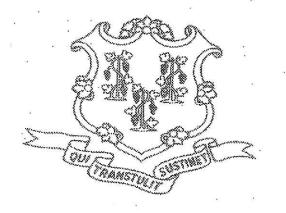
State of Connecticut





Annual Report of Long-Term Care Facility

Cost Year 2015

						REC	THE PERSON NAMED IN	/ED	
Name of Facility (as 1	icensed)					-	- 4		
Madison House Care	and Rehabilitat	ion Center				DEC	3 1	2015	Ŷ.
Address (No. & Strée	et, City, State, Z	ip Code)							W
34 Wildwood Avenue	e, Madison, CT	06443				DEPT OF S	0014	L SERVICES	20
Type of Facility					OF	FICE OF CON	4 AND	RATE SETTIN	33
Chronic and C Nursing Home	onvalescent e only (CCNH)		Rest Home win Supervision on (RHNS)		; 	(Specify)	n _a		
Report for Year Begin	nning		Report for Year	r Ending					
10/1/2014			9/30/2015						
License Numbers:		CCNH 2201-C	RHNS		(Specify)		Me	dicare Provi 07-5405	der
Medicaid Provider Nu	umbers:	C(21444	CNH	RI	HNS		ICI	F-IID	
For Department Use Sequence Number Assigned	e Only Signed and Notarized	Date Received	Sequence N Assign		Signed a	and Notariz	ed	Date Recei	ived

RECEIVED

JAN 05 2016

MYERS & STAUFFER LC

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

General Information

		- C 77 TO 1 1	D	
Name of Facility (as licensed)	License No.	Report for Year Ended	Page	OI
	2222 22	0/00/0015	1 1	27
Madison House Care and Rehabilitation Center-	2201-C	9/30/2015	1	31
Middle of the and temperature				

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 Madison 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
Control of the second s			MAN	la	1/13/2015
Printed Name (Administrator)		-	Printed Name (Owne		
Roessler, Cynthia Christine		15	Keith Davis, V.P. of	Reimb., Genesis	s Healthcare
Subscribed and Sworn	State of	Date	Signed (Notary Publi	c) /	Comm. Expires
to before me:	PA	11/13/17.	THE STATE OF THE S	My	1 1
Address of Notary Public		COMMONWEALT	H OF PENNSYLVANIA	ES .	
3 1		OLUSEGUNA ON	RIAL SEAL IOLAJA, Notary Public		
(Motory, Coal)		Unner Darby Two	o., Delaware County expires May 28, 2017	.7	

(Notary Seal)

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General Information

	General State			C
CD 'l' (-1'-mand)	License No.	Report for Year Ended	Page	of
Name of Facility (as licensed)	TERROPOR A	9/30/2015	1	37
Madison House Care and Rehabilitation Center	2201-C	7/30/2013		

Administrator's/Owner's Certification

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	Date	Signed (Owner)	Date		Signed (Administrator)
hcare	nesis Healthcare	Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesi			Printed Name (Administrator) Roessler, Cynthia Christine
n. Expires	Comm. Exp	Signed (Notary Public)	Date	State of	Subscribed and Sworn to before me:
		Signed (Notary Fubic)	Date	State of	Subscribed and Sworn to before me: Address of Notary Public

(Notary Seal)

State of Connecticut Annual Report of Long-Term Care Facility CSP-1A Rev. 6/95

State of Connecticut Department of Social Services

25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjust	me	ent		Page 1A	of 37
	_				
Name of Facility		Period Cove	ered:	From	To
Madison House Care and Rehabilitation Center				10/1/2014	9/30/2015
Address of Facility					
34 Wildwood Avenue, Madison, CT 06443					
Report Prepared By		Phone Num	ber	Date	
Thomas Farnan		978-247-50	29	12/20/2014	87
Item		Total	CCNH	RHNS	(Specify)
Dietary wages paid	\$	345,516	345,516		
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$	1			
4. Nursing wages paid	\$	3,068,674	3,068,674		
5. All other wages paid	\$	474,830	474,830		
6. Total Wages Paid	\$	3,889,020	3,889,020		
7. Total salaries paid	\$	231,076	231,076		
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$	4,120,096	4,120,096		

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.

