                           | 7.00                               |       |  |   |      |
| ANCI LLARY SERVI CE COST CENTERS                    |                                |                                    |       |  |   |      |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                | C                              | 0 0                                |       |  | 54  | 4.00 |
| 60. 00 06000 LABORATORY                             | C                              | 0 0                                |       |  |   | 0.00 |
| 65. 00 06500 RESPI RATORY THERAPY                   | C                              | 0 0                                |       |  | 65  | 5.00 |
| 66. 00 06600 PHYSI CAL THERAPY                      | C                              | 0 0                                |       |  |   | 6.00 |
| 67.00 06700 OCCUPATI ONAL THERAPY                   | C                              | 0 0                                |       |  | 67  | 7.00 |
| 68.00 06800 SPEECH PATHOLOGY                        | C                              | 0                                  |       |  | 68  | 8.00 |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | C                              | 0                                  |       |  | 71  | 1.00 |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | C                              | 0                                  |       |  | 73  | 3.00 |
| OUTPATIENT SERVICE COST CENTERS                     |                                |                                    |       |  |   |      |
| 90. 00 09000 CLINIC                                 | C                              | 0                                  |       |  | 90  | 0.00 |
| 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART     | C                              | 0                                  |       |  | 92  | 2.00 |
| 200.00 Subtotal (see instructions)                  | C                              | 0                                  |       |  | 200   | 0.00 |
| 201.00 Less PBP Clinic Lab. Services-Program        | C                              |                                    |       |  | 201   | 1.00 |
| Only Charges  |                                |                                    |       |  |   |      |
| 202.00 Net Charges (line 200 - line 201)            | C                              | 0                                  |       |  | 202   | 2.00 |

| Health Financial Systems                           | RAMAPO RIDGE    | PSYCHI ATRI C |              | In Lieu of Form CMS-2552-10 |                                |         |
|--|-----------------|---------------|--------------|-----------------------------|--------------------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE | RVICE OTHER PAS | S Provider CO | CN: 31-4019  | Peri od:                    | Worksheet D                    |         |
| THROUGH COSTS                                      |                 |               | 001 04 507/  | From 01/01/2023             |                                |         |
|  |                 | Component (   | CCN: 31-5376 | To 12/31/2023               | Date/Time Pre<br>5/20/2024 11: |         |
|  |                 | Title         | XVIII        | Skilled Nursing             |                                |         |
|  |                 | in the        |              | Facility                    | 115                            |         |
| Cost Center Description                            | Non Physician   | Nursi ng      | Nursi ng     |                             | Allied Health                  |         |
|  | Anestheti st    | Program       | Program      | Post-Stepdown               |                                |         |
|  | Cost            | Post-Stepdown | U U          | Adjustments                 |                                |         |
|  |                 | Adjustments   |              | 5                           |                                |         |
|  | 1.00            | 2A            | 2.00         | 3A                          | 3.00                           |         |
| ANCI LLARY SERVICE 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 |

| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS<br>THROUGH COSTS       Provider CCN: 31-4019<br>Component CCN: 31-5376       Period:<br>From 01/01/2023<br>To 12/31/2023       Worksheet D<br>Part IV<br>Date/Time Prepared:<br>5/20/2024 11:05 am         Title XVIII       Skilled Nursing       PPS | Health Financial Systems                            | RAMAPO RIDGE F   | PSYCHI ATRI C |              | In Lie          | u of Form CMS-2 | 2552-10 |
|---|---|------------------|---------------|--------------|-----------------|-----------------|---------|
| Component CCN: 31-5376     To     12/31/2023     Date/Time Prepared:<br>5/20/2024       Title XVIII     Skilled Nursing     PPS   | APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF | RVICE OTHER PASS | Provider CO   | CN: 31-4019  |                 |                 |         |
| Title XVIII         Skilled Nursing         PPS   | THROUGH COSTS                                       |                  | Component (   | CON. 21 E274 |                 |                 | narodi  |
| Title XVIII Skilled Nursing PPS   |   |                  | component (   | JUN. 31-3370 | 10 12/31/2023   |                 |         |
|   |   |                  | Title         | XVIII        | Skilled Nursing |                 |         |
|   |   |                  |               |              | Facility        |                 |         |
| Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost  | Cost Center Description                             |                  |               |              |                 |                 |         |
| 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.  |   | Education Cost   |               |              |                 |                 |         |
| 4) col s. 2, 3, 8) 7)   |   |                  | 4)            |              | 8)              | · · ·           |         |
| and 4) (see<br>instructions)  |   |                  |               | and 4)       |                 |                 |         |
| 4.00 5.00 6.00 7.00 8.00  |   | 4.00             | 5.00          | 6.00         | 7.00            |                 |         |
| ANCI LLARY SERVICE COST CENTERS   | ANCILLARY SERVICE COST CENTERS                      | 4.00             | 5.00          | 0.00         | 7.00            | 0.00            |         |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 275, 689 0. 000000 54. 00  |   | 0                | 0             |              | 0 275 689       | 0.00000         | 54 00   |
| 60.00 06000 LABORATORY 0 0 0 517, 445 0.000000 60.00  |   | 0                | 0             |              |                 |                 | •       |
| 65. 00 06500 RESPI RATORY THERAPY 0 0 0 196, 700 0.000000 65. 00  |   | 0                | 0             |              |                 |                 | •       |
| 66. 00 06600 PHYSI CAL THERAPY 0 0 0 4, 017, 231 0. 000000 66. 00   |   | 0                | 0             |              |                 |                 | •       |
| 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 3,176,469 0.000000 67.00   | 67.00 06700 OCCUPATI ONAL THERAPY                   | 0                | 0             |              | 0 3, 176, 469   | 0.000000        | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY 0 0 777,679 0.00000 68.00  | 68.00 06800 SPEECH PATHOLOGY                        | 0                | 0             |              | 0 777, 679      | 0.000000        | 68.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 537,488 0.000000 71.00  | 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 0                | 0             | 1            | 0 537, 488      | 0. 000000       | 71.00   |
| 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 1,500,139 0.00000 73. 00   | 73.00 07300 DRUGS CHARGED TO PATIENTS               | 0                | 0             |              | 0 1, 500, 139   | 0.00000         | 73.00   |
| OUTPATIENT SERVICE COST CENTERS   | OUTPATIENT SERVICE COST CENTERS                     |                  |               | -            |                 |                 |         |
| 90. 00 09000 CLINIC 0 0 0 6,089,788 0.00000 90.00   |   | 0                | 0             |              | 0 6, 089, 788   |                 | •       |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 0 0.000000 92. 00  |   | 0                | 0             |              | 0 0             |                 | •       |
| 200.00         Total (Lines 50 through 199)         0         0         0         17,088,628         200.00   | 200.00   Total (lines 50 through 199)               | 0                | 0             |              | 0 17, 088, 628  | l               | 200. 00 |

| Health Financial Systems                            | RAMAPO RIDGE P   | SYCHI ATRI C |              | In Lie          | u of Form CMS-                 | 2552-10 |
|---|------------------|--------------|--------------|-----------------|--------------------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF | RVICE OTHER PASS | Provider CC  | CN: 31-4019  | Peri od:        | Worksheet D                    |         |
| THROUGH COSTS                                       |                  |              | 001 04 5074  | From 01/01/2023 | Part IV                        |         |
|   |                  | Component (  | CCN: 31-5376 | To 12/31/2023   | Date/Time Pre<br>5/20/2024 11: | pared:  |
|   |                  | Title        | XVIII        | Skilled Nursing |                                |         |
|   |                  |              |              | Facility        | 110                            |         |
| Cost Center Description                             | Outpatient       | Inpati ent   | Inpati ent   | Outpati ent     | Outpati ent                    |         |
|   | Ratio of Cost    | Program      | Program      | Program         | Program                        |         |
|   | to Charges       | Charges      | Pass-Through | n Charges       | Pass-Through                   |         |
|   | (col. 6 ÷ col.   | -            | Costs (col.  | 8               | 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        | 32, 725      |              | 0 0             | 0                              | 54.00   |
| 60. 00 06000 LABORATORY                             | 0. 000000        | 139, 913     |              | 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        | 1, 611, 489  |              | 0 0             | 0                              | 66.00   |
| 67.00 06700 OCCUPATI ONAL THERAPY                   | 0. 000000        | 1, 757, 423  |              | 0 0             | 0                              | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY                        | 0. 000000        | 410, 735     |              | 0 0             | 0                              | 68.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 0. 000000        | 93, 029      |              | 0 0             | 0                              | 71.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 0. 000000        | 300, 074     |              | 0 0             | 0                              | 73.00   |
| OUTPATIENT SERVICE COST CENTERS                     |                  |              |              |                 |                                | 1       |
| 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, 345, 388  |              | 0 0             | 0                              | 200. 00 |

| 44.00       SKILLED NURSING FACILITY       1,814,854       1,814,854       82,145       22.09       44.0         45.00       NURSING FACILITY       463,743       463,743       12,634       36.71       45.0         200.00       Total (lines 30 through 199)       3,195,264       3,195,264       3,195,264       200.0         Cost Center Description         Inpatient<br>Program days         0       0       7.00       6.00       7.00       7.00       30.0         INPATIENT ROUTINE SERVICE COST CENTERS         30.00       ADULTS & PEDIATRICS       1,497       91,077       30.0       30.0         44.00       SKILLED NURSING FACILITY       36,281       801,447       44.0  | Health Financial Systems                   | RAMAPO RIDGE   | PSYCHI ATRI C |               | In Lie        | u of Form CMS- | 2552-10 |
|--|--|----------------|---------------|---------------|---------------|----------------|---------|
| Cost Center Description         Capital<br>Related Cost<br>(from Wkst. B,<br>Part II, col.<br>26)         Swing Bed<br>Adjustment         Reduced<br>Capital<br>Related Cost<br>(col. 1 - col.<br>2)         Total Patient<br>Days         Per Diem (col.<br>3 / col. 4)           1NPATI ENT ROUTINE SERVICE COST CENTERS         916, 667         0         916, 667         15, 068         60.84         30.00           44.00         SKILLED NURSING FACILITY         1, 814, 854         1, 814, 854         31, 12, 634         36, 71         45.00           200.00         Total (lines 30 through 199)         3, 195, 264         3, 195, 264         109, 847         200.00           Cost Center Description         Inpatient<br>Program<br>Capital         Inpatient<br>Program<br>Capital Cost<br>(col. 5 x col.<br>6)         916, 667         109, 847         200.00           1NPATIENT ROUTINE SERVICE COST CENTERS         3, 195, 264         3, 195, 264         109, 847         200.00  | APPORTIONMENT OF INPATIENT ROUTINE SERVICE | CAPI TAL COSTS | Provider C    |               |               |                |         |
| Impart of the structure         5/20/2024 11:05 am           Title XIX         Hospital         TEFRA           Cost Center Description         Capital<br>Related Cost<br>(from Wkst. B,<br>Part II, col.<br>26)         Reduced<br>Capital<br>Related Cost<br>(col. 1)         Total Patient<br>Days         Per Diem (col.<br>3 / col. 4)           ADULTS & PEDI ATRICS         916, 667         O         30.00         ALOD         30.00         ALOD         5/20/2024 11:05 am           Total Patient<br>Patient         Per Diamondo for the service colspan="2">Total Patient<br>Patient         Per Diamondo for the service colspan="2">Col.<br>3.0.00         ALOD         2.00         3.00         4.00         5/20/2024 11:05 am           Total Colspan="2">Capital Related Cost<br>(col. 2)         Total Patient<br>Patient         Total Patient<br>Patient         Total Cost<br>(col. 5 x col.<br>6)         Total (lines 30 through 199)         3.195, 264         109, 847         20.00           Total (lines 30 through 199)         1.192, 264         1.192, 264         109, 847           Cost Center Description         Inpatie   |  |                |               |               |               |                | pared.  |
| Cost Center Description         Capital<br>Related Cost<br>(from Wkst. B,<br>Part II, col.<br>26)         Swing Bed<br>Adjustment         Reduced<br>Capital<br>Related Cost<br>(col. 1 - col.<br>2)         Total Patient<br>Days         Per Diem (col.<br>3 / col. 4)           30.00         INPATIENT ROUTINE SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           30.00         ADULTS & PEDIATRICS         916, 667         0         916, 667         15, 068         60.84         30.0           44.00         SKILLED NURSING FACILITY         1, 814, 854         1, 814, 854         82, 145         22.09         44.0           45.00         NURSING FACILITY         463, 743         463, 743         12, 634         36.71         45.0           200.00         Total (lines 30 through 199)         3, 195, 264         1npatient<br>Program days         1npatient<br>Program Capital Cost<br>(col. 5 x col.<br>6)         109, 847         200.0         200.0           40.01 Ts & PEDIATRICS         1, 497         91, 077         30.0         30.0         40.0         40.0         40.0   |  |                |               |               | 10 12/01/2020 | 5/20/2024 11:  | 05 am   |
| Related Cost<br>(from Wkst. B,<br>Part II, col.<br>26)         Adjustment         Capital<br>Related Cost<br>(col. 1 - col.<br>2)         Days         3 / col. 4)           30.00         ADULTS & PEDIATRICS         916,667         0         916,667         15,068         60.84         30.00           44.00         SKI LLED NURSI NG FACI LI TY         1,814,854         1,814,854         82,145         22.09         44.00           200.00         Total (lines 30 through 199)         3,195,264         109,847         200.0         200.0           INPATI ENT ROUTI NE SERVICE COST CENTERS           30.00         ADULTS & PEDIATRICS         916,667         0         916,667         15,068         60.84         30.0           44.00         SKI LLED NURSI NG FACI LI TY         1,814,854         31,915,264         109,847         200.0           200.00         Total (lines 30 through 199)         3,195,264         3,195,264         109,847         200.0           Cost Center Description         Inpati ent<br>Program days         Program<br>Capital Cost<br>(col. 5 x col.<br>6)         6.00         7.00         30.0         30.0           44.00         SKI LLED NURSI NG FACI LI TY         36,281         801,447         44.0         44.0  |  |                | Titl          | e XIX         | Hospi tal     | TEFRA          |         |
| INPATI ENT ROUTI NE SERVI CE COST CENTERS         916, 667         0         916, 667         15, 068         60.84         30. 0           30. 00         ADULTS & PEDI ATRICS         916, 667         0         916, 667         15, 068         60.84         30. 0           44. 00         SKI LLED NURSING FACI LI TY         1, 814, 854         1, 814, 854         12, 634         36. 71         45. 00           200. 00         Total (lines 30 through 199)         3, 195, 264         3, 195, 264         109, 847         200. 0           INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         ADULTS & PEDI ATRICS         916, 667         0         916, 667         15, 068         60. 84         30. 0           45. 00         NURSING FACI LI TY         463, 743         148, 854         12, 634         36. 71         45. 0           200. 00         Total (lines 30 through 199)         3, 195, 264         3, 195, 264         109, 847         200. 0         200. 0         200. 0           INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         ADULTS & PEDI ATRICS         1, 497         91, 077         30. 0           30. 00         ADULTS & PEDI ATRICS         1, 497         91, 077         30. 0         44. 0   | Cost Center Description                    |                |               |               |               |                |         |
| Part II, col.         (col. 1 - col. 2)         2           1.00         2.00         3.00         4.00         5.00           30.00         ADULTS & PEDI ATRICS         916, 667         0         916, 667         15, 068         60.84         30.0           44.00         SKI LLED NURSI NG FACI LI TY         1, 814, 854         1, 814, 854         82, 145         22.09         44.0           45.00         NURSI NG FACI LI TY         463, 743         463, 743         12, 634         36. 71         45.0           200.00         Total (Lines 30 through 199)         3, 195, 264         1 npati ent         Program         200.0         -         -         -         -         45.0           200.00         Total (Lines 30 through 199)         3, 195, 264         1 npati ent         Program         -<   |  |                | Adjustment    |               |               | 3 / col. 4)    |         |
| 26)         2)         4.00         5.00           1.00         2.00         3.00         4.00         5.00           30.00         ADULTS & PEDI ATRICS         916,667         0         916,667         15,068         60.84         30.0           44.00         SKI LLED NURSING FACI LI TY         1,814,854         1,814,854         82,145         22.09         44.0           45.00         NURSI NG FACI LI TY         463,743         463,743         12,634         36.71         45.0           200.00         Total (lines 30 through 199)         3,195,264         3,195,264         109,847         200.0         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>   |  |                |               |               |               |                |         |
| INPATI ENT_ROUTI NE_SERVI CE_COST_CENTERS         1.00         2.00         3.00         4.00         5.00           30.00         ADULTS & PEDI ATRICS         ADULTS & PEDI ATRICS         916,667         0         916,667         15,068         60.84         30.0           44.00         SKI LLED NURSI NG FACI LI TY         1,814,854         1,814,854         82,145         22.09         44.0           45.00         NURSI NG FACI LI TY         463,743         463,743         12,634         36.71         45.0           200.00         Total (lines 30 through 199)         3,195,264         3,195,264         109,847         200.0           Cost Center Description         Inpati ent<br>Program days         Program<br>Capi tal Cost<br>(col . 5 x col.<br>6)         109,847         200.0           INPATIENT ROUTI NE SERVICE COST CENTERS         6.00         7.00         30.0         44.0           44.00         SKI LLED NURSI NG FACI LI TY         36,281         801,447         44.0  |  | Part II, col.  |               | (col. 1 - col |               |                |         |
| INPATIENT ROUTINE SERVICE COST CENTERS           30.00         ADULTS & PEDIATRICS         916,667         0         916,667         15,068         60.84         30.0           44.00         SKILLED NURSING FACILITY         1,814,854         1,814,854         82,145         22.09         44.0           45.00         NURSING FACILITY         463,743         463,743         12,634         36.71         45.0           200.00         Total (Lines 30 through 199)         3,195,264         3,195,264         30.0         463,743         200.0         200.0         3,195,264         109,847         200.0         200.0         200.0         3,195,264         30.0         45.0         200.0         200.0         200.0         3,195,264         30.0         46.0         45.0         200.0         200.0         200.0         3,195,264         30.0         46.00         7.00         200.0         <   |  |                |               |               |               |                |         |
| 30.00       ADULTS & PEDIATRICS       916,667       0       916,667       15,068       60.84       30.0         44.00       SKILLED NURSING FACILITY       1,814,854       1,814,854       82,145       22.09       44.0         45.00       NURSING FACILITY       463,743       463,743       12,634       36.71       45.0         200.00       Total (lines 30 through 199)       3,195,264       3,195,264       109,847       200.0         Cost Center Description       Inpatient       Program<br>Capital Cost<br>(col. 5 x col.<br>6)       109,847       200.0         INPATIENT ROUTINE SERVICE COST CENTERS         30.00       ADULTS & PEDIATRICS       1,497       91,077         44.00       SKILLED NURSING FACILITY       36,281       801,447       30.0   |  |                | 2.00          | 3.00          | 4.00          | 5.00           |         |
| 44.00       SKI LLED NURSING FACILITY       1,814,854       1,814,854       82,145       22.09       44.0         45.00       NURSING FACILITY       463,743       463,743       12,634       36.71       45.0         200.00       Total (lines 30 through 199)       3,195,264       3,195,264       3,195,264       200.0         Cost Center Description         Inpatient<br>Program days         6.00       7.00         ADULTS & PEDIATRICS         44.00       SKI LLED NURSING FACILITY       1,497       91,077         36,281       801,447       44.0  |  |                |               | -             | - F           |                |         |
| 45.00       NURSING FACILITY       463,743       12,634       36.71       45.0         200.00       Total (lines 30 through 199)       3,195,264       3,195,264       109,847       200.0         Cost Center Description         Inpatient Program Capital Cost (col. 5 x col. 6)         6.00       7.00         INPATIENT ROUTINE SERVICE COST CENTERS         30.00       ADULTS & PEDIATRICS       1,497       91,077         44.00       SKILLED NURSING FACILITY       36,281       801,447       30.0   | 30.00 ADULTS & PEDIATRICS                  | 916, 667       | 0             | 916, 66       | 7 15, 068     | 60.84          | 30.00   |
| 200. 00         Total (lines 30 through 199)         3, 195, 264         3, 195, 264         109, 847         200. 0           Cost Center Description         Inpatient<br>Program days         Inpatient<br>Program Capital Cost<br>(col. 5 x col.<br>6)         Inpatient<br>Program Capital Co | 44.00 SKILLED NURSING FACILITY             | 1, 814, 854    |               | 1, 814, 85    | 4 82, 145     | 22.09          |         |
| Cost Center Description       Inpatient<br>Program days       Inpatient<br>Program<br>Capital Cost<br>(col. 5 x col.<br>6)         1 NPATIENT ROUTINE SERVICE COST CENTERS         30.00         ADULTS & PEDIATRICS         44.00         SKILLED NURSING FACILITY  | 45.00 NURSING FACILITY                     | 463, 743       |               | 463, 74       | 3 12, 634     | 36.71          | 45.00   |
| Program days     Program<br>Capital Cost<br>(col. 5 x col.<br>6)       1 NPATI ENT ROUTI NE SERVICE COST CENTERS       30.00       ADULTS & PEDI ATRICS       44.00       SKI LLED NURSI NG FACI LITY       36, 281       801, 447   | 200.00 Total (lines 30 through 199)        | 3, 195, 264    |               | 3, 195, 26    | 4 109, 847    |                | 200.00  |
| INPATI ENT ROUTI NE SERVI CE COST CENTERS         6.00         7.00           30.00         ADULTS & PEDI ATRI CS         1,497         91,077         30.0           44.00         SKI LLED NURSI NG FACI LI TY         36,281         801,447         34.0   | Cost Center Description                    | I npati ent    | Inpati ent    |               |               |                |         |
| INPATIENT ROUTINE SERVICE COST CENTERS         1,497         91,077         30.00         30.00         SKILLED NURSING FACILITY         36,281         801,447         30.04         44.00         30.04  |  | Program days   | Program       |               |               |                |         |
| 6)         6)           6.00         7.00           INPATIENT ROUTINE SERVICE COST CENTERS         1,497           30.00         ADULTS & PEDIATRICS         1,497           44.00         SKILLED NURSING FACILITY         36,281   |  |                |               |               |               |                |         |
| 6.00         7.00           I NPATI ENT ROUTI NE SERVI CE COST CENTERS         30.00           ADULTS & PEDI ATRI CS         1,497         91,077           44.00         SKI LLED NURSI NG FACI LI TY         36,281         801,447         34.00  |  |                |               |               |               |                |         |
| INPATIENT ROUTINE SERVICE COST CENTERS           30.00         ADULTS & PEDIATRICS         1,497         91,077         30.0           44.00         SKILLED NURSING FACILITY         36,281         801,447         44.0  |  |                | /             |               |               |                |         |
| 30. 00         ADULTS & PEDIATRICS         1,497         91,077         30. 0           44. 00         SKI LLED NURSI NG FACILITY         36,281         801,447         44. 0   |  |                | 7.00          |               |               |                |         |
| 44. 00 SKILLED NURSING FACILITY 36, 281 801, 447 44. 0   | INPATIENT ROUTINE SERVICE COST CENTE       |                |               |               |               |                |         |
|  | 30. 00 ADULTS & PEDIATRICS                 | 1, 497         | 91, 077       |               |               |                | 30.00   |
| 45. 00 NURSING FACILITY 8, 309 305, 023 45. 0  | 44.00 SKILLED NURSING FACILITY             | 36, 281        | 801, 447      | 1             |               |                | 44.00   |
|  | 45.00 NURSING FACILITY                     | 8, 309         | 305, 023      |               |               |                | 45.00   |
| 200.00 Total (Lines 30 through 199) 46,087 1,197,547 200.0   | 200.00 Total (lines 30 through 199)        | 46, 087        | 1, 197, 547   |               |               |                | 200.00  |

