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

	- r
CARE ONE AT PARSIPPANY Period: Run Date Time: 5/28/2025	3:15 pm

Provider CCN: 315468 | From: 01/01/2024 | MCRIF32 | **2540-10** | 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 use only	[ X ] Electronically prepared cost report     [ Manually prepared cost report	Date:	Time:
,	3. [ 0 ] If this is an amended report enter the number of times the provider results.  3.01. [ ] No Medicare Utilization. Enter "Y" for yes or leave blank for no.	abmitted this cost report.	
Contractor use only:	4. [ 1 ] Cost Report Status	8. [ ] Last Cost I 9. NPR Date: 10. If line 4, column 11. Contractor Ven	Report for this Provider CCN Report for this Provider CCN  1 is "4": Enter number of times reopened0

#### 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 PARSIPPANY, 315468 {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	Y  I have read and agree with the above certification state certify that I intend my electronic signature on this cube 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 S	UMMARY			

	III - SETTLEMENT SUMMARY		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	-25,522	70	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	-25,522	70	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, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

CARE ONE AT PARSIPPANY Period: Run Date Time: 5/28/2025 3:15 pm From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: 2540-10 Provider CCN: 11.1.179.1 315468



## SKILLED NURSING FACILITY AND SKILLED NURSING FACILITY HEALTH CARE

Worksheet S-2

	d Nursing Facility and Skilled Nursing Facility (	Complex Address:								
.00	Street: 100 MAZDABROOK	Somplest Haureson	P.O. Box:							1.0
.00	City: PARSIPPANY - TROY		State:	NI	ZIP	Code: 07054				2.0
.00	County: MORRIS		CBSA Code:	3508	4 Urb	an / Rural:	U			3.0
.01	CBSA on/after October 1 of the Cost Reporting P	eriod (if applicable)								3.0
NF a	and SNF-Based Component Identification:	,	•					'		
							Payme	ent System (P, C	), or N)	
	Component	Co	mponent Name		Provider CCN	Date Certified	V	XVIII	XIX	
			1.00		2.00	3.00	4.00	5.00	6.00	
.00	SNF	CARE ONE AT P.	ARSIPPANY		315468	08/15/2001	N	P	N	4.0
.00	Nursing Facility									5.0
.00	ICF/IID									6.0
00	SNF-Based HHA									7.0
.00	SNF-Based RHC									8.0
00	SNF-Based FQHC									9.0
0.00	SNF-Based CMHC									10.0
1.00	SNF-Based OLTC									11.0
2.00	SNF-Based HOSPICE									12.0
3.00	SNF-Based CORF							75		13.0
						om: .00		To: 2.00		
.00	Cost Post stire Posited (see /11/)					1/2024			14	14.0
1.00	1 0 ( 17,7,7,7			4 1		,		12/31/202	24	14.0
5.00	Type of Control (See Instructions)			4 - 1	Proprietary, Cor	poration			Y/N	15.0
									1.00	
me	of Freestanding Skilled Nursing Facility								1.00	
5.00		ets the requirements set forth in	42 CFR section 483	52					Y	16.0
7.00	Is this a composite distinct part skilled nursing facility that he	•	12 GI R section 103	.5.						10.0
			set forth in 42 CFR s	section 483	52				N	17 (
	1 1	*				chapter 102. If ve	s complete V	Vorksheet	N Y	
	Are there any costs included in Worksheet A that r A-8-1.	*				, chapter 10? If ye	s, complete V	Vorksheet	N Y	_
3.00	Are there any costs included in Worksheet A that r	*				, chapter 10? If ye	s, complete V	Vorksheet		
3.00 Iisce	Are there any costs included in Worksheet A that r A-8-1. Ellaneous Cost Reporting Information	esulted from transactions with re	elated organizations a			, chapter 10? If ye	s, complete V	Vorksheet		18.0
3.00 isce	Are there any costs included in Worksheet A that r A-8-1. Ellaneous Cost Reporting Information	esulted from transactions with relicate with a "Y", for yes, or "N"	elated organizations a	as defined in	n CMS Pub. 15-1			Vorksheet	Y	18.0
8.00 <b>lisce</b> 9.00 9.01	Are there any costs included in Worksheet A that r A-8-1.  Ellaneous Cost Reporting Information  If this is a low Medicare utilization cost report, indi	esulted from transactions with re- icate with a "Y", for yes, or "N" ntractor's criteria for filing a low	elated organizations a for no. Medicare utilization	cost report,	n CMS Pub. 15-1			Worksheet	Y N	18.0
8.00 <b>fisce</b> 9.00 9.01	Are there any costs included in Worksheet A that r A-8-1.  Ellaneous Cost Reporting Information  If this is a low Medicare utilization cost report, indi  If line 19 is yes, does this cost report meet your coreciation - Enter the amount of depreciation report	esulted from transactions with re- icate with a "Y", for yes, or "N" ntractor's criteria for filing a low	elated organizations a for no. Medicare utilization	cost report,	n CMS Pub. 15-1			Worksheet	Y N	19.0 19.0
8.00 lisce 9.00 9.01 epre	Are there any costs included in Worksheet A that r A-8-1.  Ellaneous Cost Reporting Information  If this is a low Medicare utilization cost report, indi  If line 19 is yes, does this cost report meet your coreciation - Enter the amount of depreciation report	esulted from transactions with re- icate with a "Y", for yes, or "N" ntractor's criteria for filing a low	elated organizations a for no. Medicare utilization	cost report,	n CMS Pub. 15-1			Vorksheet	Y N N	19.0 19.0 9 20.0
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3.00 5.00 0.01 epre 0.00 .00	Are there any costs included in Worksheet A that r A-8-1.  Ellaneous Cost Reporting Information  If this is a low Medicare utilization cost report, indi  If line 19 is yes, does this cost report meet your coneciation - Enter the amount of depreciation report  Straight Line  Declining Balance	esulted from transactions with re- icate with a "Y", for yes, or "N" ntractor's criteria for filing a low	elated organizations a for no. Medicare utilization	cost report,	n CMS Pub. 15-1			Vorksheet	N N N 525,41	19.0 19.0 9 20.0 0 21.0 0 22.0
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3.00 6.00 0.00 1.00	Are there any costs included in Worksheet A that r A-8-1.  Ellaneous Cost Reporting Information  If this is a low Medicare utilization cost report, indi If line 19 is yes, does this cost report meet your coreciation - Enter the amount of depreciation report  Straight Line Declining Balance Sum of the Year's Digits Sum of line 20 through 22  If depreciation is funded, enter the balance as of the Were there any disposal of capital assets during the Was accelerated depreciation claimed on any assets Did you cease to participate in the Medicare prograw was there a substantial decrease in health insurance of facility contains a public or non-public provider.	esulted from transactions with residual from transactions with residual from transactions with a "Y", for yes, or "N" attractor's criteria for filing a low reted in this SNF for the method are end of the period.  The cost reporting period? (Y/N) in the current or any prior cost arm at end of the period to which a proportion of allowable cost from the proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a period to the period to which a period to the per	elated organizations :  for no.  Medicare utilization d indicated on Lin  reporting period? (Y. this cost report app om prior cost report	cost report, es 20 - 22.  /N) lies? (Y/N) s? (Y/N)	n CMS Pub. 15-1	"Y", for yes, or "N"	Part A	Part B 2.00	N N N 525,41 N N N N Other 3.00	19.0 19.0 9 20.0 0 21.0 0 22.0 9 23.0 0 24.0 25.0 27.0 28.0
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3.00 6.00 0.00 1.00	Are there any costs included in Worksheet A that r A-8-1.  Ellaneous Cost Reporting Information  If this is a low Medicare utilization cost report, indi If line 19 is yes, does this cost report meet your coreciation - Enter the amount of depreciation report  Straight Line  Declining Balance  Sum of the Year's Digits  Sum of line 20 through 22  If depreciation is funded, enter the balance as of the Were there any disposal of capital assets during the Was accelerated depreciation claimed on any assets  Did you cease to participate in the Medicare progration was there a substantial decrease in health insurance as a facility contains a public or non-public provider qualifies for the exemption.  Skilled Nursing Facility  Nursing Facility  ICF/IID  SNF-Based HHA  SNF-Based RHC  SNF-Based FQHC	esulted from transactions with residual from transactions with residual from transactions with a "Y", for yes, or "N" attractor's criteria for filing a low reted in this SNF for the method are end of the period.  The cost reporting period? (Y/N) in the current or any prior cost arm at end of the period to which a proportion of allowable cost from the proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a period to the period to which a period to the per	elated organizations :  for no.  Medicare utilization d indicated on Lin  reporting period? (Y. this cost report app om prior cost report	cost report, es 20 - 22.  /N) lies? (Y/N) s? (Y/N)	n CMS Pub. 15-1	"Y", for yes, or "N"	Part A 1.00 er "Y" for e	Part B 2.00 ach componen	N N S25,41 S25,41 N N N N N N N Other 3.00 at and type of a second secon	0 21.0 0 22.0 9 23.0 0 24.0 25.0 26.0 27.0 28.0
3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00	Are there any costs included in Worksheet A that r A-8-1.  Ellaneous Cost Reporting Information  If this is a low Medicare utilization cost report, indi If line 19 is yes, does this cost report meet your coreciation - Enter the amount of depreciation report  Straight Line  Declining Balance  Sum of the Year's Digits  Sum of line 20 through 22  If depreciation is funded, enter the balance as of the Were there any disposal of capital assets during the Was accelerated depreciation claimed on any assets  Did you cease to participate in the Medicare progration was there a substantial decrease in health insurance as facility contains a public or non-public provider qualifies for the exemption.  Skilled Nursing Facility  Nursing Facility  ICF/IID  SNF-Based HHA  SNF-Based RHC  SNF-Based CMHC	esulted from transactions with residual from transactions with residual from transactions with a "Y", for yes, or "N" attractor's criteria for filing a low reted in this SNF for the method are end of the period.  The cost reporting period? (Y/N) in the current or any prior cost arm at end of the period to which a proportion of allowable cost from the proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a period to which a proportion of allowable cost from the current or any prior cost arm at end of the period to which a period to the period to which a period to the per	for no.  Medicare utilization d indicated on Lin  reporting period? (Y	cost report, es 20 - 22.  /N) lies? (Y/N) s? (Y/N)	n CMS Pub. 15-1	"Y", for yes, or "N"	Part A 1.00 er "Y" for e	Part B 2.00 ach component N N N Y/N	N N N S25,41 S25,41 N N N N N N N N N N N N N N N N N N N	19.0 19.0 19.0 19.0 9 20.0 0 21.0 0 22.0 9 23.0 0 24.0 25.0 27.0 28.0 31.0 31.0 32.0 33.0 34.0 35.0
3.00 Sisce 2.00 Sisce	Are there any costs included in Worksheet A that r A-8-1.  Ellaneous Cost Reporting Information  If this is a low Medicare utilization cost report, indi If line 19 is yes, does this cost report meet your coreciation - Enter the amount of depreciation report  Straight Line  Declining Balance  Sum of the Year's Digits  Sum of line 20 through 22  If depreciation is funded, enter the balance as of the Were there any disposal of capital assets during the Was accelerated depreciation claimed on any assets  Did you cease to participate in the Medicare progration was there a substantial decrease in health insurance as facility contains a public or non-public provider qualifies for the exemption.  Skilled Nursing Facility  Nursing Facility  ICF/IID  SNF-Based HHA  SNF-Based RHC  SNF-Based CMHC	esulted from transactions with residual cate with a "Y", for yes, or "N" intractor's criteria for filing a low red in this SNF for the method in this SNF for the method in the end of the period.  The cost reporting period? (Y/N) in the current or any prior cost are at end of the period to which the proportion of allowable cost from that qualifies for an exemption of the qualifies for an exemption of the period in the qualifies for an exemption of the qualifies for an exemption of the period in the qualifies for an exemption of the qualifies for an exemption of the period in the qualifies for an exemption of the qualifies for an exemption of the period in the qualifies for an exemption of the period in the qualifies for an exemption of the period in the qualifies for an exemption of the period in the per	for no.  Medicare utilization dindicated on Lin  reporting period? (Ye this cost report approm prior cost report  on from the application from the application of the	cost report, es 20 - 22.  /N) lies? (Y/N) stion of the	indicate with a lower of the co	"Y", for yes, or "N"	Part A 1.00 er "Y" for e  N	Part B 2.00 ach componen	N N S25,41 S25,41 N N N N N N N Other 3.00 at and type of a second secon	19.0 19.0 19.0 19.0 9 20.0 0 21.0 0 22.0 9 23.0 0 24.0 25.0 27.0 28.0 31.0 31.0 32.0 33.0 34.0 35.0

41-304

5/28/2025 3:15 pm **2540-10** CARE ONE AT PARSIPPANY Period: Run Date Time: From: 01/01/2024 MCRIF32 Provider CCN: 315468 To: 12/31/2024 Version: 11.1.179.1

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

State:

Worksheet S-2 Part I

47.00

0011									PPS
							Y/N		
							1.00	2.00	
39.00	Is the ma	lpractice a "claims-made" or "occurrence" policy? If	the policy is "claims-made"	enter 1. If the policy is "occurrence", enter	2.		1		39.00
					P	remiums	Paid Losses	Self Insurance	
						1.00	2.00	3.00	
41.00	List malp	ractice premiums and paid losses:				54,569	0	0	41.00
								Y/N	
								1.00	
42.00	1	ractice premiums and paid losses reported in other thest centers and amounts.	nan the Administrative and	General cost center? Enter Y or N. If yes, o	check box, and subn	nit supportir	ng schedule	N	42.00
43.00	Are there	any home office costs as defined in CMS Pub. 15-1,	Chapter 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 th	ne home office on lines 45, 46 and 47.				HB0206	44.00
If this	facility is	part of a chain organization, enter the name and	address of the home offic	ce on the lines below.					
45.00	Name:	HEALTHBRIDGE	Contractor Name:	NOVITAS SOLUTIONS	Contractor Numbe	r:	12001		45.00
46.00	Street:	173 BRIDGE PLAZA NORTH	P.O. Box:			<u> </u>			46.00