State of Connecticut Annual Report of Long-Term Care Facility CSP-2 Rev. 10/2005

General Information and Questionnaire Type of Facility - Organization Structure

•	Ī	Phone No. of Fac	ility	Report for Yea	ar Ended	Page		of
		203-245-8008		9/30/2015		2		37
N Fracility (og shown on license)		Address (No	o. & S	treet, City, Sta	te, Zip)			
Name of Facility (as shown on license) Madison House Care and Rehabilitation Center		34 Wildwoo	od Av	enue, Madison	, CT 064	43		
CCN	1H	RHNS		(Specify)		Medicare I	rovio	ler No.
License Numbers: 2201-C						07-5405		
Type of Facility (Check appropriate box(es))								
Chronic and Convalescent		Rest Home with	Nursi	ng \square	(Specify	·)		
Nursing Home only (CCNH)	Ш	Supervision only	(RH	NS)	(======================================			
Type of Ownership (Check appropriate box)								
	hin	O Profit Corp.	0	Non-Profit Cor	р. О	Government	0	Trust
O Proprietorship	шр	O Hont corp.			Date Cl	hand		
			Date	e Opened	Date Cr	osca		
If this facility opened or closed during report year p	provide	:						
					1			
Has there been any change in ownership		O Yes	0	No	If "Yes,	" explain ful	ly.	
or operation during this report year?	-	O 163		110				
,								
Administrator								
Name of Administrator				Nursing F		01222		
Roessler, Cynthia Christine				Administra		1501		
				License	No.:			
Other Operators/Owners who are assistant admini-	strators	(full or part time	e) of t	his facility.				
Name				License	No.:	(8)	*	
Trumo								
			1920 14					
						to		
							-	
					1			
					1			

State of Connecticut

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CSP-3 Rev. 10/2005

General Information and Questionnaire Partners/Members

Name of Facility	hilitation Center	License No. 2201-C	Report for Y 9/30/2015	ear Ended	Page of 37
Madison House Care and Reha Legal Name of Part		Business		State(s) and Which	l/or Town(s) in Registered
			1		
Name of Partners/Members	Business A	Address	1	Title	% Owned
Harborside Health I Corporation	101 Sun Ave. NE, All 87109	buquerque, NM		,	1
Harborside Healthcare Limited	101 Sun Ave. NE, Al 87109	buquerque, NM			. 99
		~	,		
		,			

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General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year	Ended	Page of 3A 37
Tr Command Dehabilitation Center	2201-C	9/30/2015		3A 31
f this facility is owned or operated as a corpo	oration, provide	the following inform	nation:	high Incornorate
Legal Name of Corporation	Busir	less Address	Diate(b) 112 111	hich Incorporate
Madison House Care and	101 East State S		PA	
Rehabilitation Center	Square, PA 193	348		
The state of the s	-			
				No. Shares
Name of Directors, Officers	Busin	ness Address	Title	Held by Each
N/A				
	х х			
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. 2201-C	Report for Year Ended 9/30/2015	Page 3B	of 37
a 1 D-l-aladatotion I enter	1 vistanshin	provide the following inform		
Madison House Care and Renadmation Center If this facility is owned or operated as an individual	ual proprietorship,	provide the following inform		
Ov	wner(s) of Facility			
			*	
,				
			7	
		5		
		W State of the sta		
i .				
			-112	