| Health Financial Systems                            | RAMAPO RIDGE         | PSYCHI ATRI C                                   |             | In Lie                                      | eu of Form CMS-                           | 2552-10 |
|---|----------------------|---|-------------|---|---|---------|
| APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA | L COSTS              | Provider C                                      | CN: 31-4019 | Period:<br>From 01/01/2023<br>To 12/31/2023 | Date/Time Pre<br>5/20/2024 11:            |         |
|   |                      | Titl  | e XIX       | Hospi tal                                   | TEFRA                                     |         |
| Cost Center Description                             |                      | Total Charges<br>(from Wkst. C,<br>Part I, col. | to Charges  | Program                                     | Capital Costs<br>(column 3 x<br>column 4) |         |
|   | Part II, col.<br>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, 339               | 275, 689  | 0.0048      | 57 0  | 0   | 54.00   |
| 60. 00 06000 LABORATORY                             | 2,360                | 517, 445  | 0.00456     | 51 0  | 0   | 60.00   |
| 65. 00 06500 RESPI RATORY THERAPY                   | 1,050                | 196, 700  | 0.00533     | 38 0  | 0   | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY                      | 256, 591             | 4, 017, 231                                     | 0.0638      | 73 0  | 0   | 66.00   |
| 67.00 06700 OCCUPATI ONAL THERAPY                   | 11, 678              | 3, 176, 469                                     | 0.0036      | 76 0  | 0   | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY                        | 2,859                | 777, 679  | 0.0036      | 76 0  | 0   | 68.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT     | 2, 611               | 537, 488  | 0.0048      | 58 0  | 0   | 71.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS               | 9, 203               | 1, 500, 139                                     | 0.00613     | 35 0  | 0   | 73.00   |
| OUTPATIENT SERVICE COST CENTERS                     |                      |   |             |   |   | 1       |
| 90. 00 09000 CLINIC                                 | 481, 446             | 6, 089, 788                                     | 0.0790      | 58 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)                 | 769, 137             | 17, 088, 628                                    |             | 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 OT | HER PASS THROUGH COST                   |               |               | Period:<br>From 01/01/2023<br>To 12/31/2023 | Date/Time Pre<br>5/20/2024 11: |          |
|   |   | 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                           | U             | 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                  | 0                                       | 0             |               | 0 0   |                                | 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.                              | Inpati ent                     |          |
|   | Adjustment                              | (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             | 15,06         | 8 0.00                                      | 1, 497                         | 30.00    |
| 44.00 04400 SKILLED NURSING FACILITY          |   | 0             | 82, 14        | 5 0.00                                      | 36, 281                        | 44.00    |
| 45.00 04500 NURSING FACILITY                  |   | 0             | 12, 63        |   |                                |          |
| 200.00 Total (lines 30 through 199)           |   | 0             |               |   |                                | 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 & PEDI ATRI CS            | 0                                       |               |               |   |                                | 1 30. 00 |
| 44. 00 04400 SKILLED NURSING FACILITY         | 0                                       |               |               |   |                                | 44.00    |
| 45. 00 04500 NURSING FACILITY                 | 0                                       |               |               |   |                                | 45.00    |
|   |   |               |               |   |                                |          |

| Health Financial Systems   | RAMAPO RIDGE PSYCHIATRIC             |  |                    | In Lieu of Form CMS-2552-10                   |               |         |  |
|--|--------------------------------------|--|--------------------|---|---------------|---------|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER<br>THROUGH COSTS | VICE OTHER PASS                      | S Provider CC                                      | CN: 31-4019        | Period:<br>From 01/01/2023<br>To 12/31/2023   |               |         |  |
|  |                                      | Ti tl  | e XIX              | Hospi tal                                     | TEFRA         |         |  |
| Cost Center Description  | Non Physician<br>Anesthetist<br>Cost | Nursing<br>Program<br>Post-Stepdown<br>Adjustments | Nursing<br>Program | Allied Health<br>Post-Stepdown<br>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 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 |  |

| Health Financial Systems   | ealth Financial Systems RAMAPO RIDGE PSYCHIATRIC |               |              |                            |                             | 2552-10 |
|--|--|---------------|--------------|----------------------------|-----------------------------|---------|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE<br>THROUGH COSTS | RVICE OTHER PASS                                 | S Provider C  |              | Period:<br>From 01/01/2023 | Worksheet D<br>Part IV      |         |
|  |  |               |              | To 12/31/2023              | Date/Time Pre 5/20/2024 11: |         |
|  |  | 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             |              | 0 275, 689                 | 0.00000                     | 54.00   |
| 60. 00 06000 LABORATORY  | 0  | 0             |              | 0 517, 445                 | 0.00000                     | 60.00   |
| 65. 00 06500 RESPI RATORY THERAPY                                    | 0  | 0             |              | 0 196, 700                 | 0.000000                    | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY                                       | 0  | 0             |              | 0 4, 017, 231              | 0.00000                     | 66.00   |
| 67.00 06700 OCCUPATI ONAL THERAPY                                    | 0  | 0             |              | 0 3, 176, 469              | 0. 000000                   | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY   | 0  | 0             |              | 0 777, 679                 | 0.00000                     | 68.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                      | 0  | 0             |              | 0 537, 488                 | 0.000000                    | 71.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS                                | 0  | 0             |              | 0 1, 500, 139              | 0. 000000                   | 73.00   |
| OUTPATIENT SERVICE COST CENTERS                                      |  |               |              |                            |                             | 1       |
| 90. 00 09000 CLINIC  | 0  | 0             |              | 0 6, 089, 788              | 0.00000                     | 90.00   |
| 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART                   | 0  | 0             |              | 0 0                        | 0.000000                    | 92.00   |
| 200.00 Total (lines 50 through 199)                                  | 0  | 0             |              | 0 17, 088, 628             |                             | 200.00  |
| <b>3</b>   |  |               |              |                            | •                           |         |

| Health Financial Systems                            | RAMAPO RIDGE PS  | SYCHI ATRI C |             | In Lieu of Form CMS-2552-10 |                        |        |  |
|---|------------------|--------------|-------------|-----------------------------|------------------------|--------|--|
| APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER | RVICE OTHER PASS | Provider C   | CN: 31-4019 | Period:<br>From 01/01/2023  | Worksheet D<br>Part IV |        |  |
| THROUGH COSTS                                       |                  |              |             | To 12/31/2023               | Date/Time Pre          |        |  |
|   |                  |              |             |                             | 5/20/2024 11:          | 05 am  |  |
|   | 1                |              | e XIX       | Hospi tal                   | TEFRA                  |        |  |
| Cost Center Description                             | Outpati ent      | Inpati ent   | Inpati ent  | Outpati ent                 | Outpati ent            |        |  |
|   | Ratio of Cost    | Program      | Program     | Program                     | Program                |        |  |
|   | to Charges       | Charges      | Pass-Throug | n Charges                   | Pass-Through           |        |  |
|   | (col. 6 ÷ col.   |              | Costs (col. | 8                           | 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            | 1           | 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            |             | 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)                 | 0.000000         | 0            |             | 0 0                         |                        | 200.00 |  |
|   | 1 1              | 0            | 1           | 0                           | 1 0                    | 200.00 |  |

| MPUT         | ATION OF INPATIENT OPERATING COST   | Provider CCN: 31-4019         | Period:<br>From 01/01/2023<br>To 12/31/2023 |                      | pare |
|--------------|---|-------------------------------|---|----------------------|------|
|              |   | Title XVIII                   | Hospi tal                                   | 5/20/2024 11:<br>PPS | 05 8 |
|              | Cost Center Description   |                               |   | 1.00                 |      |
|              | PART I - ALL PROVIDER COMPONENTS  |                               |   | 1.00                 |      |
|              | I NPATI ENT DAYS  |                               |   |                      |      |
| 00<br>00     | Inpatient days (including private room days and swing-bed of<br>Inpatient days (including private room days, excluding swing) |                               |   | 15, 068<br>15, 068   |      |
| 00<br>00     | Private room days (excluding swing-bed and observation bed  |                               | rivate room davs.                           | 15,008               |      |
|              | do not complete this line.  | 5, 5, 5,                      | · · · · · · · · · · · · · · · · · · ·       | -                    |      |
| 00           | Semi-private room days (excluding swing-bed and observation   |                               |   | 15, 068              |      |
| 00           | Total swing-bed SNF type inpatient days (including private reporting period   | room days) through Decembe    | er 31 of the cost                           | 0                    | 5    |
| 00           | Total swing-bed SNF type inpatient days (including private  | room days) after December     | 31 of the cost                              | 0                    | 6    |
|              | reporting period (if calendar year, enter 0 on this line)   |                               |   |                      |      |
| 00           | Total swing-bed NF type inpatient days (including private<br>reporting period   | room days) through December   | - 31 of the cost                            | 0                    | 7    |
| 00           | Total swing-bed NF type inpatient days (including private i   | room days) after December 3   | 31 of the cost                              | 0                    | 8    |
|              | reporting period (if calendar year, enter 0 on this line)   |                               |   |                      |      |
| 00           | Total inpatient days including private room days applicable newborn days) (see instructions)                                  | e to the Program (excluding   | g swing-bed and                             | 7, 546               |      |
| 00           | Swing-bed SNF type inpatient days applicable to title XVIII   | l only (including private u   | room davs)                                  | 0                    | 10   |
|              | through December 31 of the cost reporting period (see insti   | ructions)                     |   |                      |      |
| . 00         | Swing-bed SNF type inpatient days applicable to title XVIII<br>December 31 of the cost reporting period (if calendar year,    |                               | room days) after                            | 0                    | 1    |
| . 00         | Swing-bed NF type inpatient days applicable to titles V or  |                               | te room davs)                               | 0                    | 12   |
|              | through December 31 of the cost reporting period  | ,                             | 5 -   | -                    |      |
| . 00         | Swing-bed NF type inpatient days applicable to titles V or  |                               |   | 0                    | 13   |
| 00           | after December 31 of the cost reporting period (if calendar<br>Medically necessary private room days applicable to the Pro    |                               |   | 0                    | 14   |
| 00           | Total nursery days (title V or XIX only)  | ogram (exer daring swring bed | uuys)                                       | 0                    |      |
| . 00         | Nursery days (title V or XIX only)  |                               |   | 0                    | 16   |
| 00           | SWING BED ADJUSTMENT  | viene through December 21     | f the east                                  | 0.00                 | 1 1- |
| . 00         | Medicare rate for swing-bed SNF services applicable to serv<br>reporting period   | vices through December 31 (   | or the cost                                 | 0.00                 |      |
| . 00         | Medicare rate for swing-bed SNF services applicable to serv   | vices after December 31 of    | the cost                                    | 0.00                 | 18   |
|              | reporting period  |                               | ~   | 0.00                 |      |
| . 00         | Medicaid rate for swing-bed NF services applicable to servi<br>reporting period   | ices through December 31 of   | the cost                                    | 0.00                 | 19   |
| . 00         | Medicaid rate for swing-bed NF services applicable to servi   | ices after December 31 of t   | the cost                                    | 0.00                 | 20   |
|              | reporting period  |                               |   |                      |      |
| . 00<br>. 00 | Total general inpatient routine service cost (see instructi<br>Swing-bed cost applicable to SNF type services through Dece    |                               | ting period (line                           | 17, 569, 406         | 21   |
| . 00         | 5 x line 17)  | ember 31 01 the cost report   | ting period (inte                           | 0                    | 22   |
| . 00         | Swing-bed cost applicable to SNF type services after December   | ber 31 of the cost reportin   | ng period (line 6                           | 0                    | 23   |
| . 00         | x line 18)<br>Swing-bed cost applicable to NF type services through Decer   | mbor 21 of the cost reporti   | na poriod (lino                             | 0                    | 24   |
| . 00         | 7 x line 19)  | liber 31 01 the cost report   | ng period (inne                             | 0                    | 2    |
| . 00         | Swing-bed cost applicable to NF type services after December  | er 31 of the cost reporting   | g period (line 8                            | 0                    | 25   |
| . 00         | x line 20)<br>Total swing-bed cost (see instructions)   |                               |   | 0                    | 26   |
|              | General inpatient routine service cost net of swing-bed cost  | st (line 21 minus line 26)    |   | 17, 569, 406         |      |
|              | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  |                               |   |                      |      |
|              | General inpatient routine service charges (excluding swing  | -bed and observation bed ch   | narges)                                     | 0                    |      |
|              | Private room charges (excluding swing-bed charges)<br>Semi-private room charges (excluding swing-bed charges)                 |                               |   | 0                    |      |
|              | General inpatient routine service cost/charge ratio (line 2   | 27 ÷ line 28)                 |   | 0.000000             |      |
| 00           | Average private room per diem charge (line 29 ÷ line 3)   |                               |   | 0.00                 | 32   |
|              | Average semi-private room per diem charge (line 30 ÷ line 4)  |                               | ations)                                     | 0.00                 |      |
|              | Average per diem private room charge differential (line 32<br>Average per diem private room cost differential (line 34 x      | , ,                           |   | 0.00<br>0.00         |      |
| . 00         | Private room cost differential adjustment (line 3 x line 3  |                               |   | 0.00                 | 36   |
|              | General inpatient routine service cost net of swing-bed cost  |                               | fferential (line                            | 17, 569, 406         | 37   |
|              | 27 minus line 36)<br>PART II - HOSPITAL AND SUBPROVIDERS ONLY   |                               |   |                      | -    |
|              | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST A   | ADJUSTMENTS                   |   |                      | 1    |
|              | Adjusted general inpatient routine service cost per diem (s   | see instructions)             |   | 1, 166. 01           |      |
| . 00         | Program general inpatient routine service cost (line 9 x li   | -                             |   | 8, 798, 711          |      |
| . 00         | Medically necessary private room cost applicable to the Pro   |                               |   | 0                    |      |

