## State of Connecticut Long-Term Care Facility RATE COMPUTATION REPORT Based on 10/01/2014 through 09/30/2015

**DRAFT** 

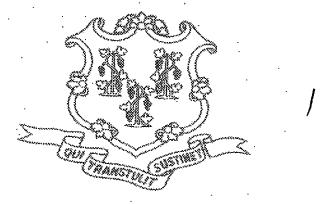
Arden House

Facility: 7 Page: 22

Date: 01/28/2016

Page - Lic. Type - Rate Yr	Error Message
2-CCH	Current cost year resident count (296) does not match prior year resident count (316)
3-CCH	Physician Hourly Limit Cost Year Variable is 0, hourly limits cannot be checked
3-CCH	Dietician Hourly Limit Cost Year Variable is 0, hourly limits cannot be checked
4-CCH	Physician Hourly Limit Cost Year Variable is 0, hourly limits cannot be checked
4-CCH	Dietician Hourly Limit Cost Year Variable is 0, hourly limits cannot be checked
4-CCH	OT fees do not agree to OT fee adjustment
16-CCH	(25,575), Television Revenue is greater than reported on page 13
17	Administrator's salary needs to be entered
DRD	Bed Capacity not entered in the DRD
18	Annual Report Fair Rent (pg. 23, 24) Additions total (51,909) does not match Real Property Additions on pg. 18 of Rate Comp. (0)
20	(2), Sum of Ttl Liab., Res., & Net W. does not match Annual Report Total Assets
RC-Nurs Fac-CCH	No Self Pay rates entered

## **State of Connecticut**



**Annual Report of Long-Term Care Facility** 

			ost Year 2	015				
			081 1 Cal 2	,013	RECEIV	ED		
								:
Name of Facility (as	licensed)				DEC 3 1	2015		
Arden House Care as	nd Rehabilitatio	n Center			0000	2010		•
Address (No. & Stree	et, City, State, 2	Zip Code)			DEPT. OF SOCIAL	OEDVICES	,	
850 Mix Avenue, Ha	mden, CT 0651	.4			DEPT, OF SOCIAL OFFICE OF CON AND P	ATE SETT	INGS	
Type of Facility								
Chronic and C Nursing Home	Convalescent e only (CCNH)	口	Rest Home win Supervision on (RHNS)	_	g □ (Speci	fy)		
Report for Year Begi 10/1/2014	•		Report for Yea 9/30/2015	r Ending				
<b>_</b>								
License Numbers:		CCNH 2199-C	RHNS		(Specify)	Me	dicar 07-5	e Provider 228
-								
Medicaid Provider Numbers:		CO 20371	CNH	RHNS		IC	ICF-IID	
For Department Us	e Only	·		•	,			
Sequence Number	Signed and	Date	Sequence N	Jumber	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	• 1		70 1
Assigned	Notarized	Received	Assigned Signed		Signed and Not	arized	Dat	e Received

RECEIVED

JAN 05 2016

MYERS & STAUFFER LC

## State of Connecticut Annual Report of Long-Term Care Facility CSP-1 Rev.9/2002

(Notary Seal)

## **General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Arden House Care and Rehabilitation Center	2199-C	9/30/2015	1	37

## Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISIONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Arden House Care and Rehabilitation Center [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

I hereby certify that I have directed the preparation of the attached General Information and Questionnaires, Schedule of Resident Statistics, Statements of Reported Expenditures, Statements of Revenues and the related Balance Sheet of this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

I have read this Report and hereby certify that the information provided is true and correct to the best of my knowledge under the penalty of perjury. I also certify that all salary and non-salary expenses presented in this Report as a basis for securing reimbursement for Title XIX and/or other State assisted residents were incurred to provide resident care in this Facility. All supporting records for the expenses recorded have been retained as required by Connecticut law and will be made available to auditors upon request.

Signed (Administrator)	Date	Signed (Owner)	Date	
	-		Me	11/12/2015
Printed Name (Administrator)			Printed Name (Owner)	
McDonnell,Patrick Michael			Keith Davis, V.P. of Reim	o., Genesis Healthcare
Subscribed and Sworn	State of	Date	Signed (Notary Public)	Comm. Expires
to before me:	PA	11/13/15		
Address of Notary Public	•			
		COMMONWI	EALTH OF PENNSYLVANIA	
		OLUSECUM	OTARIAL SEAL	
		- CONTRACTOR - CON	v Two Delaware County	

My Commission Expires May 28, 2017

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## **General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Arden House Care and Rehabilitation Center	2199-C	9/30/2015	1	37

## Administrator's/Owner's Certification

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Signed (Administrator)		Date	Signed (Owner)	Date		
Printed Name (Administrator) McDonnell,Patrick Michael	-		Printed Name (Owner) Keith Davis, V.P. of Reimb.,	Genesis Healthcare		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires		
Address of Notary Public						

(Notary Seal)

## State of Connecticut **Department of Social Services**

25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjus	Page 1A	of 37			
Name of Facility	Period Cov	ered:	From	То	
Arden House Care and Rehabilitation Center				10/1/2014	9/30/2015
Address of Facility					
850 Mix Avenue, Hamden, CT 06514					
Report Prepared By		Phone Nun	ıber	Date	
Thomas Farnan		978-247 <b>-</b> 50	)29	12/20/2014	
Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$	1,427,154	1,427,154		
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$				
4. Nursing wages paid	\$	10,463,605	10,463,605		
5. All other wages paid	\$	1,263,971	1,263,971		
6. Total Wages Paid	\$	13,154,731	13,154,731		
7. Total salaries paid	\$	411,086	411,086		
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$	13,565,817	13,565,817		

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

**DO NOT include Fringe Benefit Costs.** 

## General Information and Questionnaire Type of Facility - Organization Structure

		Pho	ne No. of Fac	ility	Report for Ye	ar Ended	Page	of	•
		203-	281-3500		9/30/2015		2	37	
Name of Facility (as shown on license)			Address (No	. & S	Street, City, Sta	te, Zip )			
Arden House Care and Rehabilitation Center		850 Mix Av	enue	, Hamden, CT	06514				
CCN	1H		RHNS		(Specify)		Medicare I	Provider	No.
License Numbers: 2199-C							07-5228		
Type of Facility (Check appropriate box(es))									
☐ Chronic and Convalescent Nursing Home only (CCNH)			: Home with I ervision only		- 11	(Specify)	)		
Type of Ownership (Check appropriate box)									
O Proprietorship O LLC O Partnersl	hip	0	Profit Corp.		Non-Profit Cor		Government	O T	rust
If this facility opened or closed during report year p	rovide	ə:		Date	e Opened	Date Clo	sed		
Has there been any change in ownership					,				
or operation during this report year?		0	Yes	0	No	If "Yes,"	explain full	у.	
	·····			·					
Administrator					_				
Name of Administrator					Nursing H				
McDonnell,Patrick Michael					Administra		1574		
		/C 11		- C (1-	License	No.:			
Other Operators/Owners who are assistant administ	rators	(Iuii	or part time)	OT III	License	No ·			
Name					License.				
			4-041						
	-								

## **General Information and Questionnaire Partners/Members**

Name of Facility		License No.	Report for	Year Ended	Page	of
Arden House Care and Rehabi	litation Center	2199-C	9/30/2015		3	37
Legal Name of Partnership/LLC		Business	Address	Address State(s) and/ Which F		
Name of Partners/Members	Business A	Address		Title	% Ox	ned
Harborside Health I Corporation	101 Sun Ave. NE, All 87109	buquerque, NM		·	1	
Harborside Healthcare Limited	101 Sun Ave. NE, All 87109	buquerque, NM			99	)

## General Information and Questionnaire Corporate Owners

Name of Facility	License No. Report for Year Ended			Page of
Arden House Care and Rehabilitation Center				3A 37
If this facility is owned or operated as a corpo	oration, provide the	e following informat	ion:	
Legal Name of Corporation		ss Address	State(s) in Whi	ch Incorporated
Arden House Care and	101 East State Str	eet, Kennett	PA	
Rehabilitation Center	Square, PA 1934	8		
Name of Directors, Officers	Busine	ss Address	Title	No. Shares Held by Each
N/A				
Names of Stockholders Owning at Least 10% of Shares				
N/A				
-				

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3B Rev. 10/2005

## General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page of					
Arden House Care and Rehabilitation Center	2199-C	9/30/2015	3B 37					
If this facility is owned or operated as an individua	If this facility is owned or operated as an individual proprietorship, provide the following information:							
Owi	ner(s) of Facility							
			,					
+								

State of Connecticut Annual Report of Long-Term Care Facility CSP-4 Rev. 10/2005

## General Information and Questionnaire Related Parties\*

				- management of the second			
Name of Facility		License No.	િ. છે.	Report for Year Ended		Page	of
Arden House Care and Rehabilitation Center	Cehabilitation Center	71	199-C	9/30/2013		4	37
Are any individuals rece	Are any individuals receiving compensation from the facility related through	acility rela	ated throug	7	If "Yes," provide the Name/Address and	e Name/Add	fress and
marriage, ability to cont	marriage, ability to control, ownership, family or business association?	ess associ	ation?	yes © No	complete the information on Page 11 of the report.	nation on Pa	ge 11 of the report.
Are any individuals or c	Are any individuals or companies which provide goods or services,	or servic	es,				
including the rental of p.	including the rental of property or the loaning of funds to this facility,	to this fac	ility,				
related through family a	related through family association, common ownership, control,	, control,	or business	⊙ Yes O No			
association to any of the	association to any of the owners, operators, or officials of this facility?	of this fa	cility?		If "Yes," provide the following information:	e following	information:
		Also	Provides		Indicate Where		
		Goods/	Goods/Services to		Costs are Included		
Name of Related	Business	Non-Rel	Non-Related Parties	Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes	No   %**	Provided	Page #/Line#	Reported	Related Party
	101 East State Street, Kennett	-					
Genesis Health Ventures	Square, PA 19348	•		Home Office	Pg 16/m12	1,263,639	1,263,639
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	•	0	63% PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	1,442,382	1,442,382
Genesis ElderCare Staffing	101 East State Street, Kennett	0					
Services	Square, PA 19348	9	0 559	55% Staffing Pooi	Pg 10/A12	63,569	63,569
Genesis ElderCare Physician Services	Genesis ElderCare Physician 101 East State Street, Kennett Services   Square, PA 19348	•	0	85% Case Management	Pg 13/B8, Pg 10/A12	113,563	113,563
	101 East State Street, Kennett	•					
Career Staffing	Square, PA 19348	9	)	Staffing Pool	Pg 13/B11 a,b,c	65'059	65,059
S15 Fairmount Ave, 6th F  Respiratory Health Services   600, Towson, MD 21286	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	•	0	43% Respiratory Therapy	Pg 13/B12, Pg 20/C5E	94,273	94,273
7	101 Bast State Street, Kennett	•	0	,		070	400 040
Genesis Healmeare Corp.	Square, FA 19348			Insurance	Fg 2//14	42/,743	645,774
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	•	0	Capital Interest	Page 17, page 26-12A	119,003	119,003
		0	0				
* Use additional sheets if necessary	s if necessary.						

Use additional sheets if necessary.
 Provide the percentage amount of revenue received from non-related parties.