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

General Information and Questionnaire Related Parties*

Name of Facility		License No	0.0	Rep	Report for Year Ended		Page 4	of 37
Madison House Care and Rehabilitation Center	l Rehabilitation Center	22	2201-C	15/15/	9/30/2013			
Are any individuals recei marriage, ability to contr	Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?	acility rela	ated throu	gh O Yes	o No	If "Yes," provide the Name/Address and complete the information on Page 11 of the report.	: Name/Addi ation on Pag	ess and e 11 of the report.
		15						N.
Are any individuals or concluding the rental of princleding the rental of princled through family as	Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business	s or service to this fare, control,	es, cility, or busine	SS	© Yes O No	If "Yes," provide the following information:	e following i	nformation:
association to any of me	OWIEIS, Operators, or orrection							
			1.100	-		Indicate Where		
		Also	Also Provides			Costs are Included		(
betolo Claration	Business	Non-Re	Non-Related Parties	ies	Description of Goods/Services	in Annual Report		Actual Cost to the Related Party
Tradividual or Company		Yes	No %	**%	Provided	Fage # / Line #	INCOURCE	
The second second	_	0	0	H	Home Office	Pg 16/m12	387,911	387,911
Genesis Health Ventures	Square, PA 19348							1 068 345
Genesis ElderCare	101 East State Street, Neumen Square, PA 19348	0	0	63% PT	63% PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	1,068,345	1,000,1
Genesis ElderCare Staffing	_	0	0	70/S	Cess Ctaffing Dool	Pg 10/A12	26,162	26,162
Services	Services Square, PA 19348	((0/00	aring cov	12 mg D~ 10/A12	279 673	29,673
Genesis ElderCare ruysicia	Square, PA 19348	9)	85% C2	85% Case Management	Fg 13/Bo, Fg 10/A12	2007	
מסיים אינה אינה מיים	101 East State Street, Kennett	0	0	St	Staffing Pool	Pg 13/B11 a,b,c	2,537	2,537
Career Statung	515 Fairmount Ave, 6th Floor, Suite	• it	0	43% Re	43% Respiratory Therapy	Pg 13/B12, Pg 20/C5E	38,929	38,929
Respiratory Health Services	Respiratory Health Services 1000, 100 Sout, Ann. 2, 200.	0	0	ᄩ	Insurance	Pg 27/14	125,043	125,043
Genesis Healthcare Corp.	Square, PA 19348 101 East State Street, Kennett	•	0		Capital Interest	Page 17, page 26-12A	38,838	38,838
Genesis Healthcare Corp.	Square, FA 19340				*	vi		
		0	0					
	The opposite of the state of th							

* 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 of 5 37
	ter 2201-C		9/30/2015	
If the facility is licensed as CDH and/or RCI	Hor provides A	IDS or TBI	services with special Med	icaid rates, cosis
must be allocated to CCNH and RHNS as fo	llows:			
Item			Method of Allocat	1011
Dietary		Number of	meals served to residents	
Laundry		Number of	pounds processed	
Housekeeping		Number of	square feet serviced	ided by EACH
Housekeeping		Number of	hours of routine care prov	(or Charge Nurse)
Nursing		employee of	classification, i.e., Director	Of Charge Nuise),
Nursing			Nurses, Licensed Practica	I Nuises, Alues and
		Attendants		:1-4 by EACH
Direct Resident Care Consultants		Number of	hours of resident care pro	vided by EACH
Direct Resident Care Consum			(See listing page 13)	
Maintenance and operation of plant		Square fee		
Property costs (depreciation)		Square fee		
Employee health and welfare		Gross sala	ries	
Management services		Appropria	te cost center involved	
The second secon		Total of D	irect and Allocated Costs	11.1
All other General Administrative expenses The preparer of this report must answer the	following que	stions appli	cable to the cost information	on provided.
The preparer of this report must answer as	11		If "No," explain fully wh	y such allocation was
1. In the preparation of this Report, were a	o Yes	O No	not made.	
costs allocated as required?				
*				
		%		
	on and or	d attach cor	ov of appropriate supporting	ıg data.
2. Explain the allocation of related compa	my expenses an	id attach coj	of or appropriate	
			v v	
		1' '	dindinat costs to non-nur	sing home cost centers?
3. Did the Facility appropriately allocate	and self-disallo	ow direct an	Ory Care Services etc.)	
3. Did the Facility appropriately anocate (e.g., Assisted Living, Home Health, C	outpatient Servi	ices, Adult I	July Commercial Commer	
	⊙ Yes	122 101121	If "No, explain fully w	'ny such anocation was
	0 108	2 110	not made.	
,				
1				