NJ

ZIP Code:

07024

41-304

47.00 City:

FORT LEE



11.1.179.1

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

Provider CCN:

315468

Worksheet S-2 Part II

	PLEX REIMBURSEMENT QUESTIONNAIRE							-	PPS
	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 forma	t will be (mm/	dd/yyyy)			
	leted by All Skilled Nursing Facilites								
Provid	er Organization and Operation						Y/N	Date	
							1.00	2.00	
1.00	Has the provider changed ownership immediately prior to the begin	ning of the cost repor	ting period? If colun	nn 1 is "Y", enter the dat	e of the change	in column	N	2.00	1.00
	2. (see instructions)		01	·					
						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	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	icers, medical staff, ma	nagement personne			Y			3.00
						Y/N	Туре	Date	
						1.00	2.00	3.00	
	cial Data and Reports	11. 4	D.C.1. 0.15		CII 6	37			1.00
4.00	Column 1: Were the financial statements prepared by a Certified Pul Compiled, or "R" for Reviewed. Submit complete copy or enter date	e available in column 3	3. (see instructions) I	f no, see instructions.		Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from reconciliation.	those on the filed fina	ncial statements? If	column 1 is "Y", submit		N			5.00
	reconcination.						Y/N	Legal Oper.	
							1.00	2.00	
Appro	ved Educational Activities								
6.00	Column 1: Were costs claimed for Nursing School? (Y/N) Column	2: Is the provider the	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	ons.	-				N		7.00
8.00	Were approvals and/or renewals obtained during the cost reporting	period for Nursing Sc	hool and/or Allied	Health Program? (Y/N)	see instructions		N		8.00
								Y/N	
								1.00	
Bad D									0.00
9.00	Is the provider seeking reimbursement for bad debts? (Y/N) see ins If line 9 is "Y", did the provider's bad debt collection policy change		in a marie 40 TC IIXIII					Y N	9.00
11.00	If line 9 is "Y", are patient deductibles and/or coinsurance waived?			вивни сору.				N	11.00
	omplement	ir i , see instruction.	·-					1,	11.00
12.00	Have total beds available changed from prior cost reporting period?	If "Y", see instruction	ıs.					N	12.00
					Part	A	Pa	ırt B	
			Desc	ription	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	03/28/2025	Y	03/28/2025	13.00
14.00	Was the cost report prepared using the PS&R for total and the provallocation? 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 of				N		N		15.00
16.00	see Instructions.  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.	00	200	N		N 3.00		18.00
Cost B	Leport Preparer Contact Information	1.0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2.00			3.00		
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		EVECUCADE ACC	OCIATES						20.00
20.00	Enter the employer/company name of the cost report preparer.  Enter the telephone number and email address of the cost report	732-534-4390	MATES	CRWASSC@NETSCA	APE NET				20.00
21.00	preparer in columns 1 and 2, respectively.	.52 551 1570		5.CW 21000 (B) VII 1507					21.00

5/28/2025 3:15 pm **2540-10** CARE ONE AT PARSIPPANY Period: Run Date Time:

From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315468 11.1.179.1



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

Worksheet S-3 Part I PPS

				Inpatient Days/Visits							D: 1			
					Inpa	itient Days/ V	1S1TS				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	118	43,188	0	8,011	13,333	4,701	26,045	0	194	49	183	426	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			0	0	0	0	0						4.00
	COST													
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)	118	43,188	0	8,011	13,333	4,701	26,045	0	194	49	183	426	8.00
			Average Ler	ngth of Stay				Admissions			Full Time	Equivalent		
	0										Employees	Nonpaid		
	Component	Title V	Title XVIII	Title XIX	Total	Title V	Title XVIII	Title XIX	Other	Total	on Payroll	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	41.29	272.10	61.14	0	216	21	183	420	97.64	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										0.00	0.00		4.00
	COST													
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	41.29	272.10	61.14	0	216	21	183	420	97.64	0.00		8.00

5/28/2025 3:15 pm **2540-10** CARE ONE AT PARSIPPANY Period: Run Date Time:

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



SNF WAGE INDEX INFORMATION

315468

Provider CCN:

Worksheet S-3 Part II PPS

1 /11(1	'II - DIRECT SALARIES		1				
		1	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)	6,451,574	0	6,451,574	203,089.00	31.77	1.00
2.00	Physician salaries-Part A	0	0	0	0.00	0.00	2.00
3.00	Physician salaries-Part B	0	0	0	0.00	0.00	3.00
4.00	Home office personnel	0	0	0	0.00	0.00	4.00
5.00	Sum of lines 2 through 4	0	0	0	0.00	0.00	5.00
6.00	Revised wages (line 1 minus line 5)	6,451,574	0	6,451,574	203,089.00	31.77	6.00
7.00	Other Long Term Care	0	0	0	0.00	0.00	7.00
8.00	HOME HEALTH AGENCY COST	0	0	0	0.00	0.00	8.00
9.00	CMHC	0	0	0	0.00	0.00	9.00
10.00	HOSPICE	0	0	0	0.00	0.00	10.00
11.00	Other excluded areas	0	0	0	0.00	0.00	11.00
12.00	Subtotal Excluded salary (Sum of lines 7 through 11)	0	0	0	0.00	0.00	12.00
13.00	Total Adjusted Salaries (line 6 minus line 12)	6,451,574	0	6,451,574	203,089.00	31.77	13.00
OTH	ER WAGES & RELATED COSTS						
14.00	Contract Labor: Patient Related & Mgmt	89,595	0	89,595	1,446.00	61.96	14.00
15.00	Contract Labor: Physician services-Part A	0	0	0	0.00	0.00	15.00
16.00	Home office salaries & wage related costs	0	0	0	0.00	0.00	16.00
WAG	E-RELATED COSTS						•
17.00	Wage-related costs core (See Part IV)	966,966	0	966,966			17.00
18.00	Wage-related costs other (See Part IV)	0	0	0			18.00
19.00	Wage related costs (excluded units)	0	0	0			19.00
20.00	Physician Part A - WRC	0	0	0			20.00
21.00	Physician Part B - WRC	0	0	0			21.00
22.00	Total Adjusted Wage Related cost (see instructions)	966,966	0	966,966			22.00

CARE ONE AT PARSIPPANY

Period:
From: 01/01/2024
Provider CCN: 315468

Period:
From: 01/01/2024
To: 12/31/2024
Provider CCN: 315468

Run Date Time: 5/28/2025 3:15 pm
MCRIF32
2540-10
Version: 11.1.179.1

SNF WAGE INDEX INFORMATION

Worksheet S-3 Part III PPS

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	550,860	0	550,860	13,103.00	42.04	2.00
3.00	Plant Operation, Maintenance & Repairs	113,309	0	113,309	4,239.00	26.73	3.00
4.00	Laundry & Linen Service	71,946	0	71,946	4,269.00	16.85	4.00
5.00	Housekeeping	277,425	0	277,425	14,284.00	19.42	5.00
6.00	Dietary	445,403	0	445,403	21,167.00	21.04	6.00
7.00	Nursing Administration	718,692	0	718,692	17,448.00	41.19	7.00
8.00	Central Services and Supply	0	0	0	0.00	0.00	8.00
9.00	Pharmacy	0	0	0	0.00	0.00	9.00
10.00	Medical Records & Medical Records Library	47,638	0	47,638	2,107.00	22.61	10.00
11.00	Social Service	57,355	0	57,355	1,611.00	35.60	11.00
12.00	Nursing and Allied Health Ed. Act.						12.00
13.00	Other General Service	163,212	0	163,212	8,126.00	20.09	13.00
14.00	Total (sum lines 1 thru 13)	2,445,840	0	2,445,840	86,354.00	28.32	14.00

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SNF WAGE RELATED COSTS

Worksheet S-3 Part IV PPS

ART IV - WAGE RELATED COSTS	1 D 1	
	Amount Reported	
	1.00	
art A - Core List		
ETIREMENT COST		
00 401K Employer Contributions	30,286	1.00
00 Tax Sheltered Annuity (TSA) Employer Contribution		2.00
00 Qualified and Non-Qualified Pension Plan Cost		3.00
00 Prior Year Pension Service Cost	0	4.00
LAN ADMINISTRATIVE COSTS (Paid to External Organization)		
00 401K/TSA Plan Administration fees	0	5.00
00 Legal/Accounting/Management Fees-Pension Plan	0	6.00
00 Employee Managed Care Program Administration Fees	0	7.00
IEALTH AND INSURANCE COST		
00 Health Insurance (Purchased or Self Funded)	348,025	8.00
00 Prescription Drug Plan	0	9.00
0.00 Dental, Hearing and Vision Plan	0 1	10.00
1.00 Life Insurance (If employee is owner or beneficiary)	1,114	11.00
2.00 Accident Insurance (If employee is owner or beneficiary)	0 1	12.00
3.00 Disability Insurance (If employee is owner or beneficiary)	0 1	13.00
4.00 Long-Term Care Insurance (If employee is owner or beneficiary)	0 1	14.00
5.00 Workers' Compensation Insurance	33,458	15.00
6.00 Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0 1	16.00
AXES		
7.00 FICA-Employers Portion Only	458,227 1	17.00
8.00 Medicare Taxes - Employers Portion Only	0 1	18.00
9.00 Unemployment Insurance	0 1	19.00
0.00 State or Federal Unemployment Taxes	95,856 2	20.00
THER	·	
1.00 Executive Deferred Compensation	0 2	21.00
2.00 Day Care Cost and Allowances	0 2	22.00
3.00 Tuition Reimbursement	0 2	23.00
4.00 Total Wage Related cost (Sum of lines 1 - 23)	966,966	24.00
	Amount Reported	
	1.00	
art B - Other than Core Related Cost		
5.00 OTHER WAGE RELATED COST	0 3	25.00

5/28/2025 3:15 pm **2540-10** CARE ONE AT PARSIPPANY Period: Run Date Time:

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#### SNF REPORTING OF DIRECT CARE EXPENDITURES

Worksheet S-3 Part V PPS

				1	1		
	OCCUPATIONAL CATEGORY			Adjusted Salaries (col. 1	Paid Hours Related to	Average Hourly Wage	
		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)	757,502	127,436	884,938	15,186.00	58.27	1.00
2.00	Licensed Practical Nurses (LPNs)	905,621	152,354	1,057,975	26,142.00	40.47	2.00
3.00	Certified Nursing Assistant/Nursing Assistants/Aides	1,051,647	176,920	1,228,567	47,426.00	25.90	3.00
4.00	Total Nursing (sum of lines 1 through 3)	2,714,770	456,710	3,171,480	88,754.00	35.73	4.00
5.00	Physical Therapists	631,056	106,164	737,220	12,881.00	57.23	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	502,951	84,612	587,563	11,773.00	49.91	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	156,957	26,405	183,362	3,327.00	55.11	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)	5,672		5,672	63.00	90.03	14.00
15.00	Licensed Practical Nurses (LPNs)	6,316		6,316	85.00	74.31	15.00
16.00	Certified Nursing Assistant/Nursing Assistants/Aides	503		503	10.00	50.30	16.00
17.00	Total Nursing (sum of lines 14 through 16)	12,491		12,491	158.00	79.06	17.00
18.00	Physical Therapists	54,615		54,615	840.00	65.02	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	350		350	5.00	70.00	24.00
25.00	Respiratory Therapists	22,139		22,139	443.00	49.98	25.00
26.00	Other Medical Staff	0		0	0.00	0.00	26.00

5/28/2025 3:15 pm **2540-10** CARE ONE AT PARSIPPANY Period: Run Date Time: From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315468 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
<b>4.00 5.00</b>	RVL RHX		4.00 5.00
6.00	RHL		6.00
7.00	RMX		7.00
8.00	RML		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
	RHC		16.00
	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 HE2		26.00
27.00	HE1		27.00 28.00
	HD2		29.00
30.00	HD1		30.00
31.00	HC2		31.00
32.00	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	LD1		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
	CE1		44.00
	CD2		45.00
46.00	CD1		46.00
47.00	CC2		47.00
	CC1		48.00
49.00 50.00	CB2 CB1		49.00 50.00
51.00	CA2		51.00
	CA1		52.00
	SE3		53.00
	SE2		54.00
	SE1 SE1		55.00
	SSC		56.00
	SSB		57.00

CARE ONE AT PARSIPPANY

Period:
From: 01/01/2024
Provider CCN: 315468

Period:
From: 01/01/2024
Provider CCN: 12/31/2024
Provider CCN: 315468

Run Date Time: 5/28/2025 3:15 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 PARSIPPANY

315468

Provider CCN:

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

Run Date Time: 5/ MCRIF32 25

5/28/2025 3:15 pm **2540-10** 11.1.179.1



#### RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

Worksheet A

TY	
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Content   Cont											PPS
Company							Reclassifications	Reclassified Trial	Adjustments to	Net Expenses	
100   200   100   150			Cost Center Description			Total (col. 1 +	Increase/Decrease	Balance (col. 3 +-	1 '	For Allocation	
STATEMENA SERVICE COST CENTERS   1,711/00   1,571,960   0   1,571,970   1,161   1,571,980   1.00   1,571,970   1,161   1,571,980   1.00   1,571,970   1,161   1,571,980   1.00   1,571,970   1,161   1,571,980   1.00   1,571,970   1,161   1,571,980   1.00   1,571,970   1,161   1,571,980   1.00   1,071,780   1.00   1,						,	,		,	,	
100   CAP RILL CONST. BLINKS & STRETCHES   1,571,990   1,571,990   1,571,090   1,571,000   1,571,000   1,005,378   0   197,78   2,000   1,005,370				1.00	2.00	3.00	4.00	5.00	6.00	7.00	
200			1				1				
100   MALLOPHERENNETN   100   1,085.599   1,085.599   0   1,085.599   3.00											
			`					-			
500				v							
MATERIAN PRINCE NETWOOD   116,799   0   116,799   0   10											
200   1000   1				-				,			
1800   1800		_									
1900   1900   1000				-				007,000			
1000   1000   CENTRALSERVICES & SUPPLY				-		-		-			
10.00   10.10		_		-				-			
1200   1200   M.DICAL RECORDS & LIBRARY						-	-	-	-		
1,00   0.100   SOCIAL SERVICE   57,355   0   57,355   0   0   0   0   0   0   0   0   0				v		-					
1490   1490   NURSING AND ALLIED HEALTH EDUCATION   0   0   0   0   0   0   178,945   10   10   10   10   10   10   10   1				,			0		0		
15.00   10.00   ACTIVITIES   163,212   15,733   178,945   0   178,945   5.00   178,945   5.00   178,945   5.00   178,945   5.00   178,945   5.00   178,945   5.00   178,945   5.00   178,945   5.00				-	0	•	0			-	
	15.00			163,212	15,733	178,945	0	178,945	0	178,945	15.00
13.00   0.300   0.300   0.300   0.300   0.300   0.00   0   0   0   0   0   0   0	INPA'	TIENT	ROUTINE SERVICE COST CENTERS								
	30.00	03000	SKILLED NURSING FACILITY	2,714,770	84,602	2,799,372	0	2,799,372	-27,315	2,772,057	30.00
18300   OTHER LONG TERM CARE   0   0   0   0   0   0   0   33.00	31.00	03100	NURSING FACILITY	0	0	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS	32.00	03200	ICF/IID	0	0	0	0	0	0	0	32.00
40.00   04000   RADIOLOGY	33.00	03300	OTHER LONG TERM CARE	0	0	0	0	0	0	0	33.00
10   10   10   10   10   10   10   10	ANCI	LLARY	SERVICE COST CENTERS								
42.00   42.00   NTRAYENOUS THERAPY	40.00	04000	RADIOLOGY	0	22,662	22,662	0	22,662	0	22,662	40.00
43.00   04500   OXYGEN (INHALATION) THERAPY   0   0   0   0   0   0   0   0   3.30     44.00   04400   PHYSICAL THERAPY   631,056   75,195   706,251   0   706,251   0   706,251   4.00     44.00   04400   PHYSICAL THERAPY   502,051   0   502,951   0   502,951   0   502,951   4.00     44.00   04600   OCCUPATIONAL THERAPY   502,051   0   502,951   0   502,951   4.00     46.00   04600   SPECEL PATHOLOGY   156,957   350   157,307   0   157,307   0   157,307   4.00     47.00   04700   ELECTROCARDIOLOGY   0   0   0   0   0   0   0   0   0     47.00   04700   ELECTROCARDIOLOGY   0   0   0   0   0   0   0   0   0     49.00   04800   GEDICAL SUPPLIES CHARGED TO PATIENTS   0   381,466   381,466   0   381,466   30,517   350,949   49.00     49.00   09900   DRUGS CHARGED TO PATIENTS   0   381,466   381,466   0   381,466   30,517   350,949   49.00     50.00   05000   DENTAL CARE TITLE XIX ONLY   0   0   0   0   0   0   0   0   0     50.00   05000   DENTAL CARE TITLE XIX ONLY   0   0   0   0   0   0   0   0   0     50.00   05000   COMPLEX MEDICAL EQUIPMENT   0   0   0   0   0   0   0   0   0     50.01   OXIDIO ONLO ONLO ONLO ONLO ONLO ONLO ONLO ON	41.00	04100	LABORATORY	0	47,379	47,379	0	47,379	0	47,379	41.00
44.00   44400   PHYSICAL THERAPY   631,056   75,195   706,251   0   706,251   0   706,251   44.00     45.00   04500   OCCUPATIONAL THERAPY   502,951   0   502,951   0   502,951   0     45.00   04500   OCCUPATIONAL THERAPY   502,951   0   502,951   0     45.00   04500   OCCUPATIONAL THERAPY   150,957   350   157,307   0   157,307   0     47.00   04700   EPECTROCARDIOLOGY   150,957   350   157,307   0   0   0   0   0     47.00   04700   ELECTROCARDIOLOGY   150,957   350   157,307   0   157,307   46.00     48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   1,186   48.00     48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   314,66   331,466   0   331,466   331,466   301,	42.00			0	-7,249	-7,249	0	-7,249	580	-6,669	
45.00   04500   OCCUPATIONAL THERAPY   502,951   0   502,951   0   502,951   0   502,951   45.00     46.00   04600   SPEECH PATHOLOGY   156,957   350   157,307   0   157,307   0   157,307   46.00     46.00   04800   SPEECH PATHOLOGY   0   0   0   0   0   0   0   0     48.00   04800   MEDICAL SUPPLIES CHARGED TO PATHENTS   0   0   0   0   1,186   1,186   0   1,186   48.00     49.00   04900   DRUGS CHARGED TO PATHENTS   0   381,466   381,466   0   381,466   -30,517   350,949   49.00     50.00   50.00   DENTAL CARE TITLE XIX ONLY   0   0   0   0   0   0   0   0     51.00   51.00   DENTAL CARE TITLE XIX ONLY   0   0   0   0   0   0   0   0     52.00   0500   DENTAL CARE TITLE XIX ONLY   0   0   0   0   0   0   0   0     52.00   0500   COMPLEX MEDICAL EQUIPMENT   0   0   0   0   0   0   0   0     52.01   0500   OTHER ANCILLARY SERVICES COST   0   0   0   0   0   0   0   0     52.02   0500   MEDICAL SERVICES   0   0   0   0   0   0   0   0     52.02   0500   MEDICAL SERVICES   0   0   0   0   0   0   0     61.00   06000   CLINIC   CLINIC   0   0   0   0   0   0   0     61.00   06000   CLINIC   CLINIC   0   0   0   0   0   0   0     62.00   06000   CLINIC   CLINIC   0   0   0   0   0   0   0     62.00   06000   CLINIC   CLINIC   0   0   0   0   0   0   0     63.00   0300   DALYSIS   0   0   0   0   0   0   0   0    COTOTAL REMIDERABLE COST CENTERS   CLINIC   0   0   0   0   0   0   0    COTOTAL REMIDERABLE COST CENTERS   CLINIC   0   0   0   0   0   0   0    COTOTAL REMIDERABLE COST CENTERS   CLINIC   0   0   0   0   0   0   0    COTOTAL REMIBURABLE COST CENTERS   CLINIC   0   0   0   0   0   0   0    COTOTAL REMIBURABLE COST CENTERS   CLINIC   0   0   0   0   0   0   0    COTOTAL REMIBURABLE COST CENTERS   CLINIC   0   0   0   0   0   0   0    COTOTAL REMIBURABLE COST CENTERS   CLINIC   0   0   0   0   0   0    COTOTAL REMIBURABLE COST CENTERS   CLINIC   0   0   0   0   0   0   0    COTOTAL REMIBURABLE COST CENTERS   CLINIC   0   0   0   0   0   0   0    COTOTAL REMIBURABLE COST CENTERS   CLINIC   0   0   0   0   0				v						0	
46.00   04600   SPEECH PATHOLOGY   156,957   350   157,307   0   157,307   0   0   0   0   0   0   0   0   0						,		,			
47.00   04700   ELECTROCARDIOLOGY   0 0 0 0 0 0 0 0 0 0 0 0 47.00				-		-					
48.00   04800   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   381,466   381,466   0   381,466   30,517   350,949   49.00						-		-		157,307	
49.00   04900   DRUGS CHARGED TO PATIENTS   0   381,466   381,466   0   381,466   -30,517   359,949   49.00				-						0	
50.00   05000   DENTAL CARE - TITLE XIX ONLY				-			,			-	
51.00   05100   SUPPORT SURFACES   0   0   0   0   1,635   1,635   0   1,635   51.00				-		-		,		350,949	
52.00         05200         COMPLEX MEDICAL EQUIPMENT         0										1.635	
52.01   05201   OTHER ANCILLARY SERVICES COST   0   0   0   0   0   0   0   0   0				-						1,635	
S2.02   05202   MEDICAL SERVICES   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			`					-		0	
OUTPATIENT SERVICE COST CENTERS           60.00         06000         CLINIC         0				-							
60.00         06000         CLINIC         0				0	0	0	0	0	0	0	32.02
61.00         06100         RURAL HEALTH CLINIC         0<				0	0	0	0	0	0	0	60.00
62.00         66200         FQHC         62.00           63.00         06300         DIALYSIS         0 <t< td=""><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>				-							
0		_									0 - 1 - 0
OTHER REIMBURSABLE COST CENTERS           70.00         07000         HOME HEALTH AGENCY COST         0			+ `	0	0	0	0	0	0	0	
71.00         07100         AMBULANCE         0         38,007         38,007         0         38,007         71.00           73.00         07300         CMHC         0				- 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         74.00           SPECIAL PURPOSE COST CENTERS           80.00         08000         MALPRACTICE PREMIUMS & PAID LOSSES         0         0         0         0         0         0         80.00           81.00         08100         INTEREST EXPENSE         0         0         0         0         0         0         0         81.00           82.00         08200         UTILIZATION REVIEW - SNF         0         0         0         0         0         0         0         82.00           83.00         08300         HOSPICE         0         0         0         0         0         0         0         83.00           84.00         08400         OTHER SPECIAL PURPOSE COST I         0         0         0         0         0         0         0         84.00           84.01         08401         OTHER SPECIAL PURPOSE COST II         0         0         0         0         0         0         0         0         84.01	71.00	07100	AMBULANCE	0	38,007	38,007	0	38,007	0	38,007	71.00
SPECIAL PURPOSE COST CENTERS	73.00	07300	CMHC	0	0	0	0	0	0	0	73.00
80.00         08000         MALPRACTICE PREMIUMS & PAID LOSSES         0         0         0         0         0         0         0         80.00           81.00         08100         INTEREST EXPENSE         0         0         0         0         0         0         0         0         0         81.00           82.00         08200         UTILIZATION REVIEW - SNF         0         0         0         0         0         0         0         0         0         0         82.00           83.00         08300         HOSPICE         0         0         0         0         0         0         0         0         83.00           84.00         08400         OTHER SPECIAL PURPOSE COST I         0	74.00	07400	OTHER REIMBURSEMENT	0	0	0	0	0	0	0	74.00
81.00         08100         INTEREST EXPENSE         0         0         0         0         0         0         0         81.00           82.00         08200         UTILIZATION REVIEW - SNF         0	SPEC	IAL PU	RPOSE COST CENTERS								
82.00         08200         UTILIZATION REVIEW - SNF         0         <	80.00	08000	MALPRACTICE PREMIUMS & PAID LOSSES		0	0	0	0	0	0	80.00
83.00         08300         HOSPICE         0         0         0         0         0         0         0         83.00           84.00         08400         OTHER SPECIAL PURPOSE COST I         0         0         0         0         0         0         0         0         0         84.00           84.01         OTHER SPECIAL PURPOSE COST II         0         0         0         0         0         0         0         84.01	81.00	08100	INTEREST EXPENSE		0	0	0	0	0	0	81.00
84.00         08400         OTHER SPECIAL PURPOSE COST I         0         0         0         0         0         0         0         84.00           84.01         08401         OTHER SPECIAL PURPOSE COST II         0         0         0         0         0         0         0         84.01	82.00	08200	UTILIZATION REVIEW - SNF	0	0	0	0	0	0	0	82.00
84.01 08401 OTHER SPECIAL PURPOSE COST II 0 0 0 0 0 0 84.01	83.00	08300	HOSPICE	0	0	0	0	0	0	0	83.00
	84.00			0	0	0	0	0	0	0	84.00
89.00 SUBTOTALS (sum of lines 1-84) 6,451,574 6,639,149 13,090,723 0 13,090,723 -78,300 13,012,423 89.00		<del>                                     </del>		- v						0	
	89.00		SUBTOTALS (sum of lines 1-84)	6,451,574	6,639,149	13,090,723	0	13,090,723	-78,300	13,012,423	89.00

CARE ONE AT PARSIPPANY

Period:
From: 01/01/2024
Provider CCN: 315468

Run Date Time: 5/28/2025 3:15 pm
MCRIF32 2540-10
Version: 11.1.179.1

#### RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

### Worksheet A

										113
						Reclassifications	Reclassified Trial	Adjustments to	Net Expenses	
		Cost Center Description			Total (col. 1 +	Increase/Decrease	Balance (col. 3 +-	Expenses (Fr	For Allocation	
			Salaries	Other	col. 2)	(Fr Wkst A-6)	col. 4)	Wkst A-8)	(col. 5 +- col. 6)	
			1.00	2.00	3.00	4.00	5.00	6.00	7.00	
NONI	NONREIMBURSABLE COST CENTERS									
90.00	09000	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	9,961	9,961	0	9,961	0	9,961	90.00
91.00	09100	BARBER AND BEAUTY SHOP	0	0	0	0	0	0	0	91.00
92.00	09200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	0	0	92.00
93.00	09300	NONPAID WORKERS	0	0	0	0	0	0	0	93.00
94.00	09400	PATIENTS LAUNDRY	0	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	6,451,574	6,649,110	13,100,684	0	13,100,684	-78,300	13,022,384	100.00

5/28/2025 3:15 pm **2540-10** CARE ONE AT PARSIPPANY Period: Run Date Time: From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315468 11.1.179.1