|                  | Financial Systems I<br>ATION OF INPATIENT OPERATING COST   | RAMAPO RIDGE PS          | YCHI ATRI C<br>Provi der C | CN: 31-4019     | In Lie<br>Period:                | u of Form CMS-<br>Worksheet D-1 |                |  |  |
|------------------|--|--------------------------|----------------------------|-----------------|----------------------------------|---------------------------------|----------------|--|--|
|                  |  |                          |                            |                 | From 01/01/2023<br>To 12/31/2023 |                                 | pared:         |  |  |
|                  |  |                          | Title                      | XVIII           | Hospi tal                        | PPS                             | <u> </u>       |  |  |
|                  | Cost Center Description  | Total<br>npatient Costln | Total<br>patient Days      |                 | + Program Days                   | Program Cost<br>(col. 3 x col.  |                |  |  |
|                  | —  | 1.00                     | 2.00                       | col. 2)<br>3.00 | 4.00                             | 4)                              |                |  |  |
| 42.00            | NURSERY (title V & XIX only)   |                          |                            |                 |                                  |                                 | 42.00          |  |  |
| 43.00            | Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT   |                          |                            |                 |                                  |                                 | 43.00          |  |  |
| 44.00            | CORONARY CARE UNI T  |                          |                            |                 |                                  |                                 | 44.00          |  |  |
| 45.00            | BURN INTENSIVE CARE UNIT   |                          |                            |                 |                                  |                                 | 45.00          |  |  |
| 46.00<br>47.00   | SURGICAL INTENSIVE CARE UNIT<br>OTHER SPECIAL CARE (SPECIFY)   |                          |                            |                 |                                  |                                 | 46.00          |  |  |
| 47.00            | Cost Center Description  |                          |                            |                 |                                  |                                 | 47.00          |  |  |
| 40.00            |  | D 2 2                    | 11 200)                    |                 |                                  | 1.00                            | 40.00          |  |  |
| 48. 00<br>48. 01 | Program inpatient ancillary service cost (Wkst<br>Program inpatient cellular therapy acquisition   |                          |                            | III line 10     | column 1)                        | 125, 269                        | 1              |  |  |
| 49.00            | Total Program inpatient costs (sum of lines 41   |                          |                            |                 |                                  | 8, 923, 980                     |                |  |  |
| F0 00            | PASS THROUGH COST ADJUSTMENTS  |                          |                            | Wheet D arm     | -f Danta I and                   | 450,000                         |                |  |  |
| 50.00            | Pass through costs applicable to Program inpat III)  | lent routine se          | ervices (trom              | WKST. D, SUM    | or Parts I and                   | 459, 099                        | 50.00          |  |  |
| 51.00            | Pass through costs applicable to Program inpat and IV)   | ient ancillary           | services (fr               | om Wkst. D, s   | um of Parts II                   | 799                             | 51.00          |  |  |
| 52.00            | Total Program excludable cost (sum of lines 50   | ,                        |                            |                 |                                  | 459, 898                        | •              |  |  |
| 53.00            | Total Program inpatient operating cost excludi medical education costs (line 49 minus line 52  |                          | ited, non-phy              | sician anesth   | etist, and                       | 8, 464, 082                     | 53.00          |  |  |
|                  | TARGET AMOUNT AND LIMIT COMPUTATION  | )                        |                            |                 |                                  |                                 |                |  |  |
| 54.00            | Program di scharges  |                          |                            |                 |                                  | 0                               |                |  |  |
| 55. 00<br>55. 01 | Target amount per discharge<br>Permanent adjustment amount per discharge   |                          |                            |                 |                                  | 0.00                            | •              |  |  |
| 55.02            | Adjustment amount per discharge (contractor us   | e only)                  |                            |                 |                                  | 0.00                            | •              |  |  |
| 56.00            | Target amount (line 54 x sum of lines 55, 55.0   |                          |                            |                 |                                  | 0                               | 56.00          |  |  |
| 57.00<br>58.00   | Difference between adjusted inpatient operatin<br>Bonus payment (see instructions)   | g cost and targ          | jet amount (I              | ine 56 minus    | line 53)                         | 0                               | 57.00<br>58.00 |  |  |
| 59.00            | Trended costs (lesser of line 53 ÷ line 54, or   | line 55 from t           | he cost repo               | rting period    | endi ng 1996,                    | 0.00                            |                |  |  |
| 60. 00           | updated and compounded by the market basket)<br>00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the   |                          |                            |                 |                                  |                                 |                |  |  |
| 61.00            | <pre>market basket) 00 Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line</pre> |                          |                            |                 |                                  |                                 |                |  |  |
|                  | 53) are less than expected costs (lines $54 \times 6$ enter zero. (see instructions)   | 0), or 1 % of t          | he target am               | ount (line 56   | ), otherwise                     |                                 |                |  |  |
| 62.00<br>63.00   |  |                          |                            |                 |                                  |                                 |                |  |  |
| 64.00            | PROGRAM INPATIENT ROUTINE SWING BED COST<br>Medicare swing-bed SNF inpatient routine costs   | through Decemb           | er 31 of the               | cost reporti    | ng period (See                   | 0                               | 64.00          |  |  |
|                  | instructions)(title XVIII only)<br>Medicare swing-bed SNF inpatient routine costs  | after December           | 31 of the c                | ost renortina   | period (See                      | 0                               | 65.00          |  |  |
| 66.00            | instructions)(title XVIII only)<br>Total Medicare swing-bed SNF inpatient routine  |                          |                            |                 |                                  | 0                               |                |  |  |
|                  | CAH, see instructions  | ·                        |                            | , .             | 5.                               |                                 |                |  |  |
| 67.00            | Title V or XIX swing-bed NF inpatient routine<br>(line 12 x line 19)   | Ū                        |                            |                 |                                  | 0                               |                |  |  |
| 68.00            | Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)  | costs after Dec          | ember 31 of                | the cost repo   | rting period                     | 0                               | 68.00          |  |  |
| 69.00            | Total title V or XIX swing-bed NF inpatient ro<br>PART III - SKILLED NURSING FACILITY, OTHER NURS  |                          |                            | ,               |                                  | 0                               | 69.00          |  |  |
| 70.00            | Skilled nursing facility/other nursing facilit   |                          |                            |                 |                                  |                                 | 70.00          |  |  |
| 71.00            | Adjusted general inpatient routine service cos   |                          | ne 70 ÷ line               | 2)              |                                  |                                 | 71.00          |  |  |
| 72.00<br>73.00   | Program routine service cost (line 9 x line 71<br>Medically necessary private room cost applicab   |                          | line 14 x li               | ne 35)          |                                  |                                 | 72.00          |  |  |
| 74.00            | Total Program general inpatient routine servic   |                          |                            |                 |                                  |                                 | 74.00          |  |  |
| 75.00            | Capital-related cost allocated to inpatient ro   | utine service c          | costs (from W              | orksheet B, P   | art II, column                   |                                 | 75.00          |  |  |
| 76.00            | 26, line 45)<br>Per diem capital-related costs (line 75 ÷ line   | 2)                       |                            |                 |                                  |                                 | 76.00          |  |  |
| 77.00            | Program capital-related costs (line 9 x line 7   | 6)                       |                            |                 |                                  |                                 | 77.00          |  |  |
| 78.00<br>79.00   | Inpatient routine service cost (line 74 minus<br>Aggregate charges to beneficiaries for excess   |                          | wider record               | e)              |                                  |                                 | 78.00          |  |  |
| 80.00            | Total Program routine service costs for compar   | • •                      |                            |                 | us line 79)                      |                                 | 80.00          |  |  |
| 81.00            | Inpatient routine service cost per diem limita   | tion                     |                            |                 | -                                |                                 | 81.00          |  |  |
| 82.00<br>83.00   | Inpatient routine service cost limitation (lin<br>Reasonable inpatient routine service costs (se   |                          |                            |                 |                                  |                                 | 82.00<br>83.00 |  |  |
| 83.00<br>84.00   | Program inpatient ancillary services (see inst   |                          |                            |                 |                                  |                                 | 84.00          |  |  |
| 85.00            | Utilization review - physician compensation (s   | ee instructions          |                            |                 |                                  |                                 | 85.00          |  |  |
| 86.00            | Total Program inpatient operating costs (sum o<br>PART IV - COMPUTATION OF OBSERVATION BED PASS  |                          | ough 85)                   |                 |                                  |                                 | 86.00          |  |  |
| 87.00            | Total observation bed days (see instructions)  |                          |                            |                 |                                  | 0                               | •              |  |  |
| 88.00            | Adjusted general inpatient routine cost per di   | •                        | ine 2)                     |                 |                                  |                                 | 88.00          |  |  |
| 89.00            | Observation bed cost (line 87 x line 88) (see  | instructions)            |                            |                 |                                  | 0                               | 89.00          |  |  |

| Health Financial Systems                      | RAMAPO RIDGE PSYCHIATRIC |                |            | In Lieu of Form CMS-2552-10      |                                |       |  |
|---|--------------------------|----------------|------------|----------------------------------|--------------------------------|-------|--|
| COMPUTATION OF INPATIENT OPERATING COST       |                          | Provider CO    |            | Period:                          | Worksheet D-1                  |       |  |
|   |                          |                |            | From 01/01/2023<br>To 12/31/2023 | Date/Time Pre<br>5/20/2024 11: |       |  |
|   |                          | Title          | XVIII      | Hospi tal                        | PPS                            |       |  |
| Cost Center Description                       | Cost                     | Routine Cost   | column 1 ÷ | Total                            | Observati on                   |       |  |
|   |                          | (from line 21) | column 2   | Observati on                     | Bed Pass                       |       |  |
|   |                          |                |            | Bed Cost (from                   | Through Cost                   |       |  |
|   |                          |                |            | 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                    | 916, 667                 | 17, 569, 406   | 0. 05217   | 4 0                              | 0                              | 90.00 |  |
| 91.00 Nursing Program cost                    | 0                        | 17, 569, 406   | 0.00000    | 0 0                              | 0                              | 91.00 |  |
| 92.00 Allied health cost                      | 0                        | 17, 569, 406   | 0.00000    | 0 0                              | 0                              | 92.00 |  |
| 93.00 All other Medical Education             | 0                        | 17, 569, 406   | 0.00000    | 0 0                              | 0                              | 93.00 |  |

| COMPUT         |  | ovider CCN: 31-4019<br>mponent CCN: 31-5376 | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet D-1<br>Date/Time Prep | pared:         |
|----------------|--|---|---|---------------------------------|----------------|
|                |  | Title XVIII                                 | Skilled Nursing<br>Facility                 | 5/20/2024 11:0<br>PPS           |                |
|                | Cost Center Description  |   | - Taciffy                                   | 1.00                            |                |
|                | PART I - ALL PROVIDER COMPONENTS   |   | I   |                                 |                |
| 1.00           | INPATIENT DAYS<br>Inpatient days (including private room days and swing-bed days, e  | excluding newborn)                          |   | 82, 145                         | 1.00           |
| 2.00           | Inpatient days (including private room days, excluding swing-bed   |   |   | 82, 145                         | 2.00           |
| 3.00           | Private room days (excluding swing-bed and observation bed days).  |   | ivate room days,                            | 0                               | 3.00           |
| 4.00           | do not complete this line.<br>Semi-private room days (excluding swing-bed and observation bed o  | lavs)                                       |   | 82, 145                         | 4.00           |
| 5.00           | Total swing-bed SNF type inpatient days (including private room of   |   | r 31 of the cost                            | 02, 143                         | 5.00           |
| ( 00           | reporting period   |   |   |                                 |                |
| 6.00           | Total swing-bed SNF type inpatient days (including private room c<br>reporting period (if calendar year, enter 0 on this line)         | lays) after December                        | 31 of the cost                              | 0                               | 6.00           |
| 7.00           | Total swing-bed NF type inpatient days (including private room da  | ays) through December                       | 31 of the cost                              | 0                               | 7.00           |
|                | reporting period   |   |   |                                 |                |
| 8.00           | Total swing-bed NF type inpatient days (including private room da reporting period (if calendar year, enter 0 on this line)            | iys) after December 3                       | 1 of the cost                               | 0                               | 8.00           |
| 9.00           | Total inpatient days including private room days applicable to the   | ne Program (excluding                       | swing-bed and                               | 19, 928                         | 9.00           |
|                | newborn days) (see instructions)   | /· · · ·                                    |   |                                 | 10.00          |
| 10.00          | Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction     |   | oom days)                                   | 0                               | 10.00          |
| 11.00          | Swing-bed SNF type inpatient days applicable to title XVIII only   | (including private r                        | oom days) after                             | 0                               | 11.00          |
|                | December 31 of the cost reporting period (if calendar year, enter  |   |   |                                 | 10.00          |
| 12.00          | Swing-bed NF type inpatient days applicable to titles V or XIX or through December 31 of the cost reporting period                     | nly (including privat                       | e room days)                                | 0                               | 12.00          |
| 3.00           | Swing-bed NF type inpatient days applicable to titles V or XIX or  | nly (including privat                       | e room days)                                | 0                               | 13.0           |
| 14.00          | after December 31 of the cost reporting period (if calendar year,  |   |   |                                 |                |
|                | Medically necessary private room days applicable to the Program (<br>Total nursery days (title V or XIX only)                          | excluding swing-bed                         | days)                                       | 0                               | 14.0<br>15.0   |
| 16.00          | Nursery days (title V or XIX only)   |   |   | 0                               |                |
|                | SWING BED ADJUSTMENT   |   |   |                                 |                |
| 17.00          | Medicare rate for swing-bed SNF services applicable to services t<br>reporting period  | hrough December 31 o                        | f the cost                                  | 0.00                            | 17.00          |
| 18.00          | Medicare rate for swing-bed SNF services applicable to services a  | after December 31 of                        | the cost                                    | 0.00                            | 18.00          |
|                | reporting period   |   |   |                                 |                |
| 19.00          | Medicaid rate for swing-bed NF services applicable to services the reporting period  | rough December 31 or                        | the cost                                    | 0.00                            | 19.00          |
| 20. 00         | Medicaid rate for swing-bed NF services applicable to services af  | ter December 31 of t                        | he cost                                     | 0.00                            | 20. 0          |
| 21.00          | reporting period<br>Total general inpatient routine service cost (see instructions)  |   |   | 33, 952, 782                    | 21.0           |
| 22.00          | Swing-bed cost applicable to SNF type services through December 3  | 31 of the cost report                       | ing period (line                            | 33, 452, 782                    | 22.0           |
|                | 5 x line 17)   |   |   |                                 |                |
| 23.00          | Swing-bed cost applicable to SNF type services after December 31 x line 18)  | of the cost reportin                        | g period (line 6                            | 0                               | 23.0           |
| 24.00          | Swing-bed cost applicable to NF type services through December 31  | of the cost reporti                         | ng period (line                             | 0                               | 24.0           |
| 05 00          | 7 x line 19)   |   |   |                                 | 05.0           |
| 25.00          | Swing-bed cost applicable to NF type services after December 31 c x line 20)   | of the cost reporting                       | period (line 8                              | 0                               | 25.0           |
| 26.00          | Total swing-bed cost (see instructions)  |   |   | 0                               | 26. 0          |
| 27.00          | General inpatient routine service cost net of swing-bed cost (lir  | ne 21 minus line 26)                        |   | 33, 952, 782                    | 27.0           |
| 28.00          | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT<br>General inpatient routine service charges (excluding swing-bed ar                              | nd observation bed ch                       | arges)                                      | 0                               | 28. 0          |
|                | Private room charges (excluding swing-bed charges)   |   | al geo)                                     | 0                               | 29.0           |
| 30. 00         | Semi-private room charges (excluding swing-bed charges)  |   |   | 0                               | 30. 0          |
| 31.00          | General inpatient routine service cost/charge ratio (line 27 ÷ li<br>Average private room per diem charge (line 29 ÷ line 3)           | ne 28)                                      |   | 0.000000                        |                |
| 32.00<br>33.00 | Average semi-private room per diem charge (fine 29 ÷ fine 3)<br>Average semi-private room per diem charge (line 30 ÷ line 4)           |   |   | 0.00<br>0.00                    | 32. 0<br>33. 0 |
| 34.00          | Average per diem private room charge differential (line 32 minus   | line 33)(see instruc                        | tions)                                      | 0.00                            |                |
|                | Average per diem private room cost differential (line 34 x line 3  | 31)   |   | 0.00                            | 35.0           |
| 36.00<br>37.00 | Private room cost differential adjustment (line 3 x line 35)<br>General inpatient routine service cost net of swing-bed cost and       | private room cost di                        | fferential (line                            | 0<br>33, 952, 782               | 36.0<br>37.0   |
|                | 27 minus line 36)  |   |   | 55, 752, 702                    | 57.0           |
|                | PART II - HOSPITAL AND SUBPROVIDERS ONLY   |   |   |                                 |                |
| 38.00          | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTN<br>Adjusted general inpatient routine service cost per diem (see ins |   | 1   |                                 | 38. 0          |
|                | Program general inpatient routine service cost (line 9 x line 38)  |   |   |                                 | 38.0           |
| 40.00          | Medically necessary private room cost applicable to the Program (  | (line 14 x line 35)                         |   |                                 | 40.00          |
| 1 00           | Total Program general inpatient routine service cost (line 39 + 1  | ine 40)                                     |   |                                 | 41.0           |