## General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No.		Report for Year Ended	Page	ot
Arden House Care and Rehabilitation Center	2199-C		9/30/2015	5	37
If the facility is licensed as CDH and/or RCH of		IDS or TB	I services with special Medica	id rates,	costs
must be allocated to CCNH and RHNS as follo	ws:				
Item			Method of Allocation		
Dietary			meals served to residents		
Laundry			pounds processed		
Housekeeping			square feet serviced		
			hours of routine care provided	•	
Nursing			classification, i.e., Director (or		
			Nurses, Licensed Practical Nu	rses, Ai	des and
		Attendants			
Direct Resident Care Consultants			hours of resident care provide	d by EA	CH
			(See listing page 13)		
Maintenance and operation of plant		Square feet			
Property costs (depreciation)		Square feet			
Employee health and welfare		Gross salar			
Management services			e cost center involved		
All other General Administrative expenses			rect and Allocated Costs		
The preparer of this report must answer the fol	lowing ques	ions applic			
1. In the preparation of this Report, were all	<ul><li>Yes</li></ul>	O No	If "No," explain fully why su	ch alloca	ation was
costs allocated as required?	<u> </u>	O 110	not made.		
	•				
			•		
2. Explain the allocation of related company e	expenses and	attach copy	of appropriate supporting dat	a	
3. Did the Facility appropriately allocate and s				ome cos	st centers?
(e.g., Assisted Living, Home Health, Outpa	tient Service	s, Adult Da	y Care Services, etc.)		
	⊙ Yes	O No	If "No," explain fully why su not made.	ch alloc	ation was
			- Mary		

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## General Information and Questionnaire Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals

should not be included in these amounts.

SHOULD HOU DE INCIDUEU IN MESE AMOUNDS.							
Name of Facility		<u>, .</u>	License No.	Report for Year Ended	ar Ended		Page of
Arden House Care and Rehabilitation Center	£		2199-C	9/30/2015			6 37
	Related * to	d * to					
	Owners,	ers,				•	
	Operators, Officers	tors,		Date of	Term of	Annual Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	ofLease	Claimed
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					
	0	0					·
- Company of the Comp	0	0					
	0	0					
To a Mileage I at Book Majntajned for All I eased Vehicles?	V besce	ahirlec	O Yes	O No	No	Total ***	

Is a Mileage Log Book Maintained for All Leased Vehicles?

Total \*\*\*

<sup>\*</sup> Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

<sup>\*\*</sup> Attach copies of newly acquired leases.

<sup>\*\*\*</sup> Amount should agree to Page 22, Line 6e.

## General Information and Questionnaire **Accounting Basis**

Name of Facility	License No.	Report for Year Ended	Page	of
Arden House Care and Rehabilitat		9/30/2015	7	37
The records of this facility for the	period covered by this rep	port were maintained on the following basis:		
	Modified Cash			<u> </u>
Is the accounting basis for this		TOID T II . 1 .		
F	Yes	If "No," explain.		
previous period? O	No	4 14 14 14 14 14 14 14 14 14 14 14 14 14		
		, <u>'17668-74-1-1-</u>		
Independent Accounting Firm	<u></u>	1 11 OT 9 Ct 1 C' Ct 7: C 1.	`	
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code		
1 KPMG Peat Marwick		1600 Market Street, Philadelphia, PA 19	103	
2				
3 4				
Services Provided by This Firm (d	escribe fully )			· · · · · · · · · · · · · · · · · · ·
1 Year end financial audit			\$	
2			\$	
3			\$	
4		A list of the feet	\$	
			Charge for Services	Provided
			s	
Are These Charges Reflected in the Expe	enditure Portion of This Repo	rt? If Yes, Specify Expense Classification and Line No.		
O Yes O No	1			
Legal Services Information			- H	
Name of Legal Firm or Independe	nt Attorney		Telephone Number	
1 American Arbitration Associa	ıtion			
2 Hamden Government Center	Cout of Probate		203-287-7082	
3 Timothy S Wall State Marsha	11		203-265-7173	
[4		•		
5	ur s		,	
Address (No. & Street, City, State,	•			
1 45 Notch Rd Bolton, CT 0604				
2 2750 Dixwell Ave Hamden, (				
3 PO Box 297 Wallingford, Cl	1 06492			
4		•		
Services Provided by This Firm (a	lescribe fully )	1707-1807-18		
1 Arbitrator Compensation regarding	lawsuit with nursing agency	union -NE Healthcare Employees Union, District 1199, SE	IU \$	
2 Probate Court Fees			\$	
3 Citation and Return/Appointment of	of Conservator		\$	
4			\$	
5		1.00	\$	
-		4.400.2004 P.W. 200 W. 111	Charge for Services	Provided
			\$	
Are These Charges Reflected in the Exp	enditure Portion of This Repo	art? If Yes, Specify Expense Classification and Line No.		
	Legal Fees pg. 15 1-e	<del></del>		
O Yes O No		22004 1142 23200		

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## Schedule of Resident Statistics

Name of Facility			License No.	.o.			Report fo	Report for Year Ended	þ		Page	of
Arden House Care and Rehabilitation Center			21	2199-C			9/30/2015	14			8	37
					ĭ	eriod 10/	Period 10/1 Thru 6/30	30	,	Period 7/1 Thru 9/30	Thru 9/3	0
	Total All	Total CCNH	Total RHNS	Total (Snecify)	Total	CCNH	RHMS	(Snecify)	Total	CCNH	REDNS	(Specify)
1. Certified Bed Capacity  A. On lost day of DDEXYOUS ranged nation	98	95		(cupate)	360	360		(6.37-)	360	360		
	360	360			360	360			360	360		
1 5	296	296			296	296			305	305		
	298	298			305	305			298	298		
1 22												
A. Medicare	8,710	8,710			7,055	7,055			1,655	1,655		
B. Medicaid (Conn.)	97,793	97,793			72,946	72,946			24,847	24,847		
C. Medicaid (other states)												
D. Private Pay	4,814	4,814			3,683	3,683			1,131	1,131		
E. State SSI for RCH												
F. Other (Specify)	2,982	2,982			2,527	2,527			455	455		
G. Total Care Days During Period (3A thru F)	114,299	114,299			86,211	86,211			28,088	28,088		
A. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds     A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	5	5							5	5		
5. Total Resident Days (3G+4A+4B)	114,304	114,304			86,211	86,211			28,093	28,093		
							L					

## Annual Report of Long-Term Care Facility

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Schedule of Resident Statistics (Cont'd)

Name of Faci	lity			Licer	ise No.				Report	for Year	Ended		Page	of
Arden House	Care an	d Rehab	ilitation Center	2	199-C					9/30/201	5		9	37
	•	-	in the certified b		pacity du	ring tl	ie repoi	rt year	7	0	Yes	•	No	•
	<del>,</del>		Change		Cl	nange	in Bed	s		Ca	oacity Afte	er Change		
Date of	_	RHNS	(Specify)		Lost			Gaine	1			<u> </u>		
			(			[								
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason fo	or Change
<u> </u>	<u> </u>													
	-	_	in certified bed of			the re	eport ye	ear (as	report	ed in item	4 above)	provide the num	lber of	
			Change in R	esider	nt Days					CC	NH	RHNS	(Spe	cify)
1st chan														
2nd char 3rd chan														
4th chan							•							
		dents and	d Rates on Septe	mber	30 of Co	st Yea	ar			I			,	
			Medicare		Medi					Se	lf-Pay		Other Sta	e Assisted
	_		~~~	ا	160 TT		· · · · · · · · · · · · · · · · · · ·	a.	`N 157	20.7	n ta	(6	D G H	ter m
No. of R	Item		CCNH	1	CNH 268	+	HNS	Ç	CNH 15		INS	(Specify)	R.C.H.	ICF-IID
Per Dier		s	15		208				13					
a. One l							**********		435.00		***************************************			
b. Two		١.	520.21		213.80				413.01					
c. Three	or mor	e												
bed	rms.						,			<u> </u>				
		f Physic	al Therapy Trea	tment:	s					то	TAL	CCNH	RHNS	(Specify)
		are - Par									7,296	7,296		
В.			lusive of Part B)	)										
<b></b>			e Treatments Treatments							-	2,537	2,537		
C	Other	шашче	Treatments							1	23,393	23,393		
		Physical	Therapy Treati	nents		-				<u> </u>	33,226	33,226		
			Therapy Treate											
A.	. Medica	are - Par	t B								994	994		
В			lusive of Part B	)										
			e Treatments							ļ				
		storative	Treatments								259	259		
	. Other	C- anala (	Thomas Tuontus	au ta					<del></del>	┼	2,291 3,544	2,291 3,544		
			Therapy Treatmational Therapy		mente						2,44	3,344		
		are - Par		11cau	шень						4,464	4,464		
			lusive of Part B	)					···		, , , , ,	3,33		
			e Treatments	· 										
	2. Res		Treatments								2,127	2,127		
	. Other										20,059	20,059		
D	. Total (	Occupat	ional Therapy T	ream	ients					<u> </u>	26,650	26,650	<u> </u>	

## Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	200	Report for Yea		Page	of
Arden House Care and Rehabilitation Center	2199-C		9/30/2015		10	37
Are time records maintained by all individuals receiving co	1	•	Yes	0	No	
Fig. time records managined by an internal section in	3		Total Cost a	nd Hours		
	ļ 1		10tal Cost a	III TIOUIS	T .	
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
<ol> <li>Operators/Owners (Complete also Sec. I</li> </ol>						
of Schedule A1)						
2. Administrator(s) (Complete also Sec. III		9.505	,		1	
of Schedule A1)	153,398	2,597	'			
3. Assistant Administrator (Complete also Sec. IV	50.000	1.500				
of Schedule A1)	57,983	1,502	4			
4. Other Administrative Salaries (telephone	396,695	16,381				
operator, clerks, receptionists, etc.)  5. Dietary Service	390,093	10,561	L			
a. Head Dietitian	71,246	2,225	5	***************************************		***************************************
b. Food Service Supervisor	189,029					
c. Dietary Workers	1,166,880					
6. Housekeeping Service						
a. Head Housekeeper	ļ					
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services	120,796	4,430	ς			
a. Engineer or Chief of Maintenance b. Other Maintenance Workers	154,244			<del> </del>	<u> </u>	<b>†</b>
8. Laundry Service	157,211	0,01	'			
a. Supervisor	200000000000000000000000000000000000000				***************************************	0.0000000000000000000000000000000000000
b. Other Laundry Workers						
Barber and Beautician Services	· ·					
10. Protective Services						
11. Accounting Services						
a. Head Accountant		<del> </del>				<u> </u>
b. Other Accountants 12. Professional Care of Residents						
	199,706	3,85	1	***************************************		
a. Directors and Assistant Director of Nurses	199,700	3,03	A			
b. RN 1. Direct Care	1,461,164	39,65	5		***************************************	***************************************
2. Administrative**	91,738		8			
c. LPN						
1. Direct Care	3,624,855	122,60	6			
2. Administrative**		201.01				
d. Aides and Attendants	5,059,285	281,86	2		<del> </del>	<del> </del>
e. Physical Therapists		<del>  -</del> -			+	
f. Speech Therapists g. Occupational Therapists	<del>                                     </del>	<b>-</b>	+	-		<del>                                     </del>
h. Recreation Workers	294,226	16,04	6			1
i, Physicians						
Medical Director	***************************************					
Utilization Review		<u> </u>		ļ		
3. Resident Care***						
4. Other (Specify)						
i. Dentists	<del></del>	1	-	+		
k. Pharmacists		<del>                                     </del>	1			
1. Podiatrists						
m. Social Workers/Case Management	298,010	12,78	8			
n, Marketing	,					
o. Other (Specify)						
See Attached Schedule	226,562			<del> </del>	+	+
A-13. Total Salary Expenditures	13,565,81	7 600,06	<u> </u>		i	<u> </u>

