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

FORM APPROVED OMB NO. 0938-0463 EXPIRES: 12/31/2021

CARE ONE AT MADISON AVENUE Period:	Run Date Time:	5/28/2025 2:59 pm
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From: 01/01/2024 MCRIF32 **2540-10**Provider CCN: 315488 To: 12/31/2024 Version: 11.1.179.1



SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

Worksheet S Parts I, II & III

PART I - COST	REPORT STATUS	
Provider	[X] Electronically prepared cost report	Date: Time:
use only	2. [] Manually prepared cost report	
	3. [0] If this is an amended report enter the number of times the provider resubmitted the	is cost report.
	3.01. No Medicare Utilization. Enter "Y" for yes or leave blank for no.	
Contractor	4. [1] Cost Report Status	6. Contractor No.:
use only:	(1) As Submitted	7. [] First Cost Report for this Provider CCN
	(2) Settled without audit	8. [] Last Cost Report for this Provider CCN
	(3) Settled with audit	9. NPR Date:
	(4) Reopened	10. If line 4, column 1 is "4": Enter number of times reopened 0
	(5) Amended	11. Contractor Vendor Code: 4
	5. Date Received:	12. [F] Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no utilization.

PART II - CERTIFICATION OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF FACILITY

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ___CARE ONE AT MADISON AVENUE, 315488 __{1000} {Provider Name(s)} and CCN(s)} for the cost reporting period beginning ___01/01/2024 ____ and ending ___12/31/2024 ____ and that to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATUI	RE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX 2	ELECTRONIC SIGNATURE STATEMENT	
1		David Baruch		I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	DAVID BARUCH			2
3	Signatory Title	AUTHORIZED SIGNOR			3
4	Signature Date	(Dated when report is electronically signed.)			4
PART	III - SETTLEMENT SI	IMMARY			

IANI	III - SETTLEMENT SUMMART					
			Title 2	XVIII		
	Cost Center Description	Title V	Part A	Part B	Title XIX	
		1.00	2.00	3.00	4.00	
1.00	SKILLED NURSING FACILITY	0	-8,986	-60	0	1.00
2.00	NURSING FACILITY	0			0	2.00
3.00	ICF/IID				0	3.00
4.00	SNF - BASED HHA I	0	0	0		4.00
5.00	SNF - BASED RHC I	0		0		5.00
6.00	SNF - BASED FQHC I	0		0		6.00
7.00	SNF - BASED CMHC I	0		0		7.00
100.00	TOTAL	0	-8,986	-60	0	100.00

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 valid OMB control number for this information collection is 0938-0463. The time required to complete this information collection is estimated 202 hours per response, including the time to review instructions, search existing data 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 this 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, 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.

To:

12/31/2024 Version:

11.1.179.1

CARE ONE AT MADISON AVENUE

Period:
From: 01/01/2024
Run Date Time: 5/28/2025 2:59 pm
ACRIF32

2540-10



SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX INDENTIFICATION DATA

Provider CCN:

315488

Worksheet S-2 Part I

	l Nursing	Facility and Skilled Nursing Facility Comp	olex Address:								
1.00	Street:	151 MADISON AVENUE		P.O. Box:							1.0
2.00	City:	MORRISTOWN		State:	NJ	ZII	Code: 07960				2.0
3.00	County:	MORRIS		CBSA Code:	3508	4 Url	oan / Rural:	U			3.0
3.01	CBSA on	/after October 1 of the Cost Reporting Period	(if applicable)				<u>'</u>				3.0
SNF a	nd SNF-I	Based Component Identification:		•							
								Payme	ent System (P, O	, or N)	
		Component	Co	omponent Name		Provider CCN	Date Certified	V	XVIII	XIX	
				1.00		2.00	3.00	4.00	5.00	6.00	
4.00	SNF		CARE ONE AT M	IADISON AVENU	JE	315488	01/04/2005	N	P	N	4.0
5.00	Nursing I	•									5.0
5.00	ICF/IID						_				6.0
7.00	SNF-Bas										7.0
8.00	SNF-Bas										8.0
9.00 10.00		ed FQHC ed CMHC									9.0
11.00	SNF-Bas										11.0
12.00		ed HOSPICE									12.0
13.00	SNF-Bas										13.0
-5.50	Dasi					F	rom:		To:		15.0
							.00		2.00		
14.00	Cost Rep	orting Period (mm/dd/yyyy)				01/0	1/2024		12/31/202	4	14.0
15.00		Control (See Instructions)			4 - 1	Proprietary, Con	poration				15.0
	-/1					1 7	1			Y/N	
										1.00	
Type	of Freesta	nding Skilled Nursing Facility								1	
16.00	Is this a c	listinct part skilled nursing facility that meets the	e requirements set forth in	42 CFR section 483	3.5?					Y	16.0
17.00	Is this a c	composite distinct part skilled nursing facility the	at meets the requirements	set forth in 42 CER						N.T.	
				set forth in 42 Cr K	section 483.	5?				N	17.0
18.00		any costs included in Worksheet A that resulte	ed from transactions with r				1, chapter 10? If ye	s, complete V	Vorksheet	Y	17.0
18.00	Are there A-8-1.	any costs included in Worksheet A that resulte	ed from transactions with r				1, chapter 10? If ye	s, complete V	Vorksheet		
	A-8-1.	any costs included in Worksheet A that resulte	ed from transactions with r				1, chapter 10? If ye	s, complete V	Worksheet		
Misce 19.00	A-8-1.	Cost Reporting Information a low Medicare utilization cost report, indicate w	with a "Y", for yes, or "N"	elated organizations for no.	as defined in	CMS Pub. 15-		•	Vorksheet	Y N	18.0
Misce 19.00 19.01	A-8-1. Ilaneous C If this is a If line 19	Cost Reporting Information a low Medicare utilization cost report, indicate wis yes, does this cost report meet your contractor.	with a "Y", for yes, or "N" or's criteria for filing a low	elated organizations for no. Medicare utilization	as defined in	CMS Pub. 15-		•	Vorksheet	Y	18.0
Misce 19.00 19.01 Depre	A-8-1. Ilaneous (If this is a If line 19 ciation - I	Cost Reporting Information a low Medicare utilization cost report, indicate w is yes, does this cost report meet your contractor Enter the amount of depreciation reported in	with a "Y", for yes, or "N" or's criteria for filing a low	elated organizations for no. Medicare utilization	as defined in	CMS Pub. 15-		•	Vorksheet	Y N N	19.0 19.0
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Misce 19.00 19.01 Depre 20.00 21.00 22.00	A-8-1. If this is a If line 19 ciation - I Straight I Declining	Cost Reporting Information a low Medicare utilization cost report, indicate wis yes, does this cost report meet your contracted that the amount of depreciation reported in time Balance Medicare Vear's Digits	with a "Y", for yes, or "N" or's criteria for filing a low	elated organizations for no. Medicare utilization	as defined in	CMS Pub. 15-		•	Vorksheet	N N N	19.0 19.0 19.0 4 20.0 0 21.0 0 22.0
Misce 19.00 19.01 Depre 20.00 21.00 22.00 23.00	A-8-1. Il aneous (If this is a If line 19 ciation - I Straight I Declining Sum of the	Cost Reporting Information a low Medicare utilization cost report, indicate was is yes, does this cost report meet your contracted that the amount of depreciation reported in time as Balance me Year's Digits no 20 through 22	with a "Y", for yes, or "N" or's criteria for filing a low n this SNF for the metho	elated organizations for no. Medicare utilization	as defined in	CMS Pub. 15-		•	Vorksheet	Y N N N 855,54	19.0 19.0 19.0 4 20.0 0 21.0 0 22.0 4 23.0
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19.00 19.01 Depre 20.00 21.00 22.00 23.00 24.00 25.00	A-8-1. Ilaneous (If this is a If line 19 ciation - I Straight I Declining Sum of th Sum of li If deprect	Cost Reporting Information a low Medicare utilization cost report, indicate was is yes, does this cost report meet your contracted that the amount of depreciation reported in time as Balance me Year's Digits no 20 through 22 intion is funded, enter the balance as of the ender any disposal of capital assets during the cost is	with a "Y", for yes, or "N" or's criteria for filing a low n this SNF for the metho d of the period. reporting period? (Y/N)	elated organizations for no. Medicare utilization od indicated on Lin	as defined in a cost report, nes 20 - 22.	CMS Pub. 15-		•	Vorksheet	Y N N N 855,54	19.0 19.0 19.0 4 20.0 0 21.0 0 22.0 4 23.0 0 24.0 25.0
Misce 19.00 19.01 Depre 20.00 21.00 22.00 23.00 24.00 25.00 26.00	A-8-1. Ilaneous C If this is a If line 19 ciation - I Straight I Declining Sum of tl Sum of li If deprec Were the Was acce	Cost Reporting Information a low Medicare utilization cost report, indicate was is yes, does this cost report meet your contracted that the amount of depreciation reported in time as Balance me Year's Digits no 20 through 22 diation is funded, enter the balance as of the endere any disposal of capital assets during the cost elerated depreciation claimed on any assets in the	with a "Y", for yes, or "N" or's criteria for filing a low n this SNF for the method d of the period. reporting period? (Y/N) e current or any prior cost	elated organizations for no. Medicare utilization od indicated on Lin reporting period? ()	as defined in a cost report, nes 20 - 22.	CMS Pub. 15-		•	Vorksheet	N N N 855,54	19.0 19.0 19.0 4 20.0 0 21.0 0 22.0 4 23.0 0 24.0 25.0 26.0
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Miscee 19.00 19.01 19.01 Depree 22.00 221.00 223.00 224.00 225.00 27.00 27.00 28.00 If this tq	A-8-1. Ilaneous (If this is a If line 19 ciation - I Straight I Declining Sum of tl Sum of li If deprect Were the Was acce Did you of Was there facility conalifies for	Cost Reporting Information a low Medicare utilization cost report, indicate was is yes, does this cost report meet your contracted that the amount of depreciation reported in the graph of	with a "Y", for yes, or "N" or's criteria for filing a low n this SNF for the method of the period. d of the period. reporting period? (Y/N) e current or any prior cost end of the period to which portion of allowable cost fr	elated organizations for no. Medicare utilization od indicated on Lin reporting period? (n this cost report approm prior cost report	as defined in a cost report, nes 20 - 22. Y/N) plies? (Y/N)	CMS Pub. 15-indicate with a	"Y", for yes, or "N"	Part A	Part B 2.00	N N 855,54 855,54 N N N N Other 3.00 t and type of s	18.0 19.0 19.0 19.0 4 20.0 0 21.0 0 22.0 4 23.0 0 24.0 25.0 26.0 27.0 28.0
Miscee 19.00 19.01 19.01 Depree 22.00 221.00 223.00 224.00 225.00 226.00 27.00 18 this q that q 30.00	A-8-1. Ilaneous (If this is a If line 19 ciation - I Straight I Declining Sum of the Sum of li If deprect Were the Was acce Did you of Was there facility condifies for Skilled N Nursing I	Cost Reporting Information a low Medicare utilization cost report, indicate was is yes, does this cost report meet your contracted that the amount of depreciation reported in the graph of	with a "Y", for yes, or "N" or's criteria for filing a low n this SNF for the method of the period. d of the period. reporting period? (Y/N) e current or any prior cost end of the period to which portion of allowable cost fr	elated organizations for no. Medicare utilization od indicated on Lin reporting period? (n this cost report approm prior cost report	as defined in a cost report, nes 20 - 22. Y/N) plies? (Y/N)	CMS Pub. 15-indicate with a	"Y", for yes, or "N"	Part A 1.00 er "Y" for e	Part B 2.00 ach componen	N N N 855,54 855,54 N N N N Other 3.00	19.0 19.0 19.0 0 21.0 0 22.0 4 23.0 0 24.0 25.0 26.0 27.0 28.0 service
Misce 19.00 19.01 19.01 Depre 220.00 221.00 222.00 224.00 225.00 226.00 27.00 288.00 11f this that q 29.00 30.00 331.00	A-8-1. Ilaneous (If this is a If line 19 ciation - I Straight I Declining Sum of tl Sum of li If deprect Were the Was acce Did you of Was there facility condifies for Skilled N Nursing I ICF/IID	Cost Reporting Information a low Medicare utilization cost report, indicate was is yes, does this cost report meet your contracted that the amount of depreciation reported in the galance me Year's Digits me 20 through 22 mation is funded, enter the balance as of the ending and is for a capital assets during the cost is learned depreciation claimed on any assets in the cease to participate in the Medicare program at the east of the authorization and the cost is a substantial decrease in health insurance proportions a public or non-public provider that in the exemption. The provider of the provider of the exemption.	with a "Y", for yes, or "N" or's criteria for filing a low n this SNF for the method of the period. d of the period. reporting period? (Y/N) e current or any prior cost end of the period to which portion of allowable cost fr	elated organizations for no. Medicare utilization od indicated on Lin reporting period? (n this cost report approm prior cost report	as defined in a cost report, nes 20 - 22. Y/N) plies? (Y/N)	CMS Pub. 15-indicate with a	"Y", for yes, or "N"	Part A 1.00 er "Y" for e	Part B 2.00 ach componen	N N 855,54 855,54 N N N N Other 3.00 t and type of s	19.0 19.0 19.0 19.0 4 20.0 0 21.0 0 22.0 4 23.0 0 24.0 25.0 27.0 28.0 service 29.0 30.0 31.0
Misce 19.00 19.01 Depre 20.00 22.00 22.00 22.00 24.00 25.00 26.00 26.00 30.00 31.00	A-8-1. Ilaneous (If this is a If line 19 ciation - I Straight I Declining Sum of tl Sum of li If deprec Were the Was acce Did you of Was there A sum of li If deprec Skilled N Nursing I ICF/IID SNF-Bass	Cost Reporting Information a low Medicare utilization cost report, indicate was is yes, does this cost report meet your contracted that the amount of depreciation reported in the graph of	with a "Y", for yes, or "N" or's criteria for filing a low n this SNF for the method of the period. d of the period. reporting period? (Y/N) e current or any prior cost end of the period to which portion of allowable cost fr	elated organizations for no. Medicare utilization od indicated on Lin reporting period? (n this cost report approm prior cost report	as defined in a cost report, nes 20 - 22. Y/N) plies? (Y/N)	CMS Pub. 15-indicate with a	"Y", for yes, or "N"	Part A 1.00 er "Y" for e	Part B 2.00 ach componen	N N 855,54 855,54 N N N N Other 3.00 t and type of s	19.0 19.0 19.0 19.0 4 20.0 0 21.0 0 22.0 4 23.0 0 24.0 25.0 27.0 28.0 29.0 30.0 31.0 32.0
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Misce 19.00 19.01 Depre 20.00 22.00 22.00 22.00 22.00 22.00 25.00 26.00 27.00 28.00 30.00 30.00 331.00 332.00 34.00	A-8-1. Ilaneous (If this is a If line 19 ciation - I Straight I Declining Sum of tl Sum of tl If deprec Were the Was acce Did you of Was there Skilled N Nursing I ICF/IID SNF-Bas SNF-Bas SNF-Bas	Cost Reporting Information a low Medicare utilization cost report, indicate was is yes, does this cost report meet your contracted that the amount of depreciation reported in the galance me Year's Digits ne 20 through 22 man and the end of th	with a "Y", for yes, or "N" or's criteria for filing a low n this SNF for the method of the period. d of the period. reporting period? (Y/N) e current or any prior cost end of the period to which portion of allowable cost fr	elated organizations for no. Medicare utilization od indicated on Lin reporting period? (n this cost report approm prior cost report	as defined in a cost report, nes 20 - 22. Y/N) plies? (Y/N)	CMS Pub. 15-indicate with a	"Y", for yes, or "N"	Part A 1.00 er "Y" for e	Part B 2.00 ach componen N	N N 855,54 855,54 N N N N Other 3.00 t and type of s	19.0 19.0 19.0 19.0 19.0 4 20.0 0 21.0 0 22.0 4 23.0 0 24.0 25.0 27.0 28.0 30.0 31.0 32.0 33.0 34.0
Misce 19.00 19.01 Depre 20.00 22.00 22.00 22.00 23.00 25.00 25.00 26.00 30.00 30.00 30.00 33.00 33.00 34.00	A-8-1. Ilaneous (If this is a If line 19 ciation - I Straight I Declining Sum of the Sum of the Sum of the Sum of the Were the Was acce Did you of Was there Skilled N Nursing I ICF/IID SNF-Bas SNF-Bas	Cost Reporting Information a low Medicare utilization cost report, indicate was is yes, does this cost report meet your contracted in the cost of the	with a "Y", for yes, or "N" or's criteria for filing a low n this SNF for the method of the period. d of the period. reporting period? (Y/N) e current or any prior cost end of the period to which portion of allowable cost fr	elated organizations for no. Medicare utilization od indicated on Lin reporting period? (n this cost report approm prior cost report	as defined in a cost report, nes 20 - 22. Y/N) plies? (Y/N)	CMS Pub. 15-indicate with a	"Y", for yes, or "N"	Part A 1.00 er "Y" for e	Part B 2.00 ach componen	N N 855,54 855,54 N N N N Other 3.00 t and type of s	18.0 19.0 19.0 19.0 21.0 0 21.0 0 22.0 4 23.0 25.0 27.0 28.0 28.0 31.0 32.0 33.0 34.0 35.0
Misce 19.00 19.01 19.01 Depre 20.00 21.00 22.00 23.00 24.00 25.00 27.00 28.00	A-8-1. Ilaneous (If this is a If line 19 ciation - I Straight I Declining Sum of the Sum of the Sum of the Sum of the Were the Was acce Did you of Was there Skilled N Nursing I ICF/IID SNF-Bas SNF-Bas	Cost Reporting Information a low Medicare utilization cost report, indicate was is yes, does this cost report meet your contracted that the amount of depreciation reported in the galance me Year's Digits ne 20 through 22 man and the end of th	with a "Y", for yes, or "N" or's criteria for filing a low n this SNF for the method of the period. d of the period. reporting period? (Y/N) e current or any prior cost end of the period to which portion of allowable cost fr	elated organizations for no. Medicare utilization od indicated on Lin reporting period? (n this cost report approm prior cost report	as defined in a cost report, nes 20 - 22. Y/N) plies? (Y/N)	CMS Pub. 15-indicate with a	"Y", for yes, or "N"	Part A 1.00 er "Y" for e	Part B 2.00 ach componen N N	N N 855,54 855,54 N N N N Other 3.00 t and type of s	19.0 19.0 19.0 19.0 19.0 4 20.0 0 21.0 0 22.0 4 23.0 0 24.0 25.0 27.0 28.0 28.0 31.0 32.0 33.0 34.0 35.0
Misce 19.00 19.01 Depre 20.00 22.00 22.00 22.00 23.00 25.00 25.00 26.00 30.00 30.00 30.00 33.00 33.00 34.00	A-8-1. Ilaneous (If this is a If line 19 ciation - I Straight I Declining Sum of the Sum of the Sum of the Sum of the Were the Was acce Did you of Was there Skilled N Nursing I ICF/IID SNF-Bas SNF-Bas	Cost Reporting Information a low Medicare utilization cost report, indicate was is yes, does this cost report meet your contracted in the cost of the	with a "Y", for yes, or "N" or's criteria for filing a low n this SNF for the method of the period. d of the period. reporting period? (Y/N) e current or any prior cost end of the period to which portion of allowable cost fr	elated organizations for no. Medicare utilization od indicated on Lin reporting period? (n this cost report approm prior cost report	as defined in a cost report, nes 20 - 22. Y/N) plies? (Y/N)	CMS Pub. 15-indicate with a	"Y", for yes, or "N"	Part A 1.00 er "Y" for e	Part B 2.00 ach componen N N N Y/N	N N N S55,54 855,54 N N N N N N N Other 3.00 t and type of s	19.0 19.0 19.0 19.0 19.0 4 20.0 0 21.0 0 22.0 4 23.0 0 24.0 25.0 27.0 28.0 28.0 31.0 32.0 33.0 34.0 35.0
Misce 19.00 19.01 Depre 20.00 22.00 22.00 22.00 22.00 25.00 26.00 26.00 30.00 31.00 332.00 333.00 34.00	A-8-1. Ilaneous (If this is a If line 19 ciation - I Straight I Declining Sum of the Sum of the	Cost Reporting Information a low Medicare utilization cost report, indicate was is yes, does this cost report meet your contracted in the cost of the	with a "Y", for yes, or "N" or's criteria for filing a low n this SNF for the method of the period. Treporting period? (Y/N) e current or any prior cost end of the period to which cortion of allowable cost from qualifies for an exemption of the period to which cortion of allowable cost from the period to which cortion of allowable cost from qualifies for an exemption of the period to which cortion of allowable cost from the period to which cortion of allowable cost from the period to which the period	for no. Medicare utilization od indicated on Lin reporting period? (\) a this cost report approm prior cost reportion prior cost reportion from the applic	as defined in a cost report, nes 20 - 22. Y/N) plies? (Y/N) ration of the	indicate with a	"Y", for yes, or "N" osts or charges ent	Part A 1.00 er "Y" for e N	Part B 2.00 ach componen N N	N N 855,54 855,54 N N N N Other 3.00 t and type of s	19.0 19.0 19.0 0 21.0 0 22.0 4 23.0 0 24.0 25.0 26.0 27.0 28.0

SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX INDENTIFICATION DATA

State:

Worksheet S-2 Part I

47.00

COIV	11 1414	NDLIVIII ICATION BATA							PPS
							Y/N		
							1.00	2.00	
39.00	Is the ma	practice a "claims-made" or "occurrence" policy? If the p	policy is "claims-made"	enter 1. If the policy is "occurrence", ent	er 2.		1		39.00
						Premiums	Paid Losses	Self Insurance	
						1.00	2.00	3.00	
41.00	List malp	ractice premiums and paid losses:				1,641	0	0	41.00
								Y/N	
								1.00	
42.00	1 .	ractice premiums and paid losses reported in other than t st centers and amounts.	the Administrative and	General cost center? Enter Y or N. If yes	s, check box, and so	ıbmit supportir	ng schedule	N	42.00
43.00	Are there	any home office costs as defined in CMS Pub. 15-1, Cha	pter 10?					Y	43.00
								Provider CCN	
								1.00	
44.00	If line 43	is yes, enter the home office chain number and enter the	name and address of the	he home office on lines 45, 46 and 47.				HB0206	44.00
If this	facility is	part of a chain organization, enter the name and add	dress of the home offi	ce on the lines below.				•	
45.00	Name:	HEALTHBRIDGE	Contractor Name:	NOVITAS SOLUTIONS	Contractor Nun	nber:	12001		45.00
46.00	Street:	173 BRIDGE PLAZA NORTH	P.O. Box:			•			46.00

NJ

ZIP Code:

07024

41-304

47.00 City:

FORT LEE

From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: 11.1.179.1



SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

Provider CCN:

315488

Worksheet S-2 Part II

Genera	al Instruction: For all column 1 responses enter in column 1, "Y	" for Yes or "N" for	No. For all the da	te responses the form	at will be (m	m/dd/vyvy)			PPS
	leted by All Skilled Nursing Facilities	101 103 01 14 101	140. I of all the da	te responses the form	iat wiii be (iiii	iii/ dd/ yyyy)			
	er Organization and Operation								
							Y/N	Date	
							1.00	2.00	
1.00	Has the provider changed ownership immediately prior to the begin 2. (see instructions)	ning of the cost repor	ting period? If colur	nn 1 is "Y", enter the d	ate of the char	nge in column	N		1.00
						Y/N	Date	V/I	
						1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? 3, "V" for voluntary or "I" for involuntary.	If column 1 is yes, en	ter in column 2 the	date of termination and	d in column	N			2.00
3.00	Is the provider involved in business transactions, including manager medical supply companies) that are related to the provider or its offi directors through ownership, control, or family and other similar rel	cers, medical staff, ma	inagement personne			Y			3.00
						Y/N	Туре	Date	
						1.00	2.00	3.00	
Financ	cial Data and Reports								
4.00	Column 1: Were the financial statements prepared by a Certified Pul Compiled, or "R" for Reviewed. Submit complete copy or enter date				"C" for	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from reconciliation.	those on the filed fina	incial statements? If	column 1 is "Y", subm	iit	N			5.00
							Y/N	Legal Oper.	
							1.00	2.00	
Approv	ved Educational Activities							-	,
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column		legal operator of the	e program? (Y/N)			N	N	6.00
7.00	Were costs claimed for Allied Health Programs? (Y/N) see instruction						N		7.00
8.00	Were approvals and/or renewals obtained during the cost reporting	period for Nursing Sc	thool and/or Allied	Health Program? (Y/N) see instruction	ons.	N	77.67	8.00
								Y/N	
Bad D	ohto							1.00	
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see ins	tructions						Y	9.00
	If line 9 is "Y", did the provider's bad debt collection policy change		ring period? If "V"	submit copy				N	10.00
	If line 9 is "Y", are patient deductibles and/or coinsurance waived?			завине сору.				N	11.00
	omplement	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	×-						
12.00	Have total beds available changed from prior cost reporting period?	If "Y", see instruction	15.					N	12.00
	0 1 01				Pa	ırt A	P	art B	
			Desc	cription	Y/N	Date	Y/N	Date	
				0	1.00	2.00	3.00	4.00	
PS&R	Data								
13.00	Was the cost report prepared using the PS&R only? If either col. 1 or paid through date of the PS&R used to prepare this cost report in co Instructions.)				Y	03/12/2020	Y	03/12/2020	13.00
14.00	Was the cost report prepared using the PS&R for total and the prov allocation? If either col. 1 or 3 is "Y" enter the paid through date of prepare this cost report in columns 2 and 4.				N		N		14.00
15.00	If line 13 or 14 is "Y", were adjustments made to PS&R data for add have been billed but are not included on the PS&R used to file this data for see Instructions.				N		N		15.00
16.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for other PS&R Report information? If yes, see instructions.	or corrections of			N		N		16.00
17.00	If line 13 or 14 is "Y", then were adjustments made to PS&R data for the other adjustments:	or Other? Describe			N		N		17.00
18.00	Was the cost report prepared only using the provider's records? If "	Y" see Instructions.			N		N		18.00
		1.0	00	2.0	00		3.00		
Cost R	eport Preparer Contact Information								
19.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	CHARLES		REED		VICE-PR	ESIDENT		19.00
20.00	Enter the employer/company name of the cost report preparer.	EXECUCARE ASSO	OCIATES						20.00
21.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	732-534-4390		CRWASSC@NETSO	CAPE.NET				21.00

5/28/2025 2:59 pm **2540-10** CARE ONE AT MADISON AVENUE Period: Run Date Time:

From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315488 11.1.179.1



SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE COMPLEX STATISTICAL DATA

Worksheet S-3 Part I PPS

					Inpa	tient Days/V	isits				Discharges			
	Component	Number of	Bed Days											
	1	Beds	Available	Title V	Title XVIII	Title XIX	Other	Total	Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	10.00	11.00	12.00	
1.00	SKILLED NURSING FACILITY	178	65,148	0	9,456	14,962	9,912	34,330	0	246	54	273	573	1.00
2.00	NURSING FACILITY	0	0	0		0	0	0	0		0	0	0	2.00
3.00	ICF/IID	0	0			0	0	0			0	0	0	3.00
4.00	HOME HEALTH AGENCY COST			0	0	0	0	0						4.00
5.00	Other Long Term Care	0	0				0	0				0	0	5.00
6.00	SNF-Based CMHC													6.00
7.00	HOSPICE	0	0	0	0	0	0	0	0	0	0	0	0	7.00
8.00	Total (Sum of lines 1-7)	178	65,148	0	9,456	14,962	9,912	34,330	0	246	54	273	573	8.00
			Average Lei	ngth of Stay				Admissions			Full Time	Equivalent		
	Component	Title V	Title XVIII	Title XIX	Total	Title V	Title XVIII	Title XIX	Other	Total	Employees on Payroll	Nonpaid Workers		
		13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00	21.00	22.00	23.00		
1.00	SKILLED NURSING FACILITY	0.00	38.44	277.07	59.91	0	229	23	322	574	151.28	0.00		1.00
2.00	NURSING FACILITY	0.00		0.00	0.00	0		0	0	0	0.00	0.00		2.00
3.00	ICF/IID			0.00	0.00			0	0	0	0.00	0.00		3.00
4.00	HOME HEALTH AGENCY COST										0.00	0.00		4.00
5.00	Other Long Term Care				0.00				0	0	0.00	0.00		5.00
6.00	SNF-Based CMHC										0.00	0.00		6.00
7.00	HOSPICE	0.00	0.00	0.00	0.00	0	0	0	0	0	0.00	0.00		7.00
8.00	Total (Sum of lines 1-7)	0.00	38.44	277.07	59.91	0	229	23	322	574	151.28	0.00		8.00

5/28/2025 2:59 pm **2540-10** CARE ONE AT MADISON AVENUE Period: Run Date Time:

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SNF WAGE INDEX INFORMATION

315488

Provider CCN:

Worksheet S-3 Part II PPS

			Reclass. of Salaries from	Adjusted Salaries (col. 1	Paid Hours Related to	Average Hourly Wage	
		Amount Reported	Worksheet A-6	± col. 2)	Salary in col. 3	(col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
SALA	RIES						
1.00	Total salaries (See Instructions)	9,691,263	0	9,691,263	314,668.00	30.80	1.0
2.00	Physician salaries-Part A	0	0	0	0.00	0.00	2.0
3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3.0
4.00	Home office personnel	0	0	0	0.00	0.00	4.0
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5.0
6.00	Revised wages (line 1 minus line 5)	9,691,263	0	9,691,263	314,668.00	30.80	6.0
7.00	Other Long Term Care	0	0	0	0.00	0.00	7.0
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8.0
9.00	СМНС	0	0	0	0.00	0.00	9.0
10.00	HOSPICE	0	0	0	0.00	0.00	10.0
11.00	Other excluded areas	0	0	0	0.00	0.00	11.0
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00	12.0
13.00	Total Adjusted Salaries (line 6 minus line 12)	9,691,263	0	9,691,263	314,668.00	30.80	13.0
отн	ER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	19,888	0	19,888	398.00	49.97	14.0
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00	15.0
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16.0
WAG	E-RELATED COSTS						
17.00	Wage-related costs core (See Part IV)	660,546	0	660,546			17.0
18.00	Wage-related costs other (See Part IV)	0	0	0			18.0
19.00	Wage related costs (excluded units)	0	0	0			19.0
20.00	Physician Part A - WRC	0	0	0			20.
21.00	Physician Part B - WRC	0	0	0			21.
22.00	Total Adjusted Wage Related cost (see instructions)	660,546	0	660,546			22.0

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SNF WAGE INDEX INFORMATION

315488

Provider CCN:

Worksheet S-3 Part III PPS

11.1.179.1

PART	III - OVERHEAD COST - DIRECT SALARIES						
			Reclass. of Salaries from	Adjusted Salaries (col. 1	Paid Hours Related to	Average Hourly Wage	
		Amount Reported	Worksheet A-6	± col. 2)	Salary in col. 3	(col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1.00	Employee Benefits	0	0	0	0.00	0.00	1.00
2.00	Administrative & General	607,979	0	607,979	14,138.00	43.00	2.00
3.00	Plant Operation, Maintenance & Repairs	121,057	0	121,057	3,513.00	34.46	3.00
4.00	Laundry & Linen Service	84,998	0	84,998	5,343.00	15.91	4.00
5.00	Housekeeping	418,048	0	418,048	24,467.00	17.09	5.00
6.00	Dietary	590,969	0	590,969	27,079.00	21.82	6.00
7.00	Nursing Administration	632,617	0	632,617	14,592.00	43.35	7.00
8.00	Central Services and Supply	34,559	0	34,559	1,990.00	17.37	8.00
9.00	Pharmacy	0	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	37,628	0	37,628	2,008.00	18.74	10.00
11.00	Social Service	106,277	0	106,277	2,867.00	37.07	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	201,762	0	201,762	10,222.00	19.74	13.00
14.00	Total (sum lines 1 thru 13)	2,835,894	0	2,835,894	106,219.00	26.70	14.00