| OMPUT        | Financial Systems<br>ATION OF INPATIENT OPERATING COST  | RAMAPO RIDGE P           | Provider C             | CN: 31-4019                | Period:                          | wof Form CMS-<br>Worksheet D-1 |              |  |
|--------------|---|--------------------------|------------------------|----------------------------|----------------------------------|--------------------------------|--------------|--|
| 2.11         |   |                          |                        | CCN: 31-5376               | From 01/01/2023<br>To 12/31/2023 | Date/Time Pre                  | epared       |  |
|              |   |                          | Title                  | XVIII                      | Skilled Nursing                  | 5/20/2024 11:<br>PPS           | <u>05 am</u> |  |
|              | Cost Center Description   | Total<br>Inpatient Costl | Total<br>npatient Days | Average Pe<br>Diem (col. 1 |                                  | Program Cost<br>(col. 3 x col. |              |  |
|              |   | 1.00                     | 2.00                   | <u>col.2)</u><br>3.00      | 4.00                             | 4)<br>5.00                     |              |  |
| 2.00         | NURSERY (title V & XIX only)  |                          | 2.00                   | 3.00                       | 4.00                             | 5.00                           | 42. (        |  |
|              | Intensive Care Type Inpatient Hospital Unit   | S                        |                        |                            |                                  |                                | 1 /          |  |
| 3.00<br>4.00 | INTENSIVE CARE UNIT<br>CORONARY CARE UNIT   |                          |                        |                            |                                  |                                | 43.0         |  |
| 5.00         | BURN INTENSIVE CARE UNIT  |                          |                        |                            |                                  |                                | 45.0         |  |
| 5.00         | SURGI CAL I NTENSI VE CARE UNI T  |                          |                        |                            |                                  |                                | 46.          |  |
| 7.00         | OTHER SPECIAL CARE (SPECIFY)  |                          |                        |                            |                                  |                                | 47.          |  |
|              | Cost Center Description   |                          |                        |                            |                                  | 1.00                           |              |  |
| 8.00         | Program inpatient ancillary service cost (W   | /kst. D-3, col. 3,       | line 200)              |                            |                                  | 1.00                           | 48.          |  |
| 8. 01        | Program inpatient cellular therapy acquisit   |                          |                        |                            | , column 1)                      |                                | 48. (        |  |
| Э. 00        | Total Program inpatient costs (sum of lines   | 5 41 through 48.01       | )(see instruc          | tions)                     |                                  |                                | 49.0         |  |
| 0. 00        | PASS THROUGH COST ADJUSTMENTS<br>Pass through costs applicable to Program in  | patient routine s        | ervices (from          | Wkst. D. su                | m of Parts I and                 |                                | 50. (        |  |
| 0.00         |   |                          |                        | intot: D, 30               |                                  |                                | 00.          |  |
| 1. 00        | Pass through costs applicable to Program in   | npatient ancillary       | services (fr           | om Wkst. D,                | sum of Parts II                  |                                | 51.0         |  |
| 2.00         | and IV)<br>Total Program excludable cost (sum of lines  | 50 and 51)               |                        |                            |                                  |                                | 52.0         |  |
| 2.00<br>3.00 | Total Program inpatient operating cost excl   | ,                        | ated, non-phv          | sician anest               | hetist, and                      |                                | 52.          |  |
| -            | medical education costs (line 49 minus line   |                          |                        |                            |                                  |                                |              |  |
| 1 00         | TARGET AMOUNT AND LIMIT COMPUTATION   |                          |                        |                            |                                  |                                |              |  |
| 4.00<br>5.00 | Program discharges<br>Target amount per discharge   |                          |                        |                            |                                  |                                | 54.<br>55.   |  |
| 5. 01        | Permanent adjustment amount per discharge   |                          |                        |                            |                                  |                                | 55.          |  |
| 5. 02        | Adjustment amount per discharge (contractor   | use only)                |                        |                            |                                  |                                | 55.          |  |
| . 00         | Target amount (line 54 x sum of lines 55, 5   |                          |                        |                            |                                  |                                | 56.          |  |
| . 00         | Difference between adjusted inpatient opera   | iting cost and tar       | get amount (I          | ine 56 minus               | line 53)                         |                                | 57.          |  |
| 3.00<br>9.00 | Bonus payment (see instructions)<br>Trended costs (lesser of line 53 ÷ line 54,   | or line 55 from          | the cost rend          | rting period               | ending 1006                      |                                | 58.<br>59.   |  |
| . 00         | updated and compounded by the market basket   |                          | the cost repo          | rting period               | ending 1990,                     |                                | 57.          |  |
| 0. 00        | 00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the                      |                          |                        |                            |                                  |                                |              |  |
| 00           | market basket)<br>Continuous improvement bonus payment (ifli  | no E2 , lino E4 i        | c locc than t          | he lowest of               | Lines FE plus                    |                                | 61.          |  |
| 1.00         | 55.01, or line 59, or line 60, enter the le<br>53) are less than expected costs (lines 54<br>enter zero. (see instructions) | esser of 50% of th       | e amount by w          | hich operati               | ng costs (line                   |                                | 01.          |  |
| 2. 00        | Relief payment (see instructions)   |                          |                        |                            |                                  |                                | 62.          |  |
| 3.00         | Allowable Inpatient cost plus incentive pay   | ment (see instruc        | tions)                 |                            |                                  |                                | 63.          |  |
| 1.00         | PROGRAM INPATIENT ROUTINE SWING BED COST<br>Medicare swing-bed SNF inpatient routine co                                     | sts through Decem        | her 31 of the          | cost report                | ing period (See                  |                                | 64.          |  |
| r. 00        | instructions) (title XVIII only)  | St3 through becch        |                        |                            | rig period (See                  |                                | 04.          |  |
| 5.00         | Medicare swing-bed SNF inpatient routine co   | sts after Decembe        | r 31 of the c          | ost reportin               | g period (See                    |                                | 65.          |  |
| 00           | instructions)(title XVIII only)   | ina costa (lina 4        | 4 plus lips 4          | E) (+; +  o V)/            | I only), for                     |                                | 44           |  |
| b. 00        | Total Medicare swing-bed SNF inpatient rout CAH, see instructions   | THE COSTS (ITTIE C       | - prus iine d          |                            | ii oniy), ioi                    |                                | 66.          |  |
| . 00         | Title V or XIX swing-bed NF inpatient routi   | ne costs through         | December 31 c          | f the cost r               | eporting period                  |                                | 67.          |  |
| 3. 00        | (line 12 x line 19)<br>Title V or XIX swing-bed NF inpatient routi  | ne costs after De        | cember 31 of           | the cost ren               | orting period                    |                                | 68.          |  |
|              | (line 13 x line 20)   |                          |                        |                            | g por loa                        |                                |              |  |
| 9.00         | Total title V or XIX swing-bed NF inpatient   |                          |                        | ,                          |                                  |                                | 69.          |  |
| 0. 00        | PART III - SKILLED NURSING FACILITY, OTHER<br>Skilled nursing facility/other nursing faci                                   |                          |                        |                            | )                                | 33, 952, 782                   | 70.          |  |
| I. 00        | Adjusted general inpatient routine service  | 2                        |                        | •                          | ,                                | 413.33                         |              |  |
| 2.00         | Program routine service cost (line 9 x line   |                          |                        | -                          |                                  | 8, 236, 840                    |              |  |
|              | Medically necessary private room cost appli   |                          |                        | ne 35)                     |                                  | 0                              |              |  |
| . 00         | Total Program general inpatient routine ser<br>Capital-related cost allocated to inpatient                                  |                          |                        | orkshaat P                 | Part II column                   | 8, 236, 840<br>0               |              |  |
| . 00         | 26, line 45)  | Toutine Selvice          | COSIS (ITUII W         | UINSHEEL D,                | raitir, curumn                   |                                | / /5.        |  |
| . 00         | Per diem capital-related costs (line 75 ÷ l   |                          |                        |                            |                                  | 0.00                           |              |  |
| . 00         | Program capital-related costs (line 9 x lin   |                          |                        |                            |                                  | 0                              |              |  |
| . 00         | Inpatient routine service cost (line 74 min   |                          | ovidor record          | c)                         |                                  | 0                              |              |  |
| . 00<br>. 00 | Aggregate charges to beneficiaries for exce<br>Total Program routine service costs for com                                  | • •                      |                        |                            | nus line 79)                     | 0                              |              |  |
| . 00         | Inpatient routine service cost per diem lim   | •                        |                        |                            |                                  | 0.00                           |              |  |
| . 00         | Inpatient routine service cost limitation (   |                          |                        |                            |                                  | 0                              |              |  |
| . 00         | Reasonable inpatient routine service costs  | •                        | )                      |                            |                                  | 8, 236, 840                    |              |  |
| . 00         | Program inpatient ancillary services (see i   |                          |                        |                            |                                  | 2, 809, 829                    |              |  |
|              | Utilization review - physician compensation   |                          |                        |                            |                                  |                                | 85.          |  |
| 5.00<br>6.00 | Total Program inpatient operating costs (su   | M OT LINes X⊀ Thr        | OUON 851               |                            |                                  |                                | 1 86         |  |
|              | Total Program inpatient operating costs (su<br>PART IV - COMPUTATION OF OBSERVATION BED PA                                  |                          | ougn 85)               |                            |                                  | 11, 046, 669                   | 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  | Peri od:                         | Worksheet D-1   |                 |
|   |                 | Component (    | CCN: 31-5376 | From 01/01/2023<br>To 12/31/2023 |                 | pared:<br>05 am |
|   |                 | Title          | XVIII        | Skilled Nursing                  | PPS             |                 |
|   |                 |                | _            | Facility                         |                 |                 |
| 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                   | Through Cost    |                 |
|   |                 |                |              | 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                          | 0               | 0              | 0.0000       | 0 00                             | 0               | 90.00           |
| 91.00 Nursing Program cost                          | 0               | 0              | 0.0000       | 0 00                             | 0               | 91.00           |
| 92.00 Allied health cost                            | 0               | 0              | 0.0000       | 0 00                             | 0               | 92.00           |
| 93.00 All other Medical Education                   | 0               | 0              | 0.0000       | 0 00                             | 0               | 93.00           |

|      | Financial Systems RAMAPO RIDGE PS<br>ATION OF INPATIENT OPERATING COST  | Provider CCN: 31-4019     | Peri od:                         | u of Form CMS-2<br>Worksheet D-1 |      |
|------|---|---------------------------|----------------------------------|----------------------------------|------|
|      |   |                           | From 01/01/2023<br>To 12/31/2023 | Date/Time Pre                    | pare |
|      |   |                           |                                  | 5/20/2024 11:                    | 05 a |
|      | Cost Center Description   | Title XIX                 | Hospi tal                        | TEFRA                            |      |
|      |   |                           |                                  | 1.00                             |      |
|      | PART I - ALL PROVIDER COMPONENTS  |                           |                                  |                                  |      |
|      | INPATIENT DAYS<br>Inpatient days (including private room days and swing-bed day   | (s excluding newborn)     |                                  | 15, 068                          | 1 1  |
|      | Inpatient days (including private room days and swing bed day<br>Inpatient days (including private room days, excluding swing-  |                           |                                  | 15, 068                          |      |
|      | Private room days (excluding swing-bed and observation bed da   |                           | rivate room days,                | 0                                | 3    |
| 00   | do not complete this line.<br>Semi-private room days (excluding swing-bed and observation b                                     | od dave)                  |                                  | 15, 068                          | 4    |
| 00   | Total swing-bed SNF type inpatient days (including private ro   | 5 7                       | er 31 of the cost                | 15,008                           |      |
|      | reporting period  |                           |                                  |                                  |      |
| 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)<br>Total swing-bed NF type inpatient days (including private roo      | om davs) through December | 31 of the cost                   | 0                                | 7    |
|      | reporting period  | 3.                        |                                  | C .                              |      |
| 00   | Total swing-bed NF type inpatient days (including private roc   | om days) after December 3 | 31 of the cost                   | 0                                | 8    |
| 00   | reporting period (if calendar year, enter 0 on this line)<br>Total inpatient days including private room days applicable t      | o the Program (excluding  | swing_bed and                    | 1, 497                           | 9    |
| 50   | newborn days) (see instructions)  |                           | g swillig-bed and                | 1,477                            | 7    |
| . 00 | Swing-bed SNF type inpatient days applicable to title XVIII o   | only (including private r | room days)                       | 0                                | 10   |
| 00   | through December 31 of the cost reporting period (see instruc<br>Swing-bed SNF type inpatient days applicable to title XVIII of |                           | coom days) after                 | 0                                | 11   |
| 00   | December 31 of the cost reporting period (if calendar year, e   |                           | oom days) arter                  | 0                                | ''   |
| . 00 | 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<br>Swing-bed NF type inpatient days applicable to titles V or XI               | V only (including privat  | o room dave)                     | 0                                | 12   |
| . 00 | after December 31 of the cost reporting period (if calendar y   |                           |                                  | 0                                | 13   |
|      | Medically necessary private room days applicable to the Progr   |                           |                                  | 0                                | 14   |
|      | Total nursery days (title V or XIX only)  |                           |                                  | 0                                |      |
|      | Nursery days (title V or XIX only)<br>SWING BED ADJUSTMENT  |                           |                                  | 0                                | 16   |
|      | Medicare rate for swing-bed SNF services applicable to servic   | es through December 31 d  | of the cost                      | 0.00                             | 17   |
|      | reporting period  | Ū.                        |                                  |                                  |      |
| . 00 | Medicare rate for swing-bed SNF services applicable to servic<br>reporting period   | ces after December 31 of  | the cost                         | 0.00                             | 18   |
| . 00 | Medicaid rate for swing-bed NF services applicable to service   | es through December 31 of | f the cost                       | 0.00                             | 19   |
|      | reporting period  | <u> </u>                  |                                  |                                  |      |
| . 00 | Medicaid rate for swing-bed NF services applicable to service<br>reporting period   | es after December 31 of 1 | the cost                         | 0.00                             | 20   |
| . 00 | Total general inpatient routine service cost (see instruction   | าร)                       |                                  | 17, 401, 105                     | 21   |
| . 00 | Swing-bed cost applicable to SNF type services through Decemb   | per 31 of the cost report | ing period (line                 | 0                                | 22   |
| . 00 | 5 x line 17)<br>Swing had east appliable to SNE type capilogs offer December  | 21 of the east reporting  | a ported (line (                 | 0                                | 23   |
| . 00 | Swing-bed cost applicable to SNF type services after December x line 18)  | ST OF THE COST TEPOLET    | ig period (Title o               | 0                                | 23   |
| . 00 | Swing-bed cost applicable to NF type services through Decembe   | er 31 of the cost reporti | ng period (line                  | 0                                | 24   |
| 00   | 7 x line 19)  |                           |                                  | 0                                | 0    |
| . 00 | Swing-bed cost applicable to NF type services after December x line 20)   | 31 of the cost reporting  | period (inne 8                   | 0                                | 25   |
| . 00 | Total swing-bed cost (see instructions)   |                           |                                  | 0                                | 26   |
|      | General inpatient routine service cost net of swing-bed cost  | (line 21 minus line 26)   |                                  | 17, 401, 105                     | 27   |
|      | PRIVATE ROOM DIFFERENTIAL ADJUSTMENT<br>General inpatient routine service charges (excluding swing-be                           | and observation bed ch    | ardes)                           | 0                                | 28   |
|      | Private room charges (excluding swing-bed charges)  | and observation bed ci    | iai ges)                         | 0                                |      |
| . 00 | Semi-private room charges (excluding swing-bed charges)   |                           |                                  | 0                                | 30   |
|      | General inpatient routine service cost/charge ratio (line 27  | ÷line 28)                 |                                  | 0.000000                         |      |
|      | Average private room per diem charge (line 29 ÷ line 3)<br>Average semi-private room per diem charge (line 30 ÷ line 4)         |                           |                                  | 0.00<br>0.00                     |      |
|      | Average per diem private room charge differential (line 32 mi   | nus line 33)(see instruc  | ctions)                          | 0.00                             |      |
|      | Average per diem private room cost differential (line 34 x li   | ne 31)                    |                                  | 0.00                             |      |
|      | Private room cost differential adjustment (line 3 x line 35)<br>General inpatient routine service cost pet of swing-bed cost    | and privato room cost di  | fforential (line                 | 17 401 105                       | 36   |
| . 00 | General inpatient routine service cost net of swing-bed cost 27 minus line 36)  | and private room cost di  | rielential (line                 | 17, 401, 105                     | 37   |
|      | PART II - HOSPITAL AND SUBPROVIDERS ONLY  |                           |                                  |                                  | 1    |
|      | PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ   |                           |                                  |                                  | 1 ~~ |
|      | Adjusted general inpatient routine service cost per diem (see<br>Program general inpatient routine service cost (line 9 x line  |                           |                                  | 1, 154. 84<br>1, 728, 795        |      |
|      | Medically necessary private room cost applicable to the Progr   | -                         |                                  | 1, 728, 795                      | 40   |
|      |   |                           |                                  |                                  |      |