<sup>\*</sup> Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

<sup>\*\*</sup> Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

<sup>\*\*\*</sup> This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

## Schedule of Other Salaries and Wages (Page 10)

	CCN	NH.	RH	NS	(Sp	ecify)
Position	\$	Hours	\$	Hours	\$	Hours
Ward Clerks	0 \$ -	- 1			S -	
0	0 \$	-			S -	-
Central Supply	0 \$ 76,229.28	3,421.09			\$ -	-
Medical Records	0 \$ 85,475.92	4,037.98			\$ -	-
Coordinator-Staffing Cen	0 \$ 52,386.68	2,514,30			\$ -	-
Asst-Administrative Nurs	0 \$ 12,470,20	563.68			\$ -	
0	0 \$ -				\$ -	-
0	0 \$ -				\$ -	
0	0 \$ -				\$ -	-
0	0 \$ -				8 -	-
0	0 \$ -				\$ -	-
0	0 \$ +	-			S -	
0	0 \$ -	-			\$ -	-
0	0 \$ -				S -	
0	0 \$ - 1				S -	-
0	0 \$ -				\$ -	-
0	0 \$ -				S -	
0	0 \$ -				S -	
Total	226562	10537	\$		s -	-

Schedule of Other Fees (Page 13)

		CC	NH	RH	INS	(Spe	ci <del>fy</del> )
Service		\$	Hours	\$	Hours	\$	Hours
1020620010	Consulting Fees	\$ 148.85	n/a			-	
1020620010	Consulting Fees	\$ 409.70	n/a				
1020620010	Consulting Fees	\$ (7.21)	n/a			-	
3010620020	Purchased Services	\$ 5,241.72	n/a			-	
3010620020	Purchased Services	\$ (5,242.00)	n/a			-	
3015620020	Purchased Services	\$ 150.00	n/a			-	
3155620020	Purchased Services	\$ (975.63)	D/A			-	
3155620020	Purchased Services	\$ 12,084.35	n/a			-	
0		0 \$ -				-	
0		0 \$ -	-				
Total		\$ 11,809.78	(	\$ -		S -	

State of Connecticut Annual Report of Long-Term Care Facility CSP-11 Rev. 10/2005 Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties\*

Nome of Dovility		1	Tana Car	T icense No	Tiones No	Report for	Renort for Year Ended		Рабе	Jo
LAMING OF PACHICY				Treeman 140.		ייין זייעלאיי	TOTAL TOTAL		200	· ·
Arden House Care and Rehabilitation Center	ion Center			2199-C		9/30/2015			11	37
		Salary Paid	r.t.							
				Aringe Benerits and/or Other		Total	Line Where		Total	
Name	CCNH	RHNS	(Specify)	Payments (describe fully)	Full Description of Services Rendered	Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
				:						

<sup>\*</sup> No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

<sup>\*\*</sup> Include all employment worked during the cost year.

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-12 Rev. 10/2005

# Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties\*

Name of Facility (as licensed)				License No		Renort for Year Ended	ar Ended		Page	Jo
rams of ractify (as received)				ALCONOMICS 1.00.						; ;
Arden House Care and Rehabilitation Center	on Center			2199-C		9/30/2015			12	37
		Salary Paid	,							
				Fringe Benefits and/or Other			Line Where		Total	
Name	HNOO	REENS	(Specify)	Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Claimed on Page 10	Name and Address of All Other Employment**	Hours Worked	Compensation Received
Section III - Administrators***										
McDonnell,Patrick Michael 6/1515-9/30/15	39,201				Management of Center	630	2			
Kevin Cleary 10/1/14-5/27/15	91,552				Management of Center	1,320	2			
Vitko-Aniolek, Stephanie Margaret 4/26/15-8/27/15	22,645				Management of Center	647	2			
Section IV - Assistant Administrators										
Vitko-Aniolek, Stephanie Margaret 8/27/15-9/30/15	6,753				Assists in Overseeing Facility	190	9			on value
Jona C. Tarnowicz 10/1/2014- 8/5/2015	51,230				Assists in Overseeing Facility	1,312	3			
		,								
						,				

<sup>\*</sup>No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

<sup>\*\*</sup> Include  $\underline{all}$  other employment worked during the cost year.

<sup>\*\*\*</sup> If more than one Administrator is reported, include dates of employment for each.

## Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

**B.** Report of Expenditures - Professional Fees

Name of Facility Arden House Care and Rehabilitation Center	License No. 2199	)-C	Report for Y 9/30/2015	Year Ended	Page 13	of 37
			Total Cost	and Hours	<u></u>	town two
			10442 0000		T	
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee						
for service basis in lieu of salary						
(For all such services complete Schedule B1)						
1. Dietitian	2,217	60				
2. Dentist	46,792	320				-
3. Pharmacist	26,684	545				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	1,106,881	15,163				
b. Other					<u>                                     </u>	
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	113,563	601				
b. Utilization Review						
(Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1 Infection Control Committee			1			
(Quarterly meetings) 2. Pharmaceutical Committee					-	
(Quarterly meetings)			İ			
3. Staff Development Committee						
(Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	125,022	1,603	1			
b. Other	125,022	1,003	<u> </u>			
10. Occupational Therapist						
a. Resident Care	222,008	3,041				
b. Other	222,000	3,011	<u> </u>	-	1	
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	83,180	1,387			1	
2. Administrative***	33,100	1,551	†	1		
b. LPN						
1. Direct Care	93,995	2,219		T		
2. Administrative***		->	1			
c. Aides				1		<del> </del>
d. Other						
12. Other (Specify)						
See Attached Schedule	11,810					
B-13 Total Fees Paid in Lieu of Salaries	1,832,151	24,939				
TO TOOMER ONG THEM SIGNATURE OF PROMISED		,	<u> </u>	<del></del>	<del></del>	

<sup>\*</sup> Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

<sup>\*\*</sup> This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

<sup>\*\*\*</sup> Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

## Report of Expenditures Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis\*

Name of Facility Arden House Care and Rehabilitation Center	License No.		Report for Y 9/30/2015	Year Ended Page of 14 37
Name & Address of Individual	Full Explanation of Service		to Owners, rs, Officers	Explanation of Relationship
Genesis Eldercare Hospitality Services, 101 East State Street, Kennett Square, PA 19348	Diefary Services	•	0	Common Ownership
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	•	0	Common Ownership
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	•	0	Common Ownership
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	0	0	Common Ownership
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	0	0	Common Ownership
		0	0	
		0	0	
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		0	0	
		0	0	

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

## C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	1	Report for Ye	ar Ended	Page	of
Arden House Care and Rehabilitation Center	2199-C	19	)/30/2015		15	37
		ļ				
τ,			Total	CCNH	RHNS	(Specify)
Item			10tai	CCIVII	KIIINO	(Specify)
1. Administrative and General						
a. Employee Health & Welfare Benefits		¢ ∭	960 607	869,607		
1. Workmen's Compensation		\$ \$	869,607	809,007		
2. Disability Insurance	<del></del>		266 502	266 502		
3. Unemployment Insurance		\$	266,593	266,593		
4. Social Security (F.I.C.A.)		\$	995,409	995,409		
5. Health Insurance		\$	1,014,339	1,014,339		
6. Life Insurance (employees only)						
(not-owners and not-operators)		\$	1.00	1.07		
7. Pensions (Non-Discriminatory)		\$	167	167		
(not-owners and not-operators)						
8. Uniform Allowance		\$				
9. Other (Specify)		\$	97,227	97,227		
See Attached Schedule						
b. Personal Retirement Plans, Pensions, and		\$[				
Profit Sharing Plans for Owners and						
Operators (Discriminatory)*						
c. Bad Debts*		\$	281,734	281,734		
d. Accounting and Auditing		\$				
e. Legal (Services should be fully described of	on Page 7)	\$	0	0		<u> </u>
f. Insurance on Lives of Owners and		\$				
Operators (Specify)*						
g. Office Supplies		\$	57,556	57,556		<u> </u>
h. Telephone and Cellular Phones						
Telephone & Pagers		\$	35,389	35,389		
2. Cellular Phones		\$	5,108	5,108		
i. Appraisal (Specify purpose and		\$				
attach copy )*						
www.vopy)						
j. Corporation Business Taxes (franchise tax	ε)	\$				
k. Other Taxes (Not related to property - Sec						
1. Income*	.5 /	\$			***************************************	
2. Other (Specify)		\$	5,473	5,473		
See Attached Schedule	•	*	-,			
3. Resident Day User Fee		\$	1,669,262	1,669,262		
Subtotal		\$	5,297,864	5,297,864		
DROWAL		Ψ	2,22,1,001		stale forward	<u> </u>

<sup>\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

## \*\*\* DO NOT Include Holiday Parties / Awards / Gifts to Staff

Arden House Care and Rehabilitation Center 9/30/2015

Attachment Page 15

## **Schedule of Other Employee Benefits**

Description			CCNH	RHNS	(Specify)
1020520020	Union Health & Welfare	\$	893	\$ -	
3005520020	Union Health & Welfare	\$	287	\$ -	
3030520020	Union Health & Welfare	\$	10,892	\$ -	
3080520020	Umon Health & Welfare	S	1,239	\$ -	
3210520020	Union Health & Welfare	S	174	\$ -	
3215520020	Union Health & Welfare	S	32,893	\$ -	
3225520020	Union Health & Welfare	\$	49,283	\$ -	
5035520020	Union Health & Welfare	\$	1,566	\$ -	
	0	0 \$	-	\$ -	
	0	0 \$	-	\$ -	
	0	0 \$	-	\$ -	
	()	0 \$	_	\$ -	
	0	0 \$	-	\$ -	
	0	0 \$	-	\$ -	
	0	0 \$	-	\$ -	
	()	0 \$	-	\$ -	
	0	0 \$	+	\$ -	
	0	0 \$	-	\$ -	
Total		\$	97,227	\$ -	\$ -

## **Schedule of Other Taxes**

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax	\$ 5,473	\$ -	\$ -
1020640110	Bulk Sales Expense	\$ -	\$ -	\$ -
()	0	\$ -	\$ -	\$ -
()	0	\$ -	\$ -	S -
Total		\$ 5,473	\$ -	\$ -

## C. Expenditures Other Than Salaries (cont'd) - Administrative and General

Name of Facility	License No.		Report for Y	ear Ended	Page	of
Arden House Care and Rehabilitation Center	2199-C		9/30/2015		16	37
Item			Total	CCNH	RHNS	(Specify)
Subtoto	als Brought Forwa	rd:	5,297,864	5,297,864		
Travel and Entertainment						
Resident Travel and Entertainment		\$				
2. Holiday Parties for Staff		\$				
Gifts to Staff and Residents		\$				
4. Employee Travel		\$	3,703	3,703		
<ol><li>Education Expenses Related to Seminars a</li></ol>	and Conventions	\$	554	554		
6. Automobile Expense (not purchase or depr	reciation)	\$				
7. Other (Specify)		\$				
See Attached Schedule						
m. Other Administrative and General Expenses						
1. Advertising Help Wanted (all such expense	es )	\$	,			
2. Advertising Telephone Directory (all such	expenses )***	\$				
3. Advertising Other (Specify)***		\$	12,402	12,402		
See Attached Schedule						
4. Fund-Raising***		\$				
5. Medical Records		\$				
6. Barber and Beauty Supplies (if this service	e is supplied	\$				
directly and not by contract or fee for serv						
7. Postage		\$	11,169	11,169		
* 8. Dues and Membership Fees to Professiona	al	\$	21,178	21,178		
Associations (Specify)						
See Attached Schedule	****	_				
8a. Dues to Chamber of Commerce & Other Non-	Allowable Org.***	\$	4,702	4,702		
9. Subscriptions		\$	151	151		
10. Contributions***		\$	4,837	4,837		
See Attached Schedule						
11. Services Provided by Contract Specify and	d Complete	\$	7,072	7,072	***************************************	
Schedule C-2, Page 21 for each firm or in	dividual)					
12. Administrative Management Services**		\$	1,305,736	1,305,736		
13. Other (Specify)		\$	127,893	127,893		,
See Attached Schedule						
C-14 Total Administrative & General Expenditure:	S	\$	6,797,260	6,797,260		