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SNF WAGE RELATED COSTS

Worksheet S-3 Part IV PPS

No. 1	PART IV - WAGE RELATED COSTS		
Part		Amount Reported	
No. Post P		1.00	
100	Part A - Core List		
200 Tax Sheltered Annuity (TSA) Employer Contribution 2.00 300 Qualified and Non-Qualified Pension Plan Cost 0.00 400 Pore Yen Pension Service Cost 0.00 **** ADMINISTRATIVE COSTS (Paid to External Organization)*** **** DATE ADMINISTRATIVE COSTS (Paid to External Organization)** 500 \$201 Accounting/Management Fees-Pension Plan 0.00 600 Employee Managed Care Program Administration Fees ************************************	RETIREMENT COST		
3.00 Qualified and Non-Qualified Pension Plan Cost 0	1.00 401K Employer Contributions	50,673	1.00
4.00 Pror Year Pension Service Cost 0.00 4.00 PLAN ADMINISTRATIVE COSTS (Paid to External Organization) 3.00 5.00 4.01/K3P Plan Administration fees 0.00 5.00 6.00 1.29/J Accounting/Management Fees-Pension Plan 0.00 6.00 1.00 1.00 2.00 7.00 Employee Managed Care Program Administration Fees 0.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 7.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00<	2.00 Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
PLAN DMINISTRATIVE COSTS (Paid to External Organization)	3.00 Qualified and Non-Qualified Pension Plan Cost	0	3.00
5.00 401K/TSA Plan Administration fees 0 5.00 6.00 Legal/Accounting/Management Fees-Pension Plan 0 6.00 6.00 Legal/Accounting/Management Fees-Pension Plan 0 0.00 HEALTHAND INSURANCE COST 8.00 Health Insurance (Purchased or Self Funded) 31,749 8.00 9.00 Prescription Drug Plan 0 9.00 1.00 Dental, Hearing and Vision Plan 0 10.00 1.00 Disability Insurance (If employee is owner or beneficiary) 1 10.00 1.00 Disability Insurance	4.00 Prior Year Pension Service Cost	0	4.00
6.00 Legal/Accounting/Management Fees-Pension Plan 6.00 6.00 7.00 Employee Managed Care Program Administration Fees 0.00 7.00 Health Insurance (Purchased or Self Funded) 3.1,740 8.00 9.00 Prescription Drug Plan 0.00 0.00 1.00 Dental, Hearing and Vision Plan 0.00 0.00 1.00 Description Drug Plan 0.00 0.00 1.00 Description Drug Plan 0.00 1.00 1.00 Disability Insurance (If employee is owner or beneficiary) 0.00 1.00 1.00 Disability Insurance (If employee is owner or beneficiary) 1.00 1.00 1.00 Recirement Health Care Cost (Only current year, not the extraor	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
7.00 Employee Managed Care Program Administration Fees 0 7.00 HEALTH AND INSURANCE COST 8.00 Health Insurance (Purchased or Self Funded) 3.17.40 8.00 9.00 Pescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 0 10.00 11.00 Life Insurance (If employee is owner or beneficiary) 0 1.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 1.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 1.00 14.00 Jong-Term Care Insurance (If employee is owner or beneficiary) 0 1.00 15.00 Workers' Compensation Insurance 1 1.00 15.00 Workers' Compensation Insurance 1 1.00 15.00 Workers' Compensation Insurance 1 0 1.00 15.00 Workers' Compensation Insurance 1 0 1.00 18.00 Medicare Taxes - Employers Portion Only 0 6 0 1.00 20.00 <td>5.00 401K/TSA Plan Administration fees</td> <td>0</td> <td>5.00</td>	5.00 401K/TSA Plan Administration fees	0	5.00
Health Insurance (Purchased or Self Funded)	6.00 Legal/Accounting/Management Fees-Pension Plan	0	6.00
8.00 Health Insurance (Purchased or Self Funded) 31,740 8.00 9.00 Prescription Drug Plan 0 9.00 10.00 Dental, Hearing and Vision Plan 0 0 10.00 Life Insurance (If employee is owner or beneficiary) 1,48 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 1.20 13.00 Disability Insurance (If employee is owner or beneficiary) 0 1.30 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 1.40 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 1.40 15.00 Verify Compensation Insurance -193,579 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) 0 1.60 17.00 FCA-Employers Portion Only 669,465 17.00 19.00 Medicare Taxes - Employers Portion Only 0 1.00 19.00 Unemployment Insurance 0 1.00 19.00 Security Deferred Compensation		0	7.00
9.00 Prescription Drug Plan 0.00 9.00 10.00 Dental, Hearing and Vision Plan 0.00 1.00 11.00 Life Insurance (If employee is owner or beneficiary) 1.48 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0.13.00 13.00 13.00 Isiability Insurance (If employee is owner or beneficiary) 0.13.00 14.00 15.00 Workers' Compensation Insurance 1.93,579 15.00 16.00 Retirem Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) 0.0 1.90 16.00 Medicare Taxes - Employers Portion Only 669,465 1.70 18.00 Medicare Taxes - Employers Portion Only 0.0 1.80 19.00 Unemployment Insurance 0.0 1.90 1.90 20.00 State or Federal Unemployment Taxes 0.0 1.90 1.90 20.00 State or Federal Unemployment Taxes 0.0 2.0 2.0 2.0 2.0 2.0 2.0 2.0 2.0 2.0 2.0 2.0	HEALTH AND INSURANCE COST		
10.00 Dental, Hearing and Vision Plan 0.00 10.00 11.	8.00 Health Insurance (Purchased or Self Funded)	31,740	8.00
11.00 Life Insurance (If employee is owner or beneficiary) 11.448 11.00 12.00 Accident Insurance (If employee is owner or beneficiary) 0 12.00 13.00 Disability Insurance (If employee is owner or beneficiary) 0 13.00 14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance -193,579 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) 0 16.00 TAXES 17.00 FICA-Employers Portion Only 669,465 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 100,799 20.00 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 23.00 3.00 Tuition Reimbursement 0 23.00 4.00 Amount Reported 1.00 1.00	9.00 Prescription Drug Plan	0	9.00
12.00 Accident Insurance (If employee is owner or beneficiary) 0 13.00 13.00 13.00 13.00 14.00 14.00 14.00 14.00 15.00 14.00 15.00	10.00 Dental, Hearing and Vision Plan	0	10.00
13.00 Disability Insurance (If employee is owner or beneficiary) 13.00 14.00 14.00 14.00 14.00 15.00 14.00 15.00	11.00 Life Insurance (If employee is owner or beneficiary)	1,448	11.00
14.00 Long-Term Care Insurance (If employee is owner or beneficiary) 0 14.00 15.00 Workers' Compensation Insurance -193,579 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) 0 16.00 TAXES 17.00 FICA-Employers Portion Only 669,465 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 100,799 20.00 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 660,546 24.00 Amount Reported 1.00 1.00 1.00	12.00 Accident Insurance (If employee is owner or beneficiary)	0	12.00
15.00 Workers' Compensation Insurance -193,579 15.00 16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) 0 16.00 16.00 16.00 17.00	13.00 Disability Insurance (If employee is owner or beneficiary)	0	13.00
16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion) 0 16.00 TAXES 17.00 FICA-Employers Portion Only 669,465 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 100,799 20.00 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported Amount Reported 1.00	14.00 Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
TAXES 17.00 FICA-Employers Portion Only 669,465 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 100,799 20.00 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported Amount Reported 1.00	15.00 Workers' Compensation Insurance	-193,579	15.00
17.00 FICA-Employers Portion Only 669,465 17.00 18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 100,799 20.00 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 660,546 24.00 Amount Reported 1.00	16.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
18.00 Medicare Taxes - Employers Portion Only 0 18.00 19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 100,799 20.00 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 660,546 24.00 Amount Reported 1.00 1.00	TAXES	·	
19.00 Unemployment Insurance 0 19.00 20.00 State or Federal Unemployment Taxes 100,799 20.00 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 660,546 24.00 Amount Reported 1.00	17.00 FICA-Employers Portion Only	669,465	17.00
20.00 State or Federal Unemployment Taxes 100,799 20.00 OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) Amount Reported Amount Reported 1.00 1.00	18.00 Medicare Taxes - Employers Portion Only	0	18.00
OTHER 21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 660,546 24.00 Amount Reported 1.00 1.00	19.00 Unemployment Insurance	0	19.00
21.00 Executive Deferred Compensation 0 21.00 22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 660,546 24.00 Amount Reported 1.00 1.00	20.00 State or Federal Unemployment Taxes	100,799	20.00
22.00 Day Care Cost and Allowances 0 22.00 23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 660,546 24.00 Amount Reported 1.00 1.00	OTHER		
23.00 Tuition Reimbursement 0 23.00 24.00 Total Wage Related cost (Sum of lines 1 - 23) 660,546 24.00 Amount Reported 1.00 1.00	21.00 Executive Deferred Compensation	0	21.00
24.00 Total Wage Related cost (Sum of lines 1 - 23) 660,546 24.00 Amount Reported 1.00	22.00 Day Care Cost and Allowances	0	22.00
Amount Reported 1.00	23.00 Tuition Reimbursement	0	23.00
1.00	24.00 Total Wage Related cost (Sum of lines 1 - 23)	660,546	24.00
		Amount Reported	
Part B - Other than Core Related Cost		1.00	
	Part B - Other than Core Related Cost		
25.00 OTHER WAGE RELATED COST 0 25.00	25.00 OTHER WAGE RELATED COST	0	25.00

5/28/2025 2:59 pm **2540-10** CARE ONE AT MADISON AVENUE Period: Run Date Time:

From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315488 11.1.179.1



SNF REPORTING OF DIRECT CARE EXPENDITURES

Worksheet S-3 Part V PPS

	1						
	OCCUPATIONAL CATEGORY			Adjusted Salaries (col. 1	Paid Hours Related to	Average Hourly Wage	
	0 000011100111100111	Amount Reported	Fringe Benefits	+ col. 2)	Salary in col. 3	(col. 3 ÷ col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	Salaries						
Nursi	ng Occupations						
1.00	Registered Nurses (RNs)	735,832	62,754	798,586	15,985.00	49.96	1.00
2.00	Licensed Practical Nurses (LPNs)	2,718,608	231,850	2,950,458	70,790.00	41.68	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	2,191,241	186,875	2,378,116	95,372.00	24.94	3.00
4.00	Total Nursing (sum of lines 1 through 3)	5,645,681	481,479	6,127,160	182,147.00	33.64	4.00
5.00	Physical Therapists	600,093	51,178	651,271	12,850.00	50.68	5.00
6.00	Physical Therapy Assistants	0	0	0	0.00	0.00	6.00
7.00	Physical Therapy Aides	0	0	0	0.00	0.00	7.00
8.00	Occupational Therapists	514,006	43,836	557,842	11,442.00	48.75	8.00
9.00	Occupational Therapy Assistants	0	0	0	0.00	0.00	9.00
10.00	Occupational Therapy Aides	0	0	0	0.00	0.00	10.00
11.00	Speech Therapists	95,589	8,152	103,741	2,011.00	51.59	11.00
12.00	Respiratory Therapists	0	0	0	0.00	0.00	12.00
13.00	Other Medical Staff	0	0	0	0.00	0.00	13.00
Contr	act Labor						
Nursi	ng Occupations						
14.00	Registered Nurses (RNs)	0		0	0.00	0.00	14.00
15.00	Licensed Practical Nurses (LPNs)	0		0	0.00	0.00	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	0		0	0.00	0.00	16.00
17.00	Total Nursing (sum of lines 14 through 16)	0		0	0.00	0.00	17.00
18.00	Physical Therapists	0		0	0.00	0.00	18.00
19.00	Physical Therapy Assistants	0		0	0.00	0.00	19.00
20.00	Physical Therapy Aides	0		0	0.00	0.00	20.00
21.00	Occupational Therapists	0		0	0.00	0.00	21.00
22.00	Occupational Therapy Assistants	0		0	0.00	0.00	22.00
23.00	Occupational Therapy Aides	0		0	0.00	0.00	23.00
24.00	Speech Therapists	50		50	1.00	50.00	24.00
25.00	Respiratory Therapists	19,838		19,838	397.00	49.97	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

CARE ONE AT MADISON AVENUE

Period:
From: 01/01/2024
Provider CCN: 315488

Run Date Time: 5/28/2025 2:59 pm
MCRIF32
2540-10
To: 12/31/2024
Version: 11.1.179.1



PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Worksheet S-7

			PPS
	Group	Days	
	1.00	2.00	
1.00	RUX		1.00
2.00	RUL		2.00
3.00	RVX		3.00
4.00	RVL		4.00
5.00	RHX		5.00
7.00	RHL		6.00
8.00	RMX RML		7.00 8.00
9.00	RLX		9.00
10.00	RUC		10.00
11.00	RUB		11.00
12.00	RUA		12.00
13.00	RVC		13.00
14.00	RVB		14.00
15.00	RVA		15.00
16.00	RHC		16.00
17.00	RHB		17.00
18.00	RHA		18.00
19.00	RMC		19.00
20.00	RMB		20.00
21.00	RMA		21.00
22.00	RLB		22.00
23.00	RLA		23.00
24.00	ES3		24.00
25.00	ES2		25.00
26.00	ES1		26.00
27.00	HE2		27.00
28.00	HE1		28.00
29.00	HD2		29.00
30.00	HD1		30.00 31.00
32.00	HC2 HC1		32.00
33.00	HB2		33.00
34.00	HB1		34.00
35.00	LE2		35.00
36.00	LE1		36.00
37.00	LD2		37.00
38.00	LDI		38.00
39.00	LC2		39.00
40.00	LCI		40.00
41.00	LB2		41.00
42.00	LB1		42.00 43.00
43.00	CE2		43.00
44.00			44.00
45.00			45.00
46.00			46.00
47.00			47.00
48.00			48.00
49.00			49.00
			50.00
51.00			51.00
52.00			52.00
53.00			53.00
55.00			54.00 55.00
56.00			56.00
57.00			57.00
57.00			37.00

CARE ONE AT MADISON AVENUE

Period:
From: 01/01/2024
Provider CCN: 315488

Period:
From: 01/01/2024
Provider CCN: 12/31/2024
Provider CCN: 315488

Run Date Time: 5/28/2025 2:59 pm
MCRIF32
2540-10
Version: 11.1.179.1

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Worksheet S-7

PPS

					113
	Group			Days	
	1.00			2.00	
58.00	SSA				58.00
59.00	IB2				59.00
60.00	IB1				60.00
61.00	IA2				61.00
62.00	IA1				62.00
63.00	BB2				63.00
64.00	BB1				64.00
65.00	BA2				65.00
66.00	BA1				66.00
67.00	PE2				67.00
68.00	PE1				68.00
69.00	PD2				69.00
70.00	PD1				70.00
71.00	PC2				71.00
72.00	PC1				72.00
73.00	PB2				73.00
	PB1				74.00
75.00	PA2				75.00
76.00	PA1				76.00
99.00	AAA				99.00
100.00					100.00
		Expenses	Percentage	Y/N	
		1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 101 through 106: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 1, column 3. Indicate in column 3 "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (If column 2 is zero, enter N/A in column 3) (See instructions)

101.00	Staffing		101.00
102.00	Recruitment		102.00
103.00	Retention of employees		103.00
104.00	Training		104.00
105.00	OTHER (SPECIFY)		105.00
106.00	Total SNF revenue (Worksheet G-2, Part I, line 1, column 3)		106.00

CARE ONE AT MADISON AVENUE

315488

Provider CCN:

Period: From: 01/01/2024 MCRIF32 To: 12/31/2024 Version:

Run Date Time:

5/28/2025 2:59 pm **2540-10** 11.1.179.1



RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Worksheet A

1	D.	D۷
	L.	Ŀι

OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 69,666 0 69,666 0 69,666 0 69,666 0 69,666 0 69,666 0 69,666 0 <											PPS
CRESTRAL SERVICE COST CENTERS							Reclassifications	Reclassified Trial	Adjustments to	Net Expenses	
CREWARD SPRICE COST CENTERS			Cost Center Description			Total (col. 1 +		Balance (col. 3 +-	Expenses (Fr	For Allocation	
CENERAL SERVICE COST CENTERS						,	(Fr Wkst A-6)	/	Wkst A-8)		
100 100 CAP REL CONS. MILIGIS A HYLLENS 2,256,776 2,256,776 3.05 2,256,775 3.05 3.05 2,256,775 3.06 3.00 3.000 EDRELOYER SENSETTS 0 8.26,498 0 4.26,448 0 4.26,44				1.00	2.00	3.00	4.00	5.00	6.00	7.00	
200 0.000 CAP RELOCKIN NOVARELE QUIPMENT							1			1	
100 1000 1								- , ,			
1.00 0.0000 ADMINISTRATIVIA GIONERAL 07.797 1,077.664 2,306,643 0 2,306,643 1,309,991 3,4075,040 0.0000 0.0000 LAINDEY & LININ SERVICE 58.998 73,449 158,447 0 158			-								
120,000 0.000 LANT OPERATION, MAINT, & REPAIRS 121,077 599,248 720,305 0 720,005 0				, ,				,			
0000 LAINDRY & INNES SERVICE 54.998 73,449 158,447 0 158,447 0 158,447 0 158,447 0 158,447 0 158,447 0 158,447 0 158,447 0 158,447 0 158,448 0 458,3								-))			
100 100								,			
1000 1000 1ECAMY								-			
0.000 0.00								-			
1000 1000								,			
11.00						-		,			
1200 0.1200 MEDICAL RECORDS & LIBRARY 37,628				1		-					
13.00 13.00 NOCIAL SERVICE 110,277 0 106,277				v		-		-			
14.00 0.100 0.00						-					
15.00 0.500 ACTIVITES ERVICE COST CENTERS 201,762 15,016 216,778 0 216,778 0 216,778 1.5016 1.50						-		,		100,277	13.00
INPATIENT ROUTINE SERVICE COST CENTERS				v						216 779	_
0.000 SKILLED NURSING FACILITY				201,702	15,010	210,776	0	210,776	0	210,776	13.00
				5 645 681	83 328	5 729 009	0	5 729 009	29 370	5 600 630	30.00
32.00 03200 CEF/IIID				1 1				-,,		3,077,037	31.00
13300 03300 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0				· ·						0	32.00
ANCILLARY SERVICE COST CENTERS				-				-		0	
40.00 04000 RADIOLOGY			l .	, ,							35.00
41.00 04100 LABORATORY			1	0	30.385	30,385	0	30.385	0	30,385	40.00
42.00 04200 NTRAVENOUS THERAPY 0											
43.00 04300 04300 04300 04300 04300 04300 04300 04300 0440						-		,			
44.00 04400 PHYSICAL THERAPY 600,093 21,643 621,736 0 621,736 0 621,736 14500 04500 00CCUPATIONAL THERAPY 514,006 0 514,006 0 514,006 0 514,006 0 514,006 0 514,006 0 514,006 0 514,006 0 514,006 0 514,006 0 0 0 0 0 0 0 0 0						,				0	43.00
45.00 04500 04500 OCCUPATIONAL THERAPY 514,006 0 514,006 0 514,006 0 514,006 0 64,000 04600 04600 04600 04600 04600 04700 04700 045000 045000 045000 045000 045000 045000 045000			,	600,093	21,643	621,736	0	621,736		621,736	_
46.00 04600 04600 SPEECH PATHOLOGY 95,589 50 95,639 0 95,639 0 0 0 0 0 0 0 0 0							0		0		
48.00 04800 MEDICAL SUPPLIES CHARGED TO PATTENTS 0 0 0 0 0 0 0 0 0		04600			50		0	-	0		
49.00 04900 DRUGS CHARGED TO PATIENTS	47.00	04700	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	47.00
50.00 05000 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 0	48.00	04800	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	48.00
51.00 05100 SUPPORT SURFACES 0 0 0 0 151 151 0 151 152 0 0 152 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	49.00	04900	DRUGS CHARGED TO PATIENTS	0	743,803	743,803	0	743,803	-59,504	684,299	49.00
52.00 05200 COMPLEX MEDICAL EQUIPMENT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50.00	05000	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	50.00
52.01 05201 OTHER ANCILLARY SERVICES COST 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	51.00	05100	SUPPORT SURFACES	0	0	0	151	151	0	151	51.00
Description	52.00	05200	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS 60.00 06000 CLINIC 0 0 0 0 0 0 0 0 0 0	52.01	05201	OTHER ANCILLARY SERVICES COST	0	0	0	0	0	0	0	52.01
60.00 06000 CLINIC 0				0	0	0	0	0	0	0	52.02
61.00 06100 RURAL HEALTH CLINIC 0<	OUTP	ATIEN	VT SERVICE COST CENTERS							•	
62.00 6200 FQHC	60.00	06000	CLINIC	0	0	0	0	0	0	C	60.00
Column C	61.00			0	0	0	0	0	0	0	61.00
OTHER REIMBURSABLE COST CENTERS 70.00 07000 HOME HEALTH AGENCY COST 0 69,666 0 69,666 0 69,666 0 69,666 0 69,666 0 69,666 0<	62.00	06200	FQHC								62.00
70.00 07000 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 0 0 0 0 0 0 0 69,666 0 69,666 0 69,666 0 69,666 0 69,666 0 69,666 0				0	0	0	0	0	0	0	63.00
71.00 07100 AMBULANCE 0 69,666 0 69,666 0 69,666 73.00 07300 CMHC 0 <td>OTHE</td> <td></td> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	OTHE		1								
73.00 07300 CMHC 0 <t< td=""><td>70.00</td><td>07000</td><td>HOME HEALTH AGENCY COST</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>70.00</td></t<>	70.00	07000	HOME HEALTH AGENCY COST	0	0	0	0	0	0	0	70.00
74.00 07400 OTHER REIMBURSEMENT 0 0 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 0 <t< td=""><td></td><td></td><td></td><td>0</td><td>69,666</td><td>69,666</td><td></td><td></td><td></td><td>69,666</td><td></td></t<>				0	69,666	69,666				69,666	
SPECIAL PURPOSE COST CENTERS 80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 0 0 0 0 0 0 0 81.00 08100 INTEREST EXPENSE 0 0 0 0 0 0 0											
80.00 08000 MALPRACTICE PREMIUMS & PAID LOSSES 0 0 0 0 0 0 81.00 08100 INTEREST EXPENSE 0 0 0 0 0 0 0				0	0	0	0	0	0	0	74.00
81.00 08100 INTEREST EXPENSE 0 0 0 0 0 0											
											80.00
92 00 1 08200 HTH IZATION PEVIEW SNE											
	82.00		UTILIZATION REVIEW - SNF	0	0	0		0	0	0	0=100
83.00 08300 HOSPICE 0 0 0 0 0 0 0										0	83.00
84.00 08400 OTHER SPECIAL PURPOSE COST I 0 0 0 0 0 0 0											
84.01 08401 OTHER SPECIAL PURPOSE COST II 0 0 0 0 0 0 0		08401									
89.00 SUBTOTALS (sum of lines 1-84) 9,691,263 7,773,501 17,464,764 0 17,464,764 1,294,702 18,759,466	89.00		SUBTOTALS (sum of lines 1-84)	9,691,263	7,773,501	17,464,764	0	17,464,764	1,294,702	18,759,466	89.00

CARE ONE AT MADISON AVENUE

Period:
From: 01/01/2024
Provider CCN: 315488

Run Date Time: 5/28/2025 2:59 pm
MCRIF32 2540-10
Version: 11.1.179.1

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Worksheet A

PPS

Cost Center Description Salaries Other Total (col. 1 + col. 2) Reclassifications Increase/Decrease Balance (col. 3 + col. 4) Wkst A-8) Col. 5	ation
Salaries Other col. 2) (Fr Wkst A-6) col. 4) Wkst A-8) (col. 5 1.00 2.00 3.00 4.00 5.00 6.00 7	col. 6)
1.00 2.00 3.00 4.00 5.00 6.00 7 NONREIMBURSABLE COST CENTERS	
NONREIMBURSABLE COST CENTERS 90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 9,896 9,896 0 9,896 0 91.00 09100 BARBER AND BEAUTY SHOP 0 2,179 2,179 0 2,179 0	0.806 00.00
90.00 09000 GIFT, FLOWER, COFFEE SHOPS & CANTEEN 0 9,896 9,896 0 9,896 0 91.00 09100 BARBER AND BEAUTY SHOP 0 2,179 2,179 0 2,179 0	0.806 00.00
91.00 09100 BARBER AND BEAUTY SHOP 0 2,179 0 2,179 0	0.806 00.00
	9,090 90.00
92 00 00200 PHYSICIANS PRIVATE OFFICES 0 0 0 0	2,179 91.00
72.00 07200 ITITOCHINO INIVITE OFFICES	0 92.00
93.00 09300 NONPAID WORKERS 0 0 0 0 0	0 93.00
94.00 09400 PATIENTS LAUNDRY 0 0 0 0 0	0 94.00
95.00 09500 OTHER NONREIMBURSABLE COST 0 0 0 0 0 0	0 95.00
100.00 TOTAL 9,691,263 7,785,576 17,476,839 0 17,476,839 1,294,702 1	1,541 100.00

5/28/2025 2:59 pm **2540-10** CARE ONE AT MADISON AVENUE Period: Run Date Time: From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315488 11.1.179.1

Worksheet A-6

									PPS
	Increases				Decreases				
	Cost Center Line #		Salary	Non Salary	Cost Center		Salary	Non Salary	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
C - RE	C - RECLASS SUPP SURFACES								
1.00	SUPPORT SURFACES 51.00		0	151	CAP REL COSTS - MOVABLE EQUIPMENT		0	151	1.00
	TOTAL RECLASSIFICATIONS (Sum of columns 4 must equal sum of columns 8 and 9 (2)	and 5	0	151			0	151	100.00

⁽¹⁾ A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.

RECLASSIFICATIONS

⁽²⁾ Transfer the amounts in columns 4, 5, 8 and 9 to Worksheet A, column 4, lines as appropriate.

5/28/2025 2:59 pm **2540-10** CARE ONE AT MADISON AVENUE Period: Run Date Time: From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: 11.1.179.1



RECONCILIATION OF CAPITAL COSTS CENTERS

315488

Provider CCN:

Worksheet A-7

PPS

									113
				Acquisitions					
								Fully	
		Beginning				Disposals and	Ending	Depreciated	
		Balances	Purchases	Donation	Total	Retirements	Balance	Assets	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	
ANAL	ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	0	0	0	0	0	0	0	1.00
2.00	Land Improvements	14,131	0	0	0	0	14,131	0	2.00
3.00	Buildings and Fixtures	18,431,160	372,086	0	372,086	0	18,803,246	0	3.00
4.00	Building Improvements	0	0	0	0	0	0	0	4.00
5.00	Fixed Equipment	1,114,837	84,829	0	84,829	0	1,199,666	0	5.00
6.00	Movable Equipment	4,447,685	3,381	0	3,381	0	4,451,066	0	6.00
7.00	Subtotal (sum of lines 1-6)	24,007,813	460,296	0	460,296	0	24,468,109	0	7.00
8.00	Reconciling Items	0	0	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	24,007,813	460,296	0	460,296	0	24,468,109	0	9.00

5/28/2025 2:59 pm **2540-10** CARE ONE AT MADISON AVENUE Period: Run Date Time: From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315488 11.1.179.1

ADJUSTMENTS TO EXPENSES

Worksheet A-8

						PPS
				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
	Description (1)	(2) Basis For Adjustment	Amount	Cost Center	Line No.	
		1.00	2.00	3.00	4.00	
1.00	Investment income on restricted funds (chapter 2)	В	-305	CAP REL COSTS - BLDGS & FIXTURES	1.00	1.00
2.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	2.00
3.00	Refunds and rebates of expenses (chapter 8)		0		0.00	3.00
4.00	Rental of provider space by suppliers (chapter 8)		0		0.00	4.00
5.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	5.00
6.00	Television and radio service (chapter 21)		0		0.00	6.00
7.00	Parking lot (chapter 21)		0		0.00	7.00
8.00	Remuneration applicable to provider-based physician adjustment	A-8-2	0			8.00
9.00	Home office cost (chapter 21)		0		0.00	9.00
10.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	10.00
11.00	Nonallowable costs related to certain Capital expenditures (chapter 24)		0		0.00	11.00
12.00	Adjustment resulting from transactions with related organizations (chapter 10)	A-8-1	1,568,927			12.00
13.00	Laundry and linen service		0		0.00	13.00
14.00	Revenue - Employee meals		0		0.00	14.00
15.00	Cost of meals - Guests		0		0.00	15.00
16.00	Sale of medical supplies to other than patients		0		0.00	16.00
17.00	Sale of drugs to other than patients		0		0.00	17.00
18.00	Sale of medical records and abstracts		0		0.00	18.00
19.00	Vending machines		0		0.00	19.00
20.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	20.00
21.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	21.00
22.00	Utilization reviewphysicians' compensation (chapter 21)		0	UTILIZATION REVIEW - SNF	82.00	22.00
23.00	Depreciationbuildings and fixtures		0	CAP REL COSTS - BLDGS & FIXTURES	1.00	23.00
24.00	Depreciationmovable equipment		0	CAP REL COSTS - MOVABLE EQUIPMENT	2.00	24.00
25.00	RESIDENT REPLACEMENT ITEMS	A	3,900	ADMINISTRATIVE & GENERAL	4.00	25.00
25.01	MARKETING EXPENSE	A	-11,015	ADMINISTRATIVE & GENERAL	4.00	25.01
25.02	MARKETING CORP EXPENSE	A	-1,558	ADMINISTRATIVE & GENERAL	4.00	25.02
25.03	MARKETING - MEALS	A	-10,205	ADMINISTRATIVE & GENERAL	4.00	25.03
25.04	BAD DEBT EXPENSE	A	-120,334	ADMINISTRATIVE & GENERAL	4.00	25.04
25.05	BAD DEBT EXPENSE - MEDICARE	A	-96,312	ADMINISTRATIVE & GENERAL	4.00	25.05
25.06	OTHER MEDICAL SERVICES EXPENSE	A	-29,370	SKILLED NURSING FACILITY	30.00	25.06
25.07	OTHER REVENUE	В	-9,026	ADMINISTRATIVE & GENERAL	4.00	25.07
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		1,294,702			100.00
(1) De	scription - All chapter references in this column pertain to CMS Pub. 15-1.					

⁽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.

CARE ONE AT MADISON AVENUE Period: Run Date Time: 5/28/2025 2:59 pm 2540-10 From: 01/01/2024 MCRIF32

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Worksheet A-8-1 Parts I & II

PART I. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

To:

12/31/2024

Version:

11.1.179.1

				Amount Allowable	Amount Included	Adjustments (col. 4	
	Line No.	Cost Center	Expense Items	In Cost	in Wkst. A, col. 5	minus col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
1.00	4.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEES	2,465,360	830,919	1,634,441	1.00
2.00	9.00	NURSING ADMINISTRATION	PHARMACY CONSULTANT	34,595	37,603	-3,008	2.00
3.00	10.00	CENTRAL SERVICES & SUPPLY	WOUND CARE EXPENSE	44,468	44,468	0	3.00
4.00	11.00	PHARMACY	DRUGS-NON-PRESCRIPTION, NON-LEGEND	32,415	35,234	-2,819	4.00
5.00	11.00	PHARMACY	PHARMACY SUPPLIES	3,120	3,391	-271	5.00
6.00	42.00	INTRAVENOUS THERAPY	IV EXPENSE	-1,006	-1,094	88	6.00
7.00	49.00	DRUGS CHARGED TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS OTH	46,413	50,449	-4,036	7.00
8.00	49.00	DRUGS CHARGED TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS MAN	306,514	333,167	-26,653	8.00
9.00	49.00	DRUGS CHARGED TO PATIENTS	DRUGS-PRESCRIPTION, MEDICARE A	331,372	360,187	-28,815	9.00
10.00	TOTALS (sur	n of lines 1-9). Transfer column 6, line 10 to Workshee	et A-8, column 3, line 12.	3,263,251	1,694,324	1,568,927	10.00

PART II. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part II of this worksheet.

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that the costs applicable to services, facilities, and supplies furnished by organizations related to you by common ownership or control represent reasonable costs as determined under section 1861 of the Social Security Act. If you do not provide all or any part of the requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

				Related Organi	ization(s) and/o	r Home Office	
	Symbol				Percentage of		
	(1)	Name	Percentage of Ownership	Name	Ownership	Type of Business	
	1.00	2.00	3.00	4.00	5.00	6.00	
1.00	A	DANIEL STRAUS	41.00	HEALTHBRIDGE MANAGEMENT LLC	100.00	MANAGEMENT	1.00
2.00	A	DANIEL STRAUS	41.00	TOTALCARE LLC	99.00	WOUND CARE	2.00
3.00	Α	DES HOLDING CO. INC.	22.00	TOTALCARE LLC	1.00	WOUND CARE	3.00
4.00	F	PARTNERS PHARMACY SERVICES LLC	0.00	PARTNERS PHARMACY LLC	100.00	PHARMACY	4.00
5.00			0.00		0.00		5.00
6.00			0.00		0.00		6.00
7.00			0.00		0.00		7.00
8.00			0.00		0.00		8.00
9.00			0.00		0.00		9.00
10.00			0.00		0.00		10.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider. C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or organization.
- E. Individual is director, officer, administrator or key person of provider and related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.
- G. Other (financial or non-financial) specify:

Provider CCN:

315488

5/28/2025 2:59 pm **2540-10** CARE ONE AT MADISON AVENUE Period: Run Date Time:

From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315488 11.1.179.1



COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B Part I

										PPS
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDGS & FIXTURES	MOVABLE EQUIPMENT 2.00	EMPLOYEE BENEFITS 3.00	Subtotal 3A	ADMINISTRA TIVE & GENERAL 4.00	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE 6.00	
CENI	LERAL SERVICE COST CENTERS	0	1.00	2.00	3.00	3/1	4.00	3.00	0.00	
1.00	CAP REL COSTS - BLDGS & FIXTURES	2,526,371	2,526,371							1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT	308,574	2,320,371	308,574						2.00
3.00	EMPLOYEE BENEFITS	826,498	0	0	826,498					3.00
4.00	ADMINISTRATIVE & GENERAL	3,695,534	0	0	51,850	3,747,384	3,747,384			4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	720,305	0	0	-	730,629	182,224	912,853		5.00
6.00	LAUNDRY & LINEN SERVICE	158,447	0	0	7,249	165,696	41,326	0	207,022	6.00
7.00	HOUSEKEEPING	458,348	0	0		494,000	123,207	0		7.00
8.00	DIETARY	943,958	0	0	50,400	994,358	248,000	0	0	8.00
9.00	NURSING ADMINISTRATION	747,408	0	0	53,951	801,359	199,865	0	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	181,102	0	0	2,947	184,049	45,903	0	0	10.00
11.00	PHARMACY	35,535	0	0	0	35,535	8,863	0	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	37,588	0	0	3,209	40,797	10,175	0	0	12.00
13.00	SOCIAL SERVICE	106,277	0	0	9,064	115,341	28,767	0	0	
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	0	0	0	14.00
15.00	ACTIVITES	216,778	0	0	17,207	233,985	58,357	0	0	15.00
INPA'	TIENT ROUTINE SERVICE COST CENTERS									
30.00	SKILLED NURSING FACILITY	5,699,639	2,411,473	294,540	481,479	8,887,131	2,216,517	871,337	207,022	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0		0	0			0=.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
	LLARY SERVICE COST CENTERS			_						
40.00	RADIOLOGY	30,385	0	0	0	30,385	7,578	0		70.00
41.00	LABORATORY	82,228	0	0	0	82,228 -1,006	20,508	0		
42.00	INTRAVENOUS THERAPY OXYGEN (INHALATION) THERAPY	-1,006 0	0	0	0	-1,000	0			
44.00	PHYSICAL THERAPY	621,736	68,939	8,420	51,178	750,273	187,123	24,910	0	44.00
45.00	OCCUPATIONAL THERAPY	514,006	45,959	5,614	43,836	609,415	151,992	16,606	0	
46.00	SPEECH PATHOLOGY	95,639	0	0,011	8,152	103,791	25,886	0		
47.00	ELECTROCARDIOLOGY	0	0	0	0,102	0	0			
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0		_	48.00
49.00	DRUGS CHARGED TO PATIENTS	684,299	0	0	0	684,299	170,669	0	0	
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	50.00
51.00	SUPPORT SURFACES	151	0	0	0	151	38	0	0	51.00
52.00	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	0	0	0	52.00
52.01	OTHER ANCILLARY SERVICES COST	0	0	0	0	0	0	0	0	52.01
52.02	MEDICAL SERVICES	0	0	0	0	0	0	0	0	52.02
OUTF	PATIENT SERVICE COST CENTERS									
	CLINIC	0	0			0		<u> </u>		60.00
	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00
	FQHC									62.00
	DIALYSIS ED DEIMBURGABLE COST CENTERS	0	0	0	0	0	0	0	0	63.00
	ER REIMBURSABLE COST CENTERS	0	0	0		^	0			70.00
	HOME HEALTH AGENCY COST AMBULANCE	69,666	0	0		69,666	17,375			70.00
	CMHC	09,000	0	0	-	09,666	1/,3/5			
74.00	OTHER REIMBURSEMENT	0	0	0	0	0	0		0	74.00
	IAL PURPOSE COST CENTERS	0	0	0	0	U	0	0	0	7 7.00
	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
80.00										81.00
	INTEREST EXPENSE									
81.00	INTEREST EXPENSE UTILIZATION REVIEW - SNF									82.00
81.00 82.00		0	0	0	0	0	0	0	0	

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COST ALLOCATION - GENERAL SERVICE COSTS

315488

Provider CCN:

Worksheet B Part I PPS

		Net Expenses for Cost						PLANT		
	Cost Center Description	Allocation					ADMINISTRA	OPERATION,	LAUNDRY &	
	1	(from Wkst A	BLDGS &	MOVABLE	EMPLOYEE		TIVE &	MAINT. &	LINEN	
		col. 7)	FIXTURES	EQUIPMENT	BENEFITS	Subtotal	GENERAL	REPAIRS	SERVICE	
		0	1.00	2.00	3.00	3A	4.00	5.00	6.00	
84.01	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	18,759,466	2,526,371	308,574	826,498	18,759,466	3,744,373	912,853	207,022	89.00
NONI	REIMBURSABLE COST CENTERS									
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	9,896	0	0	0	9,896	2,468	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	2,179	0	0	0	2,179	543	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
95.00	OTHER NONREIMBURSABLE COST	0	0	0	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments	0	0	0	0	0	0	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	0	0	0	0	99.00
100.00	TOTAL	18,771,541	2,526,371	308,574	826,498	18,771,541	3,747,384	912,853	207,022	100.00

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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B Part I

										PPS
				NURSING	CENTRAL		MEDICAL		NURSING AND ALLIED	
	Cost Center Description	HOUSEKEEPI		ADMINISTRA			RECORDS &	SOCIAL	HEALTH	
		NG	DIETARY	TION	SUPPLY	PHARMACY	LIBRARY	SERVICE	EDUCATION	
		7.00	8.00	9.00	10.00	11.00	12.00	13.00	14.00	
GENE	ERAL SERVICE COST CENTERS			1			1			
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT									2.00
3.00	EMPLOYEE BENEFITS									3.00
4.00	ADMINISTRATIVE & GENERAL									4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS									5.00
6.00	LAUNDRY & LINEN SERVICE									6.00
7.00	HOUSEKEEPING	617,207								7.00
8.00	DIETARY	0	1,242,358							8.00
9.00	NURSING ADMINISTRATION	0	0	1,001,224						9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0	229,952					10.00
11.00	PHARMACY	0	0	0	0	44,398				11.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	50,972			12.00
13.00	SOCIAL SERVICE	0	0	0	0	0	0	144,108		13.00
14.00	NURSING AND ALLIED HEALTH	0	0	0	0	0	0	0	0	14.00
	EDUCATION									
	ACTIVITES	0	0	0	0	0	0	0	0	15.00
_	TIENT ROUTINE SERVICE COST CENTERS									
30.00	SKILLED NURSING FACILITY	589,137	1,242,358	1,001,224	229,952	44,398	50,972	144,108	0	
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	
	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCI	LLARY SERVICE COST CENTERS									
40.00	RADIOLOGY	0	0	0	0	0	0	0	0	
41.00	LABORATORY	0	0	0	0	0	0	0	0	
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	16,842	0	0	0	0	0	0	0	44.00
45.00	OCCUPATIONAL THERAPY	11,228	0	0	0	0	0	0		
46.00	SPEECH PATHOLOGY	0	0	0	0	0	0	0	0	
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0		48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	0		
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	7 50.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
52.00	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	0	0		52.00
52.01	OTHER ANCILLARY SERVICES COST	0	0	0	0	0	0	0		
	MEDICAL SERVICES	0	0	0	0	0	0	0	0	52.02
	PATIENT SERVICE COST CENTERS								1	
60.00	CLINIC	0	0	0	0	0	0	0	0	
	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00
	FQHC									62.00
	DIALYSIS	0	0	0	0	0	0	0	0	63.00
	ER REIMBURSABLE COST CENTERS									T C 25
	HOME HEALTH AGENCY COST	0	0	0		0	0	0		70.00
	AMBULANCE	0	0	0		0	0	0	0	, , , , , ,
	CMHC	0	0	0	0	0	0	0	0	73.00
	OTHER REIMBURSEMENT	0	0	0	0	0	0	0	0	74.00
	IAL PURPOSE COST CENTERS									00.11
	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
	INTEREST EXPENSE									81.00
	UTILIZATION REVIEW - SNF									82.00
	HOSPICE	0	0	0	-	0	0	0	0	
84.00	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	0	0	0	
	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	01			84.01

CARE ONE AT MADISON AVENUE

Period:
From: 01/01/2024
Provider CCN: 315488

Period:
From: 01/01/2024
To: 12/31/2024
Provider CCN: 315488

Run Date Time: 5/28/2025 2:59 pm
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2540-10
Version: 11.1.179.1

COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
PPS

	Cost Center Description	HOUSEKEEPI NG 7.00	DIETARY 8.00	NURSING ADMINISTRA TION 9.00	CENTRAL SERVICES & SUPPLY	PHARMACY 11.00	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE 13.00	NURSING AND ALLIED HEALTH EDUCATION 14.00	
89.00	SUBTOTALS (sum of lines 1-84)	617,207	1,242,358	1,001,224	229,952	44,398	50,972	144,108		89.00
NONI	REIMBURSABLE COST CENTERS									
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
95.00	OTHER NONREIMBURSABLE COST	0	0	0	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments	0	0	0	0				0	98.00
99.00	Negative Cost Centers	0	0	0	0	0	0	0	0	99.00
100.00	TOTAL	617,207	1,242,358	1,001,224	229,952	44,398	50,972	144,108	0	100.00

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COST ALLOCATION - GENERAL SERVICE COSTS

315488

Provider CCN:

Worksheet B Part I

					P
Cost Center Description			Post Stepdown		
Cost Center Description	ACTIVITES	Subtotal	Adjustments	Total	
	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS					
1.00 CAP REL COSTS - BLDGS & FIXTURES					1
2.00 CAP REL COSTS - MOVABLE EQUIPMEN	NT				2
3.00 EMPLOYEE BENEFITS					3
4.00 ADMINISTRATIVE & GENERAL					4
5.00 PLANT OPERATION, MAINT. & REPAIR	S				5
6.00 LAUNDRY & LINEN SERVICE					6
7.00 HOUSEKEEPING					7
8.00 DIETARY					8
9.00 NURSING ADMINISTRATION					9
10.00 CENTRAL SERVICES & SUPPLY					10
11.00 PHARMACY					11
12.00 MEDICAL RECORDS & LIBRARY					12
13.00 SOCIAL SERVICE					13
14.00 NURSING AND ALLIED HEALTH EDUCATION					14
15.00 ACTIVITES	292,342				15
INPATIENT ROUTINE SERVICE COST CEN	,				
30.00 SKILLED NURSING FACILITY	292,342	15,776,498	0	15,776,498	30
31.00 NURSING FACILITY	0	0		0	31
32.00 ICF/IID	0	0	0	0	32
33.00 OTHER LONG TERM CARE	0	0	-	0	33
ANCILLARY SERVICE COST CENTERS	0	U	0	U	
40.00 RADIOLOGY	0	37,963	0	27.062	40
41.00 LABORATORY	0			37,963	40
		102,736		102,736	
42.00 INTRAVENOUS THERAPY	0	-1,006 0	0	-1,006	42
43.00 OXYGEN (INHALATION) THERAPY	0		0	0	43
44.00 PHYSICAL THERAPY	0	979,148		979,148	44
45.00 OCCUPATIONAL THERAPY	0	789,241	0	789,241	45
46.00 SPEECH PATHOLOGY	0	129,677	0	129,677	46
47.00 ELECTROCARDIOLOGY	0	0	0	0	47
48.00 MEDICAL SUPPLIES CHARGED TO PAT		0	0	0	48
49.00 DRUGS CHARGED TO PATIENTS	0	854,968	0	854,968	49
50.00 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50
51.00 SUPPORT SURFACES	0	189		189	51
52.00 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	52
52.01 OTHER ANCILLARY SERVICES COST	0	0	0	0	52
52.02 MEDICAL SERVICES	0	0	0	0	52
OUTPATIENT SERVICE COST CENTERS					
60.00 CLINIC	0	0	0	0	60
61.00 RURAL HEALTH CLINIC	0	0	0	0	61
62.00 FQHC					62
63.00 DIALYSIS	0	0	0	0	63
OTHER REIMBURSABLE COST CENTERS			'		<u>'</u>
70.00 HOME HEALTH AGENCY COST	0	0	0	0	70
71.00 AMBULANCE	0	87,041	0	87,041	71
73.00 CMHC	0	0		0	73
74.00 OTHER REIMBURSEMENT	0	0		0	74
SPECIAL PURPOSE COST CENTERS			· · · · · · · · · · · · · · · · · · ·	· ·	
80.00 MALPRACTICE PREMIUMS & PAID LOSS	SES				80
81.00 INTEREST EXPENSE					81
82.00 UTILIZATION REVIEW - SNF					82
83.00 HOSPICE	0	0	0	0	83
		0		0	
	0	0	0		84
84.01 OTHER SPECIAL PURPOSE COST II	-			10.756.455	84
89.00 SUBTOTALS (sum of lines 1-84)	292,342	18,756,455	0	18,756,455	89

CARE ONE AT MADISON AVENUE

Period:
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COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
PPS

	Cost Center Description	ACTIVITES	Subtotal	Post Stepdown Adjustments	Total						
		15.00	16.00	17.00	18.00						
NONI	NONREIMBURSABLE COST CENTERS										
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	12,364	0	12,364		90.00				
91.00	BARBER AND BEAUTY SHOP	0	2,722	0	2,722		91.00				
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0		92.00				
93.00	NONPAID WORKERS	0	0	0	0		93.00				
94.00	PATIENTS LAUNDRY	0	0	0	0		94.00				
95.00	OTHER NONREIMBURSABLE COST	0	0	0	0		95.00				
98.00	Cross Foot Adjustments	0	0	0	0		98.00				
99.00	Negative Cost Centers	0	0	0	0		99.00				
100.00	TOTAL	292,342	18,771,541	0	18,771,541		100.00				

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From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315488 11.1.179.1



ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B Part II

1.00 C 2.00 C 3.00 E 4.00 A 5.00 Pl 6.00 L 7.00 H 8.00 D	Cost Center Description LAL SERVICE COST CENTERS LAP REL COSTS - BLDGS & FIXTURES LAP REL COSTS - MOVABLE EQUIPMENT LMPLOYEE BENEFITS	Directly Assigned New Capital Related Costs 0	BLDGS & FIXTURES 1.00	MOVABLE EQUIPMENT 2.00	Subtotal	EMPLOYEE BENEFITS	ADMINISTRA TIVE & GENERAL	MAINT. &	LAUNDRY & LINEN	
1.00 C 2.00 C 3.00 E 4.00 A 5.00 Pl 6.00 L 7.00 H 8.00 D	AL SERVICE COST CENTERS AP REL COSTS - BLDGS & FIXTURES AP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS	Capital Related Costs	FIXTURES	EQUIPMENT			TIVE &	MAINT. &	LINEN	
1.00 C 2.00 C 3.00 E 4.00 A 5.00 Pl 6.00 L 7.00 H 8.00 D	AL SERVICE COST CENTERS AP REL COSTS - BLDGS & FIXTURES AP REL COSTS - MOVABLE EQUIPMENT EMPLOYEE BENEFITS	Costs	FIXTURES	EQUIPMENT						
1.00 C 2.00 C 3.00 E 4.00 A 5.00 Pl 6.00 L 7.00 H 8.00 D	CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT CMPLOYEE BENEFITS			_`		BENEFITS	CENIEDAL	DEDATE		
1.00 C 2.00 C 3.00 E 4.00 A 5.00 Pl 6.00 L 7.00 H 8.00 D	CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT CMPLOYEE BENEFITS	0	1.00	2.00			GENERAL	REPAIRS	SERVICE	
1.00 C 2.00 C 3.00 E 4.00 A 5.00 Pl 6.00 L 7.00 H 8.00 D	CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT CMPLOYEE BENEFITS			2.00	2A	3.00	4.00	5.00	6.00	
2.00 C 3.00 E 4.00 A 5.00 P 6.00 L 7.00 H 8.00 D	CAP REL COSTS - MOVABLE EQUIPMENT CMPLOYEE BENEFITS									
3.00 E 4.00 A 5.00 Pl 6.00 L 7.00 H 8.00 D	MPLOYEE BENEFITS									1.00
4.00 A 5.00 Pl 6.00 L 7.00 H 8.00 D										2.00
5.00 Pl 6.00 L. 7.00 H 8.00 D		0	0	0	0	0				3.00
6.00 L. 7.00 H 8.00 D	DMINISTRATIVE & GENERAL	0	0	0	0	0	0			4.00
7.00 H 8.00 D	LANT OPERATION, MAINT. & REPAIRS	0	0	0	0	0	0	0		5.00
8.00 D	AUNDRY & LINEN SERVICE	0	0	0	0	0	0	0	0	6.00
	IOUSEKEEPING	0	0	0	0	0	0	0	0	7.00
9.00 N	DIETARY	0	0	0	0	0	0	0	0	8.00
	URSING ADMINISTRATION	0	0	0	0	0	0	0	0	9.00
10.00 C	ENTRAL SERVICES & SUPPLY	0	0	0	0	0	0	0	0	10.00
11.00 P	HARMACY	0	0	0	0	0	0	0	0	11.00
12.00 M	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	0	0	0	12.00
13.00 Sc	OCIAL SERVICE	0	0	0	0	0	0	0	0	13.00
14.00 N	JURSING AND ALLIED HEALTH	0	0	0	0	0	0	0	0	14.00
	DUCATION									
15.00 A	CTIVITES	0	0	0	0	0	0	0	0	15.00
INPATI	ENT ROUTINE SERVICE COST CENTERS									
30.00 SI	KILLED NURSING FACILITY	0	2,411,473	294,540	2,706,013	0	0	0	0	30.00
	JURSING FACILITY	0	0	0	0	0	0	0	0	31.00
	CF/IID	0	0	0	0	0	0	0	0	
	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	
	ARY SERVICE COST CENTERS									00.00
	ADIOLOGY	0	0	0	0	0	0	0	0	40.00
	ABORATORY	0	0	0	0	0	0		0	
	NTRAVENOUS THERAPY	0	0	0	0	0	0	t	0	42.00
	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	0		0	43.00
	PHYSICAL THERAPY	0	68,939	8,420	77,359	0	0		0	44.00
	OCCUPATIONAL THERAPY	0	45,959	5,614	51,573	0	0		0	
	PEECH PATHOLOGY	0	45,959	0,014	0	0	0		0	
	ELECTROCARDIOLOGY	0	0	0	0	0	0		0	47.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0		0	48.00
	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0		0	
		0	0	0	0	0	0		0	
	DENTAL CARE - TITLE XIX ONLY UPPORT SURFACES	0	0	0	0	0	0		0	50.00
					0	0			0	51.00
	COMPLEX MEDICAL EQUIPMENT	0	0	0			0		0	52.00
	OTHER ANCILLARY SERVICES COST		0		0	0	0	t	0	0=101
	MEDICAL SERVICES	0	0	0	0	0	0	0	0	52.02
	TIENT SERVICE COST CENTERS		0	0	0	0		1	0	60.00
	ZINIC	0	0	0	0	0	0		0	
	URAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00
62.00 F	`									62.00
63.00 D		0	0	0	0	0	0	0	0	63.00
	REIMBURSABLE COST CENTERS									
	IOME HEALTH AGENCY COST	0	0	0	0	0	0			70.00
	MBULANCE	0	0	0	0	0	0		0	,
73.00 C		0	0	0	0	0	0		0	73.00
	THER REIMBURSEMENT	0	0	0	0	0	0	0	0	74.00
	L PURPOSE COST CENTERS									
	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00 IN	NTEREST EXPENSE									81.00
82.00 U	TILIZATION REVIEW - SNF									82.00
83.00 H	IOSPICE	0	0	0	0	0	0	0	0	83.00
84.00 O	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	0	0	0	84.00
84.01 O	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	0	0	0	84.01