|        |   |                         |                        |  | Erom 01/01/2022                  |                                      |                |
|--------|---|-------------------------|------------------------|--|----------------------------------|--------------------------------------|----------------|
|        |   |                         |                        |  | From 01/01/2023<br>To 12/31/2023 |                                      |                |
|        |   |                         | Titl                   | e XIX                                  | Hospi tal                        | TEFRA                                |                |
|        | Cost Center Description   | Total<br>patient Costli | Total<br>npatient Days | Average Per<br>Diem (col. 1<br>col. 2) |                                  | Program Cost<br>(col. 3 x col.<br>4) |                |
|        |   | 1.00                    | 2.00                   | 3.00                                   | 4.00                             | 5.00                                 |                |
| 42.00  | NURSERY (title V & XIX only)<br>ntensive Care Type Inpatient Hospital Units   |                         |                        |  |                                  |                                      | 42.00          |
| 43.00  | INTENSIVE CARE UNIT   |                         |                        |  |                                  |                                      | 43.00          |
|        | CORONARY CARE UNIT<br>BURN INTENSIVE CARE UNIT  |                         |                        |  |                                  |                                      | 44.00          |
|        | SURGICAL INTENSIVE CARE UNIT  |                         |                        |  |                                  |                                      | 45.00          |
| 47.00  | OTHER SPECIAL CARE (SPECIFY)  |                         |                        |  |                                  |                                      | 47.00          |
|        | Cost Center Description   |                         |                        |  |                                  | 1.00                                 |                |
|        | Program inpatient ancillary service cost (Wkst.<br>Program inpatient cellular therapy acquisition   |                         |                        | III line 10                            | column 1)                        | 0                                    |                |
|        | Total Program inpatient costs (sum of lines 41  |                         |                        |  | , corumn r)                      | 1, 728, 795                          |                |
|        | PASS THROUGH COST ADJUSTMENTS   |                         |                        |  |                                  |                                      |                |
| 50.00  | Pass through costs applicable to Program inpati-<br>III)  | ent routine s           | ervices (trom          | i WKST. D, SU                          | m of Parts I and                 | 91, 077                              | 50.00          |
| 51.00  | Pass through costs applicable to Program inpati   | ent ancillary           | services (fr           | om Wkst. D,                            | sum of Parts II                  | 0                                    | 51.00          |
| 52.00  | and IV)<br>Total Program excludable cost (sum of lines 50 -   | and 51)                 |                        |  |                                  | 91, 077                              | 52.00          |
|        | Total Program inpatient operating cost excludin   | g capital rel           | ated, non-phy          | sician anest                           | hetist, and                      | 1, 637, 718                          |                |
| ī      | medical education costs (line 49 minus line 52)<br>FARGET AMOUNT AND LIMIT COMPUTATION  |                         |                        |  |                                  |                                      | -              |
|        | Program di scharges   |                         |                        |  |                                  | 108                                  | 54.00          |
|        | Target amount per discharge   |                         |                        |  |                                  | 0.00                                 |                |
|        | Permanent adjustment amount per discharge<br>Adjustment amount per discharge (contractor use  | onl v)                  |                        |  |                                  | 0.00                                 |                |
| 56.00  | Target amount (line 54 x sum of lines 55, 55.01   | , and 55.02)            |                        |  |                                  | 0                                    | 56.00          |
|        | Difference between adjusted inpatient operating<br>Bonus payment (see instructions)   | cost and tar            | get amount (I          | ine 56 minus                           | line 53)                         | -1, 637, 718                         | 57.00          |
|        | Trended costs (lesser of line 53 ÷ line 54, or  | line 55 from            | the cost repo          | orting period                          | endi ng 1996,                    | 0.00                                 |                |
| 40.00  | updated and compounded by the market basket)  | ling EE from            | prior year o           | act report                             | undated by the                   | 0.00                                 | 60.00          |
| 60. 00 | Expected costs (lesser of line 53 ÷ line 54, or<br>market basket)   | TTHE 55 TION            | prior year c           | JUST TEPOTT,                           | upuated by the                   | 0.00                                 | 80.00          |
| 61.00  | Continuous improvement bonus payment (if line 5<br>55.01, or line 59, or line 60, enter the lesser<br>53) are less than expected costs (lines 54 x 60 | of 50% of th            | e amount by w          | hich operati                           | ng costs (line                   | 0                                    | 61.00          |
| 62.00  | enter zero. (see instructions)<br>Relief payment (see instructions)   |                         |                        |  |                                  | 0                                    | 62.00          |
|        | Allowable Inpatient cost plus incentive payment<br>PROGRAM INPATIENT ROUTINE SWING BED COST   | (see instruc            | tions)                 |  |                                  | 91, 077                              | 63.00          |
|        | Medicare swing-bed SNF inpatient routine costs  | through Decem           | per 31 of the          | e cost report                          | ing period (See                  | 0                                    | 64.00          |
| 65 00  | instructions)(title XVIII only)<br>Medicare swing-bed SNF inpatient routine costs -   | after Decembe           | r 31 of the c          | ost reportin                           | a period (See                    | 0                                    | 65.00          |
|        | instructions)(title XVIII only)   |                         |                        |  |                                  |                                      |                |
| 66.00  | Total Medicare swing-bed SNF inpatient routine<br>CAH, see instructions   | costs (line 6           | 4 plus line 6          | 5)(title XVI                           | II only); for                    | 0                                    | 66.00          |
| 67.00  | Title V or XIX swing-bed NF inpatient routine c   | osts through            | December 31 c          | of the cost r                          | eporting period                  | 0                                    | 67.00          |
| 68.00  | (line 12 x line 19)<br>Title V or XIX swing-bed NF inpatient routine c  | osts after De           | cember 31 of           | the cost rep                           | orting period                    | 0                                    | 68.00          |
|        | (line 13 x line 20)<br>Total title V or XIX swing-bed NF inpatient rou  |                         |                        |  |                                  | 0                                    | 69.00          |
| ļ      | PART III - SKILLED NURSING FACILITY, OTHER NURS   | ING FACILITY,           | AND ICF/IID            | ONLY                                   |                                  | 1                                    | 70.00          |
|        | Skilled nursing facility/other nursing facility<br>Adjusted general inpatient routine service cost  |                         |                        |  | )                                |                                      | 70.00          |
| 72.00  | Program routine service cost (line 9 x line 71)   |                         |                        | ,                                      |                                  |                                      | 72.00          |
|        | Medically necessary private room cost applicabl<br>Total Program general inpatient routine service  |                         |                        |  |                                  |                                      | 73.00          |
|        | Capital-related cost allocated to inpatient rou   | •                       |                        |  | Part II, column                  |                                      | 75.00          |
| 76.00  | 26, line 45)<br>Per diem capital-related costs (line 75 ÷ line  | 2)                      |                        |  |                                  |                                      | 76.00          |
|        | Program capital-related costs (line 9 x line 76   |                         |                        |  |                                  |                                      | 77.00          |
| 78.00  | Inpatient routine service cost (line 74 minus l   | ine 77)                 | a dala                 | 1->                                    |                                  |                                      | 78.00          |
|        | Aggregate charges to beneficiaries for excess c<br>Total Program routine service costs for compari  | • •                     |                        |  | nus line 79)                     |                                      | 79.00          |
| 81.00  | Inpatient routine service cost per diem limitat   | i on                    |                        | (                                      |                                  |                                      | 81.00          |
|        | Inpatient routine service cost limitation (line   | ,                       | )                      |  |                                  |                                      | 82.00          |
|        | Reasonable inpatient routine service costs (see<br>Program inpatient ancillary services (see instr  |                         | 1                      |  |                                  |                                      | 83.00<br>84.00 |
| 85.00  | Utilization review - physician compensation (se   | e instruction           |                        |  |                                  |                                      | 85.00          |
|        | Total Program inpatient operating costs (sum of<br>PART IV - COMPUTATION OF OBSERVATION BED PASS TI   |                         | ough 85)               |  |                                  | l                                    | 86.00          |
|        | Total observation bed days (see instructions)   |                         |                        |  |                                  | 0                                    | 1              |
|        | Adjusted general inpatient routine cost per die   | m (line 27 ÷            | ine 2)                 |  |                                  | 0.00                                 | 88.00          |

| Health Financial Systems                      | RAMAPO RIDGE | PSYCHI ATRI C  |            | In Lie                           | eu of Form CMS-2 | 2552-10 |
|---|--------------|----------------|------------|----------------------------------|------------------|---------|
| COMPUTATION OF INPATIENT OPERATING COST       |              | Provider CC    |            | Period:                          | Worksheet D-1    |         |
|   |              |                |            | From 01/01/2023<br>To 12/31/2023 |                  |         |
|   |              | Titl           | e XIX      | Hospi tal                        | TEFRA            |         |
| Cost Center Description                       | Cost         | Routine Cost   | column 1 ÷ | Total                            | Observati on     |         |
|   |              | (from line 21) | column 2   | Observati on                     | Bed Pass         |         |
|   |              |                |            | Bed Cost (from                   | Through Cost     |         |
|   |              |                |            | 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                    | 916, 667     | 17, 401, 105   | 0. 05267   | 9 0                              | 0                | 90.00   |
| 91.00 Nursing Program cost                    | 0            | 17, 401, 105   | 0.00000    | 0 0                              | 0                | 91.00   |
| 92.00 Allied health cost                      | 0            | 17, 401, 105   | 0. 00000   | 0 0                              | 0                | 92.00   |
| 93.00 All other Medical Education             | 0            | 17, 401, 105   | 0.00000    | o o                              | 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 01/01/2023<br>To 12/31/2023 | Date/Time Pre<br>5/20/2024 11: |         |
|   | 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                           |         |
| INPATIENT ROUTINE SERVICE COST CENTERS                          |             | 1            |                                  |                                |         |
| 30. 00 03000 ADULTS & PEDIATRICS                                |             |              | 12, 553, 600                     |                                | 30.00   |
| ANCI LLARY SERVI CE COST CENTERS                                |             | 1            |                                  |                                |         |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                            |             | 0. 76180     |                                  |                                | 54.00   |
| 60. 00 06000 LABORATORY   |             | 0. 71500     |                                  | 18, 031                        | 60.00   |
| 65. 00 06500 RESPI RATORY THERAPY                               |             | 0. 83689     |                                  | 0                              | 65.00   |
| 66. 00 06600 PHYSI CAL THERAPY                                  |             | 0.6673       | -                                | 0                              | 66.00   |
| 67.00 06700 0CCUPATI ONAL THERAPY                               |             | 0. 5764      |                                  | 0                              | 67.00   |
| 68.00 06800 SPEECH PATHOLOGY                                    |             | 0. 5764      |                                  | 0                              | 68.00   |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT                 |             | 0. 76180     |                                  | 0                              | 71.00   |
| 73.00 07300 DRUGS CHARGED TO PATIENTS                           |             | 0. 96194     | 102, 674                         | 98, 767                        | 73.00   |
| OUTPATIENT SERVICE COST CENTERS                                 |             |              |                                  |                                |         |
| 90. 00 09000 CLINIC   |             | 0. 82924     |                                  | 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)     |             |              | 139, 012                         |                                |         |
| 201.00 Less PBP Clinic Laboratory Services-Program only charges | 5 (line 61) |              | 0                                |                                | 201.00  |
| 202.00 Net charges (line 200 minus line 201)                    |             |              | 139, 012                         |                                | 202.00  |
|   |             |              |                                  |                                |         |

| INPATIENT ANCILLARY SERVICE COST APPORTIONMENT          | Provider Component  | CN: 31-4019  | Period:                          |                |        |
|---|---------------------|--------------|----------------------------------|----------------|--------|
|   | Component           |              |                                  | Worksheet D-3  |        |
|   |                     | CCN- 21 5276 | From 01/01/2023<br>To 12/31/2023 | Date/Time Pre  | narod  |
|   |                     | CCN. 31-3370 | 10 12/31/2023                    | 5/20/2024 11:  | 05 am  |
|   | Title               | e XVIII      | Skilled Nursing                  |                |        |
|   |                     |              | Facility                         |                |        |
| Cost Center Description                                 |                     | Ratio of Cos |                                  | Inpati ent     |        |
|   |                     | To Charges   | Program                          | Program Costs  |        |
|   |                     |              | Charges                          | (col. 1 x col. |        |
|   |                     | 1.00         | 2.00                             | 2)             |        |
| INPATIENT ROUTINE SERVICE COST CENTERS                  |                     | 1.00         | 2.00                             | 3.00           |        |
| 30. 00 03000 ADULTS & PEDIATRICS                        |                     | 1            |                                  |                | 30.00  |
| ANCI LLARY SERVICE COST CENTERS                         |                     |              |                                  |                | 30.00  |
| 54. 00 05400 RADI OLOGY-DI AGNOSTI C                    |                     | 0. 76180     | 32, 725                          | 24, 930        | 54.00  |
| 60. 00 06000 LABORATORY                                 |                     | 0.7150       |                                  |                |        |
| 65. 00 06500 RESPIRATORY THERAPY                        |                     | 0. 83689     |                                  | 0              | 65.00  |
| 66. 00 06600 PHYSI CAL THERAPY                          |                     | 0.66739      |                                  | 1, 075, 501    | 66.00  |
| 67. 00 06700 OCCUPATI ONAL THERAPY                      |                     | 0. 5764      |                                  |                | 67.00  |
| 68.00 06800 SPEECH PATHOLOGY                            |                     | 0. 5764      | 410, 735                         | 236, 769       | 68.00  |
| 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT         |                     | 0. 76180     | 93, 029                          | 70, 870        | 71.00  |
| 73.00 07300 DRUGS CHARGED TO PATIENTS                   |                     | 0. 96194     | 46 300, 074                      | 288, 655       | 73.00  |
| OUTPATIENT SERVICE COST CENTERS                         |                     |              |                                  |                |        |
| 90. 00 09000 CLINIC                                     |                     | 0. 82924     |                                  | 0              |        |
| 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 |                     |              | 4, 345, 388                      |                |        |
| 201.00 Less PBP Clinic Laboratory Services-Program on   | y charges (line 61) |              | 0                                |                | 201.00 |
| 202.00 Net charges (line 200 minus line 201)            |                     |              | 4, 345, 388                      |                | 202.00 |