<sup>\*</sup> Do not include Subscriptions, which should go in item 9.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

## Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
0 0	\$ -	S -	S
0 0	\$ -	\$ -	\$ -
0 0	\$ -	\$ -	\$ -
0 0	8 -	\$ -	\$ -
0	\$ -	S +	\$ -
0 0	3	S -	\$ -
0 0	<b>s</b> -	\$ +	\$ +
Total Other Travel and Entertainment	\$	s -	S -

Schedule of Other Advertising

Description			CCNH	RHNS	(Specify)
1020630020	Advertising	\$	41	\$ -	\$ -
1020630020	Advertising	\$	385	S +	S -
1020630020	Advertising	\$	1,016	S -	g .
1020630330	Marketing Expense	5	5,510	s -	S -
1020630330	Marketing Expense	8	26	\$ -	\$ -
1020630331	Marketing Exp-Corporate Spend		844	\$ -	s .
1020630331	Marketing Exp- Corporate Spend	\$	4,581	\$ -	S -
0	0			\$ .	\$ -
0	0	\$		5 -	\$ -
0	0	\$		\$ -	\$ -
0	0	\$		\$ -	\$
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0	0			\$ -	8 -
0	0	\$		\$	\$ -
0	0	S		8 -	\$ -
0	0	\$		\$ ·	\$
0	0	8		\$ -	\$ -
Total Other Ad	vertising	\$	12,402	\$	8 -

## Schedule of Dues

Description	CCNH	RHNS	(Specify)
1020630310 Licenses & Certifications	\$ 21,178	\$ -	\$ -
0	\$ -	s -	\$ -
0 0	s -	\$ +	S -
0 0	\$ -	\$ -	\$ -
0 0	\$ -	S -	S -
0 0	\$ -	\$ -	s -
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0 0	\$	S	\$

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## Schedule of Contributions

Description	CCNH	RHINS	(Specify)
Total Contributi	0 \$ 4,837	\$ -	S
0	0 \$ -	\$ .	5 -
0	0 \$ -	\$ -	\$ -
Total Contributions	\$ 4,837	\$ -	\$ -

## Schedule of Other Administrative and General

Description			CCNH	RHNS	(Specify)
1020630060	Bank Service Charges	\$	7,888	\$ -	\$
1020630060	Bank Service Charges	S	52	self-disallowed	\$
1020630120	Collection Fees	\$	43,840	self-disallowed	S -
1020630120	Collection Fees	\$	23	self-disallowed	\$
1020630120	Collection Fees	8	66	self-disallowed	S -
1020630120	Collection Fees	\$	11,773	self-disallowed	S -
1020630140	Education Expense	\$	134	\$ -	\$ -
1020630140	Education Expense	\$	39	\$ -	S -
1020630180	Employee Physicals	\$	19,893	\$ -	s -
1020630200	Employee Relations	\$	6,390	\$ -	\$ -
1020630200	Employee Relations	- 8	212	S -	\$ -
1020630380	Printing	\$	112	S -	\$ -
1020630380	Printing	\$	154	\$ -	S -
3210630440	Recruiting Fees	\$	4,041	\$ -	\$ -
1020630610	Training Expense	\$	87	\$ -	3 -
1020630610	Training Expense	\$	84	S -	\$ -
1020630610	Training Expense	\$	652	S -	\$ .
1020630640	Uniforms	S	242	\$ -	S -
1020640080	Fines & Penalties	\$	11,628	self-disallowed	\$
1020640090	Miscellaneous	\$	746	5 .	\$
1020640090	Miscellaneous	\$	(8)	\$ -	s -
1020660080	Rental Expense	S	14,157	S -	\$ -
1020660990	Accrued Expense Estimation	S	2,135	self-disallowed	\$ -
5095720020	Cap Stk/Franchise Tax	\$	1,151	s -	\$
5095720090	Landlord Operating Taxes	8	2,400	\$ +	S
	0	0 \$		\$ -	\$ -
	0	0 \$		\$ :	\$ -
	0	0 \$		s -	\$ -
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	o e	0 \$		S -	\$ -
Total Other A	dministrative and General	\$	127,893	\$ .	\$ -

## Schedule C-1 - Management Services\*

Name of Facility	License No.	Report for Year Ended	Page of
Arden House Care and Rehabilitation Cent	2199-C	9/30/2015	17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	1,263,639	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	119,003	Capital Interest	pg 26 12-A-1

<sup>\*</sup> In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.

C. Expenditures Other Than Salaries (cont'd) - Dietary Basis for Allocation of Costs (See Note on Page 5)

NInz	ne of Facility		License	No	Report for Y	ear Ended	Page	of
	en House Care and Rehabilitation Center		į.	2199-C	9/30/2015		18	37
Aiu	en riouse Care and Renadilitation Center			1111-0	7/30/2013		1 10	
	Item			Total	CCNH	RHNS	(Sp	ecify)
2.	Dietary							
	a. In-House Preparation & Service							
	1. Raw Food		\$	· · · · · · · · · · · · · · · · · · ·	545,910			
	2. Non-Food Supplies		\$		69,754			
	3. Other (Specify)		. , \$	(3,880)	(3,880)	-		
	•							
	b. Purchased Services (by contract other		\$					
1	than through Management Services)							
	(Complete Schedule C-2 att. Page 21)							
	c. Management Services**		\$					
	d. Other (Specify)		. \$					
2E.	Total Dietary Expenditures $(2a+b+c+d)$		\$	611,784	611,784			
2,15.	Tome Dientify Emperium es (24 · 0 · 0 · 0 · 0 · 0 · 0 · 0 · 0 · 0 ·		φ	011,701	011,701			
2F.	Dietary Questionnaire			Total	CCNH	RHNS	(Sp	ecify)
G.	Resident Meals: Total no. of meals served pe	r da	v:*					
H.	Is cost of employee meals included in 2E?		Yes	•	No	, I,	•	
I.	Did you receive revenue from employees?	0	Yes	•	No	If yes, specify amt.		
J.	Where is the revenue received reported in the	Co	st R <i>e</i> poi	t? (Page/Line	Item)			
	Is cost of meals provided to persons other					Tf		
K.	than employees or residents (i.e., Board	0	Yes	•	No	If yes, specify cost.		
	Members, Guests) included in 2E?					cosi.		
L.	Is any revenue collected from these people?	0	Yes	•	No	If yes, specify amt.		
M.	Where is the revenue received reported in the	Co	st R <i>e</i> poi	rt? (Page/Line	Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	0	Yes	•	No	If yes, specify cost.		
О.	Is any revenue collected from employees?	0	Yes	•	No	If yes, specify amt.		
P.	Where is the revenue received reported in the	Co	st Repo	rt? (Page/Line	Item)			
1								

<sup>\*</sup> Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

## C. Expenditures Other Than Salaries (cont'd) - Laundry Basis for Allocation of Costs (See Note on Page 5)

Name of Facility Arden House Care and Rehabilitation Center	License	No. 199-C	Report for Y 9/30/2015	ear Ended	Page 19	of   37
Arden House Care and Renadmitation Center		133.0	7/30/2013		17	<u> </u>
Item		Total	CCNH	RHNS	(S <sub>1</sub>	pecify)
<ul> <li>3. Laundry</li> <li>a. In-House Processing*</li> <li>1. Bed linens, cubicle curtains, draperies,</li> </ul>	Lbs.					
gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	19,365	19,365			
Employee items including uniforms, gowns, etc. washed, ironed and/or	Lbs.					
processed.***	Amt. \$					
3. Personal clothing of residents	Lbs.					
washed, ironed, and/or processed.***	Amt. \$					
4. Repair and/or purchase of linens.***	Lbs.					
1 Developed Coming the continue other	Amt. \$		24,972 774,721		<u> </u>	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	Ф	774,721	7/4,721			
c. Management Services**	\$					
d. Other (Specify)	\$					
3E. Total Laundry Expenditures $(3a+b+c+d)$	\$	819,058	819,058			
3F. Laundry Questionnaire						
G. Is cost of employee laundry included in 3E? O	Yes	•	No	If yes, specify cost.		
H. Did you receive revenue from employees?	Yes	•	No	If yes, specify amt.		
I. Where is the revenue received reported in the Cos	t Report	?	(Page/Lin	e Item)		
In Cost of loundry provided to persons other	Yes		No	If yes, specify cost.		
K. Did you receive revenue from these people?	Yes	•	No	If yes, specify amt.		
L. Where is the revenue received reported in the Cos	t Report	?	(Page/Lin	e Item)		

<sup>\*</sup> Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4. All allocations should add to total recorded in 3E.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> Pounds of Laundry only required for multi-level facilities.

## C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care Basis for Allocation of Costs (See Note on Page 5)

Name of Facility	License No.	Repo	ort for Year E	nded	Page	of
Arden House Care and Rehabilitation Center	2199-C		9/30/2015		20	37
Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced		1			
a. In-House Care	by Personnel					
1. Supplies - Cleaning (Mops,	Amt.	\$	48,394	48,394		
pails, brooms, etc.)						
b. Purchased Services (by contract other	Sq. Ft. Serviced					
than through Management Services)	by Personnel					
(Complete Schedule C-2 att.	Amt.	\$	1,163,065	1,163,065		
Page 21)						
c. Management Services*		\$				
d. Other (Specify)		\$				
4E. Total Housekeeping Expenditures (4a+	+ b + c + d)	\$	1,211,459	1,211,459		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		\$				
2. Purchased from		\$	405,587	405,587	~~~~~	
b. Medicine Cabinet Drugs		\$	23,509	23,509		
c. Medical and Therapeutic Supplies		\$	299,470	299,470		
d. Ambulance/Limousine***		\$	38,985	38,985		
e. Oxygen						
1. For Emergency Use	•	\$				
2. Other***		\$	26,126	26,126		
f. X-rays and Related Radiological		\$	15,198	15,198	*******************************	
Procedures***						
g. Dental (Not dentists who should be ind	cluded under	\$		000000000000000000000000000000000000000		,
salaries or fees)						
h. Laboratory***		\$	42,633	42,633		
i. Recreation		\$	45,025	45,025		
j. Other (Specify)****		\$	220,437	220,437		
See Attached Schedule						
5K. Total Resident Care Expenditures (5a -	5j)	\$	1,116,971	1,116,971		

<sup>\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*</sup> Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 29 of the Cost Report.

<sup>\*\*\*\*</sup> ICFMR's should provide a detailed schedule of all Day Program Costs.