#### Worksheet A-6

									PPS	
	Increases				Decreases					
	Cost Center	Line #	Salary	Non Salary	Cost Center	Line #	Salary	Non Salary		
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
A - RE	A - RECLASS MED SUPP CHARGED									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	48.00	0	1,186	CENTRAL SERVICES & SUPPLY	10.00	0	1,186	1.00	
C - RE	ECLASS SUPPORT SURFACES									
1.00	SUPPORT SURFACES	51.00	0	1,635	CAP REL COSTS - MOVABLE EQUIPMENT	2.00	0	1,635	1.00	
100.00	TOTAL RECLASSIFICATIONS (Sum of columns 4	and 5	0	2,821			0	2,821	100.00	
	must equal sum of columns 8 and 9 (2)									
(1) A la	etter (A. B. etc.) must be entered on each line to identify ea	ch reclae	eification entry							

RECLASSIFICATIONS

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

CARE ONE AT PARSIPPANY

Period:
From: 01/01/2024
Provider CCN: 315468

Run Date Time: 5/28/2025 3:15 pm
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C540-10
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#### RECONCILIATION OF CAPITAL COSTS CENTERS

#### Worksheet A-7

									PPS
				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	YSIS OF CHANGES IN CAPITAL ASSET BALANCES								
1.00	Land	2,322,092	0	0	0	0	2,322,092	0	1.00
2.00	Land Improvements	42,500	0	0	0	0	42,500	0	2.00
3.00	Buildings and Fixtures	9,438,698	61,043	0	61,043	0	9,499,741	0	3.00
4.00	Building Improvements	0	0	0	0	0	0	0	4.00
5.00	Fixed Equipment	388,016	49,872	0	49,872	0	437,888	0	5.00
6.00	Movable Equipment	2,491,561	18,910	0	18,910	0	2,510,471	0	6.00
7.00	Subtotal (sum of lines 1-6)	14,682,867	129,825	0	129,825	0	14,812,692	0	7.00
8.00	Reconciling Items	0	0	0	0	0	0	0	8.00
9.00	Total (line 7 minus line 8)	14,682,867	129,825	0	129,825	0	14,812,692	0	9.00

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#### ADJUSTMENTS TO EXPENSES

#### Worksheet A-8

						PPS
				Expense Classification on Worksheet A To/From Amount is to be Adjusted	Which the	
	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	-1,161	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	420,259			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	-487	ADMINISTRATIVE & GENERAL	4.00	25.00
25.01	MARKETING EXPENSE	A	-12,442	ADMINISTRATIVE & GENERAL	4.00	25.01
25.02	MARKETING CORP EXPENSE	A	-918	ADMINISTRATIVE & GENERAL	4.00	25.02
25.03	MARKETING - MEALS	A	-3,890	ADMINISTRATIVE & GENERAL	4.00	25.03
25.04	BAD DEBT EXPENSE	A	-352,592	ADMINISTRATIVE & GENERAL	4.00	25.04
25.05	BAD DEBT EXPENSE - MEDICARE	A	-97,346	ADMINISTRATIVE & GENERAL	4.00	25.05
25.06	OTHER MEDICAL SERVICES EXPENSE	A	-27,315	SKILLED NURSING FACILITY	30.00	25.06
25.07	OTHER REVENUE	В	-2,408	ADMINISTRATIVE & GENERAL	4.00	25.07
100.00	Total (sum of lines 1 through 99) (Transfer to Worksheet A, col. 6, line 100)		-78,300			100.00
(1) Des	cription - All chapter references in this column pertain to CMS Pub. 15-1.					

<sup>(1)</sup> 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 PARSIPPANY

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# shoot A 9.1

## 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:

				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	1,096,227	640,798	455,429	1.00
2.00	9.00	NURSING ADMINISTRATION	PHARMACY CONSULTANT	26,076	28,344	-2,268	2.00
3.00	10.00	CENTRAL SERVICES & SUPPLY	WOUND CARE EXPENSE	14,687	14,687	0	3.00
4.00	11.00	PHARMACY	DRUGS-NON-PRESCRIPTION, NON-LEGEND	24,868	27,030	-2,162	4.00
5.00	11.00	PHARMACY	PHARMACY SUPPLIES	9,238	10,041	-803	5.00
6.00	42.00	INTRAVENOUS THERAPY	IV EXPENSE	-6,669	-7,249	580	6.00
7.00	49.00	DRUGS CHARGED TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS OTH	35,710	38,815	-3,105	7.00
8.00	49.00	DRUGS CHARGED TO PATIENTS	DRUGS-PRESCRIPTION, LEGEND DRUGS MAN	115,954	126,037	-10,083	8.00
9.00	49.00	DRUGS CHARGED TO PATIENTS	DRUGS-PRESCRIPTION, MEDICARE A	199,285	216,614	-17,329	9.00
10.00	TOTALS (sur	n of lines 1-9). Transfer column 6, line 10 to Workshe	et A-8, column 3, line 12.	1,515,376	1,095,117	420,259	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	zation(s) and/o	r Home Office	
	Symbol	N. T.	D	N	Percentage of	TI CD :	
	(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	F	DES HOLDING CO. INC.	0.00	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:

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#### 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	EMPLOYEE BENEFITS	Subtotal	ADMINISTRA TIVE & GENERAL	PLANT OPERATION, MAINT. & REPAIRS	LAUNDRY & LINEN SERVICE	
		0	1.00	2.00	3.00	3A	4.00	5.00	6.00	
GENI	ERAL SERVICE COST CENTERS									
1.00	CAP REL COSTS - BLDGS & FIXTURES	1,570,829	1,570,829							1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT	193,738		193,738						2.00
3.00	EMPLOYEE BENEFITS	1,085,359	0	0	1,085,359					3.00
4.00	ADMINISTRATIVE & GENERAL	2,591,468	157,811	19,464	92,672	2,861,415	2,861,415			4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	646,077	46,759	5,767	19,062	717,665	201,968	919,633		5.00
6.00	LAUNDRY & LINEN SERVICE	116,799	10,378	1,280	12,104	140,561	39,557	6,985	187,103	6.00
7.00	HOUSEKEEPING	309,586	10,855	1,339	46,672	368,452	103,691	7,306	0	7.00
8.00	DIETARY	699,158	145,524	17,948	74,931	937,561	263,852	97,953	0	8.00
9.00	NURSING ADMINISTRATION	780,768	121,907	15,035	120,907	1,038,617	292,292	82,056	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	106,992	0	0	0	106,992	30,110	0	0	10.00
11.00	PHARMACY	34,106	0	0	0	34,106	9,598	0	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	47,528	0	0	8,014	55,542	15,631	0	0	12.00
13.00	SOCIAL SERVICE	57,355	0	0	9,649	67,004	18,857	0	0	13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	0	0	0	14.00
15.00	ACTIVITES	178,945	0	0	27,457	206,402	58,086	0	0	15.00
INPA	TIENT ROUTINE SERVICE COST CENTERS			1			1	1		
30.00	SKILLED NURSING FACILITY	2,772,057	997,557	123,034	456,710	4,349,358	1,224,011	671,459	187,103	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			1			1	1		
40.00	RADIOLOGY	22,662	0	0	0	22,662	6,378	0	0	40.00
41.00	LABORATORY	47,379	0	0	0	47,379	13,334	0	0	41.00
42.00	INTRAVENOUS THERAPY	-6,669	0	0	0	-6,669	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	706,251	58,448	7,209	106,164	878,072	247,111	39,342	0	44.00
45.00	OCCUPATIONAL THERAPY	502,951	2,028	250	84,612	589,841	165,995	1,365	0	45.00
46.00	SPEECH PATHOLOGY	157,307	3,757	463	26,405	187,932	52,889	2,529	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	1,186	7,515	927	0	9,628	2,710	5,058	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	350,949	8,290	1,022	0	360,261	101,386	5,580	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	50.00
51.00	SUPPORT SURFACES	1,635	0	0	0	1,635	460	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
OUTI	PATIENT SERVICE COST CENTERS									
60.00	CLINIC	0	0	0	0	0	0	0	0	60.00
	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00
62.00	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	0	0	0	0	0	
71.00	AMBULANCE	38,007	0	0	0	38,007	10,696	0	0	71.00
	CMHC	0	0	0	0	0	0			_
	OTHER REIMBURSEMENT	0	0	0	0	0	0	0	0	74.00
SPEC	IAL PURPOSE COST CENTERS									
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
	UTILIZATION REVIEW - SNF									82.00
	HOSPICE OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	0		0	83.00

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#### COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
PPS

		Net Expenses for Cost						PLANT		
	Cost Center Description	Allocation					ADMINISTRA	OPERATION,	LAUNDRY &	
	•	(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)	13,012,423	1,570,829	193,738	1,085,359	13,012,423	2,858,612	919,633	187,103	89.00
NONI	REIMBURSABLE COST CENTERS									
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	9,961	0	0	0	9,961	2,803	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	0	0	98.00
99.00	Negative Cost Centers	0	0	0	0	0	0	0	0	99.00
100.00	TOTAL	13,022,384	1,570,829	193,738	1,085,359	13,022,384	2,861,415	919,633	187,103	100.00

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#### COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B Part I

										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	
	ERAL SERVICE COST CENTERS								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	479,449								7.00
8.00	DIETARY	51,874	1,351,240							8.00
9.00	NURSING ADMINISTRATION	43,455	0	1,456,420						9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0	137,102					10.00
11.00	PHARMACY	0	0	0	0	43,704				11.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	71,173			12.00
13.00	SOCIAL SERVICE	0	0	0	0	0	0	85,861		13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	0	0	0	14.00
15.00	ACTIVITES	0	0	0	0	0	0	0	0	15.00
INPA'	TIENT ROUTINE SERVICE COST CENTERS									
30.00	SKILLED NURSING FACILITY	355,589	1,351,240	1,456,420	137,102	43,704	71,173	85,861	0	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	
44.00	PHYSICAL THERAPY	20,835	0	0	0	0	0	0	0	
45.00	OCCUPATIONAL THERAPY	723	0	0	0	0	0	0	0	45.00
46.00	SPEECH PATHOLOGY	1,339	0	0	0	0	0	0	0	_
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0		
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,679	0	0	0	0	0	0		_
49.00	DRUGS CHARGED TO PATIENTS	2,955	0	0	0	0	0	0	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	_
51.00	SUPPORT SURFACES	0	0	0	0	0	0	0		
52.00	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	0	0		
52.01	OTHER ANCILLARY SERVICES COST	0	0	0	0	0	0	0		52.00
52.02	MEDICAL SERVICES	0	0	0	0	0	0	0		
	PATIENT SERVICE COST CENTERS	0	0	0		U	0	0	0	32.02
60.00	CLINIC	0	0	0	0	0	0	0	0	60.00
_	RURAL HEALTH CLINIC	0	0					0		61.00
	FQHC	0	0	0	0	0	U	0	0	62.00
	DIALYSIS	0	0	0	0	0	0	0	0	63.00
	ER REIMBURSABLE COST CENTERS	0	0	0	0	0	U	0		05.00
			0	0	0	0	0	0		70.00
	HOME HEALTH AGENCY COST	0	0	0	0	0	0	0		
71.00	AMBULANCE	0	0	0	0	0	0	0		
	CMHC	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									00.00
	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
	UTILIZATION REVIEW - SNF									82.00
83.00	HOSPICE	0	0	0	0	0	0	0		00.00
	LOTHER CRECIAL DURDOCE COCT I	0	0	0	0	0	0	0	0	84.00
84.00 84.01	OTHER SPECIAL PURPOSE COST I OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	0	0		84.01

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#### COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
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)	479,449	1,351,240	1,456,420	137,102	43,704	71,173	85,861	0	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	479,449	1,351,240	1,456,420	137,102	43,704	71,173	85,861	0	100.00

5/28/2025 3:15 pm **2540-10** CARE ONE AT PARSIPPANY Period: Run Date Time: From: 01/01/2024 MCRIF32 To: 12/31/2024 Version:

COST ALLOCATION - GENERAL SERVICE COSTS

315468

Provider CCN:

Worksheet B Part I

11.1.179.1

						PPS
	Cost Center Description			Post Stepdown		
	Cost Center Description	ACTIVITES	Subtotal	Adjustments	Total	
		15.00	16.00	17.00	18.00	
GEN	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	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	264,488				15.00
INPA	TIENT ROUTINE SERVICE COST CENTERS					
30.00	SKILLED NURSING FACILITY	264,488	10,197,508	0	10,197,508	30.00
31.00	NURSING FACILITY	0	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
ANCI	LLARY SERVICE COST CENTERS					
40.00	RADIOLOGY	0	29,040	0	29,040	40.00
41.00	LABORATORY	0	60,713	0	60,713	41.00
42.00	INTRAVENOUS THERAPY	0	-6,669	0	-6,669	42.00
43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	0	1,185,360	0	1,185,360	44.00
45.00	OCCUPATIONAL THERAPY	0	757,924	0	757,924	45.00
46.00	SPEECH PATHOLOGY	0	244,689	0	244,689	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	20,075	0	20,075	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	470,182	0	470,182	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0	2,095	0	2,095	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
OUT	PATIENT SERVICE COST CENTERS					
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
OTH	ER REIMBURSABLE COST CENTERS					
70.00	HOME HEALTH AGENCY COST	0	0	0	0	70.00
71.00	AMBULANCE	0	48,703	0	48,703	71.00
73.00	CMHC	0	0	0	0	73.00
74.00	OTHER REIMBURSEMENT	0	0	0	0	74.00
SPEC	IAL PURPOSE COST CENTERS					
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	0	84.01
		264,488	13,009,620	0	13,009,620	89.00