| ALCUL        | ATION OF REIMBURSEMENT SETTLEMENT  | Provider CCN: 31-4019   | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet E<br>Part B<br>Date/Time Pre<br>5/20/2024 11: |                |
|--------------|--|-------------------------|---|---|----------------|
|              |  | Title XVIII             | Hospi tal                                   | PPS   |                |
|              |  |                         |   | 1.00  |                |
|              | PART B - MEDICAL AND OTHER HEALTH SERVICES   |                         |   |   |                |
| . 00         | Medical and other services (see instructions)  | :)                      |   | 0   | 1.00           |
| . 00         | Medical and other services reimbursed under OPPS (see instruct OPPS or REH payments  | I ONS)                  |   | 2, 091, 816<br>2, 247, 195                              | 2.00<br>3.00   |
| . 00         | Outlier payment (see instructions)   |                         |   | 2, 247, 193   | 4.00           |
| . 01         | Outlier reconciliation amount (see instructions)   |                         |   | 0   | 4.01           |
| . 00         | Enter the hospital specific payment to cost ratio (see instruc<br>Line 2 times line 5  | tions)                  |   | 0.000   | 5.00           |
| . 00<br>. 00 | Sum of lines 3, 4, and 4.01, divided by line 6   |                         |   | 0<br>0.00   | 6.00<br>7.00   |
| . 00         | Transitional corridor payment (see instructions)   |                         |   | 0   | 8.00           |
| . 00         | Ancillary service other pass through costs including REH direc   | t graduate medical educ | cation costs from                           | 0   | 9.00           |
| 0. 00        | Wkst. D, Pt. IV, col. 13, line 200<br>Organ acquisitions   |                         |   | 0   | 10.00          |
| 1.00         | Total cost (sum of lines 1 and 10) (see instructions)  |                         |   | 0   |                |
|              | COMPUTATION OF LESSER OF COST OR CHARGES   |                         |   |   |                |
| 2.00         | Reasonable charges<br>Ancillary service charges  |                         |   | 0   | 12.00          |
| 3.00         | Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii   | ne 69)                  |   | 0   |                |
| 4.00         | Total reasonable charges (sum of lines 12 and 13)  |                         |   | 0   |                |
| F 00         | Customary charges  |                         |   | 0   |                |
| 5.00<br>6.00 | Aggregate amount actually collected from patients liable for p<br>Amounts that would have been realized from patients liable for |                         |   | 0   |                |
| 0.00         | had such payment been made in accordance with 42 CFR §413.13(e   |                         | in a chargebasi s                           | Ū   | 10.00          |
| 7.00         | Ratio of line 15 to line 16 (not to exceed 1.000000)   |                         |   | 0.000000  |                |
| 8.00<br>9.00 | Total customary charges (see instructions)<br>Excess of customary charges over reasonable cost (complete onl)                    | vifling 18 evceeds li   | no 11) (soo                                 | 0   |                |
| 9.00         | instructions)  | y IT THE TO EXCEEDS IT  | ne n) (see                                  | 0   | 17.00          |
| 0.00         | Excess of reasonable cost over customary charges (complete onl   | y if line 11 exceeds li | ne 18) (see                                 | 0   | 20. 00         |
| 1.00         | instructions)<br>Lesser of cost or charges (see instructions)  |                         |   | 0   | 21.00          |
| 2.00         | Interns and residents (see instructions)   |                         |   | 0   | 22.00          |
| 3.00         | Cost of physicians' services in a teaching hospital (see instr   | uctions)                |   | 0   |                |
| 4.00         | Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   |                         |   | 2, 247, 195   | 24.00          |
| 5.00         | COMPUTATION OF REIMBURSEMENT SETTLEMENT<br>Deductibles and coinsurance amounts (for CAH, see instructions                        | )                       |   | 0   | 25.00          |
| 6. 00        | Deductibles and Coinsurance amounts relating to amount on line   | 24 (for CAH, see instr  |   | 524, 690  |                |
| 7.00         | Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p   | lus the sum of lines 22 | 2 and 23] (see                              | 1, 722, 505   | 27.00          |
| 8.00         | instructions)<br>Direct graduate medical education payments (from Wkst. E-4, li  | ne 50)                  |   | 0   | 28.00          |
| 8.50         | REH facility payment amount (see instructions)   | ,                       |   |   | 28.50          |
| 9.00         | ESRD direct medical education costs (from Wkst. E-4, line 36)  |                         |   | 0   |                |
| 0.00         | Subtotal (sum of lines 27, 28, 28.50 and 29)<br>Primary payer payments   |                         |   | 1, 722, 505<br>0  |                |
| 2.00         | Subtotal (line 30 minus line 31)   |                         |   | 1, 722, 505   |                |
|              | ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC   | ES)                     |   |   |                |
| 3.00         | Composite rate ESRD (from Wkst. I-5, line 11)<br>Allowable bad debts (see instructions)  |                         |   | 0   |                |
| 5.00         | Adjusted reimbursable bad debts (see instructions)   |                         |   | 0   |                |
| 6.00         | Allowable bad debts for dual eligible beneficiaries (see instr   | uctions)                |   | 0   | 36.0           |
| 7.00         | Subtotal (see instructions)  |                         |   | 1, 722, 505   | 37.0<br>38.0   |
| 8.00         | MSP-LCC reconciliation amount from PS&R<br>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  |                         |   | 0   | 39.0           |
| 9.50         | Pioneer ACO demonstration payment adjustment (see instructions   | )                       |   | -   | 39.5           |
| 9.75         | N95 respirator payment adjustment amount (see instructions)  |                         |   | 0   | 39.7           |
| 9.97<br>9.98 | Demonstration payment adjustment amount before sequestration<br>Partial or full credits received from manufacturers for replac   | ed devices (see instruc | tions)                                      | 0   | 39.9<br>39.9   |
| 9.99         | RECOVERY OF ACCELERATED DEPRECIATION   |                         |   | 0   | 39.90          |
| 0.00         | Subtotal (see instructions)  |                         |   | 1, 722, 505   | 40.0           |
| 0.01         | Sequestration adjustment (see instructions)<br>Demonstration payment adjustment amount after sequestration                       |                         |   | 34, 450<br>0  | 40. 0<br>40. 0 |
| 0.02         | Sequestration adjustment-PARHM pass-throughs   |                         |   | 0   | 40.0           |
| 1.00         | Interim payments   |                         |   | 1, 688, 030   | 41.0           |
| 1.01         | Interim payments-PARHM   |                         |   | ^   | 41.0           |
| 2.00         | Tentative settlement (for contractors use only)<br>Tentative settlement-PARHM (for contractor use only)                          |                         |   | 0   | 42.0<br>42.0   |
| 3.00         | Balance due provider/program (see instructions)  |                         |   | 25  | 43.0           |
| 3.01         | Balance due provider/program-PARHM (see instructions)  |                         |   |   | 43.0           |
| 4.00         | Protested amounts (nonallowable cost report items) in accordan §115.2  | ce with CMS Pub. 15-2,  | chapter 1,                                  | 0   | 44.0           |
|              | TO BE COMPLETED BY CONTRACTOR  |                         |   |   |                |
| 0.00         | Original outlier amount (see instructions)   |                         |   | 0   |                |
| 1.00         | Outlier reconciliation adjustment amount (see instructions)<br>The rate used to calculate the Time Value of Money                |                         |   | 0   | 91.0<br>92.0   |
| ∠. UU        | Time Value of Money (see instructions)   |                         |   |   | 92.0           |

| 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 01/01/2023<br>To 12/31/2023 |               | epared <sup>.</sup> |
|   |                          | 10 12/01/2020                    | 5/20/2024 11  | :05 am              |
|   | Title XVIII              | Hospi tal                        | PPS           |                     |
|   |                          |                                  |               |                     |
|   |                          |                                  | 1.00          |                     |
| 94.00 Total (sum of lines 91 and 93)    |                          |                                  | (             | 94.00               |
|   |                          |                                  |               |                     |
|   |                          |                                  | 1.00          |                     |
| MEDICARE PART B ANCILLARY COSTS         |                          |                                  |               |                     |
| 200.00 Part B Combined Billed Days      |                          |                                  | (             | 200. 00             |

| VALY:                            | SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED  | Provider CC | CN: 31-4019          | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet E-1<br>Part I<br>Date/Time Prep<br>5/20/2024 11:0 | pared                            |
|----------------------------------|---|-------------|----------------------|---|---|----------------------------------|
|                                  |   | Title       | XVIII                | Hospi tal                                   | PPS   |                                  |
|                                  |   | I npati en  | t Part A             | Par   | tВ  |                                  |
|                                  |   | mm/dd/yyyy  | Amount               | mm/dd/yyyy                                  | Amount  |                                  |
|                                  |   | 1.00        | 2.00                 | 3.00  | 4.00  |                                  |
| 00<br>00<br>00                   | Total interim payments paid to provider<br>Interim payments payable on individual bills, either<br>submitted or to be submitted to the contractor for<br>services rendered in the cost reporting period. If none,<br>write "NONE" or enter a zero<br>List separately each retroactive lump sum adjustment<br>amount based on subsequent revision of the interim rate<br>for the cost reporting period. Also show date of each |             | 9, 146, 15           | 54<br>0                                     | 1, 688, 030<br>0  | 1.<br>2.<br>3.                   |
|                                  | payment. If none, write "NONE" or enter a zero. (1)   |             |                      |   |   |                                  |
|                                  | Program to Provider   |             |                      |   |   |                                  |
| 01<br>02<br>03<br>04<br>05       | ADJUSTMENTS TO PROVIDER   | 10/24/2023  | 86, 36               | 53<br>0<br>0<br>0                           | 0<br>0<br>0<br>0  | 3.<br>3.<br>3.<br>3.<br>3.       |
|                                  | Provider to Program   |             |                      |   |   |                                  |
| 50<br>51<br>52<br>53<br>54<br>99 | ADJUSTMENTS TO PROGRAM<br>Subtotal (sum of lines 3.01-3.49 minus sum of lines   |             | 86, 36               | 0<br>0<br>0<br>0<br>53                      | 0<br>0<br>0<br>0<br>0                                       | 3.<br>3.<br>3.<br>3.<br>3.<br>3. |
| 00                               | 3.50-3.98)<br>Total interim payments (sum of lines 1, 2, and 3.99)<br>(transfer to Wkst. E or Wkst. E-3, line and column as<br>appropriate)   |             | 9, 232, 51           | 17  | 1, 688, 030   | 4                                |
|                                  | TO BE COMPLETED BY CONTRACTOR   | 1           |                      |   |   |                                  |
| 00                               | List separately each tentative settlement payment after<br>desk review. Also show date of each payment. If none,<br>write "NONE" or enter a zero. (1)<br>Program to Provider  |             |                      |   |   | 5                                |
| )1                               | TENTATI VE TO PROVIDER  |             |                      | 0   | 0   | 5                                |
| )2                               |   |             |                      | 0   | 0   |                                  |
| )3                               |   |             |                      | 0   | 0   | 5                                |
| 0                                | Provider to Program TENTATIVE TO PROGRAM  | 1           |                      | 0   | 0   | 5                                |
| 1<br>2<br>9                      | Subtotal (sum of lines 5.01-5.49 minus sum of lines   |             |                      | 0   | 0<br>0<br>0   | 5<br>5                           |
| 0                                | 5.50-5.98)<br>Determined net settlement amount (balance due) based on   |             |                      |   | Ŭ   | 6                                |
| 01                               | the cost report. (1)<br>SETTLEMENT TO PROVIDER  |             |                      | 0   | 25  | 6                                |
| 02<br>00                         | SETTLEMENT TO PROGRAM<br>Total Medicare program liability (see instructions)  |             | 91, 39<br>9, 141, 12 | 27  | 0<br>1, 688, 055  | 6<br>7                           |
|                                  |   | C           |                      | Contractor<br>Number<br>1.00                | NPR Date<br>(Mo/Day/Yr)<br>2.00                             |                                  |

| IALYS    | SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED   | Provider CC<br>Component C | CN: 31-4019<br>CCN: 31-5376 | Period:<br>From 01/01/2023<br>To 12/31/2023 |               | epare |
|----------|--|----------------------------|-----------------------------|---|---------------|-------|
|          |  | Title                      | XVIII                       | Skilled Nursing                             |               | 05 a  |
|          |  | Inpatien                   | t Part A                    | Facility<br>Pa                              | rt B          |       |
|          |  | mm/dd/yyyy                 | Amount                      | mm/dd/yyyy                                  | Amount        |       |
|          |  | 1.00                       | 2.00                        | 3.00  | 4.00          |       |
| 00<br>00 | Total interim payments paid to provider<br>Interim payments payable on individual bills, either<br>submitted or to be submitted to the contractor for<br>services rendered in the cost reporting period. If none,<br>write "NONE" or enter a zero      |                            | 15, 001, 6                  | 57<br>0                                     | 0             | ) 2.  |
| 00       | List separately each retroactive lump sum adjustment<br>amount based on subsequent revision of the interim rate<br>for the cost reporting period. Also show date of each<br>payment. If none, write "NONE" or enter a zero. (1)<br>Program to Provider |                            |                             |   |               | 3.    |
| D1       | ADJUSTMENTS TO PROVIDER  |                            |                             | 0   | 0             | ) 3   |
| 02       |  |                            |                             | 0   | 0             |       |
| 03       |  |                            |                             | 0   | 0             | ) 3   |
| 04       |  |                            |                             | 0   | 0             |       |
| )5       |  |                            |                             | 0   | 0             | ) 3   |
| 50       | Provider to Program ADJUSTMENTS TO PROGRAM   |                            |                             | 0   | 0             | ) 3   |
| 1        | ADJUSTMENTS TU PRUGRAM   |                            |                             | 0   | 0             |       |
| 52       |  |                            |                             | 0   | 0             |       |
| 53       |  |                            |                             | 0   | 0             |       |
| 54<br>54 |  |                            |                             | 0   | 0             |       |
| 99       | Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)   |                            |                             | 0   | 0             |       |
| 00       | Total interim payments (sum of lines 1, 2, and 3.99)<br>(transfer to Wkst. E or Wkst. E-3, line and column as<br>appropriate)  |                            | 15, 001, 6                  | 57  | 0             | ) 4   |
|          | TO BE COMPLETED BY CONTRACTOR  |                            |                             |   |               |       |
| 00       | List separately each tentative settlement payment after<br>desk review. Also show date of each payment. If none,<br>write "NONE" or enter a zero. (1)  |                            |                             |   |               | 5     |
|          | Program to Provider  |                            |                             |   |               |       |
| )1<br>)2 | TENTATI VE TO PROVI DER  |                            |                             | 0   | 0             |       |
| )2<br>)3 |  |                            |                             | 0   | 0             |       |
| ,0       | Provider to Program  |                            |                             | <u>Ч</u>                                    | 0             | 4 5   |
| 50       | TENTATI VE TO PROGRAM  |                            |                             | 0   | 0             | 5 5   |
| 51       |  |                            |                             | 0   | 0             |       |
| 52       |  |                            |                             | 0   | 0             |       |
| 9        | Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   |                            |                             | 0   | 0             |       |
| 00       | Determined net settlement amount (balance due) based on<br>the cost report. (1)  |                            |                             |   |               | 6     |
| )1       | SETTLEMENT TO PROVIDER   |                            |                             | 1   | 0             |       |
| )2       | SETTLEMENT TO PROGRAM  |                            | 15 001 (                    | 0   | 0             |       |
| 00       | Total Medicare program liability (see instructions)  |                            | 15, 001, 6                  |   | 0<br>NPR Date | ) 7   |
|          |  |                            |                             | Contractor<br>Number                        | (Mo/Day/Yr)   |       |
|          |  |                            | )                           | 1.00  | 2.00          | -     |

| CALCUL         | ATION OF REIMBURSEMENT SETTLEMENT  | Provider CCN: 31-4019       | Period:<br>From 01/01/2023<br>To 12/31/2023 |                         |                |
|----------------|--|-----------------------------|---|-------------------------|----------------|
|                |  |                             |   | 5/20/2024 11:0          | 05 am          |
|                | · · · · · · · · · · · · · · · · · · ·  | Title XVIII                 | Hospi tal                                   | PPS                     |                |
|                |  |                             |   | 1.00                    |                |
| 1 00           | PART II - MEDICARE PART A SERVICES - IPF PPS   |                             | <u>,</u>                                    | 10 151 /1/              | 1 1 00         |
| 1.00<br>2.00   | Net Federal IPF PPS Payments (excluding outlier, ECT, and r<br>Net IPF PPS Outlier Payments                          | nedical education payments, | )   | 10, 151, 616<br>0       | 1              |
| 3.00           | Net IPF PPS ECT Payments   |                             |   | 0                       |                |
| 4.00           | Unweighted intern and resident FTE count in the most recent  | t cost report filed on or l | oefore November                             | 0.00                    | 4.00           |
| 4 01           | 15, 2004. (see instructions)<br>Cap increases for the unweighted intern and resident FTE co                          | aunt fan naai danta that wa | a diaplaced by                              | 0.00                    | 4 01           |
| 4.01           | program or hospital closure, that would not be counted with $CFR$ §412.424(d)(1)(ii)(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 i  | n the new program growth p  | period of a "new                            | 0.00                    | 6.00           |
| 7.00           | teaching program" (see instuctions)<br>Current year's unweighted I&R FTE count for residents withi                   | n the new program growth i  | period of a "new                            | 0.00                    | 7.00           |
|                | teaching program" (see instuctions)  |                             |   | 0100                    |                |
| 8.00           | Intern and resident count for IPF PPS medical education adj  | ustment (see instructions)  | )   | 0.00                    |                |
| 9.00           | Average Daily Census (see instructions)<br>Teaching Adjustment Factor {((1 + (line 8/line 9)) raised 1               | to the newer of $[150, 1]$  |   | 41. 282192<br>0. 000000 |                |
| 10.00<br>11.00 | Teaching Adjustment (line 1 multiplied by line 10).  | to the power of . 5150 -1}. |   | 0.000000                |                |
| 12.00          | Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 1  | 1)                          |   | 10, 151, 616            | •              |
| 13.00          | Nursing and Allied Health Managed Care payment (see instruc  |                             |   | 0                       |                |
| 14.00          | Organ acquisition (DO NOT USE THIS LINE)   |                             |   |                         | 14.00          |
| 15.00          | Cost of physicians' services in a teaching hospital (see in  | nstructions)                |   | 0                       |                |
| 16.00          | Subtotal (see instructions)<br>Primary payer payments  |                             |   | 10, 151, 616<br>0       | 1              |
| 18.00          | Subtotal (line 16 less line 17).   |                             |   | 10, 151, 616            | •              |
|                | Deducti bl es  |                             |   | 271, 604                | •              |
| 20. 00         | Subtotal (line 18 minus line 19)   |                             |   | 9, 880, 012             |                |
| 21.00          | Coinsurance  |                             |   | 620, 775                |                |
| 22.00<br>23.00 | Subtotal (line 20 minus line 21)<br>Allowable bad debts (exclude bad debts for professional ser                      | wices) (see instructions)   |   | 9, 259, 237<br>105, 299 |                |
|                | Adjusted reimbursable bad debts (see instructions)   |                             |   | 68, 444                 |                |
|                | Allowable bad debts for dual eligible beneficiaries (see in  | nstructions)                |   | 38, 293                 |                |
|                | Subtotal (sum of lines 22 and 24)  |                             |   | 9, 327, 681             |                |
| 27.00          | Direct graduate medical education payments (see instruction  | าร)                         |   | 0                       |                |
| 28.00<br>29.00 | Other pass through costs (see instructions)<br>Outlier payments reconciliation                                       |                             |   | 0                       |                |
| 30.00          | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   |                             |   | 0                       |                |
| 30. 50         | Pioneer ACO demonstration payment adjustment (see instructi  | ons)                        |   | 0                       | 30.50          |
| 30. 98         | Recovery of accel erated depreciation.   |                             |   | 0                       |                |
| 30.99          | Demonstration payment adjustment amount before sequestration   | on                          |   | 0                       |                |
| 31.00<br>31.01 | Total amount payable to the provider (see instructions)<br>Sequestration adjustment (see instructions)               |                             |   | 9, 327, 681<br>186, 554 |                |
|                | Demonstration payment adjustment amount after sequestration  | ı                           |   | 00, 334                 |                |
|                | Interim payments   |                             |   | 9, 232, 517             | 32.00          |
| 33.00          |  |                             |   | 0                       |                |
| 34.00          | Balance due provider/program (line 31 minus lines 31.01, 3'  |                             |   | -91, 390                |                |
| 35.00          | Protested amounts (nonallowable cost report items) in accor<br>§115.2  | rdance with CMS Pub. 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                       |                |
| 51.00          | Outlier reconciliation adjustment amount (see instructions)  | )                           |   | 0                       | 51.00<br>52.00 |
| 52.00<br>53.00 | The rate used to calculate the Time Value of Money<br>Time Value of Money (see instructions)                         |                             |   | 0. 00<br>0              | 1              |
|                | FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 A<br>THE COVID-19 PHE)                                     |                             |   |                         |                |
| 99.00          | Teaching Adjustment Factor for the cost reporting period in  | mediately preceding Februa  | ary 29 2020                                 | 0.000000                | 99.00          |