CARE ONE AT MADISON AVENUE

Period:
From: 01/01/2024
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ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B Part II PPS

	Cost Center Description	Directly Assigned New Capital Related Costs	BLDGS & FIXTURES	MOVABLE EQUIPMENT	Subtotal	EMPLOYEE BENEFITS	TIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	
		0	1.00	2.00	2A	3.00	4.00	5.00	6.00	
89.00	SUBTOTALS (sum of lines 1-84)	0	2,526,371	308,574	2,834,945	0	0	0	0	89.00
NONE	REIMBURSABLE COST CENTERS									
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
95.00	OTHER NONREIMBURSABLE COST	0	0	0	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments								0	98.00
99.00	Negative Cost Centers		0	0	0	0	0	0	0	99.00
100.00	TOTAL	0	2,526,371	308,574	2,834,945	0	0	0	0	100.00

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5/28/2025 2:59 pm **2540-10** CARE ONE AT MADISON AVENUE Period: Run Date Time:

From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315488 11.1.179.1



ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B Part II

HOUSEKEEPI NG	URSING D ALLIED EALTH JCATION 14.00 1 2 3 4 5 6 7 8 9 10 11 12 13 0 14 0 14 0 14 0 0 14 0 0 14 0 0 14 13 0 14 13 0 14 14 15
HOUSEKEEP NG DIETARY TION SUPPLY PHARMACY LIBRARY SERVICE EDI	EALTH JCATION 14.00 1.0 2.1 3.1 4.1 5.1 6.1 7.1 8.8 9.0 10.1 11.1 12.1 13.1
NG	1.00 14.00 1.00 1.00 1.00 1.00 1.00 1.00
7.00	14.00 2.0 3.1 4.1 5.1 6.1 7.1 8.8 9.0 10.0 11.1 12.0 13.1
CENERAL SERVICE COST CENTERS	1.0 2.0 3.1 4.1 5.1 6.1 7.1 8.8 9.0 10.0 11.1 12.0 13.1
1.00 CAP REL COSTS - BLDGS & FIXTURES 2.00 CAP REL COSTS - MOVABLE EQUIPMENT 3.00 EMPLOYEE BENEFITS 4.00 ADMINISTRATIVE & GENERAL 5.00 PLANT OPERATION, MAINT. & REPAIRS 6.00 LAUNDRY & LINEN SERVICE 7.00 HOUSEKEEPING 8.00 DIETARY 9.00 NURSING ADMINISTRATION 10.00 CENTRAL SERVICES & SUPPLY 0 0 11.00 PHARMACY 0 0 12.00 MEDICAL RECORDS & LIBRARY 0 0 13.00 SOCIAL SERVICE	2.0 3.3 4.4 5.1 6.1 7.1 8.8 9.1 10.1 11.1 12.2 13.4
2.00 CAP REL COSTS - MOVABLE EQUIPMENT 3.00 EMPLOYEE BENEFITS 4.00 ADMINISTRATIVE & GENERAL 5.00 PLANT OPERATION, MAINT. & REPAIRS 6.00 LAUNDRY & LINEN SERVICE 7.00 HOUSEKEEPING 8.00 DIETARY 9.00 NURSING ADMINISTRATION 10.00 CENTRAL SERVICES & SUPPLY 0 0 11.00 PHARMACY 0 0 12.00 MEDICAL RECORDS & LIBRARY 0 0 13.00 SOCIAL SERVICE	2.0 3.3 4.4 5.1 6.1 7.1 8.8 9.1 10.1 11.1 12.2 13.4
3.00 EMPLOYEE BENEFITS	3.0 4.1 5.1 6.1 7.1 8.8 9.1 10.1 11.1 12.2 13.4
4.00 ADMINISTRATIVE & GENERAL 5.00 PLANT OPERATION, MAINT. & REPAIRS 6.00 LAUNDRY & LINEN SERVICE 7.00 HOUSEKEEPING 8.00 DIETARY 9.00 NURSING ADMINISTRATION 10.00 CENTRAL SERVICES & SUPPLY 0 0 11.00 PHARMACY 0 0 12.00 MEDICAL RECORDS & LIBRARY 0 0 13.00 SOCIAL SERVICE	4.4 5.5 6.1 7.1 8.8 9.1 10.1 11.1 12.2 13.4
5.00 PLANT OPERATION, MAINT. & REPAIRS 6.00 LAUNDRY & LINEN SERVICE 7.00 HOUSEKEEPING 8.00 DIETARY 9.00 NURSING ADMINISTRATION 10.00 CENTRAL SERVICES & SUPPLY 0 0 11.00 PHARMACY 0 0 12.00 MEDICAL RECORDS & LIBRARY 0 0 13.00 SOCIAL SERVICE 0 0 0	5.0 6.0 7.1 8.0 9.0 10.0 11.1 12.0 13.0
6.00 LAUNDRY & LINEN SERVICE 7.00 HOUSEKEEPING 8.00 DIETARY 9.00 NURSING ADMINISTRATION 10.00 CENTRAL SERVICES & SUPPLY 0 0 11.00 PHARMACY 0 0 12.00 MEDICAL RECORDS & LIBRARY 0 0 13.00 SOCIAL SERVICE 0 0 <tr< td=""><td>6.0 7.1 8.1 9.1 10.1 11.1 12.1 13.1</td></tr<>	6.0 7.1 8.1 9.1 10.1 11.1 12.1 13.1
7.00 HOUSEKEEPING 0 0 8.00 DIETARY 0 0 9.00 NURSING ADMINISTRATION 0 0 10.00 CENTRAL SERVICES & SUPPLY 0 0 0 11.00 PHARMACY 0 0 0 0 12.00 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 13.00 SOCIAL SERVICE 0 0 0 0 0 0	7.3 8.3 9.3 10.3 11.3 12.4 13.6
8.00 DIETARY 0	8.4 9.4 10.4 11.4 12.4 13.4
10.00 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 11.00 PHARMACY 0 0 0 0 0 0 12.00 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 0 13.00 SOCIAL SERVICE 0 0 0 0 0 0 0 0 0	10. 11. 12. 13.
11.00 PHARMACY 0 0 0 0 0 12.00 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 13.00 SOCIAL SERVICE 0 0 0 0 0 0 0 0	11. 12. 13.
12.00 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 0 13.00 SOCIAL SERVICE 0 0 0 0 0 0 0 0	12. 13.
13.00 SOCIAL SERVICE 0 0 0 0 0 0 0	13.
1400 NUMERING AND ALLIED HEALTH	0 14.
14.00 NURSING AND ALLIED HEALTH 0 0 0 0 0 0	
EDUCATION	
15.00 ACTIVITES 0 0 0 0 0 0 0 0	0 15.
INPATIENT ROUTINE SERVICE COST CENTERS	
30.00 SKILLED NURSING FACILITY 0 0 0 0 0 0 0	0 30.
31.00 NURSING FACILITY 0 0 0 0 0 0 0 0	0 31.
32.00 ICF/IID 0 0 0 0 0 0	0 32.
33.00 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0	0 33.
ANCILLARY SERVICE COST CENTERS	
40.00 RADIOLOGY 0 0 0 0 0 0 0	0 40.
41.00 LABORATORY 0 0 0 0 0 0 0 0	0 41.
42.00 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0	0 42.
43.00 OXYGEN (INHALATION) THERAPY 0 0 0 0 0 0 0 0	0 43.
44.00 PHYSICAL THERAPY 0 0 0 0 0 0 0	0 44.
45.00 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0	0 45.0
46.00 SPEECH PATHOLOGY 0 0 0 0 0 0	0 46.
47.00 ELECTROCARDIOLOGY 0 0 0 0 0 0 0	0 47.
48.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0	0 48.
49.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0	0 49.
50.00 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0	0 50.0
51.00 SUPPORT SURFACES 0 0 0 0 0 0 0 0	0 51.
52.00 COMPLEX MEDICAL EQUIPMENT 0 0 0 0 0 0	0 52.0
52.01 OTHER ANCILLARY SERVICES COST 0 0 0 0 0 0 0 0	0 52.0
52.02 MEDICAL SERVICES 0 0 0 0 0 0 0	0 52.
OUTPATIENT SERVICE COST CENTERS	
60.00 CLINIC 0 0 0 0 0 0 0	0 60.
61.00 RURAL HEALTH CLINIC 0 0 0 0 0 0 0	0 61.
62.00 FQHC	62.0
63.00 DIALYSIS 0 0 0 0 0 0 0 0 0	0 63.
	0 70
	0 70.
73.00 CMHC 0 0 0 0 0 0 74.00 OTHER REIMBURSEMENT 0 0 0 0 0 0 0 0	0 73.
SPECIAL PURPOSE COST CENTERS	0 74.
80.00 MALPRACTICE PREMIUMS & PAID LOSSES	80.0
81.00 INTEREST EXPENSE	81.
82.00 UTILIZATION REVIEW - SNF	82.0
83.00 HOSPICE 0 0 0 0 0 0 0 0	0 83.
84.00 OTHER SPECIAL PURPOSE COST I 0 0 0 0 0 0 0	0 84.
84.01 OTHER SPECIAL PURPOSE COST II 0 0 0 0 0 0 0	
	0 84.

CARE ONE AT MADISON AVENUE

Period:
From: 01/01/2024
Provider CCN: 315488

Run Date Time: 5/28/2025 2:59 pm
MCRIF32 2540-10
To: 12/31/2024
Version: 11.1.179.1

ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B Part II PPS

	Cost Center Description	HOUSEKEEPI NG	DIETARY	NURSING ADMINISTRA TION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NURSING AND ALLIED HEALTH EDUCATION	
		7.00	8.00	9.00	10.00	11.00	12.00	13.00	14.00	
89.00	SUBTOTALS (sum of lines 1-84)	0	0	0	0	0	0	0	0	89.00
NONE	REIMBURSABLE COST CENTERS									
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
95.00	OTHER NONREIMBURSABLE COST	0	0	0	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments	0	0	0	0	0			0	98.00
99.00	Negative Cost Centers	0	0	0	0	0	0	0	0	99.00
100.00	TOTAL	0	0	0	0	0	0	0	0	100.00

5/28/2025 2:59 pm **2540-10** CARE ONE AT MADISON AVENUE Period: Run Date Time:

From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: 11.1.179.1



ALLOCATION OF CAPITAL RELATED COSTS

315488

Provider CCN:

Worksheet B Part II

					PPS
			Post		
Cost Center Description			Step-Down		
	ACTIVITES	Subtotal	Adjustments	Total	
	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS					
1.00 CAP REL COSTS - BLDGS & FIXTURES					1.00
2.00 CAP REL COSTS - MOVABLE EQUIPMENT					2.00
3.00 EMPLOYEE BENEFITS					3.00
4.00 ADMINISTRATIVE & GENERAL					4.00
5.00 PLANT OPERATION, MAINT. & REPAIRS					5.00
6.00 LAUNDRY & LINEN SERVICE					6.00
7.00 HOUSEKEEPING					7.00
8.00 DIETARY					8.00
9.00 NURSING ADMINISTRATION					9.00
10.00 CENTRAL SERVICES & SUPPLY					10.00
11.00 PHARMACY					11.00
12.00 MEDICAL RECORDS & LIBRARY					12.00
13.00 SOCIAL SERVICE					13.00
14.00 NURSING AND ALLIED HEALTH EDUCATION					14.00
15.00 ACTIVITES	0				15.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 SKILLED NURSING FACILITY	0	2,706,013	0	2,706,013	30.00
31.00 NURSING FACILITY	0	0	0	' '	31.00
32.00 ICF/IID	0	0	0	0	32.00
33.00 OTHER LONG TERM CARE	0	0	0	0	33.00
ANCILLARY SERVICE COST CENTERS					55.00
40.00 RADIOLOGY	0	0	0	0	40.00
41.00 LABORATORY	0	0	0	0	41.00
42.00 INTRAVENOUS THERAPY	0	0	0	0	42.00
43.00 OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00 PHYSICAL THERAPY	0	77,359	0	77,359	44.00
45.00 OCCUPATIONAL THERAPY	0	51,573	0	51,573	45.00
46.00 SPEECH PATHOLOGY	0	0	0	0	46.00
47.00 ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	48.00
49.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	49.00
50.00 DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00 SUPPORT SURFACES	0	0	0	0	51.00
52.00 COMPLEX MEDICAL EQUIPMENT	0	0	0	0	52.00
52.01 OTHER ANCILLARY SERVICES COST	0	0	0	0	52.01
52.02 MEDICAL SERVICES	0	0	0	0	52.02
OUTPATIENT SERVICE COST CENTERS					32.02
60.00 CLINIC	0	0	0	0	60.00
61.00 RURAL HEALTH CLINIC	0	0	0	0	61.00
62.00 FQHC				-	62.00
63.00 DIALYSIS	0	0	0	0	63.00
OTHER REIMBURSABLE COST CENTERS					03.00
70.00 HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00 AMBULANCE	0	0	0	0	71.00
73.00 CMHC	0	0	0		73.00
74.00 OTHER REIMBURSEMENT	0	0	0	0	74.00
SPECIAL PURPOSE COST CENTERS			0		
80.00 MALPRACTICE PREMIUMS & PAID LOSSES					80.00
81.00 INTEREST EXPENSE					81.00
82.00 UTILIZATION REVIEW - SNF					82.00
83.00 HOSPICE	0	0	0	0	83.00
84.00 OTHER SPECIAL PURPOSE COST I	0	0	0	0	84.00
84.01 OTHER SPECIAL PURPOSE COST II	0	0	0		84.01
			V		

CARE ONE AT MADISON AVENUE

Period:
From: 01/01/2024
Provider CCN: 315488

Run Date Time: 5/28/2025 2:59 pm
MCRIF32
2540-10
To: 12/31/2024
Version: 11.1.179.1

ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B Part II PPS

	Cost Center Description	ACTIVITES	Subtotal	Post Step-Down Adjustments	Total		
		15.00	16.00	17.00	18.00		
89.00	SUBTOTALS (sum of lines 1-84)	0	2,834,945	0	2,834,945	8	39.00
NON	REIMBURSABLE COST CENTERS						
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	9	00.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	9	01.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	9.	2.00
93.00	NONPAID WORKERS	0	0	0	0	9.	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	9.	94.00
95.00	OTHER NONREIMBURSABLE COST	0	0	0	0	9	95.00
98.00	Cross Foot Adjustments	0	0	0	0	9	08.00
99.00	Negative Cost Centers	0	0	0	0	9	9.00
100.00	TOTAL	0	2,834,945	0	2,834,945	10	00.00

CARE ONE AT MADISON AVENUE

Period: From: 01/01/2024 MCRIF32 To: 12/31/2024 Version:

Run Date Time:

5/28/2025 2:59 pm **2540-10** 11.1.179.1



315488 COST ALLOCATION - STATISTICAL BASIS

Provider CCN:

Worksheet B-1

										PPS
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRA TIVE & GENERAL (ACCUM COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPI NG (SQUARE FEET)	
CENT	EDAL CEDILICE COST CENTREDS	1.00	2.00	3.00	4A	4.00	5.00	6.00	7.00	
	ERAL SERVICE COST CENTERS	27,200								1.00
2.00	CAP REL COSTS - BLDGS & FIXTURES CAP REL COSTS - MOVABLE EQUIPMENT	36,280	36,280							2.00
3.00	EMPLOYEE BENEFITS	0	30,280	9,691,263						3.00
4.00	ADMINISTRATIVE & GENERAL	0	0	607,979	-3,747,384	15,025,163				4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	0	0	121,057	0	730,629	36,280			5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	84,998	0	165,696	0,200	34,330		6.00
7.00	HOUSEKEEPING	0	0	418,048	0	494,000	0		36,280	7.00
8.00	DIETARY	0	0	590,969	0	994,358	0	0	-	
9.00	NURSING ADMINISTRATION	0	0	632,617	0	801,359	0	0	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	34,559	0	184,049	0	0	0	10.00
11.00	PHARMACY	0	0	0	0	35,535	0	0	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	37,628	0	40,797	0	0	0	12.00
13.00	SOCIAL SERVICE	0	0	106,277	0	115,341	0	0	0	13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	0	0	0	14.00
15.00	ACTIVITES	0	0	201,762	0	233,985	0	0	0	15.00
INPA'	TIENT ROUTINE SERVICE COST CENTERS									
30.00	SKILLED NURSING FACILITY	34,630	34,630	5,645,681	0	8,887,131	34,630	34,330	34,630	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0			0 = 100
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
	LLARY SERVICE COST CENTERS					l	1	1	1	
40.00	RADIOLOGY	0	0	0	0	30,385	0		0	10.00
41.00	LABORATORY	0	0	0	0	82,228	0			
42.00	INTRAVENOUS THERAPY	0	0	0		0	0			
43.00	OXYGEN (INHALATION) THERAPY	990	990	0	0	750.272	990	0		10100
44.00	PHYSICAL THERAPY OCCUPATIONAL THERAPY	660		600,093	0	750,273		0		44.00
46.00	SPEECH PATHOLOGY	000	660	514,006 95,589	0	609,415 103,791	660		-	
47.00	ELECTROCARDIOLOGY	0	0	0	0	103,791	0			
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0		· ·	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	684,299	0		0	
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0		0	0		0	
51.00	SUPPORT SURFACES	0	0	0	0	151	0	0	0	
52.00	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	0	0	0	52.00
52.01	OTHER ANCILLARY SERVICES COST	0	0	0	0	0	0	0	0	52.01
52.02	MEDICAL SERVICES	0	0	0	0	0	0	0	0	52.02
OUTF	PATIENT SERVICE COST CENTERS									
	CLINIC	0	0	0	0	0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00
	FQHC									62.00
	DIALYSIS	0	0	0	0	0	0	0	0	63.00
	ER REIMBURSABLE COST CENTERS						_			
	HOME HEALTH AGENCY COST	0	0	0						70.00
	AMBULANCE	0	0	0			0			71.00
	CMHC OTHER REIMBURGEMENT	0	0	0		0	0			
	OTHER REIMBURSEMENT IAL PURPOSE COST CENTERS	0	0	0	0	0	0	0	0	74.00
	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
	INTEREST EXPENSE									81.00
	UTILIZATION REVIEW - SNF									82.00
	HOSPICE	0	0	0	0	0	0	0	0	83.00
	-					1		· · · · · ·		

CARE ONE AT MADISON AVENUE

Period:
From: 01/01/2024
Provider CCN: 315488

Period:
From: 01/01/2024
Provider CCN: 315488

Run Date Time: 5/28/2025 2:59 pm
MCRIF32
2540-10
Version: 11.1.179.1

COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

PPS

										PPS
	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET) 2.00	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation 4A	ADMINISTRA TIVE & GENERAL (ACCUM COST) 4.00	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET) 5.00	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPI NG (SQUARE FEET) 7.00	
84.00	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	0	0.00	0	84.00
	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	36,280	36,280	9,691,263	-3,746,378	15,013,088	36,280	34,330	36,280	89.00
NONI	REIMBURSABLE COST CENTERS		,							
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	9,896	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	2,179	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
95.00	OTHER NONREIMBURSABLE COST	0	0	0	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments									98.00
99.00	Negative Cost Centers									99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	2,526,371	308,574	826,498		3,747,384	912,853	207,022	617,207	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	69.635364	8.505347	0.085283		0.249407	25.161329	6.030352	17.012321	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			0		0	0	0	0	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.000000	0.000000	0.000000	0.000000	105.00

5/28/2025 2:59 pm **2540-10** CARE ONE AT MADISON AVENUE Period: Run Date Time:

From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315488 11.1.179.1



COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

										PPS
	Cost Center Description	DIETARY (MEALS SERVED)	NURSING ADMINISTRA TION (PATIENT DAYS)	CENTRAL SERVICES & SUPPLY (PATIENT DAYS)	PHARMACY (PATIENT DAYS)	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS)	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME)	ACTIVITES (PATIENT DAYS)	
		8.00	9.00	10.00	11.00	12.00	13.00	14.00	15.00	
	ERAL SERVICE COST CENTERS									
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT									2.00
3.00	EMPLOYEE BENEFITS									3.00
4.00	ADMINISTRATIVE & GENERAL									4.00
5.00 6.00	PLANT OPERATION, MAINT. & REPAIRS LAUNDRY & LINEN SERVICE									5.00
7.00	HOUSEKEEPING									7.00
8.00	DIETARY	102,990								8.00
9.00	NURSING ADMINISTRATION	102,990	34,330							9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	34,330						10.00
11.00	PHARMACY	0	0	0	34,330					11.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	34,330				12.00
13.00	SOCIAL SERVICE	0	0	0	0	0	34,330			13.00
14.00	NURSING AND ALLIED HEALTH	0	0	0	0	0	0 1,550	0		14.00
11.00	EDUCATION	· ·	v	V	V	Ĭ	V			11.00
15.00	ACTIVITES	0	0	0	0	0	0	0	34,330	15.00
INPA'	TIENT ROUTINE SERVICE COST CENTERS								,	
30.00	SKILLED NURSING FACILITY	102,990	34,330	34,330	34,330	34,330	34,330	0	34,330	30.00
31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
ANCI	LLARY SERVICE COST CENTERS									
40.00	RADIOLOGY	0	0	0	0	0	0	0	0	40.00
41.00	LABORATORY	0	0	0	0	0	0	0	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	0	0	0	0	0	0	0	0	44.00
45.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	0	0	45.00
46.00	SPEECH PATHOLOGY	0	0	0	0	0	0	0	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0		0	17.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0	0	0	0	0	0		0	51.00
52.00	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	0		0	52.00
52.01	OTHER ANCILLARY SERVICES COST	0	0	0	0	0	0	-	0	52.01
52.02	MEDICAL SERVICES	0	0	0	0	0	0	0	0	52.02
	PATIENT SERVICE COST CENTERS			0				1 0		10.00
	CLINIC	0	0	0	0	0	0		0	
	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	
	FQHC DIALYSIS	0	0	0	0	0	0	0	0	62.00
	ER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	0	0	63.00
	HOME HEALTH AGENCY COST	0	0	0	0	0	0	0	0	70.00
71.00	AMBULANCE	0	0	0	0	0	0		0	
	CMHC	0	0	0	0	0	0		0	
	OTHER REIMBURSEMENT	0	0	0	0	0	0	0	0	74.00
	IAL PURPOSE COST CENTERS		0	0	0	0	0			7 1.00
	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
	INTEREST EXPENSE									81.00
	UTILIZATION REVIEW - SNF									82.00
	HOSPICE	0	0	0	0	0	0	0	0	
	· · · · ·	· · · · · · · · · · · · · · · · · · ·			V	V		·		

CARE ONE AT MADISON AVENUE

Period:
From: 01/01/2024
Provider CCN: 315488

Run Date Time: 5/28/2025 2:59 pm
MCRIF32
2540-10
To: 12/31/2024
Version: 11.1.179.1

COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

PPS

										PPS
	Cost Center Description	DIETARY (MEALS SERVED) 8.00	NURSING ADMINISTRA TION (PATIENT DAYS) 9.00	CENTRAL SERVICES & SUPPLY (PATIENT DAYS)	PHARMACY (PATIENT DAYS) 11.00	MEDICAL RECORDS & LIBRARY (PATIENT DAYS)	SOCIAL SERVICE (PATIENT DAYS) 13.00	NURSING AND ALLIED HEALTH EDUCATION (ASSIGNED TIME) 14.00	ACTIVITES (PATIENT DAYS) 15.00	
84.00	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	0	0	0	84.00
84.01	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	0	0	0	84.01
89.00	SUBTOTALS (sum of lines 1-84)	102,990	34,330	34,330	34,330	34,330	34,330	0	34,330	89.00
NONI	REIMBURSABLE COST CENTERS									
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	0	0	0	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	0	0	91.00
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	0	92.00
93.00	NONPAID WORKERS	0	0	0	0	0	0	0	0	93.00
94.00	PATIENTS LAUNDRY	0	0	0	0	0	0	0	0	94.00
95.00	OTHER NONREIMBURSABLE COST	0	0	0	0	0	0	0	0	95.00
98.00	Cross Foot Adjustments									98.00
99.00	Negative Cost Centers									99.00
102.00	Cost to be allocated (per Wkst. B, Part I)	1,242,358	1,001,224	229,952	44,398	50,972	144,108	0	292,342	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	12.062899	29.164696	6.698281	1.293271	1.484766	4.197728	0.000000	8.515642	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	0	0	0	0	0	0	0	0	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	105.00

CARE ONE AT MADISON AVENUE

Period:
From: 01/01/2024
Provider CCN: 315488

Run Date Time: 5/28/2025 2:59 pm
MCRIF32 2540-10
Version: 11.1.179.1

RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

Worksheet C

PPS

	Cost Center Description	Total (from Wkst. B, Pt I, col. 18)	Total Charges	Ratio (col. 1 divided by col. 2	
		1.00	2.00	3.00	
ANCI	ILLARY SERVICE COST CENTERS		'		
40.00	RADIOLOGY	37,963	75,963	0.499756	40.00
41.00	LABORATORY	102,736	205,570	0.499762	41.00
42.00	INTRAVENOUS THERAPY	0	218,836	0.000000	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0.000000	43.00
44.00	PHYSICAL THERAPY	979,148	2,265,487	0.432202	44.00
45.00	OCCUPATIONAL THERAPY	789,241	2,284,083	0.345540	45.00
46.00	SPEECH PATHOLOGY	129,677	480,294	0.269995	46.00
47.00	ELECTROCARDIOLOGY	0	0	0.000000	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	48.00
49.00	DRUGS CHARGED TO PATIENTS	854,968	1,859,507	0.459782	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.00
51.00	SUPPORT SURFACES	189	378	0.500000	51.00
52.00	COMPLEX MEDICAL EQUIPMENT	0	0	0.000000	52.00
52.01	OTHER ANCILLARY SERVICES COST	0	0	0.000000	52.01
52.02	MEDICAL SERVICES	0	0	0.000000	52.02
OUT	PATIENT SERVICE COST CENTERS				
60.00	CLINIC	0	0	0.000000	60.00
61.00	RURAL HEALTH CLINIC				61.00
62.00	FQHC				62.00
63.00	DIALYSIS	0	0	0.000000	63.00
71.00	AMBULANCE	87,041	174,165	0.499762	71.00
100.00	Total	2,980,963	7,564,283	_	100.00

CARE ONE AT MADISON AVENUE Period: Run Date Time: 5/28/2025 2:59 pm

From: 01/01/2024 MCRIF32 2540-10 315488 To: 12/31/2024 Version: 11.1.179.1



APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS

Provider CCN:

Worksheet D

Part I Title XVIII Skilled Nursing Facility PPS

				11tic 20 v 111	Okined I varsing	5 1 11011111	110
PART	I - CALCULATION OF ANCILLARY AND OUTPAT	TENT COST					
			Health Care Pro	ogram Charges	Health Care I	Program Cost	
		Ratio of Cost to Charges					
		(Fr. Wkst. C Column 3)	Part A	Part B	Part A (col. 1 x col. 2)	Part B (col. 1 x col. 3)	
		1.00	2.00	3.00	4.00	5.00	
ANC	ILLARY SERVICE COST CENTERS						
40.00	RADIOLOGY	0.499756	12,972	0	6,483	0	40.00
41.00	LABORATORY	0.499762	17,663	0	8,827	0	41.00
42.00	INTRAVENOUS THERAPY	0.000000	24,417	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	0.432202	1,170,204	0	505,765	0	44.00
45.00	OCCUPATIONAL THERAPY	0.345540	1,175,929	0	406,331	0	45.00
46.00	SPEECH PATHOLOGY	0.269995	283,635	0	76,580	0	46.00
47.00	ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0.459782	56,997	0	26,206	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0.000000	0		0		50.00
51.00	SUPPORT SURFACES	0.500000	378	0	189	0	51.00
52.00	COMPLEX MEDICAL EQUIPMENT	0.000000	0	0	0	0	52.00
52.01	OTHER ANCILLARY SERVICES COST	0.000000	0	0	0	0	52.01
52.02	MEDICAL SERVICES	0.000000	0	0	0	0	52.02
OUT	PATIENT SERVICE COST CENTERS						
60.00	CLINIC	0.000000	0	0	0	0	60.00
61.00	RURAL HEALTH CLINIC						61.00
62.00	FQHC						62.00
63.00	DIALYSIS	0.000000	0	0	0	0	63.00
71.00	AMBULANCE (2)	0.499762		0		0	71.00
100.00	Total (Sum of lines 40 - 71)		2,742,195	0	1,030,381	0	100.00

⁽¹⁾ For titles V and XIX use columns 1, 2 and 4 only.
(2) Line 71 columns 2 and 4 are for titles V and XIX. No amounts should be entered here for title XVIII.

In Lieu of Form CMS-2540-10 Health Financial Systems

To:

CARE ONE AT MADISON AVENUE Period: Run Date Time: 5/28/2025 2:59 pm

854,968

2,893,922

189

0

0

From: 01/01/2024 MCRIF32 2540-10 12/31/2024 Version: 11.1.179.1

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26,206

189

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1,030,381



APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS

315488

48.00 MEDICAL SUPPLIES CHARGED TO PATIENTS

49.00 DRUGS CHARGED TO PATIENTS

50.00 DENTAL CARE - TITLE XIX ONLY

52.00 COMPLEX MEDICAL EQUIPMENT

MEDICAL SERVICES

100.00 Total (Sum of lines 40 - 52)

52.01 OTHER ANCILLARY SERVICES COST

51.00 SUPPORT SURFACES

52.02

Provider CCN:

Worksheet D

048.00

0 49.00

0 50.00

0

0 52.02

51.00

52.01

0 52.00

0 100.00

				Title XVIII	Skilled Nursin	Parts I g Facility	II-III PPS
PART	II - APPORTIONMENT OF VACCINE COST						
						1.00	
1.00	Drugs charged to patients - ratio of cost to charges (From Wor	ksheet C, column 3, line 49	9)			0.459782	1.00
2.00	Program vaccine charges (From your records, or the PS&R)					1,509	2.00
3.00	Program costs (Line 1 x line 2) (Title XVIII, PPS providers, tra	nsfer this amount to Work	sheet E, Part I, line 18)			694	3.00
PART	III - CALCULATION OF PASS THROUGH COSTS FO	R NURSING & ALLIEI	HEALTH				
				Ratio of Nursing &			
	Cost Center Description		Nursing & Allied Health	Allied Health Costs to	Program Part A Cost	Part A Nursing & Allied	
	Cost Center Description	Total Cost (From Wkst.	(From Wkst. B, Part I,	Total Costs - Part A	(From Wkst. D Part I,	Health Costs for Pass	
		B, Part I, Col. 18	Col. 14)	(Col. 2 / Col. 1)	Col. 4)	rsing Facility 1.00 0.459782 1.509 2.509 Part A Nursing & Allied Health Costs for Pass Through (Col. 3 x Col. 4) 5.00 483 0 0 40 0,827 0 0 42 0 0 0 43 0,765 0 44 3331 0 45 5,580 0 46	
		1.00	2.00	3.00	4.00	5.00	
ANCI	LLARY SERVICE COST CENTERS						
40.00	RADIOLOGY	37,963	0	0.000000	6,483	0	40.00
41.00	LABORATORY	102,736	0	0.000000	8,827	0	41.00
42.00	INTRAVENOUS THERAPY	0	0	0.000000	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0.000000	0	0	43.00
44.00	PHYSICAL THERAPY	979,148	0	0.000000	505,765	0	44.00
45.00	OCCUPATIONAL THERAPY	789,241	0	0.000000	406,331	0	45.00
46.00	SPEECH PATHOLOGY	129,677	0	0.000000	76,580	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00

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COMPUTATION OF INPATIENT ROUTINE COSTS

315488

Provider CCN:

Worksheet D-1 Part I

Title XVIII Skilled Nursing Facility

Title XVIII Skille	ed Nursing Facility	PPS
PART I CALCULATION OF INPATIENT ROUTINE COSTS		
	1.00	
INPATIENT DAYS		
1.00 Inpatient days including private room days	34,330	1.00
2.00 Private room days	С	2.00
3.00 Inpatient days including private room days applicable to the Program	9,456	3.00
4.00 Medically necessary private room days applicable to the Program	C	4.00
5.00 Total general inpatient routine service cost	15,776,498	5.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
6.00 General inpatient routine service charges	16,790,540	6.00
7.00 General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.939606	7.00
8.00 Enter private room charges from your records	C	8.00
9.00 Average private room per diem charge (Private room charges line 8 divided by private room days, line 2)	0.00	9.00
10.00 Enter semi-private room charges from your records	C	10.00
11.00 Average semi-private room per diem charge (Semi-private room charges line 10, divided by semi-private room days)	0.00	11.00
12.00 Average per diem private room charge differential (Line 9 minus line 11)	0.00	12.00
13.00 Average per diem private room cost differential (Line 7 times line 12)	0.00	13.00
14.00 Private room cost differential adjustment (Line 2 times line 13)	C	14.00
15.00 General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	15,776,498	15.00
PROGRAM INPATIENT ROUTINE SERVICE COSTS		
16.00 Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	459.55	5 16.00
17.00 Program routine service cost (Line 3 times line 16)	4,345,505	5 17.00
18.00 Medically necessary private room cost applicable to program (line 4 times line 13)	c	18.00
19.00 Total program general inpatient routine service cost (Line 17 plus line 18)	4,345,505	19.00
20.00 Capital related cost allocated to inpatient routine service costs (From Wkst. B, Part II column 18, line 30 for SNF; line 31 for NF, or line 32 for ICF/IID)	2,706,013	3 20.00
21.00 Per diem capital related costs (Line 20 divided by line 1)	78.82	2 21.00
22.00 Program capital related cost (Line 3 times line 21)	745,322	2 22.00
23.00 Inpatient routine service cost (Line 19 minus line 22)	3,600,183	3 23.00
24.00 Aggregate charges to beneficiaries for excess costs (From provider records)	c	24.00
25.00 Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	3,600,183	25.00
26.00 Enter the per diem limitation (1)		26.00
27.00 Inpatient routine service cost limitation (Line 3 times the per diem limitation line 26) (1)		27.00
28.00 Reimbursable inpatient routine service costs (Line 22 plus the lesser of line 25 or line 27) (Transfer to Worksheet E, Part II, line 4) (See instructions)		28.00
PART II CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
	1.00	
1.00 Total SNF inpatient days	34,330	1.00
2.00 Program inpatient days (see instructions)	9,456	5 2.00
3.00 Total nursing & allied health costs. (see instructions) (Do not complete for titles V or XIX)	C	3.00
4.00 Nursing & allied health ratio. (line 2 divided by line 1)	0.275444	4.00
5.00 Program nursing & allied health costs for pass-through. (line 3 times line 4)	C	5.00

To:

12/31/2024

Version:

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CARE ONE AT MADISON AVENUE Period: Run Date Time: 5/28/2025 2:59 pm From: 01/01/2024 MCRIF32 2540-10

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII

Provider CCN:

315488

Worksheet E Part I

Title XVIII Skilled Nursing Facility PPS PART A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT Inpatient PPS amount (See Instructions) 7,467,983 1.00 2.00 Nursing and Allied Health Education Activities (pass through payments) 0 2.00 7,467,983 3.00 Subtotal (Sum of lines 1 and 2) 3.00 4.00 Primary payor amounts 4.00 5.00 Coinsurance 1,236,648 5.00 Allowable bad debts (From your records) 261,623 6.00 6.00 117,559 Allowable Bad debts for dual eligible beneficiaries (See instructions) 7.00 8.00 Adjusted reimbursable bad debts. (See instructions) 170,055 8.00 9.00 Recovery of bad debts - for statistical records only 0 9.00 10.00 Utilization review 0 10.00 Subtotal (See instructions) 6,401,390 11.00 11.00 6,179,980 12.00 Interim payments (See instructions) 12.00 13.00 Tentative adjustment 0 13.00 14.00 OTHER adjustment (See instructions) 0 14.00 14.50 Demonstration payment adjustment amount before sequestration 0 14.50 14.55 Demonstration payment adjustment amount after sequestration 102,368 14.55 14.75 Sequestration for non-claims based amounts (see instructions) 3,401 14.75 Sequestration amount (see instructions) 124,627 14.99 15.00 Balance due provider/program (see Instructions) -8,986 15.00 16.00 Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2) 0 16.00 PART B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY 17.00 Ancillary services Part B 17.00 0 18.00 Vaccine cost (From Wkst D, Part II, line 3) 694 18.00 Total reasonable costs (Sum of lines 17 and 18) 694 19.00 20.00 1.509 20.00 Medicare Part B ancillary charges (See instructions) 21.00 Cost of covered services (Lesser of line 19 or line 20) 694 21.00 22.00 22.00 Primary payor amounts 0 23.00 23.00 Coinsurance and deductibles 0 24.00 24.00 Allowable bad debts (From your records) 0 0 24.01 Allowable Bad debts for dual eligible beneficiaries (see instructions) 24.01 24.02 Adjusted reimbursable bad debts (see instructions) 0 24.02 25.00 Subtotal (Sum of lines 21 and 24, minus lines 22 and 23) 694 25.00 26.00 Interim payments (See instructions) 740 26.00 27.00 Tentative adjustment 0 27.00 28.00 Other Adjustments (See instructions) Specify 0 28.00 28.50 Demonstration payment adjustment amount before sequestration 0 28.50 Demonstration payment adjustment amount after sequestration 0 28.55

28.99

30.00

14

-60 29.00

28 99

29.00

Sequestration amount (see instructions)

Balance due provider/program (see instructions)

30.00 Protested amounts (Nonallowable cost report items) in accordance with CMS Pub.15-2, section 115.2

CARE ONE AT MADISON AVENUE Period: Run Date Time:

 Period:
 Run Date Time:
 5/28/2025 2:59 pm

 From:
 01/01/2024
 MCRIF32
 2540-10

 To:
 12/31/2024
 Version:
 11.1.179.1



ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:

315488

Worksheet E-1

		Title	· XVIII	Skilled Nu	rsing Facility		PPS
			Inpatien	t Part A	Par	t B	
	DESCRIPTION		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
			1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider			6,004,340		740	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor	r for services rendered in the		188,149		0	2.00
	cost reporting period. If none, enter zero			ĺ			
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	interim rate for the cost					3.00
Progra	um to Provider					'	
3.01	ADJUSTMENTS TO PROVIDER			0		0	3.01
3.02				0		0	3.02
3.03				0		0	3.03
3.04				0		0	3.04
3.05				0		0	3.05
Provid	er to Program					1	
3.50	ADJUSTMENTS TO PROGRAM		05/21/2024	12,509		0	3.50
3.51			, ,	0		0	3.51
3.52				0		0	3.52
3.53				0		0	3.53
3.54				0		0	3.54
3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)			-12,509		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (Transfer to Wkst. E, Part I line 12 for Part A	, and line 26 for Part B)		6,179,980		740	4.00
то в	E COMPLETED BY CONTRACTOR	, ,		, ,			
5.00	List separately each tentative settlement payment after desk review. Also show date of each payme enter a zero. (1)	ent. If none, write "NONE" or					5.00
Progra	um to Provider					'	
5.01	TENTATIVE TO PROVIDER			0		0	5.01
5.02				0		0	5.02
5.03				0		0	5.03
Provid	er to Program					'	
5.50	TENTATIVE TO PROGRAM			0		0	5.50
5.51				0		0	5.51
5.52				0		0	5.52
5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)			0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	PROGRAM TO PROVIDER			0		0	6.01
6.02	PROVIDER TO PROGRAM			8,986		60	6.02
7.00	Total Medicare program liability (see instructions)			6,170,994		680	7.00
	Contractor Name		Contractor	Number			
	1.00		2.00)			
8.00							8.00

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

CARE ONE AT MADISON AVENUE

315488

Provider CCN:

Period: From: 01/01/2024 MCRIF32 To: 12/31/2024 Version:

Run Date Time:

5/28/2025 2:59 pm **2540-10** 11.1.179.1



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

Worksheet G

1	site the General Fund Column Only)					PPS
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets		·				
CURF	RENT ASSETS					
1.00	Cash on hand and in banks	42,615	0	0	(0 1.00
2.00	Temporary investments	0	0	0	(0 2.00
3.00	Notes receivable	0	0	0	(0 3.00
4.00	Accounts receivable	1,592,555	0	0	(0 4.00
5.00	Other receivables	0	0	0	(0 5.00
6.00	Less: allowances for uncollectible notes and accounts receivable	-86,584	0	0		0 6.00
7.00	Inventory	0	0	0	(0 7.00
8.00	Prepaid expenses	50,121	0	0	(0 8.00
9.00	Other current assets	8,303,969	0	0		0 9.00
10.00	Due from other funds	0 000 575	0	0		0 10.00
11.00	TOTAL CURRENT ASSETS (Sum of lines 1 - 10)	9,902,676	0	0		0 11.00
	D ASSETS			0		12.00
12.00	Land	0	0	0		0 12.00 0 13.00
13.00	Land improvements	14,131	0	0		0 13.00 0 14.00
14.00	Less: Accumulated depreciation	-5,784 18,803,246	0	0		0 15.00
16.00	Buildings Less Accumulated depreciation	-12,568,382	0	0		0 16.00
17.00	Leasehold improvements	-12,300,302	0	0		0 17.00
18.00	Less: Accumulated Amortization	0	0	0		0 18.00
19.00	Fixed equipment	1,199,666	0	0		0 19.00
20.00	Less: Accumulated depreciation	-869,839	0	0		0 20.00
21.00	Automobiles and trucks	0	0	0		0 21.00
22.00	Less: Accumulated depreciation	0	0	0		0 22.00
23.00	Major movable equipment	4,451,066	0	0		0 23.00
24.00	Less: Accumulated depreciation	-4,255,656	0	0		0 24.00
25.00	Minor equipment - Depreciable	0	0	0		0 25.00
26.00	Minor equipment nondepreciable	0	0	0	(0 26.00
27.00	Other fixed assets	552,000	0	0	(0 27.00
28.00	TOTAL FIXED ASSETS (Sum of lines 12 - 27)	7,320,448	0	0		0 28.00
OTH	ER ASSETS		'	'		
29.00	Investments	0	0	0	(0 29.00
30.00	Deposits on leases	0	0	0	(0 30.00
31.00	Due from owners/officers	0	0	0	(0 31.00
32.00	Other assets	1,986,922	0	0	(0 32.00
33.00	TOTAL OTHER ASSETS (Sum of lines 29 - 32)	1,986,922	0	0	(0 33.00
34.00	TOTAL ASSETS (Sum of lines 11, 28, and 33)	19,210,046	0	0		0 34.00
Liabil	ities and Fund Balances					
CURF	RENT LIABILITIES					
35.00	Accounts payable	1,053,301	0	0	(0 35.00
36.00	Salaries, wages, and fees payable	342,175	0	0	(0 36.00
37.00	Payroll taxes payable	5,107	0	0		0 37.00
38.00	Notes & loans payable (Short term)	0	0	0		0 38.00
39.00	Deferred income	0	0	0	(0 39.00
40.00	Accelerated payments	0				40.00
41.00	Due to other funds	15,109	0	0		0 41.00
42.00	Other current liabilities	1,689,056	0	0		0 42.00
43.00	TOTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	3,104,748	0	0		0 43.00
	G TERM LIABILITIES			.1		0 (155
44.00	Mortgage payable	13,451,833	0	0		0 44.00
45.00	Notes payable	0	0	0		0 45.00
46.00	Unsecured loans	0	0	0		0 46.00
47.00	Loans from owners:	0	0	0		0 47.00
48.00	Other long term liabilities	13,730,951	0	0		0 48.00
49.00	OTHER (SPECIFY) TOTAL LONG TERM LIABILITIES (Sum of Fines 44, 40)	27 192 794	0	0		0 49.00
50.00	TOTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	27,182,784	0	0		0 50.00

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

Provider CCN:

315488

Worksheet G

11.1.179.1

PPS

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
51.00	TOTAL LIABILITIES (Sum of lines 43 and 50)	30,287,532	0	0	0	51.00
CAPI	TAL ACCOUNTS					
52.00	General fund balance	-11,077,486				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	TOTAL FUND BALANCES (Sum of lines 52 thru 58)	-11,077,486	0	0	0	59.00
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	19,210,046	0	0	0	60.00
()=	contra amount					

CARE ONE AT MADISON AVENUE

Period:
From: 01/01/2024
Provider CCN: 315488

Period:
From: 01/01/2024
To: 12/31/2024
Version: 5/28/2025 2:59 pm
MCRIF32
2540-10
11.1.179.1

STATEMENT OF CHANGES IN FUND BALANCES

Worksheet G-1

PPS

										PPS
		Genera	l Fund	Special Pur	pose Fund	Endown	ent Fund	Plant	Fund	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
1.00	Fund balances at beginning of period		-10,814,427		0		0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-858,154							2.00
3.00	Total (sum of line 1 and line 2)		-11,672,581		0		0		0	3.00
4.00	Additions (credit adjustments)									4.00
5.00	ADJ	595,095		0		0		0		5.00
6.00		0		0		0		0		6.00
7.00		0		0		0		0		7.00
8.00		0		0		0		0		8.00
9.00		0		0		0		0		9.00
10.00	Total additions (sum of line 5 - 9)		595,095		0		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		-11,077,486		0		0		0	11.00
12.00	Deductions (debit adjustments)									12.00
13.00		0		0		0		0		13.00
14.00		0		0		0		0		14.00
15.00		0		0		0		0		15.00
16.00		0		0		0		0		16.00
17.00		0		0		0		0		17.00
18.00	Total deductions (sum of lines 13 - 17)		0		0		0		0	18.00
19.00	Fund balance at end of period per balance sheet (Line 11 - line 18)		-11,077,486		0		0		0	19.00

CARE ONE AT MADISON AVENUE

Period:
From: 01/01/2024
Provider CCN: 315488

Run Date Time: 5/28/2025 2:59 pm
MCRIF32
2540-10
To: 12/31/2024
Version: 11.1.179.1



STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Worksheet G-2 Part I PPS

PART	I I - PATIENT REVENUES				
	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
Gene	ral Inpatient Routine Care Services				
1.00	SKILLED NURSING FACILITY	16,790,540		16,790,540	1.00
2.00	NURSING FACILITY	0		0	2.00
3.00	ICF/IID	0		0	3.00
4.00	OTHER LONG TERM CARE	0		0	4.00
5.00	Total general inpatient care services (Sum of lines 1 - 4)	16,790,540		16,790,540	5.00
All O	ther Care Services				
6.00	ANCILLARY SERVICES	7,564,283	0	7,564,283	6.00
7.00	CLINIC		0	0	7.00
8.00	HOME HEALTH AGENCY COST		0	0	8.00
9.00	AMBULANCE		0	0	9.00
10.00	RURAL HEALTH CLINIC		0	0	10.00
10.10	FQHC		0	0	10.10
11.00	CMHC		0	0	11.00
12.00	HOSPICE	0	0	0	12.00
13.00	OTHER (SPECIFY)	0	0	0	13.00
14.00	Total Patient Revenues (Sum of lines 5 - 13) (Transfer column 3 to Worksheet G-3, Line 1)	24,354,823	0	24,354,823	14.00
PART	T II - OPERATING EXPENSES				
			1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			17,476,839	1.00
2.00	Add (Specify)		0		2.00
3.00			0		3.00
4.00			0		4.00
5.00			0		5.00
6.00			0		6.00
7.00			0		7.00
8.00	Total Additions (Sum of lines 2 - 7)			0	8.00
9.00	Deduct (Specify)		0		9.00
10.00			0		10.00
11.00			0		11.00
12.00			0		12.00
			0		13.00
13.00					
13.00	Total Deductions (Sum of lines 9 - 13)			0	14.00

5/28/2025 2:59 pm **2540-10** CARE ONE AT MADISON AVENUE Period: Run Date Time: From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315488 11.1.179.1

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Worksheet G-3

	PP		
		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	24,354,823	1.0
2.00	Less: contractual allowances and discounts on patients accounts	7,745,485	2.0
3.00	Net patient revenues (Line 1 minus line 2)	16,609,338	3.0
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	17,476,839	4.0
5.00	Net income from service to patients (Line 3 minus 4)	-867,501	5.0
Other	r income:		
5.00	Contributions, donations, bequests, etc	0	6.0
7.00	Income from investments	305	7.0
8.00	Revenues from communications (Telephone and Internet service)	0	8.0
9.00	Revenue from television and radio service	0	9.0
10.00	Purchase discounts	0	10.0
11.00	Rebates and refunds of expenses	0	11.0
12.00	Parking lot receipts	0	12.0
13.00	Revenue from laundry and linen service	0	13.0
14.00	Revenue from meals sold to employees and guests	0	14.0
15.00	Revenue from rental of living quarters	0	15.0
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.0
17.00	Revenue from sale of drugs to other than patients	0	17.0
18.00	Revenue from sale of medical records and abstracts	0	18.0
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.0
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.0
21.00	Rental of vending machines	0	21.0
22.00	Rental of skilled nursing space	0	22.0
23.00	Governmental appropriations	0	23.0
24.00	BARBER AND BEAUTY	16	24.0
24.01	OTHER REV	9,026	24.0
24.02		0	24.0
24.50	COVID-19 PHE Funding	0	24.5
25.00	Total other income (Sum of lines 6 - 24)	9,347	25.0
26.00	Total (Line 5 plus line 25)	-858,154	26.0
27.00	Other expenses (specify)	0	27.0
28.00		0	28.0
29.00		0	29.0
30.00	Total other expenses (Sum of lines 27 - 29)	0	30.0
31.00	Net income (or loss) for the period (Line 26 minus line 30)	-858,154	31.0

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