State of Connecticut Annual Report of Long-Term Care Facility CSP-6 Rev. 9/2002

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

Page of	6 37				Amount Claimed										l l						
				Annual	Amount															Total ***	
ear Fnded	car runa				Term of	Scano														o No	
Donout for Vear Finded	9/30/2015				Date of	LCasc														O	
	License No.	O-1077				Description of Items Leased	*													O Yes	
			Related * to	Owners,	Operators, Officers	s No	0	0	+	0	0	+	0	0	+	0	-)	0		1 4 7
should not be included in these amounts.	Name of Facility	Madison House Care and Rehabilitation Center	Rel	0	do	Name and Address of Lessor	0	C		0	C		0	0		0		O			1

Is a Mileage Log Book Maintained for All Leased Vehicles?

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

** Attach copies of newly acquired leases.

*** Amount should agree to Page 22, Line 6e.

CSP-7 Rev. 6/95

General Information and Questionnaire Accounting Basis

ame of Facility License No.	Report for Year Ended	Page of 7 37
Transfer of Pohobility 2201-C	9/30/2015	
he records of this facility for the period covered by this	report were maintained on the following basis	s:
10 10 1		
Accrual O Cash O Modified Cash		
the accounting basis for this	If "No," explain.	
riod the same as for the O Yes	II No, explain.	
evious period? O No		
	8	
	,	8
1 / Atime Firm		
ndependent Accounting Firm	Address (No. & Street, City, State, Z	ip Code)
Tame of Accounting Firm KPMG Peat Marwick	1600 Market Street, Philadelphia	a, PA 19103
	/	
Services Provided by This Firm (describe fully)		
Year end financial audit		\$
1 car cha manota, water		\$
		\$
		\$
		Charge for Services Provided
		\$
Are These Charges Reflected in the Expenditure Portion of This I	Report? If Yes, Specify Expense Classification and L	ine No.
O Yes O No		
Legal Services Information		Telephone Number
Name of Legal Firm or Independent Attorney		203-787-4805
1 State of Connecticut - Court of Probate		617 456-0500
2 Bloom & Witkin		017 150 000
3		
4		
5		
Address (No. & Street, City, State, Zip Code)		8
1 8 Meetinghouse Lane Madison, Ct 06443		
2 470 Atlantic Ave - 3rd Fl Boston, MA 02210		
3		
4		
Services Provided by This Firm (describe fully)		
		\$
1 Probate Court Fees	of Real Fetate Tax	\$ 13,950
2 Real Estate Tax Abatement-reduced the assessment values	Of Real Estate Tark	\$
3		\$
4		\$
5		Charge for Services Provided
55		\$ 13,950
	20 1014 Guarify Evenance Classification and	
Are These Charges Reflected in the Expenditure Portion of Th	s Report? If Yes, Specify Expense Classification and	
Legal Fees pg. 1	5 1-e	
⊙ Yes O No		

State of Connecticut Annual Report of Long-Term Care Facility CSP-8 Rev. 9/2002

Schedule of Resident Statistics

License No. Report for Year Ended Page of 9/30/2015 8 37	Period 10/1 Thru 6/30 Period 7/1 Thru 9/30	Total All CCNH RHNS Total Levels Levels Levels (Specify) Total CONH RHNS (Specify) Total CCNH RHNS (Specify) Total CCNH RHNS (Specify) Total CCNH RHNS (Specify)				6/	84 84	9			731 231 231			Ţ,	28,982 28,982 21,713 21,713		4	
Total	Total RHNS	Level (Specify)	06	06	1	6/	84					962					+	
ontor	Madison House Care and Rehabilitation Center			On last day of PREVIOUS report period		of PREVIOUS report period		tal Number of Days Care Provided During Period	A. Medicare	B. Medicaid (Conn.)	C. Medicaid (other states)	Private Pay	E. State SSI for RCH	F. Other (Specify) 2,182	Total Care Days During Period (3A thru F)	ed in Figures in 3G 1 for Reserved Beds	A. Medicaid Bed Reserve Days	R Other Bed Reserve Days