| Heal th        | Financial Systems  | RAMAPO RIDGE PS            | SYCHI ATRI C                                    | In Lie                                      | u of Form CMS-2       | 2552-10 |
|----------------|--|----------------------------|---|---|-----------------------|---------|
| CALCUL         | ATION OF REIMBURSEMENT SETTLEMENT  |                            | Provider CCN: 31-4019<br>Component CCN: 31-5376 | Period:<br>From 01/01/2023<br>To 12/31/2023 |                       | pared:  |
|                |  |                            | Title XVIII                                     | Skilled Nursing                             | 5/20/2024 11:0<br>PPS | 05 am   |
|                |  |                            |   | Facility                                    | 113                   |         |
|                |  |                            |   | -   |                       |         |
|                |  |                            |   |   | 1.00                  |         |
|                | PART VI - CALCULATION OF REIMBURSEMENT SERVICES                            | SEIILEMEMENI - ALL OIH     | IER HEALTH SERVICES FOR T                       | IILE XVIII PARI A                           | PPS SNF               |         |
|                | PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUC                                    |                            |   |   |                       |         |
| 1.00           | Resource Utilization Group Payment (RU                                     |                            |   |   | 17, 084, 014          |         |
| 2.00           | Routine service other pass through cos                                     |                            |   |   | 0                     | 2.00    |
| 3.00           | Ancillary service other pass through c                                     | osts                       |   |   | 0                     | 3.00    |
| 4.00           | Subtotal (sum of lines 1 through 3)  |                            |   |   | 17, 084, 014          | 4.00    |
|                | COMPUTATION OF NET COST OF COVERED SERV                                    |                            |   | 1   |                       |         |
| 5.00           | Medical and other services (Do not use                                     | this line as vaccine of    | 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, 776, 200           |         |
| 8.00           | Allowable bad debts (see instructions)                                     |                            |   |   | 0                     | 8.00    |
| 9.00           | Reimbursable bad debts for dual eligib                                     |                            | nstructions)                                    |   | 0                     | 9.00    |
| 10.00          | Adjusted reimbursable bad debts (see i                                     | istructions)               |   |   | 0                     | 10.00   |
| 11.00          | Utilization review   | · /                        |   | >   | 0                     | 11.00   |
| 12.00<br>13.00 | Subtotal (sum of lines 4, 5 minus line                                     | s 6 and 7, prus rines i    | ID and II)(see Instructio                       | ns)   | 15, 307, 814          | 12.00   |
| 13.00          | Inpatient primary payer payments<br>OTHER ADJUSTMENTS (SEE INSTRUCTIONS) ( |                            |   |   | 0                     | 13.00   |
| 14.00          | Pioneer ACO demonstration payment adju                                     |                            |   |   | 0                     | 14.00   |
| 14. 50         | Recovery of accelerated depreciation.                                      | stillent (see finstruction | 15)   |   | 0                     | 14. 50  |
| 14.98          | Demonstration payment adjustment amoun                                     | t boforo soquestration     |   |   | 0                     |         |
| 14.99          | Subtotal (see instructions   | berore sequestration       |   |   | 15, 307, 814          |         |
| 15.00          | Sequestration adjustment (see instruct                                     | ons)                       |   |   | 306, 156              |         |
| 15.01          | Demonstration payment adjustment amoun                                     |                            |   |   | 0                     | 15.01   |
| 15. 75         | Sequestration for non-claims based amo                                     |                            |   |   | 0                     | 15. 75  |
| 16.00          | Interim payments   |                            |   |   | 15, 001, 657          |         |
| 17.00          | Tentative settlement (for contractor u                                     | se only)                   |   |   | 0                     |         |
| 18.00          | Balance due provider/program (line 15                                      |                            | )2. 15.75. 16. and 17)                          |   | 1                     | 18.00   |
| 19.00          | Protested amounts (nonallowable cost r                                     |                            |   | 2 chapter 1                                 | 0                     | 19.00   |
|                | §115. 2  |                            |   | 2, 3.100101 1,                              | 0                     |         |

| CALCUL         | Financial Systems RAMAPO RIDGE PS<br>ATION OF REIMBURSEMENT SETTLEMENT  | YCHIATRIC<br>Provider CCN: 31-4019    | Peri od:                         | Worksheet E-3                              |                |
|----------------|---|---------------------------------------|----------------------------------|--|----------------|
|                |   |                                       | From 01/01/2023<br>To 12/31/2023 | Part VII<br>Date/Time Pre<br>5/20/2024 11: |                |
|                |   | Title XIX                             | Hospi tal                        | TEFRA                                      |                |
|                |   |                                       | I npati ent                      | Outpati ent                                |                |
|                |   |                                       | 1.00                             | 2.00                                       |                |
|                | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE   | RVICES FOR TITLES V OR X              | X SERVICES                       |  | -              |
| 1.00           | COMPUTATION OF NET COST OF COVERED SERVICES   |                                       | 91, 077                          |  | 1.00           |
| 2.00           | Medical and other services  |                                       | 91,077                           | 0  | 2.00           |
| 3.00           | Organ acquisition (certified transplant programs only)  |                                       | 0                                | 0  | 3.00           |
| 4.00           | Subtotal (sum of lines 1, 2 and 3)  |                                       | 91, 077                          | 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)   |                                       | 91, 077                          | 0  | 7.00           |
|                | COMPUTATION OF LESSER OF COST OR CHARGES<br>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                                | Ū  | 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          |
| 10.00          | CUSTOMARY CHARGES   | · · · · · · · · · · · · · · · · · · · |                                  |  | 1 4 9 . 0 9    |
| 13.00          | Amount actually collected from patients liable for payment for basis  | or services on a charge               | 0                                | 0  | 13.00          |
| 14.00          | Amounts that would have been realized from patients liable fo   | or navment for services o             |                                  | 0  | 14.00          |
| 14.00          | a charge basis had such payment been made in accordance with  |                                       |                                  | 0  | 14.00          |
| 15.00          | Ratio of line 13 to line 14 (not to exceed 1.000000)  |                                       | 0. 000000                        | 0.000000                                   | 15.00          |
| 16.00          | Total customary charges (see instructions)  |                                       | 0                                | 0  | 16.00          |
| 17.00          | Excess of customary charges over reasonable cost (complete or   | nly if line 16 exceeds                | 0                                | 0  | 17.00          |
| 10.00          | line 4) (see instructions)  |                                       | 01 077                           | 0  | 10.00          |
| 18.00          | Excess of reasonable cost over customary charges (complete or 16) (see instructions)                                  | ily if line 4 exceeds line            | e 91, 077                        | 0  | 18.00          |
| 19.00          | Interns and Residents (see instructions)  |                                       | 0                                | 0  | 19.00          |
| 20.00          | Cost of physicians' services in a teaching hospital (see inst   | tructions)                            | 0                                | 0  |                |
| 21.00          | Cost of covered services (enter the lesser of line 4 or line  |                                       | 0                                | 0  | •              |
|                | PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be   | e completed for PPS provid            | ders.                            |  |                |
| 22.00          | Other than outlier payments   |                                       | 0                                | 0  | 22.00          |
| 23.00          | Outlier payments  |                                       | 0                                | 0  |                |
| 24.00          | Program capital payments  |                                       | 0                                |  | 24.00<br>25.00 |
| 25.00<br>26.00 | Capital exception payments (see instructions)<br>Routine and Ancillary service other pass through costs               |                                       | 0                                | 0  | •              |
| 27.00          | Subtotal (sum of lines 22 through 26)   |                                       | 0                                | 0  | •              |
| 28.00          | Customary charges (title V or XIX PPS covered services only)  |                                       | 0                                | 0  | 28.00          |
| 29.00          | Titles V or XIX (sum of lines 21 and 27)  |                                       | 0                                | 0  | 29.00          |
|                | COMPUTATION OF REIMBURSEMENT SETTLEMENT   |                                       |                                  |  |                |
| 30.00          | Excess of reasonable cost (from line 18)  |                                       | 91, 077                          | 0  | 30.00          |
| 31.00          | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6   | 5)                                    | 0                                | 0  |                |
| 32.00          | Deducti bl es   |                                       | 0                                | 0  |                |
| 33.00          | Coinsurance<br>Allowable bad debts (see instructions)   |                                       | 0                                | 0  |                |
| 35.00          | Utilization review  |                                       | 0                                | 0  | 35.00          |
| 36.00          | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 ar   | nd 33)                                | 0                                | 0  | •              |
| 37.00          | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  | -                                     | 0                                | 0  | 37.00          |
| 38.00          | Subtotal (line 36 ± line 37)  |                                       | 0                                | 0  | 38.00          |
| 39.00          | Direct graduate medical education payments (from Wkst. E-4)   |                                       | 0                                |  | 39.00          |
| 40.00          | Total amount payable to the provider (sum of lines 38 and 39)   |                                       | 0                                | 0  |                |
| 41.00          | Interim payments<br>Relance due provider/program (line 40 minus line 41)  |                                       | 0                                | 0  | •              |
| 42.00          | Balance due provider/program (line 40 minus line 41)<br>Protested amounts (nonallowable cost report items) in accorda | ance with CMS Pub 15-2                | 0                                | 0  |                |
| 43.00          |   |                                       |                                  |  |                |

| CALCULATION OF REIMBURSEMENT SETTLEMENT |   | Provider CCN: 31-4019<br>Component CCN: 31-5376 | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet E-3<br>Part VII      |     |
|---|---|---|---|--------------------------------|-----|
|   |   | •   |   | Date/Time Pre<br>5/20/2024 11: | 05  |
|   |   | Title XIX                                       | Skilled Nursing<br>Facility                 | Cost                           |     |
|   |   |   | I npati ent                                 | Outpati ent                    |     |
|   | PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF  | WICES END TITLES V OD V                         | 1.00  | 2.00                           | -   |
|   | COMPUTATION OF NET COST OF COVERED SERVICES   | WICES FOR TITLES V OR A                         | IN JERVICES                                 |                                | 1   |
| 00                                      | Inpati ent hospi tal /SNF/NF services   |   | 0   |                                | 1 1 |
| 00                                      | Medical and other services  |   |   | 0                              |     |
| 00                                      | Organ acquisition (certified transplant programs only)  |   | 0   |                                |     |
| 00                                      | Subtotal (sum of lines 1, 2 and 3)  |   | 0   | 0                              | 4   |
| 00                                      | Inpatient primary payer payments  |   | 0   |                                | 5   |
| 00                                      | Outpatient primary payer payments   |   |   | 0                              |     |
| 00                                      | Subtotal (line 4 less sum of lines 5 and 6)   |   | 0   | 0                              |     |
|   | COMPUTATION OF LESSER OF COST OR CHARGES  |   |   |                                |     |
|   | Reasonabl e Charges   |   |   |                                | 1.  |
| 00                                      | Routine service charges   |   | 0   | ~                              | 8   |
| 00                                      | Ancillary service charges   |   | 0   | 0                              |     |
| 00<br>00                                | Organ acquisition charges, net of revenue   |   | 0   |                                | 1(  |
| 00                                      | Incentive from target amount computation  |   | 0   | 0                              |     |
| 00                                      | Total reasonable charges (sum of lines 8 through 11)<br>CUSTOMARY CHARGES   |   | 0   | 0                              | 1 1 |
| 00                                      | Amount actually collected from patients liable for payment for  | services on a charge                            | 0   | 0                              | 1:  |
| 00                                      | basi s  | services on a charge                            | Ŭ   | 0                              |     |
| 00                                      | Amounts that would have been realized from patients liable for  | payment for services o                          | n 0   | 0                              | 14  |
|   | a charge basis had such payment been made in accordance with  |   |   |                                |     |
| 00                                      | Ratio of line 13 to line 14 (not to exceed 1.000000)  | 0. 000000                                       | 0.000000                                    | 1!                             |     |
| 00                                      | Total customary charges (see instructions)  | 0   | 0   | 10                             |     |
| 00                                      | Excess of customary charges over reasonable cost (complete onl  | 0   | 0   | 1                              |     |
|   | line 4) (see instructions)  |   |   |                                |     |
| 00                                      | Excess of reasonable cost over customary charges (complete onl  | y if line 4 exceeds lin                         | e 0   | 0                              | 18  |
| ~~                                      | 16) (see instructions)  |   | 0   | 0                              | 1   |
| 00                                      | Interns and Residents (see instructions)  |   | 0   | 0                              |     |
| 00<br>00                                | Cost of physicians' services in a teaching hospital (see instructs of covered services (onter the lasser of line 4 or line 2)   |   | 0   | 0                              |     |
| 00                                      | Cost of covered services (enter the lesser of line 4 or line 7<br>PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be |   |   | 0                              | 2   |
| 00                                      | Other than outlier payments   |   | 0   | 0                              | 2   |
| 00                                      | Outlier payments  |   | 0   | 0                              |     |
| 00                                      | Program capital payments  |   | 0   | 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                              | 2   |
| 00                                      | Customary charges (title V or XIX PPS covered services only)  |   | 0   | 0                              | 28  |
| 00                                      | Titles V or XIX (sum of lines 21 and 27)  |   | 0   | 0                              | 29  |
|   | COMPUTATION OF REIMBURSEMENT SETTLEMENT   |   |   |                                |     |
| 00                                      | Excess of reasonable cost (from line 18)  |   | 0   | 0                              | 30  |
| 00                                      | Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  | )   | 0   | 0                              |     |
|   | Deductibles   |   | 0   | 0                              |     |
| 00                                      | Coinsurance   |   | 0   | 0                              |     |
| 00                                      | Allowable bad debts (see instructions)  |   | 0   | 0                              |     |
| 00                                      | Utilization review  | 4 22)   | 0   | -                              | 3!  |
| 00                                      | Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and  | 0   | 0   |                                |     |
| 00                                      | OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  | 0   | 0   |                                |     |
| 00                                      | Subtotal (line 36 ± line 37)<br>Direct graduate modical education navmonts (from Wkst E 4)                                      | 0   | 0   | 3                              |     |
| 00<br>00                                | Direct graduate medical education payments (from Wkst. E-4)<br>Total amount payable to the provider (sum of lines 38 and 39)    | 0   | 0   |                                |     |
| 00                                      |   |   | 0   | 0                              |     |
| 00                                      | Interim payments<br>Balance due provider/program (line 40 minus line 41)  |   | 0   | 0                              |     |
| 00                                      | Protested amounts (nonallowable cost report items) in accordar  | ace with CMS Pub 15-2                           | 0   | 0                              |     |
| 00                                      | chapter 1, §115.2   | iss with own tub 15-2,                          | 0   | 0                              | 1 * |

|              | E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column | Provider C                   |                          | Period:<br>From 01/01/2023 | Worksheet G                    |      |
|--------------|---|------------------------------|--------------------------|----------------------------|--------------------------------|------|
| ly)          | ype accounting records, complete the General Fund column  |                              |                          | o 12/31/2023               | Date/Time Pre<br>5/20/2024 11: |      |
|              |   | General Fund                 | Specific<br>Purpose Fund | Endowment Fund             | Plant Fund                     |      |
|              | CURRENT ASSETS  | 1.00                         | 2.00                     | 3.00                       | 4.00                           |      |
| 00           | Cash on hand in banks   | 18, 926, 006                 | 0                        | 0 0                        | 0                              | 1    |
| 00           | Temporary investments   | 998                          | ( C                      | -                          | 0                              |      |
| 00           | Notes receivable  | 2, 940, 593                  | C                        | -                          | 0                              |      |
| 00           | Accounts receivable   | 7, 493, 149                  | 0                        | -                          | 0                              |      |
| 00<br>00     | Other receivable<br>Allowances for uncollectible notes and accounts receivable                                  | 5, 212, 866<br>-71, 522      |                          | -                          | 0                              |      |
| 00           | Inventory   | 363, 129                     |                          | -                          | 0                              | 1 7  |
| 00           | Prepaid expenses  | 2, 407, 259                  |                          | -                          | 0                              |      |
| 00           | Other current assets  | 1, 035, 051                  | ( C                      | 0                          | 0                              | 9    |
| 00           | Due from other funds  | 0                            | C                        | 0 0                        | 0                              | 10   |
| . 00         | Total current assets (sum of lines 1-10)  | 38, 307, 529                 | (                        | 0 0                        | 0                              | 11   |
| 00           | FIXED ASSETS  | 000.000                      |                          |                            |                                | 1.1. |
| 00           | Land<br>Land improvements   | 992, 033<br>4, 973, 237      |                          |                            | 0                              |      |
|              | Accumulated depreciation  | -2, 659, 546                 |                          |                            | 0                              |      |
|              | Buildings   | 260, 489, 227                |                          |                            | 0                              |      |
|              | Accumulated depreciation  | -65, 630, 751                |                          | -                          | 0                              |      |
| . 00         | Leasehold improvements  | 0                            | 0                        | 0 0                        | 0                              | 17   |
|              | Accumulated depreciation  | 0                            | C                        | 0 0                        | 0                              |      |
|              | Fixed equipment   | 0                            | c c                      |                            | 0                              |      |
|              | Accumulated depreciation  | 0                            | 0                        | -                          | 0                              |      |
|              | Automobiles and trucks  | 3, 183, 261                  | 0                        |                            | 0                              |      |
|              | Accumulated depreciation<br>Major movable equipment   | -2, 926, 204<br>37, 581, 831 |                          |                            | 0                              |      |
|              | Accumulated depreciation  | -36, 458, 756                |                          | -                          | 0                              |      |
|              | Mi nor equipment depreciable  | 00, 400, 700                 |                          |                            | 0                              |      |
|              | Accumul ated depreciation   | 0                            |                          | -                          | 0                              |      |
|              | HIT designated Assets   | 0                            | C                        | 0                          | 0                              | 27   |
| . 00         | Accumulated depreciation  | 0                            | ( C                      | 0                          | 0                              | 28   |
|              | Minor equipment-nondepreciable  | 0                            | C                        |                            | 0                              |      |
| . 00         | Total fixed assets (sum of lines 12-29)   | 199, 544, 332                | 0                        | 0 0                        | 0                              | 30   |
| 00           | OTHER ASSETS  | 21 250 5/1                   | 0                        | 0                          | 0                              | 1    |
| . 00<br>. 00 | Investments<br>Deposits on Leases   | 21, 258, 561<br>130, 101     |                          |                            | 0                              |      |
| . 00         | Due from owners/officers  | 130, 101                     |                          |                            | 0                              |      |
| . 00         | Other assets  | 34, 166, 609                 |                          | 0                          | 0                              |      |
| . 00         | Total other assets (sum of lines 31-34)   | 55, 555, 271                 | 0                        | 0 0                        | 0                              | 35   |
| . 00         | Total assets (sum of lines 11, 30, and 35)  | 293, 407, 132                | C                        | 0                          | 0                              | 36   |
|              | CURRENT LI ABI LI TI ES   |                              |                          |                            |                                |      |
|              | Accounts payable  | 6, 732, 645                  | 0                        |                            | 0                              |      |
| . 00         | Salaries, wages, and fees payable   | 7, 858, 736                  |                          |                            | 0                              |      |
|              | Payroll taxes payable<br>Notes and Loans payable (short term)   | 4, 808, 541<br>2, 614, 753   |                          | 0                          | 0                              |      |
|              | Deferred income   | 83, 833, 006                 |                          |                            | 0                              |      |
| . 00         | Accel erated payments   | 03, 033, 000                 |                          |                            | 0                              | 42   |
|              | Due to other funds  | 0                            | C                        | 0                          | 0                              |      |
| . 00         | Other current liabilities   | 2, 506, 642                  | ( C                      | 0                          | 0                              | 44   |
| . 00         | Total current liabilities (sum of lines 37 thru 44)   | 108, 354, 323                | 0                        | 0 0                        | 0                              | 45   |
|              | LONG TERM LIABILITIES   |                              |                          |                            |                                | Ι.   |
| . 00         | Mortgage payable  | 135, 585, 858                |                          | 0                          | 0                              |      |
| . 00         | Notes payable   | 202, 671                     |                          | 0                          | 0                              |      |
| 00           | Unsecured Loans<br>Other Long term Liabilities  |                              |                          |                            | 0                              |      |
|              | Total long term liabilities (sum of lines 46 thru 49)   | 135, 788, 529                |                          | 0                          | 0                              |      |
|              | Total liabilities (sum of lines 45 and 50)  | 244, 142, 852                |                          | -                          | 0                              |      |
|              | CAPITAL ACCOUNTS  |                              |                          |                            |                                |      |
| 00           | General fund balance  | 49, 264, 280                 |                          |                            |                                | 52   |
| 00           | Specific purpose fund   |                              | C                        |                            |                                | 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<br>. 00 | Plant fund balance - invested in plant<br>Plant fund balance - reserve for plant improvement,                   |                              |                          |                            | 0                              |      |
| . 00         | replacement, and expansion  |                              |                          |                            | 0                              | 50   |
|              | Total fund balances (sum of lines 52 thru 58)   | 49, 264, 280                 | 0                        | 0                          | 0                              | 59   |
| . 00         |   |                              |                          |                            |                                |      |