CARE ONE AT PARSIPPANY

Period:
From: 01/01/2024
Provider CCN: 315468

Period:
From: 01/01/2024
Provider CCN: 315468

Run Date Time: 5/28/2025 3:15 pm
MCRIF32
2540-10
Version: 11.1.179.1

#### COST ALLOCATION - GENERAL SERVICE COSTS

Worksheet B
Part I
PPS

				Post Stepdown		
	Cost Center Description	ACTIVITES	Subtotal	Adjustments	Total	
		15.00	16.00	17.00	18.00	
NONI	REIMBURSABLE COST CENTERS	ı				
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	12,764	0	12,764	90.0
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	91.0
92.00	PHYSICIANS PRIVATE OFFICES	0	0	0	0	92.0
93.00	NONPAID WORKERS	0	0	0	0	93.0
94.00	PATIENTS LAUNDRY	0	0	0	0	94.0
95.00	OTHER NONREIMBURSABLE COST	0	0	0	0	95.0
98.00	Cross Foot Adjustments	0	0	0	0	98.0
99.00	Negative Cost Centers	0	0	0	0	99.0
100.00	TOTAL	264,488	13,022,384	0	13,022,384	100.0

5/28/2025 3:15 pm **2540-10** CARE ONE AT PARSIPPANY Period: Run Date Time:

From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315468 11.1.179.1



#### ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B Part II

										PPS
	Cost Center Description	Directly Assigned New Capital Related	BLDGS &	MOVABLE		EMPLOYEE	ADMINISTRA TIVE &	PLANT OPERATION, MAINT. &	LAUNDRY & LINEN	
		Costs	FIXTURES	EQUIPMENT	Subtotal	BENEFITS	GENERAL	REPAIRS	SERVICE	
CENH	EDAL CEDVICE COST CENTERS	0	1.00	2.00	2A	3.00	4.00	5.00	6.00	
	ERAL SERVICE COST CENTERS									1.00
1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
2.00	CAP REL COSTS - MOVABLE EQUIPMENT									2.00
3.00	EMPLOYEE BENEFITS	0	0	0	0	0				3.00
4.00	ADMINISTRATIVE & GENERAL	0	157,811	19,464	177,275	0				4.00
5.00	PLANT OPERATION, MAINT. & REPAIRS	0	46,759	5,767	52,526	0	-,-	65,038		5.00
6.00	LAUNDRY & LINEN SERVICE	0	10,378	1,280	11,658	0		494	14,603	6.00
7.00	HOUSEKEEPING	0	10,855	1,339	12,194	0	6,424	517	0	7.00
8.00	DIETARY	0	145,524	17,948	163,472	0		· ·	0	
9.00	NURSING ADMINISTRATION	0	121,907	15,035	136,942	0		5,803	0	
10.00	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	1,865	0	0	
11.00	PHARMACY	0	0	0	0	0	595	0	0	11.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0		0	<u> </u>	
13.00	SOCIAL SERVICE	0	0	0	0	0	1,168	0	0	
14.00	NURSING AND ALLIED HEALTH EDUCATION	0	0	0	0	0	0	0	0	14.00
15.00	ACTIVITES	0	0	0	0	0	3,599	0	0	15.00
INPA	TIENT ROUTINE SERVICE COST CENTERS									
30.00	SKILLED NURSING FACILITY	0	997,557	123,034	1,120,591	0	75,833	47,486	14,603	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	395	0	0	40.00
41.00	LABORATORY	0	0	0	0	0	826	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	58,448	7,209	65,657	0	15,309	2,782	0	44.00
45.00	OCCUPATIONAL THERAPY	0	2,028	250	2,278	0	10,284	97	0	45.00
46.00	SPEECH PATHOLOGY	0	3,757	463	4,220	0	3,277	179	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,515	927	8,442	0	168	358	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	8,290	1,022	9,312	0	6,281	395	0	49.00
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	29	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
OUTI	PATIENT SERVICE COST CENTERS	'		'	'		•			
60.00	CLINIC	0	0	0	0	0	0	0	0	60.00
	RURAL HEALTH CLINIC	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	0	0	0	0	0	70.00
71.00	AMBULANCE	0	0	0	0	0				
	CMHC	0	0	0	0	0				
	OTHER REIMBURSEMENT	0	0	0	0	0	0			
	IAL PURPOSE COST CENTERS	<u> </u>	0	0	O	0	0			7 7.00
80.00	MALPRACTICE PREMIUMS & PAID LOSSES									80.00
81.00	INTEREST EXPENSE									81.00
	UTILIZATION REVIEW - SNF									82.00
		0	0	0	0	0	0	0	0	_
	HOSPICE	0	0	0	0	0	0		0	05.00
83.00	OTHER SPECIAL DURDOSE COST I	ام ما		ام	ام		0	0	0	94.00
83.00 84.00 84.01	OTHER SPECIAL PURPOSE COST I OTHER SPECIAL PURPOSE COST II	0	0	0	0	0			<u> </u>	84.00 84.01

CARE ONE AT PARSIPPANY

Period:
From: 01/01/2024
Provider CCN: 315468

Run Date Time: 5/28/2025 3:15 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	Directly Assigned New Capital Related Costs	BLDGS & FIXTURES	MOVABLE EQUIPMENT	Subtotal	EMPLOYEE BENEFITS	ADMINISTRA 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	1,570,829	193,738	1,764,567	0	177,101	65,038	14,603	89.00
NONE	REIMBURSABLE COST CENTERS									
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	0	174	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	1,570,829	193,738	1,764,567	0	177,275	65,038	14,603	100.00

5/28/2025 3:15 pm **2540-10** CARE ONE AT PARSIPPANY Period: Run Date Time:

From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315468 11.1.179.1



#### ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B Part II

										PPS
				NILIBOING	CENTRAL		MEDICAL		NURSING	
	Cost Center Description	HOUSEKEEPI		NURSING ADMINISTRA	CENTRAL SERVICES &		MEDICAL RECORDS &	SOCIAL	AND ALLIED 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					I		I.	
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	19,135								7.00
8.00	DIETARY	2,070	188,815							8.00
9.00	NURSING ADMINISTRATION	1,734	0	162,587						9.00
10.00	CENTRAL SERVICES & SUPPLY	0	0	0	1,865					10.00
11.00	PHARMACY	0	0	0	0	595				11.00
12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	968			12.00
13.00	SOCIAL SERVICE	0	0	0	0	0	0	1,168		13.00
14.00	NURSING AND ALLIED HEALTH	0	0	0	0	0	0	0	0	14.00
	EDUCATION									
15.00	ACTIVITES	0	0	0	0	0	0	0	0	15.00
INPA'	TIENT ROUTINE SERVICE COST CENTERS	'					'			
30.00	SKILLED NURSING FACILITY	14,192	188,815	162,587	1,865	595	968	1,168	0	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	832	0	0	0	0	0	0	0	44.00
45.00	OCCUPATIONAL THERAPY	29	0	0	0	0	0	0	0	45.00
46.00	SPEECH PATHOLOGY	53	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	107	0	0	0	0	0	0	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	118	0	0	0	0	0	0	0	49.00
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	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
OUTI	PATIENT SERVICE COST CENTERS						1			
60.00	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	
	ER REIMBURSABLE COST CENTERS						'			
70.00	HOME HEALTH AGENCY COST	0	0	0	0	0	0	0	0	70.00
71.00	AMBULANCE	0	0	0	0	0	0	0	0	71.00
73.00	CMHC	0	0	0	0	0	0	0	0	73.00
74.00	OTHER REIMBURSEMENT	0	0	0	0	0	0	0	0	74.00
SPEC	IAL PURPOSE COST CENTERS									
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	0	0	0	0	
	OTHER SPECIAL PURPOSE COST I	0	0	0	0	0	0	0	0	
84.01	OTHER SPECIAL PURPOSE COST II	0	0	0	0	0	0	0	0	84.01

CARE ONE AT PARSIPPANY

Period:
From: 01/01/2024
Provider CCN: 315468

Period:
From: 01/01/2024
Provider CCN: 315468

Run Date Time: 5/28/2025 3:15 pm
MCRIF32 2540-10
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)	19,135	188,815	162,587	1,865	595	968	1,168	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	19,135	188,815	162,587	1,865	595	968	1,168	0	100.00

5/28/2025 3:15 pm **2540-10** CARE ONE AT PARSIPPANY Period: Run Date Time: From: 01/01/2024 MCRIF32 To: 12/31/2024 Version:

#### ALLOCATION OF CAPITAL RELATED COSTS

315468

Provider CCN:

Worksheet B Part II

11.1.179.1

						PPS
				Post		
	Cost Center Description			Step-Down		
		ACTIVITES	Subtotal	Adjustments	Total	
		15.00	16.00	17.00	18.00	
	ERAL SERVICE COST CENTERS				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					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						13.00
14.00	NURSING AND ALLIED HEALTH EDUCATION					14.00
15.00	ACTIVITES	3,599				15.00
INPA	TIENT ROUTINE SERVICE COST CENTERS					
30.00	SKILLED NURSING FACILITY	3,599	1,632,302	0	1,632,302	30.00
31.00	NURSING FACILITY	0	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
ANC	ILLARY SERVICE COST CENTERS					
40.00	RADIOLOGY	0	395	0	395	40.00
41.00	LABORATORY	0	826	0	826	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	84,580	0	84,580	44.00
45.00	OCCUPATIONAL THERAPY	0	12,688	0	12,688	45.00
46.00	SPEECH PATHOLOGY	0	7,729	0	7,729	46.00
47.00	ELECTROCARDIOLOGY	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9,075	0	9,075	48.00
49.00	DRUGS CHARGED TO PATIENTS	0	16,106	0	16,106	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	50.00
51.00	SUPPORT SURFACES	0	29	0	29	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		0	0	0	0	52.02
	PATIENT SERVICE COST CENTERS					
60.00	CLINIC	0	0	0	-	60.00
61.00	RURAL HEALTH CLINIC	0	0	0	0	61.00
	FQHC					62.00
	DIALYSIS	0	0	0	0	63.00
	ER REIMBURSABLE COST CENTERS					
	HOME HEALTH AGENCY COST	0	0	0		70.00
71.00		0	663	0	663	71.00
73.00		0	0	0		73.00
	OTHER REIMBURSEMENT LIAL PURPOSE COST CENTERS	0	0	0	0	74.00
						90.00
80.00						80.00
	INTEREST EXPENSE					81.00
82.00	UTILIZATION REVIEW - SNF HOSPICE			^		82.00
		0	0	0	0	83.00
84.00		0	0	0	0	84.00 84.01
04.01	OTHER SPECIAL FURIOSE COST II	0	U	0	U	04.01

CARE ONE AT PARSIPPANY

Period:
From: 01/01/2024
Provider CCN: 315468

Period:
From: 01/01/2024
Provider CCN: 315468

Run Date Time: 5/28/2025 3:15 pm
MCRIF32
2540-10
Version: 11.1.179.1

#### ALLOCATION OF CAPITAL RELATED COSTS

Worksheet B Part II PPS

				Post		
	Cost Center Description			Step-Down		
		ACTIVITES	Subtotal	Adjustments	Total	
		15.00	16.00	17.00	18.00	
89.00	SUBTOTALS (sum of lines 1-84)	3,599	1,764,393	0	1,764,393	89.00
NONI	REIMBURSABLE COST CENTERS					
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	174	0	174	90.00
91.00	BARBER AND BEAUTY SHOP	0	0	0	0	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	3,599	1,764,567	0	1,764,567	100.00

CARE ONE AT PARSIPPANY

Period: Run Date Time: 5/28/2025 3:15 pm

From: 01/01/2024 MCRIF32 **2540-10**Provider CCN: 315468 To: 12/31/2024 Version: 11.1.179.1



#### COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

PPS PLANT LAUNDRY & ADMINISTRA OPERATION, BLDGS & MOVABLE EMPLOYEE TIVE & MAINT. & LINEN HOUSEKEEPI Cost Center Description **FIXTURES EQUIPMENT** BENEFITS **GENERAL** REPAIRS SERVICE NG (SQUARE (GROSS (PATIENT (SQUARE (SOUARE (ACCUM (SOUARE FEET) FEET) SALARIES) Reconciliation COST) FEET) DAYS) FEET) 1.00 2.00 3.00 4A 4.00 5.00 6.00 7.00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS - BLDGS & FIXTURES 26,338 1.00 CAP REL COSTS - MOVABLE EQUIPMENT 2.00 26,338 2.00 3.00 EMPLOYEE BENEFITS 0 6,451,574 3.00 0 ADMINISTRATIVE & GENERAL 2,646 2,646 550,860 -2,861,415 10,167,638 4.00 PLANT OPERATION, MAINT. & REPAIRS 5.00 784 113,309 22 908 5.00 784 0 717,665 6.00 LAUNDRY & LINEN SERVICE 174 174 71,946 0 140,561 174 26,045 6.00 HOUSEKEEPING 182 182 277,425 0 368,452 182 22,552 7.00 8.00 DIETARY 2,440 2,440 445,403 0 937,561 2,440 0 2,440 8.00 NURSING ADMINISTRATION 2,044 1,038,617 2,044 2,044 9.00 2,044 718,692 0 9.00 0 CENTRAL SERVICES & SUPPLY 0 106,992 10.00 11.00 PHARMACY 0 0 0 0 34,106 0 0 0 11.00 MEDICAL RECORDS & LIBRARY 0 47,638 55,542 0 12.00 12.00 0 0 0 0 13.00 SOCIAL SERVICE 0 0 57,355 67,004 0 13.00 14.00 NURSING AND ALLIED HEALTH 0 0 0 0 14.00 EDUCATION ACTIVITES 0 0 163,212 0 206,402 0 0 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 SKILLED NURSING FACILITY 16,726 16,726 2,714,770 0 4,349,358 16,726 26,045 16,726 30.00 31.00 NURSING FACILITY 31.00 0 0 0 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 33.00 0 ANCILLARY SERVICE COST CENTERS 40.00 RADIOLOGY 0 0 0 0 22,662 0 040.00 41.00 LABORATORY 0 0 0 0 47,379 0 0 0 41.00 42.00 INTRAVENOUS THERAPY 0 0 0 6,669 0 0 0 42.00 43.00 OXYGEN (INHALATION) THERAPY 0 0 0 0 0 0 043.00 PHYSICAL THERAPY 980 0 878,072 980 980 44 00 44.00 980 631,056 0 45.00 OCCUPATIONAL THERAPY 34 34 502,951 0 589,841 34 0 34 45.00 SPEECH PATHOLOGY 63 63 156,957 0 187,932 63 63 46.00 0 0 47.00 ELECTROCARDIOLOGY 0 0 0 0 0 47.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 126 126 0 9,628 126 0 48.00 48.00 0 126 49.00 DRUGS CHARGED TO PATIENTS 139 139 0 360,261 139 0 139 49.00 50.00 DENTAL CARE - TITLE XIX ONLY 0 0 0 0 0 0 0 0 50.00 SUPPORT SURFACES 51.00 0 0 1.635 051.00 0 0 0 0 COMPLEX MEDICAL EQUIPMENT 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 OUTPATIENT SERVICE COST CENTERS 60.00 CLINIC 0 0 0 0 0 0 0 0 60.00 61.00 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 61.00 0 62.00 FQHC 62.00 63.00 DIALYSIS 0 0 0 0 0 0 0 0 63.00 OTHER REIMBURSABLE COST CENTERS 70.00 HOME HEALTH AGENCY COST 0 0 0 0 70.00 0 0 0 71.00 AMBULANCE 71.00 0 0 0 0 38,007 0 0 73.00 CMHC 0 0 0 0 0 0 0 0 73.00 74.00 OTHER REIMBURSEMENT 0 0 74.00 00 0 0 0 0 SPECIAL PURPOSE COST CENTERS MALPRACTICE PREMIUMS & PAID LOSSES 80.0081.00 INTEREST EXPENSE 81.00 UTILIZATION REVIEW - SNF 82.00 83.00 HOSPICE 0 83.00 0 0 0 0 0 0