## Schedule of Other Resident Care

Description		CCNH	RHNS	(Specify)
3060610160	Incontinency	\$ 138,668.86	\$ .	\$ -
3060610161	Incontinency - Rebates	\$ (9,185.79)	\$ -	\$ -
3080630030	Advertising-Help War	\$ 1,385.44	\$ -	\$ -
3080630030	Advertising-Help War	\$ 906.54	\$ -	\$
3080630080	Books, Dues & Subsci	\$ (152.27)	\$ -	\$ -
3080630140	Education Expense	\$ 5,940.78	\$ -	\$ -
3080630140	Education Expense	<b>\$</b> 151.08	\$ -	\$ -
3080630140	Education Expense	\$ 590.37	\$ -	\$ -
3120630530	Supplies	\$ 1,229.61	8 -	\$ -
3155630530	Supplies	\$ 6,988.49	\$ -	S -
3155630530	Supplies	\$ 22,653.95	\$ -	\$ -
3170630530	Supplies	\$ 31.24	\$ -	ş -
3090630535	Office Supplies	\$ 2,861.02	\$ -	\$ -
3120660080	Rental Expense	\$ 172.29	\$ -	\$ -
3155660080	Rental Expense	\$ 4,769.48	\$ -	\$
3155660080	Rental Expense	\$ 28,997.45	\$ -	\$ -
3010610300	Consolidated Billing	\$ 14,428.64	\$ -	\$ -
	0 0	\$ -	\$ -	\$ -
	0 0	\$ -	\$ -	\$ -
	0 0	\$ -	\$ -	\$ -
	0	8 -	\$ -	\$ -
	0 0	\$	\$ -	S -
	0 0	\$ -	\$ -	\$ -
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	0 0	\$ -	\$ -	\$ -
	0 0		\$ -	\$ -
	0 0	8 -	S -	\$ -
	0 0		8 -	\$ -
Total Other Resident Care		\$ 220,437	\$ -	\$ -

State of Connecticut Annual Report of Long-Term Care Facility CSP-21 Rev. 10/2001

# Schedule C-2 - Individuals or Firms Providing Services by Contract \* Report of Expenditures

Name of Facility Arden House Care and Rehabilitation Center	ilitation Center			License No. 2199-C	Report for Year Ended 9/30/2015				Page of 21   37
		Related ** to Owners,	o Owners, Officers				Potal Cost/	Total Cost/Page Ref.***	
		(company)			•			0	
Name of Individual or Company	Address	Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHINS	(Specify)	Pg Line
Healthcare Services Group	Drive, Bensalem, PA 19020	0	•	Vendor Contracted	Laundry Purchased Services	774,721	-		19 35
Healthcare Services Group	Drive, Bensalem, PA 19020	0	•	Vendor Contracted	Housekeeping Purchased Services	1,163,065			20 4b
		0	0	***************************************			·		
		0	0						
		0	0						
		0	0						
		0	0						
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		0	0						
		0	0						

<sup>\*</sup> List all contracted services over \$10,000. Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

<sup>\*\*\*</sup> Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

## C. Expenditures Other Than Salaries (cont'd) - Maintenance and Property

Name of Facility License No.	Report for Y	ear Ended		Page	of
Arden House Care and Rehabilitation Center 2199-C	9/30/2015			22	37
			•		
Item	Tota1	CCNH	RHNS	(S <sub>1</sub>	pecify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 451,540	451,540			
b. Heat	\$ 176,259	176,259			
c. Light & Power	\$ 302,547	302,547			
d. Water	\$ 133,431	133,431			
e. Equipment Lease (Provide detail on page 6)	\$ 				
f. Other (itemize)	\$	*****	******************************		
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 1,063,777	1,063,777			
7. Depreciation (complete schedule page 23*)					
a. Land Improvements	\$ 307	307			
b. Building & Building Improvements	\$ .62,449	62,449			
c. Non-Movable Equipment	\$ 30,951	30,951			
d. Movable Equipment	\$ 82,947	82,947			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 176,654	176,654			
8. Amortization (Complete att. Schedule Page 24*)					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$				
d. Other (Specify)	\$ 			·	
*8e. Total Amortization Costs (8a+b+c+d)	\$				
9. Rental payments on leased real property less					
real estate taxes included in item 10b	\$ 2,001,958	2,001,958			
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$ 456,433	456,433			
c. Personal property taxes	\$				
11. Total Property Expenses $(7e + 8e + 9 + 10)$	\$ 2,635,045	2,635,045			

<sup>\*</sup> Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

State of Connecticut Annual Report of Long-Term Care Facility CSP-23 Rev. 10/2006

		いっぱいし	Dept ectation Scheduse	neane					
Name of Facility Arden House Care and Rehabilitation Center		License No. 2199-C	S.C		Report for Year Ended 9/30/2015	papu		Page 23	of 37
A LUNCAL AND MANAGEMENT AND		Historical			Accumulated			000000000000000000000000000000000000000	
		Cost Exclusive of	Less Salvage	Cost to Be	Depreciation to Beginning of		Useful	Depreciation	
Property Item		Land	Value	Depreciated	Year's Operations	Depreciation	Life	for This Year	Totals
A. Land Improvements						į		100	
<ol> <li>Acquired prior to this report period</li> </ol>		3,163		3,163	378	3/7	Varnous	20.7	
2. Disposals (attach schedule)									
<ol> <li>Acquired during this report period (attach schedule)</li> </ol>	edule)								
A-4. Subtotal								3	307
B. Building and Building Improvements					:	ļ	,	i i	
<ol> <li>Acquired prior to this report period</li> </ol>		937,810		937,810	67,713 S/L	S/L	Various	61,312	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	neđule)	47,528		47,528			000000000000000000000000000000000000000	1,137	
B-4. Subtotal									62,449
C. Non-Movable Equipment								i c	
1. Acquired prior to this report period		277,941		277,941	56,561	S/L	Various	30,8/8	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	nedule)	4,381		4,381				73	1000
C-4. Subtotal									30,951
Is a mi	Is a mileage logbook	Historical			Accumulated				
maint	I? A	_	Less		Depreciation to	Method of			
		Ē		Cost to Be	Beginning of		Useful	Depreciation	Totale
Yes	No Month Year	r Land	Value	Depreciated	Year's Operations	) Depreciation		TOT THIS LESS	Lotats
D. Movable Equipment									
1. Motor Venicles (Specify name, model									
and year or each ventue)		4,900		4,900	2,246	S/L	Various	1,225	
b. Total Current Assets (Lines A1 thru									
Ú									
d,									
2. Movable Equipment						30000		* 0 * 0 1	
a. Acquired prior to this report period		390,615		390,615	152,275	S/L	Various	79,481	
b. Disposals (attach schedule)									
c. Acquired during this report period									
(attach schedule)		47,657		47,657				2,241	
D-3. Subtotal									82,947
E. Total Depreciation									1/6,634

## Schedule of Land Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
Total additions for	Eand Improvements	\$		\$ -
Deletions:				
Total deletions for I	and Improvements	\$ -		3 -

Useful

Schedule of Building Improvements Acquired during this report period

cquisition Date	Description of Item		Cost		ife	Depr	eciation
dditions:			4 202		15	\$	128
04/30/15	Upgrade 2 duraglide headers and add 1		4,597	\$			
03/31/15	Ceiling repair due to sprinkler damage		13,686	\$	10	\$	684
07/31/15	Hot water boiler	\$	29,245	>====	15	\$	325
							<u> </u>
	<del> </del>						
	1						
	+						
	-						
etal additions for	·Building Improvements	S	47,528			\$	1,13
eletions:							

<sup>\*</sup>Ties to Page 23, Line A3

<sup>\*\*</sup>Ties to Page 23, Line A2

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		******************
	@ <b>_</b>	[*************************************
	···	<del>(12000000000000000000000000000000000000</del>
Total deletions for Building Improvements \$		[ <u> </u>
Total detections for Difficulty Improvements		100.00000000000000000000000000000000000

<sup>\*</sup>Ties to Page 23, Line B3

Schedule of Non-Movable Equipment Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
7/31/2015	Lease refrigeration unit/compressor wa	\$ 685.96	10	\$ 11.43
7/31/2015	Lease refrigeration unit/compressor wa	\$ 478.58	10	§ 7.98
7/31/2015	Compressor for walk in	\$ 1,555.00	10	\$ 25,92
7/31/2015	Refrigeration unit steam clean/ compre	\$ 106.35	10	\$ 1.77
7/31/2015	Compressor for walk an	\$ 1,555.00	10	\$ 25.92
l'otal additions for	Non-Movable Equipment	\$ 4,38)		\$ 73
Deletions:	_			
		l		
Total deletions for	Non-Movable Equipment	S -		\$ -

<sup>\*</sup>Ties to Page 23, Line C3
\*\*Ties to Page 23, Line C2

<sup>\*\*</sup>Ties to Page 23, Line B2

#### Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item		Cost	Useful Life	Dej	preciation
Additions:						
3/31/2015	UCXT BED WLAMINATE PANEL	\$	2,107,80	10	\$	105.39
3/31/2015	Tracer SX5 Recliner Wheelchair	S	375.98	10	\$	18.80
3/31/2015	Bin Shelving, Solid, 36X 12, 28 Bi	1	484,32	10	8	24,22
3/31/2015	Bin Shelving, Steel, 36x18x75,28	8	723.13	10	\$	36.16
3/31/2015	Bin Shelving, Solid, 36X12,96 Bi	800	920.79	10	\$	46,04
4/30/2015	8 GEN ONLY: UCXT Beds panels ar	S	15,915.11	10	\$	663.13
4/30/2015	Direct Choice Overbed Table, S	\$	158,93	10	\$	6,62
4/30/2015	Tracer SX5 Recliner Wheelchair	8	341.98	10	S	14.25
4/30/2015	12 MATTRESS, GEN, CTM VISCO	S	3,907,22	3	S	542.67
4/30/2015	Destroyit 4005 shredder	8	5,329.07	10	8	222.04
1/31/2015	Mobile Iron licenses deployed Jan 201	\$8	15,90	3	S	3,53
1/31/2015	1 HP LaserJet PRO 400	\$	445.05	3	5	98.90
2/28/2015	Licenses deployed Feb 2015	\$	15,90	3	S	3,09
	10,000 BTU portable A/C	\$	331.38	7	\$	7.89
7/31/2015	Detecto Digital Readout Chair Scale w		1,057,09	7	8	25,17
7/31/2015	4 Affendant Vital Signs Monitor/mobi	S	8,595.70	7	8	204.66
	Medical grade refrigerator	3	1,350,00	10	\$	22,50
	10 MATTRESS, GENESIS VISCO S	1 8	3,137.33	3	8	174.30
	Haier 12,000 BTU 115 Volt Port	8	465,81	7	<b>  3</b>	5,55
8/31/2015	Direct Choice Overbed Table, S	S	1,978.10	10	\$	16.48
otal additions for	Movable Equipment	8	47,657		S	2,241
eletions:						
	-					
					1000	

<sup>\*</sup>Ties to Page 23, Line D2c

Total deletions for Movable Equipment

#### Schedule of Leasehold Improvements Acquired during this report period

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
Total additions for L	easehold Improvement	8 -		\$ "
Deletions:	//			
Total deletions for La	easehold Improvement	\$ -		\$

<sup>\*</sup>Ties to Page 24, Line C3

<sup>\*\*</sup>Ties to Page 23, Line D2b

<sup>\*\*</sup>Ties to Page 24, Line C2

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# Amortization Schedule\*

Name of Facility Arden House Care and Rehabilitation Center			License No. 2199-C	<u>-</u> ر	Report for Year Ended 9/30/2015	r Ended		Page 24	of 37
		Date of			Accumulated Amort. to	·	•		
	Acqu	Acquisition			Beginning of				
			Length of	Cost to Be	Year's		Rate	Rate Amortization	
Item	Month	Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
A. Organization Expense									
1,									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.								-	
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other	L								
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period									
(attach schedule)									
C-4. Subtotal									
D. Total Amortization									
* Straight-line method must be used									

\* Straight-line method must be used. \*\* Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.