| Health Financial Systems  | RAMAPO RIDGE PS | SYCHI ATRI C          |          | In Li                                       | eu of Form CMS-2 | 552-10                                    |
|---|-----------------|-----------------------|----------|---|------------------|---|
| STATEMENT OF CHANGES IN FUND BALANCES   |                 | Provider CCN: 31-4019 |          | Period:<br>From 01/01/2023<br>To 12/31/2023 |                  |   |
|   | General         | Fund                  | Speci al | Purpose Fund                                | Endowment Fund   |   |
|   | 1.00            | 2.00                  | 2.00     | 1.00  | 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)                                |                 | -12, 193              |          |   |                  | 2.00                                      |
| 3.00 Total (sum of line 1 and line 2)   |                 | 49, 264, 280          |          |   |                  | 3.00                                      |
| 4.00 Additions (credit adjustments) (specify)                                   | 0               |                       |          | 0   | 0                | 4.00                                      |
| 5. 00 ROUNDI NG<br>6. 00  | 0               |                       |          | 0   | 0                | 5.00<br>6.00                              |
| 7.00  | 0               |                       |          | 0   | 0                | 7.00                                      |
| 8.00  | 0               |                       |          | 0   | 0                | 8.00                                      |
| 9.00  | 0               |                       |          | 0   | 0                | 9.00                                      |
| 10.00 Total additions (sum of line 4-9)   |                 | 0                     |          | (   | D I              | 10.00                                     |
| 11.00 Subtotal (line 3 plus line 10)  |                 | 49, 264, 280          |          | (   |                  | 11.00                                     |
| 12.00 Deductions (debit adjustments) (specify)<br>13.00                         | 0               |                       |          | 0   | 0                | 12.00<br>13.00                            |
| 14.00   | 0               |                       |          | 0   | 0                | 13.00                                     |
| 15.00   | 0               |                       |          | 0   | 0                | 15.00                                     |
| 16.00   | 0               |                       |          | 0   | 0                | 16.00                                     |
| 17.00   | 0               |                       |          | 0   | 0                | 17.00                                     |
| 18.00 Total deductions (sum of lines 12-17)                                     |                 | 0                     |          |   |                  | 18.00                                     |
| 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18)   |                 | 49, 264, 280          |          | (   | D                | 19.00                                     |
|   | Endowment Fund  | PI ant                | Fund     |   |                  |   |
|   | 6.00            | 7.00                  | 8.00     |   |                  |   |
| 1.00 Fund balances at beginning of period                                       | 0               | 7.00                  | 0.00     | 0   |                  | 1.00                                      |
| 2.00 Net income (loss) (from Wkst. G-3, line 29)                                |                 |                       |          |   |                  | 2.00                                      |
| 3.00 Total (sum of line 1 and line 2)   | 0               |                       |          | 0   |                  | 3.00                                      |
| 4.00 Additions (credit adjustments) (specify)                                   |                 | 0                     |          |   |                  | 4.00                                      |
| 5. 00 ROUNDI NG<br>6. 00  |                 | 0                     |          |   |                  | 5.00<br>6.00                              |
| 7.00  |                 | 0                     |          |   |                  | 7.00                                      |
| 8.00  |                 | 0                     |          |   |                  | 8.00                                      |
| 9.00  |                 | 0                     |          |   |                  | 9.00                                      |
| 10.00 Total additions (sum of line 4-9)   | 0               |                       |          | 0   |                  | 10.00                                     |
| 11.00 Subtotal (line 3 plus line 10)  | 0               | 0                     |          | 0   |                  | 11.00                                     |
| 12.00 Deductions (debit adjustments) (specify)                                  |                 | 0                     |          |   |                  | 12.00<br>13.00                            |
| 13 00   |                 |                       |          |   |                  |   |
| 13.00<br>14.00  |                 | 0                     |          |   |                  | 14.00                                     |
|   |                 |                       |          |   |                  |   |
| 14.00<br>15.00<br>16.00   |                 | 0                     |          |   |                  | 14. 00<br>15. 00<br>16. 00                |
| 14.00<br>15.00<br>16.00<br>17.00  |                 | 0                     |          |   |                  | 14. 00<br>15. 00<br>16. 00<br>17. 00      |
| 14.00<br>15.00<br>16.00<br>17.00<br>18.00 Total deductions (sum of lines 12-17) | 0               | 0                     |          | 0   |                  | 14.00<br>15.00<br>16.00<br>17.00<br>18.00 |
| 14.00<br>15.00<br>16.00<br>17.00  | 0<br>0          | 0                     |          | 0<br>0                                      |                  | 14. 00<br>15. 00<br>16. 00<br>17. 00      |

|                | Financial Systems RAMAPO RIDGE PS<br>IENT OF PATIENT REVENUES AND OPERATING EXPENSES | RAMAPO RIDGE PSYCHIATRIC<br>Provider CCN: 31-4019 |             |        |                                    | eu of Form CMS-2552-1<br>Worksheet G-2                          |                |
|----------------|--|---|-------------|--------|------------------------------------|---|----------------|
| STATEN         | IENT OF PATTENT REVENUES AND OPERATING EXPENSES                                      | Provi der Co                                      | LN: 31-4019 |        | 10d:<br>m 01/01/2023<br>12/31/2023 | Worksneet G-2<br>Parts I & II<br>Date/Time Pre<br>5/20/2024 11: | pared:         |
|                | Cost Center Description  |   | Inpati ent  |        | Outpatient                         | Total   |                |
|                |  |   | 1.00        |        | 2.00                               | 3.00  |                |
|                | PART I - PATIENT REVENUES  |   |             |        |                                    |   | -              |
| 1 00           | General Inpatient Routine Services   |   | 25 (14 5    | 02     |                                    | 25 (14 502  | 1 1 00         |
| 1.00<br>2.00   | Hospital<br>SUBPROVIDER - IPF  |   | 25, 614, 5  | 03     |                                    | 25, 614, 503  | 1.00           |
| 2.00           | SUBPROVIDER - IRF  |   |             |        |                                    |   | 3.00           |
| 4.00           | SUBPROVI DER   |   |             |        |                                    |   | 4.00           |
| 5.00           | Swing bed - SNF  |   |             | 0      |                                    | 0   |                |
| 6.00           | Swing bed - NF   |   |             | 0      |                                    | 0   |                |
| 7.00           | SKILLED NURSING FACILITY   |   | 39, 230, 2  | 219    |                                    | 39, 230, 219  |                |
| 8.00           | NURSING FACILITY   |   | 8, 597, 5   |        |                                    | 8, 597, 574   | 8.00           |
| 9.00           | OTHER LONG TERM CARE   |   | 8, 158, 7   | '99    |                                    | 8, 158, 799   | 9.00           |
| 10.00          | Total general inpatient care services (sum of lines 1-9)                             |   | 81, 601, C  | 95     |                                    | 81, 601, 095  | 10.00          |
|                | Intensive Care Type Inpatient Hospital Services                                      |   |             |        |                                    |   | 1              |
| 11.00          | I NTENSI VE CARE UNI T   |   |             |        |                                    |   | 11.00          |
| 12.00          | CORONARY CARE UNI T  |   |             |        |                                    |   | 12.00          |
| 13.00          | BURN INTENSIVE CARE UNIT   |   |             |        |                                    |   | 13.00          |
| 14.00          | SURGICAL INTENSIVE CARE UNIT   |   |             |        |                                    |   | 14.00          |
| 15.00          | OTHER SPECIAL CARE (SPECIFY)   |   |             |        |                                    |   | 15.00          |
| 16.00          | Total intensive care type inpatient hospital services (sum o                         | flines  |             | 0      |                                    | 0   | 16.00          |
|                | 11-15)   |   |             |        |                                    |   | 1              |
| 17.00          | Total inpatient routine care services (sum of lines 10 and 10                        | 5)  | 81, 601, 0  |        | ( 000 700                          | 81, 601, 095  |                |
| 18.00          | Ancillary services<br>Outpatient services  |   | 10, 998, 8  |        | 6, 089, 788                        | 17, 088, 629  |                |
| 19.00<br>20.00 | RURAL HEALTH CLINIC  |   |             | 0<br>0 | 0                                  | 0   |                |
| 20.00          | FEDERALLY QUALIFIED HEALTH CENTER  |   |             | 0      | 0                                  | 0   |                |
| 21.00          | HOME HEALTH AGENCY   |   |             | 0      | 0                                  | 0   | 21.00          |
| 22.00          | AMBULANCE SERVICES   |   |             |        |                                    |   | 23.00          |
| 24.00          | CMHC   |   |             |        |                                    |   | 24.00          |
| 25.00          | AMBULATORY SURGICAL CENTER (D. P. )  |   |             |        |                                    |   | 25.00          |
| 26.00          | HOSPICE  |   |             |        |                                    |   | 26.00          |
| 27.00          | OTHER PATIENT REVENUE  |   | 9, 851, 3   | 360    | 0                                  | 9, 851, 360   | 27.00          |
| 28.00          | Total patient revenues (sum of lines 17-27)(transfer column 3                        | 3 to Wkst.  | 102, 451, 2 | 96     | 6, 089, 788                        | 108, 541, 084   | 28.00          |
|                | G-3, line 1)   |   |             |        |                                    |   |                |
|                | PART II - OPERATING EXPENSES   |   |             |        | 1                                  |   |                |
| 29.00          | Operating expenses (per Wkst. A, column 3, line 200)                                 |   |             |        | 113, 514, 777                      |   | 29.00          |
| 30.00          | ADD (SPECI FY)   |   |             | 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<br>36.00 | Total additions (sum of lines 20.25)   |   |             | 0      | 0                                  |   | 35.00<br>36.00 |
| 37.00          | Total additions (sum of lines 30-35)<br>DEDUCT (SPECIFY)                             |   |             | 0      | 0                                  |   | 37.00          |
| 37.00          |  |   |             | 0      |                                    |   | 37.00          |
| 39.00          |  |   |             | 0      |                                    |   | 39.00          |
| 40.00          |  |   |             | 0      |                                    |   | 40.00          |
| 41.00          |  |   |             | 0      |                                    |   | 41.00          |
| 42.00          | Total deductions (sum of lines 37-41)  |   |             | Ŭ      | 0                                  |   | 42.00          |
| 43.00          | Total operating expenses (sum of lines 29 and 36 minus line -                        | 42)(transfer                                      |             |        | 113, 514, 777                      |   | 43.00          |
|                | to Wkst. G-3, line 4)  |   |             | 1      |                                    |   |                |

| Heal th  | Financial Systems                        | RAMAPO RIDGE PS      | YCHI ATRI C  |  | In Lie                                      | u of Form CMS-2                                 | 2552-10 |
|--|--|----------------------|--------------|--|---|---|---------|
| STATEMENT OF REVENUES AND EXPENSES Provider CCN: 31-4019 Period From 0 |  |                      |              |  | Period:<br>From 01/01/2023<br>To 12/31/2023 | Worksheet G-3<br>Date/Time Pre<br>5/20/2024 11: |         |
|  |  |                      |              |  | -   | 1.00  |         |
| 1.00   | Total patient revenues (from Wkst. G-2,  | Part L column 3 lin  | e 28)        |  |   | 108, 541, 084                                   | 1.00    |
| 2.00   | Less contractual allowances and discount |                      |              |  |   | 19, 660, 232                                    | 2.00    |
| 3.00   | Net patient revenues (line 1 minus line  | •                    |              |  |   | 88, 880, 852                                    | 3.00    |
| 4.00   | Less total operating expenses (from Wkst | G-2, Part II, line   | 43)          |  |   | 113, 514, 777                                   | 4.00    |
| 5.00   | Net income from service to patients (lin | e 3 minus line 4)    | ,            |  |   | -24, 633, 925                                   | 5.00    |
|  | OTHER INCOME                             |                      |              |  |   |   |         |
| 6.00   | Contributions, donations, bequests, etc  |                      |              |  |   | 3, 841, 026                                     | 6.00    |
| 7.00   | Income from investments                  |                      |              |  |   | 839, 568  | 7.00    |
| 8.00   | Revenues from telephone and other miscel | aneous communication | servi ces    |  |   | 0   | 8.00    |
| 9.00   | Revenue from television and radio servic | 9                    |              |  |   | 22, 400   | 9.00    |
| 10.00  | Purchase di scounts                      |                      |              |  |   | 0   | 10.00   |
| 11.00  | Rebates and refunds of expenses          |                      |              |  |   | 50, 545   | 11.00   |
| 12.00  |  |                      |              |  |   | 0   | 12.00   |
| 13.00  | Revenue from laundry and linen service   |                      |              |  |   | 0   | 13.00   |
| 14.00  | Revenue from meals sold to employees and | guests               |              |  |   | 57, 383   | 14.00   |
| 15.00  | Revenue from rental of living quarters   |                      |              |  |   | 0   | 15.00   |
| 16.00  | Revenue from sale of medical and surgica | supplies to other t  | han patients |  |   | 0   | 16.00   |
| 17.00  | Revenue from sale of drugs to other than |                      |              |  |   | 0   | 17.00   |
| 18.00  | Revenue from sale of medical records and | abstracts            |              |  |   | 8, 044  | 18.00   |
| 19.00  | Tuition (fees, sale of textbooks, unifor | ns, etc.)            |              |  |   | 0   | 19.00   |
| 20.00  | Revenue from gifts, flowers, coffee shop | s, and canteen       |              |  |   | 546, 886  | 20.00   |
| 21.00  |  |                      |              |  |   | 0   | 21.00   |
| 22.00  | Rental of hospital space                 |                      |              |  |   | 102, 812  | 22.00   |
| 23.00  | Governmental appropriations              |                      |              |  |   | 0   | 23.00   |
| 24.00  | BARBER BEAUTY                            |                      |              |  |   | 207, 548  | 24.00   |
| 24.01  | MI SCELLANEOUS                           |                      |              |  |   | 1, 020, 318                                     | 24.01   |
| 24.02  | INDEPENDENT LIVING                       |                      |              |  |   | 15, 155, 911                                    | 24.02   |
| 24.50  | COVI D-19 PHE Fundi ng                   |                      |              |  |   | 2, 769, 291                                     | 24.50   |
| 25.00  | Total other income (sum of lines 6-24)   |                      |              |  |   | 24, 621, 732                                    | 25.00   |
| 26.00  | Total (line 5 plus line 25)              |                      |              |  |   | -12, 193  | 26.00   |
| 27.00  | OTHER EXPENSES (SPECIFY)                 |                      |              |  |   | 0   | 27.00   |
| 28.00  | Total other expenses (sum of line 27 and | subscripts)          |              |  |   | 0   | 28.00   |
| 29.00  | Net income (or loss) for the period (lin | e 26 minus line 28)  |              |  |   | -12, 193  | 29.00   |