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

Schedule of Resident Statistics (Cont'd)

	iliter		I	icens	se No.]	Report f	for Year I	Ended		Page	01
ame of Faci	шц ж Сэте я	and Reha	bilitation Cent		01-C				9	9/30/2015	5		9	37
									า	0	Yes	⊙ N	ĺo	
. Were th	ere any cl	hanges ir	the certified be	d cap	acity duri	ng th	e report	year	1	O	103			
If "YES	s", provide	e the foll	owing informati	on:			· n 1			Car	pacity After	Change		
		Place of	Change		Ch	ange	in Beds			Caj	Jacity Attor	Change		
Date of	CCNH	RHNS	(Specify)		Lost		G	aine	1					
			W 22		700.00			, (a)	(2)	CCNH	RHNS	(Specify)	Reason for	Change
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNII	KIINS	(Specify)		
								_	-					
													C	
5 TG th own	S TRIOG ONLY	change i	n certified bed o	apaci	ty during	the re	eport ye	ar (as	s reporte	ed in item	ı 4 above) p	rovide the numb	er of	
5. If mere	Was any	Change 1	00 days followin	g the	change.					•				
RESIL	DENT DE	4 1 5 101 3	90 days followin	g mo	onunge.									
			ci '- D	: 4	at Davia					l co	CNH	RHNS	(Spec	ify)
			Change in Re	esidei	it Days									
1st cha							-0.00							
2nd ch														
3rd cha														
4th cha	ange		1 Deter on Conte	mhei	- 30 of Co	st Ye	ar							
6. Number	er of Resi	idents an	d Rates on Septe Medicare	Intoci	Med	caid				S	Self-Pay		Other State	Assisted
			Medicare		11200	T		T						
				1				1						
					COMI	T	HNS	1	CCNH	R	HNS	(Specify)	R.C.H.	ICF-III
	Item		CCNH	+	CCNH	_	ding	 `	11					
	f Residen		2	2	5	1				-				
9770 11000 1000	iem Rate													
17000 90000	ne bed rm.		505.40	+	229,28	+		1	506.17					
	vo bed rm		575.48	+	227.20	+							1	8
	ree or mo	ore		1		1		1					150 740	
he	ed rms.									1				
- 00										-				
														(G :C
	X 1	CD1	and Thorany Tre	atmer	nts					Т	OTAL	CCNH	RHNS	(Specif
	Number	of Physic	cal Therapy Tre	atmer	nts					T	OTAL 2,943	CCNH 2,943	RHNS	(Specif
	A Medi	icare - Pa	rt B		nts					Т			RHNS	(Specif
	A. Medi B. Medi	icare - Pa icaid (Ex	rt B clusive of Part E		nts					T	2,943	2,943		(Specif
	A. Medi B. Medi 1. M	icare - Pa icaid (Ex Iaintenan	rt B clusive of Part E ce Treatments		nts					T	2,943 428	2,943		(Specif
	A. Medi B. Medi 1. M 2. R	icare - Pa icaid (Ex Iaintenan estorativ	rt B clusive of Part E		nts					Т	2,943 428 22,720	2,943 428 22,720		(Specif
7. Total	A. Medi B. Medi 1. M 2. R C. Othe	icare - Pa icaid (Ex Iaintenan estorative ex	rt B clusive of Part E ce Treatments e Treatments	3) tmen	ts					T	2,943 428	2,943 428 22,720		(Specif
7. Total	A. Medi B. Medi 1. M 2. R C. Othe	icare - Pa icaid (Ex Iaintenan estorative ex	rt B clusive of Part E ce Treatments e Treatments	3) tmen	ts					T	2,943 428 22,720 26,091	2,943 428 22,720 26,091		(Specif
7. Total	A. Medi B. Medi 1. M 2. R C. Othe D. Tota 1 Number A Med	icare - Pa icaid (Ex faintenan estorative or of Speed licare - Pa	rt B clusive of Part E ce Treatments e Treatments al Therapy Trea ch Therapy Trea art B	tment tment	ts					T	2,943 428 22,720	2,943 428 22,720 26,091		(Specif
7. Total	A. Medi B. Medi 1. M 2. R C. Othe D. Tota 1 Number A Med	icare - Pa icaid (Ex faintenan estorative or of Speed licare - Pa	rt B clusive of Part E ce Treatments e Treatments al Therapy Trea ch Therapy Trea art B	tment tment	ts					T	2,943 428 22,720 26,091	2,943 428 22,720 26,091		(Specif
7. Total	A. Medi B. Medi 1. M 2. R C. Othe D. Tota 1 Number A. Med B. Med	icare - Pa icaid (Ex Iaintenan estorative er of Physica of Speed licare - Pa licaid (Ex	cusive of Part E ce Treatments e Treatments e Treatments at Therapy Trea ch Therapy Trea art B sclusive of Part 1	tment tment	ts					T	2,943 428 22,720 26,091 281	2,943 428 22,720 26,091 281		(Specif
7. Total	A. Medi B. Medi 1. M 2. R C. Othe D. Tota 1 Number A. Med B. Med 1. M	icare - Pa icaid (Ex Iaintenan estorative or I Physica of Speedicare - Pa licaid (Ex Maintenan	rt B clusive of Part E ce Treatments e Treatments al Therapy Trea ch Therapy Trea art B	tment tment	ts					T	2,943 428 22,720 26,091 281	2,943 428 22,720 26,091 281		(Specif