CARE ONE AT PARSIPPANY

Period:
From: 01/01/2024
Provider CCN: 315468

Period:
From: 01/01/2024
To: 12/31/2024
Provider CCN: 315468

Run Date Time: 5/28/2025 3:15 pm
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#### COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

	Cost Center Description	BLDGS & FIXTURES (SQUARE FEET)	MOVABLE EQUIPMENT (SQUARE FEET)	EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	TIVE & GENERAL (ACCUM COST)	PLANT OPERATION, MAINT. & REPAIRS (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PATIENT DAYS)	HOUSEKEEPI NG (SQUARE FEET)	
		1.00	2.00	3.00	4A	4.00	5.00	6.00	7.00	
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)	26,338	26,338	6,451,574	-2,854,746	10,157,677	22,908	26,045	22,552	89.00
NONI	REIMBURSABLE COST CENTERS									
90.00	GIFT, FLOWER, COFFEE SHOPS & CANTEEN	0	0	0	0	9,961	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)	1,570,829	193,738	1,085,359		2,861,415	919,633	187,103	479,449	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	59.641165	7.355836	0.168232		0.281424	40.144622	7.183836	21.259711	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)			0		177,275	65,038	14,603	19,135	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)			0.000000		0.017435	2.839096	0.560683	0.848484	105.00

5/28/2025 3:15 pm **2540-10** CARE ONE AT PARSIPPANY Period: Run Date Time:

From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315468 11.1.179.1



#### COST ALLOCATION - STATISTICAL BASIS

Worksheet B-1

2.0   CAP REL COSTS - NOVABLE EQUIPMENT											PPS
CREMENT SERVICE COST CENTRES		Cost Center Description	(MEALS	ADMINISTRA TION (PATIENT	SERVICES & SUPPLY (PATIENT	(PATIENT	RECORDS & LIBRARY (PATIENT	SERVICE (PATIENT	AND ALLIED HEALTH EDUCATION (ASSIGNED	(PATIENT	
APRIL CORNS BUNDAS & PIXTURES			8.00	9.00	10.00	11.00	12.00	13.00	14.00	15.00	
200   CAPRIL CONTS - MOVABILI EQUIPMENT	GENE	CRAL SERVICE COST CENTERS									
ADMINISTRATUR & GENERAL	1.00	CAP REL COSTS - BLDGS & FIXTURES									1.00
400 ADMINISTRATURE & GENERAL	2.00	CAP REL COSTS - MOVABLE EQUIPMENT									2.00
Dec   ANT OPPEATION, MAINT, & REPAIRS	3.00	EMPLOYEE BENEFITS									3.00
GAUNDRY & LINEN SERVICE	4.00	ADMINISTRATIVE & GENERAL									4.00
DOUBLEMENT   100	5.00	PLANT OPERATION, MAINT. & REPAIRS									5.00
SOP   DITTARY   78,135	6.00	LAUNDRY & LINEN SERVICE									6.00
9.99 NURSING ADMINISTRATION   0   26,045   10,100   11.00 (EISPIRAL SERVICES & SUPPLY   0   0   26,045   11,11   11.00 PHARMACY   0   0   0   0   0   26,045   11,11   11.00 PHARMACY   0   0   0   0   0   0   26,045   12,11   11.00 SCOLLA RECORDS & LIBRARY   0   0   0   0   0   0   26,045   13,11   11.00 SCOLLA RECORDS & LIBRARY   0   0   0   0   0   0   0   0   0   11.00 SCOLLA RECORDS & LIBRARY   0   0   0   0   0   0   0   0   0   11.00 SCOLLA RECORD & LIBRARY   0   0   0   0   0   0   0   0   0   11.00 SCOLLA RECORD & LIBRARY   0   0   0   0   0   0   0   0   0   11.00 SCOLLA RECORD & LIBRARY   0   0   0   0   0   0   0   0   0   11.00 SCOLLA RECORD & LIBRARY   0   0   0   0   0   0   0   0   0   11.00 SCOLLA RECORD & LIBRARY   0   0   0   0   0   0   0   0   0	7.00	HOUSEKEEPING									7.00
CONTRAL SERVICE & SUPPLY	8.00	DIETARY	78,135								8.00
11-10   PHARMACY	9.00	NURSING ADMINISTRATION	0	26,045							9.00
MEDICAL RECORDS & LIBRARY	10.00	CENTRAL SERVICES & SUPPLY	0	0	26,045						10.00
1300   SOCIAL SIZEVICE   0   0   0   0   0   0   26,045   13.4	11.00	PHARMACY	0	0	0	26,045					11.00
AURISING AND ALLIED HEALTH   0	12.00	MEDICAL RECORDS & LIBRARY	0	0	0	0	26,045				12.00
EDUCATION	13.00	SOCIAL SERVICE	0	0	0	0	0	26,045			13.00
NAPATIENT BOUTIES SERVICE COST CENTERS	14.00		0	0	0	0	0	0	0		14.00
NATATIENT ROUTINE SERVICE COST CENTERS	15.00	ACTIVITES	0	0	0	0	0	0	0	26,045	15.00
S1.00   NURSING FACILITY											
51.00   URSING FACILITY	30.00	SKILLED NURSING FACILITY	78,135	26,045	26,045	26,045	26,045	26,045	0	26,045	30.00
33.00   OTHER LONG TERM CARE	31.00	NURSING FACILITY	0	0	0	0	0	0	0	0	31.00
ANCILLARY SERVICE COST CENTERS	32.00	ICF/IID	0	0	0	0	0	0	0	0	32.00
40.00   RADIOLOGY	33.00	OTHER LONG TERM CARE	0	0	0	0	0	0	0	0	33.00
41.00   LABORATORY	ANCI	LLARY SERVICE COST CENTERS					'				
42.00   INTRAVENOUS THERAPY	40.00	RADIOLOGY	0	0	0	0	0	0	0	0	40.00
43.00   OXYGEN (INHALATION) THERAPY	41.00	LABORATORY	0	0	0	0	0	0	0	0	41.00
44.00   PHYSICAL THERAPY	42.00	INTRAVENOUS THERAPY	0	0	0	0	0	0	0	0	42.00
45.00 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 45.4 46.00 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 46.4 46.00 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	43.00	OXYGEN (INHALATION) THERAPY	0	0	0	0	0	0	0	0	43.00
46.00 SPEECH PATHOLOGY	44.00	PHYSICAL THERAPY	0	0	0	0	0	0	0	0	44.00
47.00 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0 0 47.4 48.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 48.4 49.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	45.00	OCCUPATIONAL THERAPY	0	0	0	0	0	0	0	0	45.00
48.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 48.4 49.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	46.00	SPEECH PATHOLOGY	0	0	0	0	0	0	0	0	46.00
49.00   DRUGS CHARGED TO PATIENTS	47.00	ELECTROCARDIOLOGY	0	0	0	0	0	0	0	0	47.00
50.00   DENTAL CARE - TITLE XIX ONLY	48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	0	0	0	48.00
51.00   SUPPORT SURFACES	49.00	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	0	0	49.00
52.00   COMPLEX MEDICAL EQUIPMENT	50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0	0	0	0	0	0	50.00
S2.01 OTHER ANCILLARY SERVICES COST   0   0   0   0   0   0   0   0   0	51.00	SUPPORT SURFACES	0	0	0	0	0	0	0	0	51.00
52.02   MEDICAL SERVICES	52.00	COMPLEX MEDICAL EQUIPMENT	0	0	0	0	0	0	0	0	52.00
OUTPATIENT SERVICE COST CENTERS           60.00 CLINIC         0	52.01	OTHER ANCILLARY SERVICES COST	0	0	0	0	0	0	0	0	52.01
60.00 CLINIC         0 <t< td=""><td></td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>52.02</td></t<>			0	0	0	0	0	0	0	0	52.02
61.00 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 61.0 62.00 FQHC 62.00 FQHC 63.00 DIALYSIS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	OUTP	ATIENT SERVICE COST CENTERS									
62.00         FQHC         62.00         0 <t< td=""><td>60.00</td><td>CLINIC</td><td></td><td>0</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td>60.00</td></t<>	60.00	CLINIC		0	0		0	0	0	0	60.00
63.00 DIALYSIS 0 0 0 0 0 0 0 0 0 0 0 0 0 63.00 OTHER REIMBURSABLE COST CENTERS  70.00 HOME HEALTH AGENCY COST 0 0 0 0 0 0 0 0 0 0 0 0 70.00 OTHER REIMBURSABLE COST 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	61.00	RURAL HEALTH CLINIC	0	0	0	0	0	0	0	0	61.00
OTHER REIMBURSABLE COST CENTERS           70.00 HOME HEALTH AGENCY COST         0	62.00	FQHC									62.00
70.00         HOME HEALTH AGENCY COST         0<	63.00	DIALYSIS	0	0	0	0	0	0	0	0	63.00
71.00         AMBULANCE         0         0         0         0         0         0         0         71.0           73.00         CMHC         0											
73.00 CMHC         0         0         0         0         0         0         0         0         73.00           74.00 OTHER REIMBURSEMENT         0         0         0         0         0         0         0         0         0         74.00           SPECIAL PURPOSE COST CENTERS           80.00 MALPRACTICE PREMIUMS & PAID LOSSES         80.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>· · ·</td> <td></td> <td></td> <td>0</td> <td>, ,,,,,,</td>							· · ·			0	, ,,,,,,
74.00         OTHER REIMBURSEMENT         0         0         0         0         0         0         0         74.0           SPECIAL PURPOSE COST CENTERS           80.00         MALPRACTICE PREMIUMS & PAID LOSSES         80.0							· · ·	0	0	0	71.00
SPECIAL PURPOSE COST CENTERS           80.00         MALPRACTICE PREMIUMS & PAID LOSSES         80.0           81.00         INTEREST EXPENSE         81.0											
80.00         MALPRACTICE PREMIUMS & PAID LOSSES         80.0           81.00         INTEREST EXPENSE         81.0			0	0	0	0	0	0	0	0	74.00
81.00 INTEREST EXPENSE 81.0	_										
											80.00
82.00 UTILIZATION REVIEW - SNF 82.0											81.00
											82.00
83.00 HOSPICE 0 0 0 0 0 0 83.0	83.00	HOSPICE	0	0	0	0	0	0	0	0	83.00

CARE ONE AT PARSIPPANY

Period:
From: 01/01/2024
Provider CCN: 315468

Period:
From: 01/01/2024
Provider CCN: 315468

Run Date Time: 5/28/2025 3:15 pm
MCRIF32
2540-10
Version: 11.1.179.1

#### COST ALLOCATION - STATISTICAL BASIS

#### Worksheet B-1

										PPS
	Cost Center Description	DIETARY (MEALS SERVED) 8.00	NURSING ADMINISTRA TION (PATIENT DAYS) 9.00	CENTRAL SERVICES & SUPPLY (PATIENT DAYS) 10.00	PHARMACY (PATIENT DAYS) 11.00	MEDICAL RECORDS & LIBRARY (PATIENT DAYS) 12.00	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)	78,135	26,045	26,045	26,045	26,045	26,045	0	26,045	89.00
NON	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)	1,351,240	1,456,420	137,102	43,704	71,173	85,861	0	264,488	102.00
103.00	Unit cost multiplier (Wkst. B, Part I)	17.293658	55.919370	5.264043	1.678019	2.732693	3.296640	0.000000	10.155039	103.00
104.00	Cost to be allocated (per Wkst. B, Part II)	188,815	162,587	1,865	595	968	1,168	0	3,599	104.00
105.00	Unit cost multiplier (Wkst. B, Part II)	2.416523	6.242542	0.071607	0.022845	0.037166	0.044845	0.000000	0.138184	105.00

CARE ONE AT PARSIPPANY

Period:
From: 01/01/2024
Provider CCN: 315468

Run Date Time: 5/28/2025 3:15 pm
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#### RATIO OF COST TO CHARGES FOR ANCILLARY AND OUTPATIENT COST CENTERS