B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

## C. Expenditures Other Than Salaries (cont'd) - Property Questionnaire

Name of Facility License No.	Report for Year End	led		Page of
Arden House Care and Rehabilitation ( 2199-C	9/30/2015			25   37
11. Property Questionnaire				
Part A				
Is the property either owned by the Escility	~ ~ ~	0	. <del>.</del>	If "Yes," complete Part B.
or leased from a Related Party?*	O Yes	<b>⊙</b> ]	No	If "No," complete Part C.
*If any owner or operator of this facility is related by fami	ly, marriage, ownership, ab	ility to control or		
business association to any person or organization from wi	hom buildings are leased, th	en it is considered	a	
related party transaction.	Total			
Description  1. Date Land Purchased	10141			
Date Failer Literasce     Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
Date of Initial Licensure				
5. Total Licensed Bed Capacity	360			
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing	1st Wortgage	Zhu Wortgago	Sid Wortgage	+m wortgage
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained			**-	
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of				
Complete if Mortgage was Refinanced				
During Current Cost Year				
g. Type of Financing (e.g., fixed, variable) h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Propert				
Name and Address of Lessor				Annual Amount of Lease
SABRA, 101 Sun Ave. NE, Albuquerque, NM Facility	Lease	11/15/10 - 6/30	163 months	2,001,958
87107				
	- W-1-T-			
				<u> </u>

Note: Be sure required copies of leases are attached to Page 25 and real estate taxes paid by lessor are included on Page 22, Item 10b.

## C. Expenditures Other Than Salaries (cont'd) - Interest

Name of Facility  License No.		Report for Yea	ar Ended		Page 26	of 37
Arden House Care and Rehabilitation ( 2199-C		9/30/2015		***************************************	20	31
Item		Total	CCNH	RHNS	(Speci	fy)
12. Interest A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage	\$	119,003	119,003			
Name of Lender	Rate		,			
Address of Lender						
2. Second Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
Original Loan Amount	\$					
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$	119,003	119,003			
IL D 1. A Vent Disting American Amperica (III III . Do)		. <del>.</del>	v Subtotals f	ompard to n	ort nage \	

(Carry Subtotals forward to next page )

## C. Expenditures Other Than Salaries (cont'd) - Interest and Insurance

Name of Facility License	No. 99-C		Report for Year Ended 9/30/2015			Page of 27   37
Arden House Care and Rehabilitatid 21	99-C		9/30/2013			21 31
Item			Total	CCNH	RHNS	(Specify)
Su	btotals Bro	ught Forward:	119,003	119,003		
12. C. Movable Equipment						
Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender		<u> </u>				
Address of Lender						
B, Item	Amount					
Lender			-			
A 11 CY 1						
Address of Lender						
12. C. 3. Total Movable Equipment Inte Expense (C1 + 2)	erest	\$				
12. D. Other Interest Expense (Specify)		\$				
13. Total All Interest Expense (12B7 + 1	2C3 + 12D	) \$	119,003	119,003	***************************************	
14. Insurance						
a. Insurance on Property (buildings	only)	\$	10,755	10,755		
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as	specified a					
1. Umbrella (Blanket Coverage)		\$	417,188	417,188		
2. Fire and Extended Coverage		\$	<u> </u>			
3. Other (Specify)		\$				
141 m + 17 72 73	1 2 1 -1	ď	407.042	107 042		
14d. Total Insurance Expenditures (14a - 15. Total All Expenditures (A-13 thru C		<u>\$</u>		427,943 30,200,269		
15. Total All Expenditures (A-13 thru C	-14)	Į.	30,200,209	30,200,209	<u> </u>	L

## D. Adjustments to Statement of Expenditures

	e of Fa		e and Rehabilitation Center	Lic	cense No. 2199-C	Report for Ye 9/30/2015	ar Ended	Page 28	of 37
2.1.440	111011			<del>'</del>	Total				
Îtem	Page	Line			Amount of				
	No.		Item Description		Decrease	CCNH	RHNS	(Spe	cify)
			es and Wages						
1.			Outpatient Service Costs	\$					***********
2.			Salaries not related to Resident Care	\$					
3.			Occupational Therapy	\$			-		
4.			Other - See attached Schedule	*\$	7,171	7,171			
	13 - 1	Profes	sional Fees						
5.			Resident Care Physicians **	\$					
6.			Occupational Therapy	\$					
7.			Other - See attached Schedule	\$		1,465,169			
	s 15 &	16 -	Administrative and General						
8.			Discriminatory Benefits	\$					
9.	15	1-c	Bad Debts	\$		281,734	**************************************		
10.			Accounting & Legal	\$					
11.			Telephone	\$					
12.			Cellular Telephone	\$					
13.			Life insurance premiums on the life						
1			of Owners, Partners, Operators	\$					
14.			Gifts, flowers and coffee shops	\$					
15.			Education expenditures to colleges or						
			universities for tuition and related costs						
			for owners and employees	\$		***************************************	***************************************		
16.			Travel for purposes of attending						
			conferences or seminars outside the						
			continental U.S. Other out-of-state						
			travel in excess of one representative	\$					
17.			Automobile Expense (e.g. personal use)	\$					
18.	16	m-2 &	Unallowable Advertising *	\$	12,402	12,402			
19.			Income Tax / Corporate Business Tax	\$					·
20.			Fund Raising / Contributions	\$	4,837	4,837			
21.			Unallowable Management Fees	\$	1,424,739	1,424,739			
22.			Barber and Beauty	\$					
23.			Other - See attached Schedule	\$	74,167	74,167			
Page	18 - 1	Dietar	y Expenditures						
24.			Meals to employees, guests and others						
			who are not residents	\$					
Page	19 - 1	Laund	lry Expenditures						
25.			Laundry services to employees, guests						
			and others who are not residents	\$					
Page	20 - 1	House	keeping Expenditures						
26.	_		Housekeeping services to employees, guests						
			and others who are not residents	\$					
		•	Subtotal (Items 1 - 26	\$	3,270,219	3,270,219			

<sup>\*</sup> All except "Help Wanted".

<sup>(</sup>Carry Subtotal forward to next page )

<sup>\*\*</sup> Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident,

#### Schedule of Other Salaries Adjustment

Page Ref Line Ref		Description	CCNH	RHNS	(Specify)
10 2	Administrator's salary disallowed	0	\$ 7,171.00	\$ +	s -
0 0	0	0	s -	s -	\$
0 0	0	0	\$ .	\$ -	\$ -
0 0	0	0	\$ .	S -	\$ -
0 0	0	0	S -	\$ .	\$ -
0 0	0	0	\$ -	\$ -	\$ -
0 0	0	0	\$ -	\$ -	\$ -
Total Other Salaries	Adjustment		\$ 7,171	\$	\$ -

#### Schedule of Fees Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
[3]	5	Rehabilitation Services	3120620020	\$ 305,728,60	\$ -	\$ -
13	5	Rehabilitation Services	3195620020	\$ 801,152,71	\$ -	S +
13	9	Speech Therapist	3170620020	\$ 125,021.55	S -	S -
13	10	Occupational Therapist	3105620020	\$ 222,007.65	S -	S -
13	12	Ofher	3010620020	\$ (0.28)	\$	\$ -
13	12	Other	3015620020	\$ 150.00	\$	\$ -
13	12	Respiratory Purchased Servics	3155620020	\$ 11,108.72	8 -	\$ -
Total Othe	r Fees Adj	ustments		\$ 1,465,169	\$	\$ -

#### Schedule of Other A&G Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
[V.1000/100000000000		Collection Fees	1020630120	\$ 55,702.50	S .	\$ .
16	m-8a	Chamber of Commerce	1020630310	\$ 4,702.00	S	S .
16	m-13	Estimated Accrual	1020660990	\$ 2,135.42	\$ -	S -
16	m-13	Fines & Penaltics	1020640080	\$ 11,627.50	\$	\$ -
16	m-13	Non-recurring Charges	7010800030	\$ -	\$	\$
16	m-12	0	0	\$ -	\$ +	\$ -
0	0	0	0	\$ -	\$	\$ -
0	0	0	0	\$ -	\$	\$ -
0	Ø	0	0	\$ -	\$ -	\$ -
0	0	0	- 0	\$ -	\$ -	S +
0	0	0	0	\$ -	\$ -	S -
0	0	0	0	\$ -	\$ -	\$ -
0	0	0	0	\$ -	\$ -	\$ -
Total Othe	r A&G Ad	justments		\$ 74,167	S -	S -

D. Adjustments to Statement of Expenditures (cont'd)

Mare	of E	ailite-	D. Adjustments to Statemen		ense No.	Report for Y		Page	of
	of Fa			ΤΙC	2199-C	9/30/2015	Car Exacted	29	1 37
Arge	ı nous	se Car	e and Rehabilitation Center		Total	713014013		47	1 31
Tr	<b>7</b> 0	т			Amount of				
	Page		The Description		Decrease	CCNH	RHNS	(St	ecify)
No.	No.	No.	Item Description	4		3,270,219	KIMO	(5)	occary)
D	20 T		Subtotals Brought Forward	Þ	3,270,219	3,2/0,219			
			nt Care Supplies***	4	405,587	405,587			
27.			Prescription Drugs	<u>\$</u>		38,985			
28.			Ambulance/Limousine		38,985	15,198			
29.	_		X-rays, etc	\$ \$	15,198	42,633			
30.	20	5-h	Laboratory		42,633	42,033		<u> </u>	
31.			Medical Supplies	\$	26.126	26.126			
32.	20	5-e-2	Oxygen (non emergency)	\$	26,126	26,126			
33.		ļ	Occupational Therapy	\$ \$	102.077	102.277			
34.	<u> </u>		Other - See Attached Schedule	ý.	103,277	103,277			
~	22 - 1	<u> Mainte</u>	enance and Property					100	
<i>35</i> .			Excess Movable Equipment Depreciation	ф					
			See Attached Schedule	\$					
36.			Depreciation on Unallowable	ďι					
		ļ	Motor Vehicles	\$					
37.			Unallowable Property and Real	ф					
			Estate Taxes	<u>\$</u>		<u></u>		ļ	
38.			Rental of Building Space or Rooms	\$					•
39.			Other - See Attached Schedule	\$					
	27 - 1	nsura							
40.			Mortgage Insurance	\$					
41.		<u> </u>	Property Insurance	\$					
		scella	neous	Φ.					
42.	ļ <u>.</u>	ļ	Research or Experimental Activities	\$					
43.	<u> </u>		Radio and Television Revenue	\$				ļ	
44.			Vending Machine Revenue	\$					
45.		<u> </u>	Purchase Discounts and Allowances	\$					
46.		ļ	Duplications of functions or services	\$					
47.			Expenditures made for the protection,						
			enhancement or promotion of the			1			
		<u> </u>	providers interest	\$				<del> </del>	
48.		<b> </b>	Interest Income on Accounts Rec	\$				3/65/200	
49.	-		Other (include personnel and other						
			costs unrelated to resident care) - See	_					
			Attached Schedule	\$	295,711	295,711			
Not.	For P	rofit I	Providers Only						***
50.			Building/Non Movable Eq. Depreciation						
			Unallowable Building Interest -						
			See Attached Schedule	\$				ļ	
51.	. Total	l Amo	unt of Decrease (Items 1 - 50)	\$	4,197,736	4,197,736	1	<u> </u>	