7. Total	A. Medi B. Medi 1. M 2. R C. Othe D. Tota 1 Number A. Med B. Med 1. M 2. R C. Othe	icare - Pa icaid (Ex Iaintenan estorative or Il Physica of Speed licare - Pa licaid (Ex Maintenan Restorative er	cut B clusive of Part E ce Treatments e Treatments In Therapy Trea ch Therapy Trea cart B sclusive of Part I ace Treatments re Treatments re Treatments	tment (ment)	ts ts					T	2,943 428 22,720 26,091 281 66 2,296	2,943 428 22,720 26,091 281 7 67 67 67 67 67		(Specif
7. Total	A. Medi B. Medi 1. M 2. R C. Othe D. Tota 1 Number A. Med 1. M 2. R C. Othe Tota 1 Number A. Med D. Tota Tota Tota Tota Tota Tota	icare - Pa icaid (Ex Iaintenan estorative or Physica of Speec licare - Pa licaid (Ex Maintenan Restorative er	cut B clusive of Part E ce Treatments e Treatments In Therapy Treat ch Therapy Treat cart B cclusive of Part I nee Treatments re Treatments e Treatments Therapy Treat a Therapy Treat	tment (3)	ts ts					T	2,943 428 22,720 26,091 281	2,943 428 22,720 26,091 281 7 67 67 67 67 67		(Specif
7. Total	A. Medi B. Medi 1. M 2. R C. Othe D. Tota 1 Number A. Med 1. M 2. R C. Othe D. Tota 1 Number A Med A M	icare - Pa icaid (Ex Iaintenan estorative ex I Physica of Speed licare - Pa licaid (Ex Maintenan Restorative er al Speech or of Occu	cut B clusive of Part E ce Treatments e Treatments al Therapy Trea ch Therapy Trea cart B cclusive of Part I nce Treatments re Treatments a Therapy Treat capational Therapy	tment (3)	ts ts					T	2,943 428 22,720 26,091 281 6° 2,290 2,63:	2,943 428 22,720 26,091 281 7 67 0 2,290 8 2,638		(Specif
7. Total	A. Medi B. Medi 1. M 2. R C. Othe D. Tota 1 Number A. Med 1. M 2. R C. Othe D. Tota 1 Number D. Tota 1 Number A Med A Med	icare - Pa icaid (Ex faintenan estorative or of Speed licare - Pa licaid (Ex faintenan Restorative er al Speech or of Occu-	clusive of Part Ece Treatments Treatments Therapy Treat	tment (3)	ts ts					T	2,943 428 22,720 26,091 281 66 2,296	2,943 428 22,720 26,091 281 7 67 0 2,290 8 2,638		(Specif
7. Total	A. Medi B. Medi 1. M 2. R C. Othe D. Tota 1 Number A. Med 1. M 2. R C. Othe D. Tota 1 Number A. Med B. Med 1. M 2. R C. Othe D. Tota A. Med B. Med D. Tota B. Med B. Med	icare - Pa icaid (Ex Iaintenan estorative or of Speed licare - Pa licaid (Ex Iaintenan Restorative er al Speech or of Occudicare - Pa dicaid (Ex	clusive of Part E ce Treatments e Treatments In Therapy Treat ch Therapy Treat ch Therapy Treat ch Treatments re Treatments re Treatments re Treatments re Treatments re Treatments re Therapy Treat repational Therap art B acclusive of Part	tment (3)	ts ts			[2		T	2,943 428 22,720 26,091 281 6° 2,290 2,63:	2,943 428 22,720 26,091 281 7 67 0 2,290 8 2,638		(Specif
7. Total 8. Total	A. Medi B. Medi 1. M 2. R C. Othe D. Tota 1 Number A. Med 1. M 2. R C. Othe D. Tota 1 Number A. Med 1. M 2. R C. Othe D. Tota 1 Number A. Med D. Tota 1 Number A. Med 1. Med D. Tota 1 Number A. Med D. Tota 1 Number	icare - Pa icaid (Ex Iaintenan estorative or I Physica of Speed licare - Pa licaid (Ex Maintenan Restorative er al Speech or of Occu licare - Pa licaid (Ex Maintenan dicare - Pa licaid (Ex Maintenan dicare - Pa licaid (Ex Maintenan dicare - Pa licaid (Ex Maintenan	clusive of Part Ece Treatments e Treatments e Treatments In Therapy Treat eart B eclusive of Part I ence Treatments re Treatments e Treatments e Treatments exclusive of Part I exclusive of Part I exclusive of Part I exclusive of Part exclusive o	tment (3)	ts ts					T	2,943 428 22,720 26,091 281 6° 2,299 2,63:	2,943 428 22,720 26,091 281 7 67 0 2,290 8 2,638 9 2,389		(Specif
7. Total	A. Medi B. Medi 1. M 2. R C. Othe D. Tota 1 Number A. Med 1. M 2. R C. Othe D. Tota 1 Number A. Med 1. M 2. R C. Othe D. Tota 1 Number A. Med D. Tota 1 Number A. Med 1. Med D. Tota 1 Number A. Med D. Tota 1 Number	icare - Pa icaid (Ex Iaintenan estorative or I Physica of Speed licare - Pa licaid (Ex Maintenan Restorative er al Speech or of Occu licare - Pa licaid (Ex Maintenan dicare - Pa licaid (Ex Maintenan dicare - Pa licaid (Ex Maintenan dicare - Pa licaid (Ex Maintenan	clusive of Part E ce Treatments e Treatments In Therapy Treat ch Therapy Treat ch Therapy Treat ch Treatments re Treatments re Treatments re Treatments re Treatments re Treatments re Therapy Treat repational Therap art B acclusive of Part	tment (3)	ts ts			1		T	2,943 428 22,720 26,091 281 6° 2,290 2,63:	2,943 428 22,720 26,091 281 7 67 9 2,290 8 2,389 9 2,389		(Specif