#### Worksheet C

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	
ANCILLARY SERVICE COST CENTERS				
40.00 RADIOLOGY	29,040	56,655	0.512576	40.0
41.00 LABORATORY	60,713	118,447	0.512575	41.0
42.00 INTRAVENOUS THERAPY	0	51,667	0.000000	42.0
43.00 OXYGEN (INHALATION) THERAPY	0	0	0.000000	43.0
44.00 PHYSICAL THERAPY	1,185,360	2,503,488	0.473483	44.0
45.00 OCCUPATIONAL THERAPY	757,924	2,598,200	0.291711	45.0
46.00 SPEECH PATHOLOGY	244,689	623,394	0.392511	46.0
47.00 ELECTROCARDIOLOGY	0	0	0.000000	47.0
48.00 MEDICAL SUPPLIES CHARGED TO PATIENTS	20,075	2,966	6.768375	48.0
49.00 DRUGS CHARGED TO PATIENTS	470,182	953,665	0.493026	49.0
50.00 DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	50.0
51.00 SUPPORT SURFACES	2,095	4,088	0.512476	51.0
52.00 COMPLEX MEDICAL EQUIPMENT	0	0	0.000000	52.0
52.01 OTHER ANCILLARY SERVICES COST	0	0	0.000000	52.0
52.02 MEDICAL SERVICES	0	0	0.000000	52.0
OUTPATIENT SERVICE COST CENTERS				
50.00 CLINIC	0	0	0.000000	60.0
51.00 RURAL HEALTH CLINIC				61.0
52.00 FQHC				62.0
53.00 DIALYSIS	0	0	0.000000	63.0
71.00 AMBULANCE	48,703	95,018	0.512566	71.0
100.00 Total	2,818,781	7,007,588		100.0

CARE ONE AT PARSIPPANY Period: Run Date Time: 5/28/2025 3:15 pm

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



#### APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS

315468

Provider CCN:

Worksheet D

Part I Skilled Nursing Facility Title XVIII PPS

					omned i taroni	5/	
PART	I - CALCULATION OF ANCILLARY AND OUTPATII	ENT 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	
ANCI	LLARY SERVICE COST CENTERS						
40.00	RADIOLOGY	0.512576	13,646	0	6,995	0	40.00
41.00	LABORATORY	0.512575	8,840	0	4,531	0	41.00
42.00	INTRAVENOUS THERAPY	0.000000	15,532	0	0	0	42.00
43.00	OXYGEN (INHALATION) THERAPY	0.000000	0	0	0	0	43.00
44.00	PHYSICAL THERAPY	0.473483	1,072,352	0	507,740	0	44.00
45.00	OCCUPATIONAL THERAPY	0.291711	1,107,061	0	322,942	0	45.00
46.00	SPEECH PATHOLOGY	0.392511	269,424	0	105,752	0	46.00
47.00	ELECTROCARDIOLOGY	0.000000	0	0	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	6.768375	2,966	0	20,075	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	0.493026	52,349	0	25,809	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0.000000	0		0		50.00
51.00	SUPPORT SURFACES	0.512476	4,088	0	2,095	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
OUTF	ATIENT 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)	0.512566		0		0	71.00
100.00	Total (Sum of lines 40 - 71)		2,546,258	0	995,939	0	100.00

<sup>(1)</sup> 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.

To:

12/31/2024

Version:

CARE ONE AT PARSIPPANY

Period:
From: 01/01/2024

Run Date Time: 5/28/2025 3:15 pm
MCRIF32

2540-10

HF

APPORTIONMENT OF ANCILLARY AND OUTPATIENT COSTS

315468

Provider CCN:

PART II -

1.00

Worksheet D Parts II-III

PPS

Title XVIII Skilled Nursing Facility

11.1.179.1

RΤ	II - APPORTIONMENT OF VACCINE COST		
		1.00	
	Drugs charged to patients - ratio of cost to charges (From Worksheet C, column 3, line 49)	0.493026	1.00
	Program vaccine charges (From your records, or the PS&R)	3,022	2.00

1.00	13 rago crimiged to patients ratio of cost to crimiges (1 rom wo		0.125020	1.00			
2.00	Program vaccine charges (From your records, or the PS&R)					3,022	2.00
3.00	Program costs (Line 1 x line 2) (Title XVIII, PPS providers, tra	ansfer this amount to Work	sheet E, Part I, line 18)			1,490	3.00
PART	III - CALCULATION OF PASS THROUGH COSTS FO	R NURSING & ALLIEI	O HEALTH				
				Ratio of Nursing &			
	Ogram costs (Line 1 x line 2) (Title XVIII, PPS providers, transfer the CALCULATION OF PASS THROUGH COSTS FOR NUFF COST CENTER COST CENTERS COST CEN		Nursing & Allied Health	Allied Health Costs to	Program Part A Cost	Part A Nursing & Allied	
	Soot senter 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)	Through (Col. 3 x Col. 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCI	LLARY SERVICE COST CENTERS						
40.00	RADIOLOGY	29,040	0	0.000000	6,995	0	40.00
41.00	LABORATORY	60,713	0	0.000000	4,531	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	1,185,360	0	0.000000	507,740	0	44.00
45.00	OCCUPATIONAL THERAPY	757,924	0	0.000000	322,942	0	45.00
46.00	SPEECH PATHOLOGY	244,689	0	0.000000	105,752	0	46.00
47.00	ELECTROCARDIOLOGY	0	0	0.000000	0	0	47.00
48.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	20,075	0	0.000000	20,075	0	48.00
49.00	DRUGS CHARGED TO PATIENTS	470,182	0	0.000000	25,809	0	49.00
50.00	DENTAL CARE - TITLE XIX ONLY	0	0	0.000000	0	0	50.00
51.00	SUPPORT SURFACES	2,095	0	0.000000	2,095	0	51.00
52.00	COMPLEX MEDICAL EQUIPMENT	0	0	0.000000	0	0	52.00
52.01	OTHER ANCILLARY SERVICES COST	0	0	0.000000	0	0	52.01
52.02	MEDICAL SERVICES	0	0	0.000000	0	0	52.02
100.00	Total (Sum of lines 40 - 52)	2,770,078	0		995,939	0	100.00

5/28/2025 3:15 pm **2540-10** CARE ONE AT PARSIPPANY Period: Run Date Time: From: 01/01/2024 MCRIF32 To: 12/31/2024 Version: Provider CCN: 315468 11.1.179.1



#### COMPUTATION OF INPATIENT ROUTINE COSTS

5.00 Program nursing & allied health costs for pass-through. (line 3 times line 4)

Worksheet D-1 Part I

	Title XVIII Skilled N	ursing Facility	PPS
PART	' I CALCULATION OF INPATIENT ROUTINE COSTS		
		1.00	
INPA	TIENT DAYS		
1.00	Inpatient days including private room days	26,045	1.00
2.00	Private room days	0	2.00
3.00	Inpatient days including private room days applicable to the Program	8,011	3.00
4.00	Medically necessary private room days applicable to the Program	0	4.00
5.00	Total general inpatient routine service cost	10,197,508	5.00
PRIV	ATE ROOM DIFFERENTIAL ADJUSTMENT		
6.00	General inpatient routine service charges	13,979,536	6.00
7.00	General inpatient routine service cost/charge ratio (Line 5 divided by line 6)	0.729460	7.00
8.00	Enter private room charges from your records	0	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	0	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)	0	14.00
15.00	General inpatient routine service cost net of private room cost differential (Line 5 minus line 14)	10,197,508	15.00
PROC	GRAM INPATIENT ROUTINE SERVICE COSTS		
16.00	Adjusted general inpatient service cost per diem (Line 15 divided by line 1)	391.53	16.00
17.00	Program routine service cost (Line 3 times line 16)	3,136,547	17.00
18.00	Medically necessary private room cost applicable to program (line 4 times line 13)	0	18.00
19.00	Total program general inpatient routine service cost (Line 17 plus line 18)	3,136,547	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)	1,632,302	20.00
21.00	Per diem capital related costs (Line 20 divided by line 1)	62.67	21.00
22.00	Program capital related cost (Line 3 times line 21)	502,049	22.00
23.00	Inpatient routine service cost (Line 19 minus line 22)	2,634,498	23.00
24.00	Aggregate charges to beneficiaries for excess costs (From provider records)	0	24.00
25.00	Total program routine service costs for comparison to the cost limitation (Line 23 minus line 24)	2,634,498	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	TII CALCULATION OF INPATIENT NURSING & ALLIED HEALTH COSTS FOR PPS PASS-THROUGH		
		1.00	
1.00	Total SNF inpatient days	26,045	1.00
2.00	Program inpatient days (see instructions)	8,011	2.00
3.00	Total nursing & allied health costs. (see instructions) (Do not complete for titles V or XIX)	0	3.00
4.00	Nursing & allied health ratio. (line 2 divided by line 1)	0.307583	4.00

41-345

5.00

 CARE ONE AT PARSIPPANY
 Period: From: 01/01/2024
 Run Date Time: 5/28/2025 3:15 pm
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 Provider CCN: 315468
 To: 12/31/2024
 Version: 11.1.179.1



#### CALCULATION OF REIMBURSEMENT SETTLEMENT FOR TITLE XVIII

Worksheet E Part I

	Title XVIII Skilled Nurs		Part 1 PPS
PART	A - INPATIENT SERVICE PPS PROVIDER COMPUTATION OF REIMBURSEMENT		
		1.00	
1.00	Inpatient PPS amount (See Instructions)	6,278,770	1.00
2.00	Nursing and Allied Health Education Activities (pass through payments)	0	2.00
3.00	Subtotal (Sum of lines 1 and 2)	6,278,770	
4.00	Primary payor amounts	0	4.00
5.00	Coinstrance	1,032,444	
6.00	Allowable bad debts (From your records)	263,097	6.00
7.00	Allowable Bad debts for dual eligible beneficiaries (See instructions)	146,222	7.00
8.00	Adjusted reimbursable bad debts. (See instructions)	171,013	_
9.00	Recovery of bad debts - for statistical records only	0	9.00
10.00	Utilization review	0	10.00
11.00	Subtotal (See instructions)	5,417,339	
12.00	Interim payments (See instructions)	5,174,400	
13,00	Tentative adjustment	0,271,100	13.00
14.00	OTHER adjustment (See instructions)	0	14.00
14.50	Demonstration payment adjustment amount before sequestration		14.50
14.55	Demonstration payment adjustment amount after sequestration	160,114	
14.75	Sequestration for non-claims based amounts (see instructions)	3,420	
14.99	Sequestration amount (see instructions)	104,927	
15.00	Balance due provider/program (see Instructions)	-25,522	15.00
16.00	Protested amounts (Nonallowable cost report items in accordance with CMS Pub. 15-2, section 115.2)	-23,322	16.00
	T B - ANCILLARY SERVICE COMPUTATION OF REIMBURSEMENT LESSER OF COST OR CHARGES - TITLE XVIII ONLY		10.00
17.00	Ancillary services Part B	0	17.00
18.00	Vaccine cost (From Wkst D, Part II, line 3)	1,490	
19.00	Total reasonable costs (Sum of lines 17 and 18)	1,490	_
20.00	Medicare Part B ancillary charges (See instructions)	3,022	
21.00	Cost of covered services (Lesser of line 19 or line 20)	1,490	
22.00	Primary payor amounts	1,170	22.00
23,00	Coinsurance and deductibles	0	23.00
24.00	Allowable bad debts (From your records)	0	24.00
24.01	Allowable Bad debts for dual eligible beneficiaries (see instructions)	0	-
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)	1,490	
26.00	Interim payments (See instructions)	1,390	
27.00	Tentative adjustment	1,390	27.00
28.00	Other Adjustments (See instructions) Specify	0	28.00
		0	
28.50	Demonstration payment adjustment amount before sequestration	0	28.50
28.55	Demonstration payment adjustment amount after sequestration	0	28.55
28.99	Sequestration amount (see instructions)	30	28.99

**70** 29.00

0 30.00

29.00 Balance due provider/program (see instructions)

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

To:

12/31/2024

CARE ONE AT PARSIPPANY Period: Run Date Time: 5/28/2025 3:15 pm MCRIF32 Version: From: 01/01/2024 2540-10