<sup>\*\*\*</sup> Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

#### Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	V21V277300000000000000000000000000000000000		\$ 14,428.64	3010610300	\$ -
20	5-i	Respiratory Supplies	\$ 29,642,44	3155630530	\$ -
20			\$ 33,766.93	3155660080	\$ -
20	5-1	Cable TV	\$ 25,438.91	3005660130	allow \$3600
0	0-Jan	0	\$	\$ -	\$
0	0-Jan	0	\$ -	\$ .	\$ -
0	0-Jan	0	\$ -	\$ -	\$ -
0	0-Jan	0	\$ -	\$ -	\$ -
0	0-Jan	0	\$ -	8 -	\$ -
0	0-Jan	0	\$ -	\$ -	\$ -
Total Othe	r Ancillar	y Costs	\$ 103,277	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref Line Ref Description	CCNH	RHNS	(Specify)
0 0-Jan	0 \$ +	S -	\$ -
0 0-lan	0 \$ -	\$ -	\$ -
0 0-Jan	0 S +	\$ .	\$ +
0 0-Jan	0 \$	\$ -	\$ -
0 0-Jan	0 \$ -	\$ -	S -
0 0-fan	0 \$ -	\$ -	\$ -
() 0-Jan	0 \$ -	\$ -	\$ -
0 0-Jan	0 \$	\$ -	\$
0 0-Jan	0 \$	S -	S -
Total Excess Movable Equipment Depreciation	\$ -	S -	\$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0	0-Jan	0 \$	-	S -	\$ -
0	0-Jan	0 \$		\$ -	\$
0	()-Jan	0 8		\$ -	\$ -
0	0-Jan	0 \$	-	\$ -	\$ -
0	0-Jan	0 \$		S -	S -
0	0-Jan	0 \$		\$ -	\$ -
0	()-Jan	0 \$		\$ -	\$ -
0	0-Jan	0 \$		\$ -	\$ -
0	0-Jan	0 \$		\$ -	\$ -
Total Othe	r Propert	Adjustments \$	-	\$	S

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
MACHINE AND ADDRESS OF THE PARTY OF THE PART	Transfer of the second second second	General liability Insurance Adjust	\$ 295,711.37	\$ -	S -
0	0-Jan	0	\$ -	s -	S -
0	0-Jan	0	\$ +	\$ -	\$ -
0	0-Jan	0	\$ -	\$ -	S
0	0-Jan	- 0	\$ -	S	\$ -
0	0-Jan	0	\$ -	S -	\$ -
0	0-Jan	0	S -	\$ -	8 -
0	0-Jan	0	\$	\$ -	S -
0	0-Jan	0	\$ .	S -	S
0	0-Jan	0	\$ -	\$	\$
Total Othe	r Adjustm	ents	\$ 295,711	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0	0-Jan	40000000000000000000000000000000000000	\$ -	S -	\$ -
0	0-Jan	0	\$ -	\$ -	S -
0	0-Jan	0	\$ -	\$ -	\$ -
0	0-Jan	0	\$ -	\$ .	\$
0	0-Jan	0	\$ -	\$ -	\$
0	0-Јап		\$ -	\$ -	\$ -
0	0-Jan	0	\$ -	\$ -	\$ -
0	0-Jan	0	s -	\$	\$ -
0	0-Jar	0	\$ -	S -	\$ -
0	0-Jar	0.	\$ -	\$ -	\$ -
Total Unal	lowable B	uilding Interest	\$	\$ -	\$ -

## F. Statement of Revenue

		Page	of			
Arden House Care and Rehabilitation Ce: 2199-C		9/30/2015			30	37
Item		Total	CCNH	RHNS	(Spec	ify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$	38,563,162	38,563,162			
b. Medicaid Room and Board Contractual Allowance **	\$	(18,008,875)	(18,008,875)			
2. a. Medicaid (All other states)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (all inclusive)	\$	3,763,019	3,763,019			
b. Medicare Room and Board Contractual Allowance **	\$	(976,809)	(976,809)			
4. a. Private-Pay Residents and Other	\$	3,618,262	3,618,262	1. T.F		
b. Private-Pay Room and Board Contractual Allowance **	\$	(646,821)	(646,821)			*********
II. Other Resident Revenue						
a. Prescription Drugs - Medicare	\$	314,228	314,228			
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(81,568)	(81,568)	*		
c. Prescription Drugs - Non-Medicare	\$	125,747	125,747	~		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(28,392)	(28,392)	****		
2. a. Medical Supplies - Medicare	\$	252	252			
b. Medical Supplies - Medicare Contractual Allowance **	\$	(65)	(65)			
c. Medical Supplies - Non-Medicare	\$	468	468			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$	(160)	(160)			
3. a. Physical Therapy - Medicare	\$	1,247,417	1,247,417			
b. Physical Therapy - Medicare Contractual Allowance **	\$	(323,806)				
c. Physical Therapy - Non-Medicare	\$	508,516	508,516			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$	(129,042)	(129,042)			
4. a. Speech Therapy - Medicare	\$		309,688			
b. Speech Therapy - Medicare Contractual Allowance **	\$		(80,389)			
c. Speech Therapy - Non-Medicare	\$		127,813	-		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$		****			
5. a. Occupational Therapy - Medicare	\$	<del></del>	1,049,416			
b. Occupational Therapy - Medicare Contractual Allowance **	\$	· · · · · ·				
c. Occupational Therapy - Non-Medicare	\$		453,175		<u> </u>	
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$	· ·			<u> </u>	
6. a. Other (Specify) - Medicare	\$		39,727			
b. Other (Specify) - Non-Medicare	\$		26,179			
III. Total Resident Revenue (Section I. thru Section II.)	\$		29,451,081			
IV. Other Revenue *		25,151,001	25,102,002			
	\$					
1. Meals sold to guests, employees & others	<u>\$</u>	1				
2. Rental of rooms to non-residents	\$				<u> </u>	
3. Telephone	<u> </u>		25,575			
4. Rental of Television and Cable Services	<u></u> \$		1,305		<del> </del>	•
5. Interest Income (Specify)	<u>\$</u>		1,505			
6. Private Duty Nurses' Fees	<u>_</u> \$		-		· · · · · · · · · · · · · · · · · · ·	
7. Barber, Coffee, Beauty and Gift shops	<u>\$</u>		2,838		<u> </u>	
8. Other (Specify)	<u>\$</u>	1				
V. Total Other Revenue (1 thru 8)		-	29,719			
VI. Total All Revenue (III+V)	\$	29,480,800	29,480,800			

<sup>\*</sup> Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

<sup>\*\*</sup> Facility should report all contractual allowances and/or payer discounts.

#### Schedule of Other Resident Revenue - Medicare

#### Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
П-6-а	Medicare Part A	X-Ray	11,570.83		
П-6-а	Medicare Part A	Radiology Service		e e	
II-6-a	Medicare Part A	Outpatient Therapy Program		-	
II-6-a	Medicare Part A	Laboratory	21,830.59	-	
II-6-a	Medicare Part A	Respiratory Therapy & Supplie	8,792,86		
П-6-а	Medicare Part A	Norsing Treatment Supplies			
11-6-4	Medicare Part A	Audiology			
П-6-а	Medicare Part A	Incontinency			
П-6-а	Medicare Part A	Oxygen & Supplies	-		
II-6-a	Medicare Part A	Physician Visit	-	-	
11-6-a	Medicare Part A	Ambulance	-		
II-6-a	Medicare Part A	Flu Shot	11,460.71		
II-6-a	Contractuals-Medicare	X-Ray	(3,003,57)		
II-6-a	Contractuals-Medicare	Radiology Service			
11-6-a	Contractuals-Medicare	Outpatient Therapy Program			
II-6-a	Contractuals-Medicare	Laboratory	(5,666 81)	•	
П-6-а	Contractuals-Medicare	Respiratory Therapy & Supplie	(2,282.46)	-	
II-6-a	Contractuals-Medicare	Nursing Treatment Supplies			
II-6-a	Contractuals-Medicare	Audiology		н.	
II-6-a	Contractuals-Medicare	Incontinency	-		
II-6-a	Contractuals-Medicare	Oxygen & Supplies	-		
II-6-a	Contractuals-Medicare	Physician Visit			
II-6-a	Contractuals-Medicare	Ambulance			
П-6-а	Contractuals-Medicare	Flu Shot	(2,974.99)		
Total Oth	er Resident Revenue - M	edicare	\$ 39,727	\$ -	\$ -

#### Schedule of Other Non-Medicare Resident Revenue

#### Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
П-6-Ь	Medicaid	X-Ray	158,00		
II-6-b	Medicaid	Radiology Service		-	
11-6-b	Medicaid	Ontpatient Therapy Program	-		<u>.</u>
II-6-b	Medicaid	Laboratory	338.22		
II-6-b	Medicaid	Respiratory Therapy & Supplic	15,107.33		<del>.</del>
Ц-6-Б	Medicaid	Nursing Treatment Supplies	-	-	
II-6-b	Medicaid	Audiology			-
II-6-b	Medicaid	Incontinency		ų	<del>-</del>
II-6-b	Medicaid	Oxygen & Supplies	1,537.50	-	<del>-</del>
II-6-b	Medicaid	Physician Visit		-	+
11-6-b	Medicaid	Ambulance		-	
II-6-b	Medicaid	Flu Shot			-
П-6-b	Contractuals Medicaid	X-Ray	(73.79)		<del>.</del>
П-6-b	Contractuals Medicaid	Radiology Service			
П-6-в	Contractuals Medicaid	Outpatient Therapy Program	-	-	
II-6-b	Contractuals Medicaid	Laboratory	(157.95)		-
II-6-b	Contractuals Medicaid	Respiratory Therapy & Supplie	(7,055.08)	-	<del></del>
II-6-b	Contractuals Medicaid	Nursing Treatment Supplies			
II-6-b	Contractuals Medicaid	Audiology		•	
H-6-b	Contractuals Medicaid	Incontinency	•		
II-6-b	Contractuals Medicaid	Oxygen & Supplies	(718.01)		<u>.</u>
II-6-b	Contractuals Medicard	Physician Visit			

П-6-в	Contractuals Medicald	Ambulance			
П-6-b	Contractuals Medicaid	Flu Shot		-	-
11-6-b	Private and Other	X-Ray	2,471.87	-	
II-6-b	Private and Other	Radiology Service	-	-	<u>-</u>
Ц-6-b	Private and Other	Outpatient Therapy Program	-		-
II-6-b	Private and Other	Laboratory	8,556.34	•	-
II-6-b	Private and Other	Respiratory Therapy & Supplie	9,108.82	-	
П-6-b	Private and Other	Nursing Treatment Supplies			-
II-6-b	Private and Other	Audiology	<u>-</u>	-	
II-6-b	Private and Other	Incontinency			-
II-6-b	Private and Other	Oxygen & Supplies	615.00		-
II-6-b	Private and Other	Physician Visit	F	-	•
Ц-6-b	Private and Other	Ambulance	-	-	-
H-6-b	Private and Other	Flu Shot	-		-
II-6-b	Private and Other	Capitation Contracts		-	•
П-6-Ь	Contractuals-Non-Medicaio	X-Ray	(441.89)	•	<del>.</del>
П-6-b	Contractuals-Non-Medicau	Radiology Service	-	-	
II-6-b	Contractuals-Non-Medicaio	Outpatient Therapy Program		н.	-
11-6-b	Contractuals-Non-Medical	Laboratory	(1,529.58)	-	
II-6-b	Contractuals-Non-Medical	Respiratory Therapy & Supplie	(1,628.34)	<del>-</del>	
II-6-b	Contractuals-Non-Medical	Nursing Freatment Supplies	-	-	<u> </u>
П-6-Б	Contractuals-Non-Medicai	Audiology	-		
II-6-b	Contractuals-Non-Medican	Incontinency	•		-
II-6-b	Contractuals-Non-Medical	Oxygen & Supplies	(109.94)	-	-
II-6-b	Contractuals-Non-Medical	Physician Visit			<u>-</u>
II-6-b	Contractuals-Non-Medicai	Ambulance			
II-6-b	Contractuals Non-Medical	Flu Shot		-	<u> </u>
II-6-b	Contractuals-Non-Medical	Capitation Contracts	-	-	
Total Of	her Resident Revenue		\$ 26,179	\$ .	\$ -