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Report of Exp	License No.		Report for Year	Ended	Page	of
Madison House Care and Rehabilitation Center	2201-C		9/30/2015		10	37
Are time records maintained by all individuals receiving co	mpensation?	•	Yes	0	No	
the time records management by			Total Cost an	d Hours		
		or Mileson and Control	2222	TT	(Specify)	Hours
Item	CCNH	Hours	RHNS	Hours	(Specify)	110415
A. Salaries and Wages*						
Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III						
of Schedule A1)	117,546	2,078				
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						
4. Other Administrative Salaries (telephone	145 620	7,187				
operator, clerks, receptionists, etc.)	145,629	7,107				
5. Dietary Service	22,214	755		***************************************		22122222222
a. Head Dietitian b. Food Service Supervisor	59,218	2,356				
c. Dietary Workers	264,085	16,603	3			
6. Housekeeping Service			1			
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services a. Engineer or Chief of Maintenance	61,602	2,30	7			
b. Other Maintenance Workers	8,803	698	8			
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
Barber and Beautician Services						
10. Protective Services 11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents		214				*************
a. Directors and Assistant Director of Nurses	113,530	2,14	8			
b. RN	825,279	23,49	7			202000000000000000000000000000000000000
1. Direct Care	6,638					
2. Administrative** c. LPN	0,05					
1. Direct Care	907,69	31,94	19			
2. Administrative**		660	10			-
d. Aides and Attendants	1,127,04	66,24	12	+		
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists h. Recreation Workers	86,13	4 5,20	58			
i. Physicians						
Medical Director						
Utilization Review						
3. Resident Care***						
4. Other (Specify)					***************************************	
j. Dentists						-
k. Pharmacists		-			+	
1. Podiatrists	172,66	3 6,9	26			
m. Social Workers/Case Management	172,00	,5, 0,7	==			
n. Marketing o. Other (Specify)						
See Attached Schedule	202,01					
A-13. Total Salary Expenditures	4,120,09	182,8	68			