11.1.179.1

#### ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:

315468

Worksheet E-1

Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, enter zero  301   List spearable yeach retroateve lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONIB" or enter a zero. (1)  **PROGRAM TO PROVIDER***  302   Solution			Title	XVIII	Skilled Nu	rsing Facility		PPS
1.00   1.00				Inpatien	t Part A	Part	: B	
1.00   Total intertim payments paid to provider   4,981,285   1,390   1,000   2,000   1,000		DESCRIPTION		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
2.00   Interim payments payable on individual bils, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If some, enter zero   2.00   3.00   2.				1.00	2.00	3.00	4.00	
Cost reporting period. If none, enter zero	1.00	Total interim payments paid to provider			4,981,285		1,390	1.00
Reprofing period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   ADUSTMENTS TO PROVIDER   10,000   10,000   3.000   3	2.00		for services rendered in the		183,589		0	2.00
3.01   ADJUSTMENTS TO PROVIDER   0.528/2024   9.526   0.0   3.01     3.02   0.0   0.0   0.0   3.01     3.03   0.0   0.0   0.0   0.0   3.01     3.04   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0   0.0   0.0     3.06   0.0   0.0   0.0   0.0     3.07   0.0   0.0   0.0   0.0     3.07   0.0   0.0   0.0   0.0     3.08   0.0   0.0   0.0   0.0     3.09   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0   0.0     3.05   0.0   0.0   0.0     3.05   0.0   0.0   0.0     3.05   0.0   0.0   0.0     3.05   0.0   0.0   0.0     3.05   0.0   0.0   0.0     3.05   0.0   0.0   0.0     4.0   0.0   0.0     5.00   0.0	3.00		interim rate for the cost					3.00
3.02	Progra	nm to Provider						
3.03	3.01	ADJUSTMENTS TO PROVIDER		05/28/2024	9,526		0	3.01
3.04	3.02				0		0	3.02
3.05	3.03				0		0	3.03
Program	3.04				0		0	3.04
3.50   ADJUSTMENTS TO PROGRAM	3.05				0		0	3.05
3.51	Provid	ler to Program						
3.52	3.50	ADJUSTMENTS TO PROGRAM			0		0	3.50
3.53	3.51				0		0	3.51
3.54       Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)       0       3.54         3.99       Subtotal (Sum of lines 3.01 - 3.49 minus 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)       5,174,400       1,399       4.00         TO BE COMPLETED BY CONTRACTOR         5.00       List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       0       5.00       5.00         TENTATIVE TO PROVIDER       0       0       5.01       5.00       5.01       5.00       5.50       5.50       5.50       5.50       5.50       5.50       5.50       5.50       5.50 <td< td=""><td>3.52</td><td></td><td></td><td></td><td>0</td><td></td><td>0</td><td>3.52</td></td<>	3.52				0		0	3.52
3.99         Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)         9,526         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)         5,174,400         1,309         4.00           TO BE COMPLETED BY CONTRACTOR         TO BE CONTRACTOR	3.53				0		0	3.53
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)         5,174,400         1,390         4.00           TO BE COMPLETED BY CONTRACTOR           5.00         List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)         \$5.00         \$5.00           Provider           5.01         TENTATIVE TO PROVIDER         0         0         5.01           5.02         0         0         0         5.02           5.03         0         0         0         5.02           5.03         5         0         0         0         5.02           Provider           Program           Program           5.01         TENTATIVE TO PROGRAM         0         0         5.50           5.51         1         0         0         0         5.51           5.52         5         0         0         0         5.51           5.51         5         0         0         0         5.51           5.52         5         0         0         0         5.51	3.54				0		0	3.54
TO BE COMPLETED BY CONTRACTOR	3.99	Subtotal (Sum of lines 3.01 - 3.49 minus sum of lines 3.50 - 3.98)			9,526		0	3.99
Solid   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Provider   Provider	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)		5,174,400		1,390	4.00
enter a zero. (1)         Program to Provider           5.01 TENTATIVE TO PROVIDER         0         0         5.01           5.02         0         <	TO B	E COMPLETED BY CONTRACTOR	,			<u> </u>		
5.01         TENTATIVE TO PROVIDER         0         0         5.01           5.02         0         0         0         5.02           5.03         0         0         0         0         5.03           Provider to Program           5.50         TENTATIVE TO PROGRAM         0         0         0         5.50           5.51         0         0         0         0         5.51           5.52         0         0         0         0         5.51           5.59         Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)         0         0         0         5.52           5.99         Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)         0         0         0         5.99           6.00         Determined net settlement amount (balance due) based on the cost report. (1)         0         0         7.00         6.01           6.01         PROGRAM TO PROVIDER         0         0         7.00         6.01           6.02         PROVIDER TO PROGRAM         0         7.00         6.01           7.00         Total Medicare program liability (see instructions)         0         7.00         7.00         7.00         7.00	5.00		nt. If none, write "NONE" or					5.00
5.02       0       0       0       5.02         5.03       0       0       0       5.03         Provider to Program         5.50       TENTATIVE TO PROGRAM       0       0       5.50         5.51       0       0       0       0       5.51         5.52       0       0       0       0       5.52         5.99       Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)       0       0       0       5.99         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       0       0       0       5.99         6.01       PROGRAM TO PROVIDER       0       0       0       5.99         6.02       PROVIDER TO PROGRAM       0       7.00       6.01         7.00       Total Medicare program liability (see instructions)       5,148,878       1,460       7.00         Total Medicare program liability (see instructions)       Contractor Number       5,148,878       1,460       7.00         Total Medicare program liability (see instructions)       5,148,878       1,460       7.00	Progra	am to Provider						
5.03       0       0       5.00       5.50       TENTATIVE TO PROGRAM       0       0       0       5.50         5.51       I ENTATIVE TO PROGRAM       0       0       0       5.51         5.52       I Guardian Sulfane	5.01	TENTATIVE TO PROVIDER			0		0	5.01
Provider to Program	5.02				0		0	5.02
5.50       TENTATIVE TO PROGRAM       0       0       5.50         5.51       0       0       0       5.51         5.52       0       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       6.00       6.00         6.01       PROGRAM TO PROVIDER       0       70       6.01         6.02       PROVIDER TO PROGRAM       25,522       0       6.02         7.00       Total Medicare program liability (see instructions)       5,148,878       1,460       7.00         Contractor Name       Contractor Number         1.00       2.00       5.00	5.03				0		0	5.03
5.50       TENTATIVE TO PROGRAM       0       0       5.50         5.51       0       0       0       5.51         5.52       0       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       6.00       6.00         6.01       PROGRAM TO PROVIDER       0       70       6.01         6.02       PROVIDER TO PROGRAM       25,522       0       6.02         7.00       Total Medicare program liability (see instructions)       5,148,878       1,460       7.00         Contractor Name       Contractor Number         1.00       2.00       5.00	Provid	ler to Program						
5.52       0       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       6.00         6.01       PROGRAM TO PROVIDER       0       70       6.01         6.02       PROVIDER TO PROGRAM       25,522       0       6.02         7.00       Total Medicare program liability (see instructions)       5,148,878       1,460       7.00         Contractor Name       Contractor Number         1.00       2.00       1.00	5.50				0		0	5.50
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         6.00           6.01         PROGRAM TO PROVIDER         0         70         6.01           6.02         PROVIDER TO PROGRAM         25,522         0         6.02           7.00         Total Medicare program liability (see instructions)         5,148,878         1,460         7.00           Contractor Name         Contractor Number           1.00         2.00         5.00	5.51				0		0	5.51
6.00         Determined net settlement amount (balance due) based on the cost report. (1)         6.00         6.00           6.01         PROGRAM TO PROVIDER         0         70         6.01           6.02         PROVIDER TO PROGRAM         25,522         0         6.02           7.00         Total Medicare program liability (see instructions)         5,148,878         1,460         7.00           Contractor Name         Contractor Number           1.00         2.00	5.52				0		0	5.52
6.01       PROGRAM TO PROVIDER       0       70       6.01         6.02       PROVIDER TO PROGRAM       25,522       0       6.02         7.00       Total Medicare program liability (see instructions)       5,148,878       1,460       7.00         Contractor Name         6.01       Contractor Number       2.00       5.00	5.99	Subtotal (Sum of lines 5.01 - 5.49 minus sum of lines 5.50 - 5.98)			0		0	5.99
6.02         PROVIDER TO PROGRAM         25,522         0 6.02           7.00         Total Medicare program liability (see instructions)         5,148,878         1,460         7.00           Contractor Name         Contractor Number           1.00         2.00         Contractor Number	6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
7.00 Total Medicare program liability (see instructions)  Contractor Name Contractor Number  1.00 2.00  7.00	6.01				0		70	6.01
Contractor Name         Contractor Number           1.00         2.00	6.02	PROVIDER TO PROGRAM			25,522		0	6.02
Contractor Name         Contractor Number           1.00         2.00	7.00	Total Medicare program liability (see instructions)			5,148,878		1,460	7.00
1.00				Contractor	Number			
8.00				2.00	)			
	8.00							8.00

<sup>(1)</sup> 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 PARSIPPANY Period: Run Date Time:

 Period:
 Run Date Time:
 5/28/2025 3:15 pm

 From: 01/01/2024
 MCRIF32
 2540-10

 To: 12/31/2024
 Version:
 11.1.179.1



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

Provider CCN:

315468

Worksheet G

rompres	e the General I and Column only)					PPS
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
Assets						
	VT ASSETS		· · · · · · · · · · · · · · · · · · ·			_
	sh on hand and in banks	43,598	0	0	0	
	emporary investments	0	0	0	0	
	otes receivable	0	0	0	0	3.00
	counts receivable	1,635,517	0	0	0	4.00
	ther receivables	0	0	0	0	5.00
	ss: allowances for uncollectible notes and accounts receivable	-259,424	0	0	0	
	ventory	0	0	0	0	7.00
	epaid expenses	29,163	0	0	0	8.00
	ther current assets	21,458	0	0	0	, ,,,,,
	the from other funds	0	0	0	0	
	OTAL CURRENT ASSETS (Sum of lines 1 - 10)	1,470,312	0	0	U	11.00
FIXED A		2 222 002		0		120
12.00 La		2,322,092	0	0	0	
	nd improvements	42,500	0	0	0	
	ss: Accumulated depreciation	-22,667	0	0	0	14.00
	uildings	9,499,741	0	0	0	15.00
	ss Accumulated depreciation	-6,238,405	0	0	0	16.00
	asehold improvements	0	0	0	0	
	ss: Accumulated Amortization	0	0	0	0	
	xed equipment	437,888	0	0	0	19.00
	ss: Accumulated depreciation	-243,559	0	0	0	20.00
	ntomobiles and trucks	0	0	0	0	
	ss: Accumulated depreciation	0	0	0	0	22.0
	ajor movable equipment	2,510,471	0	0	0	23.0
	ss: Accumulated depreciation	-2,052,687	0	0	0	24.00
	inor equipment - Depreciable	0	0	0	0	
	inor equipment nondepreciable	0	0	0	0	26.00
	ther fixed assets	107	0	0	0	27.0
	OTAL FIXED ASSETS (Sum of lines 12 - 27)	6,255,481	0	0	0	28.0
OTHER.			· · · · · · · · · · · · · · · · · · ·			
	vestments	0	0	0	0	
	eposits on leases	0	0	0	0	30.00
	ue from owners/officers	0	0	0	0	
	ther assets	1,958,544	0	0	0	
	OTAL OTHER ASSETS (Sum of lines 29 - 32)	1,958,544	0	0	0	
	OTAL ASSETS (Sum of lines 11, 28, and 33)	9,684,337	0	0	0	34.0
	s and Fund Balances					
	VT LIABILITIES		1			_
	counts payable	1,258,807	0	0	0	35.00
	laries, wages, and fees payable	323,917	0	0	0	36.00
	yroll taxes payable	16,665	0			37.00
	otes & loans payable (Short term)	0	0	0		38.00
	eferred income	0	0	0	0	39.00
	ccelerated payments	0				40.00
	ue to other funds	23,458	0	0	-	41.00
	ther current liabilities	2,969,418	0	0		42.00
	OTAL CURRENT LIABILITIES (Sum of lines 35 - 42)	4,592,265	0	0	0	43.00
	ERM LIABILITIES		I			
	ortgage payable	14,127,945	0	0		44.0
	otes payable	0	0	0	0	45.0
	nsecured loans	0	0	0	0	46.0
	oans from owners:	0	0	0	0	
48.00 Ot	ther long term liabilities	-18,634,920	0	0		48.00
49.00 O	THER (SPECIFY)	0	0	0	0	49.00
50.00 TO	OTAL LONG TERM LIABILITIES (Sum of lines 44 - 49	-4,506,975	0	0	0	50.00

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

Worksheet G

		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)	85,290	0	0	0	51.00					
CAPI	CAPITAL ACCOUNTS										
52.00	General fund balance	9,599,047				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)	9,599,047	0	0	0	59.00					
60.00	TOTAL LIABILITIES AND FUND BALANCES (Sum of lines 51 and 59)	9,684,337	0	0	0	60.00					
( )=	contra amount										

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#### Worksheet G-1

PPS

### STATEMENT OF CHANGES IN FUND BALANCES

		Genera	al 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		9,882,599		0		0		0	1.00
2.00	Net income (loss) (from Wkst. G-3, line 31)		-283,554							2.00
3.00	Total (sum of line 1 and line 2)		9,599,045		0		0		0	3.00
4.00	Additions (credit adjustments)									4.00
5.00	ROUNDING	2		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)		2		0		0		0	10.00
11.00	Subtotal (line 3 plus line 10)		9,599,047		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)		9,599,047		0		0		0	19.00

CARE ONE AT PARSIPPANY

Period:
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#### STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Worksheet G-2 Part I PPS

	Cost Center Description	Inpatient	Outpatient	Total	
	300 300 300 300 300 300 300 300 300 300	1.00	2.00	3.00	
Gener	ral Inpatient Routine Care Services				
1.00	SKILLED NURSING FACILITY	13,979,536		13,979,536	1.00
2.00	NURSING FACILITY	0		0	2.0
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)	13,979,536		13,979,536	5.00
All Ot	ther Care Services				
6.00	ANCILLARY SERVICES	7,007,588	0	7,007,588	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)	20,987,124	0	20,987,124	14.00
PART	TII - OPERATING EXPENSES				
			1.00	2.00	
1.00	Operating Expenses (Per Worksheet A, Col. 3, Line 100)			13,100,684	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
13.00			0		13.00
14.00	Total Deductions (Sum of lines 9 - 13)			0	14.00
	Total Operating Expenses (Sum of lines 1 and 8, minus line 14)			13,100,684	-

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#### STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

#### Worksheet G-3

		1.00	
1.00	Total patient revenues (From Wkst. G-2, Part I, col. 3, line 14)	20,987,124	1.00
2.00	Less: contractual allowances and discounts on patients accounts	8,173,710	2.00
3.00	Net patient revenues (Line 1 minus line 2)	12,813,414	3.00
4.00	Less: total operating expenses (From Worksheet G-2, Part II, line 15)	13,100,684	4.00
5.00	Net income from service to patients (Line 3 minus 4)	-287,270	5.00
Other	income:	·	
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,161	7.00
8.00	Revenues from communications ( Telephone and Internet service)	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flower, coffee shops, canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of skilled nursing space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	BARBER AND BEAUTY	147	24.00
24.01	OTHER REV	2,408	24.01
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (Sum of lines 6 - 24)	3,716	25.00
26.00	Total (Line 5 plus line 25)	-283,554	26.00
27.00	Other expenses (specify)	0	27.00
28.00		0	28.00
29.00		0	29.00
30.00	Total other expenses (Sum of lines 27 - 29)	0	30.00
31.00	Net income (or loss) for the period (Line 26 minus line 30)	-283,554	31.00

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