#### **Interest Income**

#### Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 30 line	430055	Interest On Overdue Accounts	\$ 1,305.46	S .	S -
Pg 30 line	430050	0	\$ -	\$ -	\$ -
0	0	0	\$ -	5 -	\$ -
Total Inte	rest Income		\$ 1,305	\$ -	s -

#### Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
Pg 30 line l		Telephone rental charge	1,569.55		
		MEDICAL RECORDS	863.84		1
0		Donation	150,00	-	í
0	0	rent	255.00	-	
0	0	0	-	-	_
Total Othe	er Revenue		\$ 2,838	\$ -	\$ -

## G. Balance Sheet

Name of Facility	License No.		rt for Year I	Ended	Page	of
Arden House Care and Rehabilitation	C 2199-C	9/30/	2015		31	37
	Account				An	nount
Assets						
A. Current Assets						22.224
1. Cash (on hand and in banks	)				\$	33,224
2. Resident Accounts Receivab	ole (Less Allowance	for Bad	Debts)		\$	2,528,753
3. Other Accounts Receivable	(Excluding Owners	or Relate	d Parties)		\$	109
4 Inventories					\$	58,460
5. Prepaid Expenses					\$	1,452,301
a. Prepaid Escrow Replace	Reserve		1,073,424			
b. Prepaid Personal Propert	<del></del>		92,379			
c. Prepaid Personal Propert	y Tax		20,152			
d. Prepaid Escrow Insuranc			34,187			
6. Interest Receivable					\$	
7. Medicare Final Settlement I	Receivable				\$	
8. Other Current Assets (itemi:					\$	
					-	
A-9. Total Current Assets (Lines A	1 thru 8)				\$	4,072,84
B. Fixed Assets			<u> </u>	···		
1. Land					\$	
2. Land Improvements	*Historical Cost		3,163		\$	2,478
2. Daily Improvement	Accum, Deprecia	ation	685	Net		
3. Buildings	*Historical Cost		985,337		\$	855,17
J. Dunango	Accum. Deprecia		130,162	Net		
4. Leasehold Improvements	*Historical Cost				\$	
4. Leasonoid improvemente	Accum. Deprecia	ation	····	Net		
5. Non-Movable Equipment	*Historical Cost		282,322	-	\$	194,81
5. Non-Movable Equipment	Accum. Depreci		87,512	Net		
6. Movable Equipment	*Historical Cost		438,272		\$	204,27
6. Wovable Equipment	Accum. Depreci		233,997	Net		
7. Motor Vehicles	*Historical Cost		4,900		\$	1,42
7. Motor Verneics	Accum. Depreci		3,471	- Net		
8. Minor Equipment-Not Dep		<del>ation</del>			\$	
					e e	
9. Other Fixed Assets (itemize	e)				\$	
				<u></u>	4	
	D1 (1 (1)	<u></u>			· ·	1 259 16
B-10. Total Fixed Assets (Lines	B1 thru 9)				\$	1,258,16

<sup>\*</sup> Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

## G. Balance Sheet (cont'd)

		Facility	License No.	Report for Year Ended	Page	;	of 37
Arde	n Ho	ouse Care and Rehabilitation C		9/30/2015	32	A	31
	·		Account	T-t-1D	6	Amount	21 014
			1 10 75 1/ 75	Total Brought Forward	<b>4</b>		31,014
C.		asehold or like property record	led for Equity Purpos	es.	\$		
		Land	YTT'-11-01		Ψ		
	2.	Land Improvements	*Historical Cost	n Net	\$		
		75. 11.11	Accum. Depreciation *Historical Cost	net net	φ		
	3,	Buildings		n Net	\$		
		N. M. 11. F	Accum. Depreciation *Historical Cost	ni Net	Ψ		
	4.	Non-Movable Equipment		on Net	\$		
ļ <u> </u>		36 11 73 5	Accum. Depreciation *Historical Cost	inct inct	Ψ		
	Э.	Movable Equipment	Accum. Depreciation	on Net	\$		
<b></b>		36 \$7.1:-1	*Historical Cost	m 14Ct	ΙΨ		
	6.	Motor Vehicles	Accum. Depreciation	n Net	\$		
ļ		Mr. F. Santa Mat Dames		JII INCL	\$		
		Minor Equipment-Not Depre			\$		
C-8		tal Leasehold or Like Property vestment and Other Assets	ues (CI unu 1)		Ψ		
D.	Inv				<b> </b> \$		
	1.	Deferred Deposits			\$		
ļ		Escrow Deposits	*Historical Cost		Ψ		
	3.	Organization Expense	Accum. Depreciation	on Net	<b> </b> \$		
	A	Goodwill (Purchased Only)	Accum. Depreciam	311	\$		
	4.	Investments Related to Resid	lent Care (temize)		\$		
	Э,	myesiments related to resid	ioni Garo (iomizo)		Ť		
ļ					1		
<u> </u>	6	Loans to Owners or Related	Parties fitemize)		\$		
<u> </u>	0.	Name and Address	Amount	Loan Date	4		
	-	Name and Address	THIOUIL	20012			
				İ			
	7	Other Assets (itemize)			\$	(1,0	09,289
	٠.	I/C Due to/Due From Ow	neđ	(1,009,289)		``	
	I/C Due to/Due From Multicare				1		
		JO Due to Due 1 1011 Mu			7		
D-8	T/	otal Investments and Other As	ssets (Lines D1 thru 7	7)	\$	(1,0	09,289
D-0	D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	····	21,726	

<sup>\*</sup> Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

# G. Balance Sheet (cont'd)

Name of Fac	ility		License No.	·	Report for Year End	ded	Page	of
		and Rehabilitation Center	2199-C	,	9/30/2015		33	37
<del></del>		- MI	Account				An	nount
Liabilities			•	•	<del></del>			
A.	Cu	rrent Liabilities						
	1.	Trade Accounts Payable					\$	896,240
	2.	Notes Payable (itemize)					\$	
		r n 11 C 73 1		ution ) (i	tomi-a)		\$	
	3.	Loans Payable for Equipm Name of Lender	Purpos		Amount	Date Due	Ψ	
		Name of Lender	ruipos	<u> </u>	Zinount	Date Due		
					1			
			<u> </u>				-	
	4.	Accrued Payroll (Exclusive					\$	707,549
	5.	Accrued Payroll (Owners a		ders onl	v)		\$	
	6.	Accrued Payroll Taxes Pay					\$	2,510
	7.	Medicare Final Settlement					\$	
	8.	Medicare Current Financia	, <del></del>				\$	-
	9.	Mortgage Payable (Curren					\$	
		. Interest Payable (Exclusive	of Owner and/	or Relat	ed Parties )	···	\$	
		. Accrued Income Taxes*					\$	776 746
	12	. Other Current Liabilities (	temize)				\$	776,746
		Accrued Provider/Bed Tax			Acer Exp Electricity	19,031		
		A/R Credit Gross Up Liability			Deferred Revenue	53,057		
		Accr Exp Water and Sewer			Accr Exp Other	130,044		
1 10	<u>. 70</u>	Accr Exp Gas otal Current Liabilities (Lir	vec A 1 thm 12)	8,845	Accr Sales and Use Tax	11,640	\$	2,383,045
A-13	5. 10	nai Carrent Liaonnaes (Ell	ies A1 unu 12)			·	Ψ	2,303,043

<sup>\*</sup> Business Income Tax (not that withheld from employees). Attach copy of owner's Federal Income Tax Return.

# G. Balance Sheet (cont'd)

Name of Facility	License No.	I 7		Page		of
Arden House Care and Rehabilitation Center	2199-C	9/30/2015		34		37
Account				Aı	nount	
. Total Brought Forward:					2,38	3,045
Liabilities (cont'd)						
B. Long-Term Liabilities						
<ol> <li>Loans Payable-Equipment</li> </ol>	\$					
Name of Lender	Purpose	Amount	Date Due			
2. Mortgages Payable			\$			
3. Loans from Owners or Rel	ated Parties ( <i>temize</i>	)	. \$			
Name and Address of Lender	Amount	Loan D	ate			
, , , , , , , , , , , , , , , , , , ,						
4. Other Long-Term Liabiliti	\$		2,26	50,792		
LT Debt-Financing Obligation 2,260,792						
D. C. C. L. C. T. Liv.	Times D1 them A)		\$		n n	(n 702
	B-5. Total Long-Term Liabilities (Lines B1 thru 4)				4,20	50,792 13,837
C. Total All Liabilities (Lines A-13 + B-5)					4,04	10,001

## G. Balance Sheet (cont'd) Reserves and Net Worth

	ne of Facility License No. Report for Year Ended 9/30/2015	Page	of 37
Ard	en House Care and Rehabilitation ( 2199-C   9/30/2015  Account	1 33	Amount
A.	Reserves		
	Reserve for value of leased land	\$	
	Reserve for depreciation value of leased buildings and appurtenances     to be amortized	\$	
	3. Reserve for depreciation value of leased personal property *Equity*)	\$	
	4. Reserve for leasehold real properties on which fair rental value is based	\$	
	5. Reserve for funds set aside as donor restricted	\$	
ļ <u>.</u>	6. Total Reserves	\$	
В.	Net Worth 1. Owner's Capital	\$	
	2. Capital Stock	\$	
	3. Paid-in Surplus	\$	
	4. Treasury Stock	\$	
	5. Cumulated Earnings	\$	397,359
	6. Gain or Loss for Period 10/1/2014 thru 9/30/2015	\$	(719,472)
	7. Total Net Worth	\$	(322,113)
C.	Total Reserves and Net Worth	\$	(322,113)
D.	Total Liabilities, Reserves, and Net Worth	\$	4,321,724

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year	Ended	Page	of
Arden House Care and Rehabilitation Cen	2199-C	9/30/2015		36	37
Account					mount
A. Balance at End of Prior Period as she		\$	397,357		
B. Total Revenue (From Statement of R		\$ \$	29,480,799		
C. Total Expenditures (From Statement of Expenditures Page 27)					30,200,269
D. Net Income or Deficit				\$	(719,470)
E. Balance				\$	(322,113)
F. Additions	1				
1. Additional Capital Contributed (	temize)				
<u> </u>			•		
2. Other (itemize)					
	•				
			:		
F-3. Total Additions				\$	
G. Deductions					
<ol> <li>Drawings of Owners/Operators/</li> </ol>	Partners( <i>Specify</i> )			\$	
Name and Address (No., City, S	State, Zip )	Title	Amount		
,					
2. Other Withdrawings (Specify)				\$	
Purpose		Amo	unt		
3. Total Deductions		1		\$	
H. Balance at End of Period	09/30	)/15		\$	(322,113)
				h	

### I. Preparer's/Reviewer's Certification

670S-742-876	Brickstone Square, Andover, MA 01810					
<b>Б</b> ропе <i>M</i> rmpex	mas Farnan -Sr. Director of Reimbursement res Address					
·		trompoundanie Che noteonie C no morned permod'T				
.,		Printed Name of Preparer				
5/02 /82/2/	St. Dilector of Resubstances I	some of carroll				
Date Signed	əltiT	Signature of Preparer				
Preparer/Reviewer Certification  I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have prepared and reviewed this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.						
(Specify)	Rest Home with Nursing  Supervision only (RHMS)					
Check appropriate category						
LE   LE   S107/0E/6	2199-C	Arden House Care and Rehabilitation				
Report for Year Ended Page of	License No.	Name of Facility				
0.70						