^{*} 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.

^{**} 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.

^{***} 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

Schedule of Other Salaries and Wages (Page 10)

	CCN	n u	RH	INS	(Spe	cify)
Position	\$	Hours	\$	Hours	\$	Hours
Ward Clerks	0 \$ -	-	\$ -	-	\$ -	-
Other	0 \$ -	-	\$ -	-	\$ -	-
0 Assistant-Child Care	\$ 124,778.89	9,910.66	\$ -	-	\$ -	Н.
0 Director-Child Care	\$ 5,312.87	281.76	\$ -	-	\$ -	-
0 Supervisor-Child Care	\$ 15,007.88	780.86	\$ -	-	\$ -	-
0 Assistant-Child Care	\$ 1,689.09	152.28	\$ -	-	\$ -	-
Central Supply	0 \$ 16,511.65	1,067.10	\$ -	-	\$ -	+
Medical Records	0 \$ 38,716.68	2,516.58	\$ -	-	\$ -	-
0	0 \$ -	_	\$ -	-	\$ -	+
0	0 \$ -	-	\$ -	-	\$ -	-
0	0 \$ -	-	\$ -	н	\$ -	+
0	0 \$ -	ī	\$ -	-	\$ -	-
0	0 \$ -	1	\$ -	-	\$ -	-
0	0 \$ -	-	\$ -	-	\$ -	-
0	0 \$ -	-	\$ -	-	\$ -	-
0	0 \$ -	-	\$ -	-	\$ -	-
0	0 \$ -	-	\$ -	-	\$ -	-
0	0 \$ -	-	\$ -	-	\$ -	-
Total	\$ 202,017.05	\$ 14,709.23	\$ -		\$ -	<u> </u>

Schedule of Other Fees (Page 13)

		CC	NH	R	HNS	(S	pecify)
Service		\$	Hours	\$	Hours	\$	Hours
1020620010	Consulting Fees	\$ 148.85	n/a	\$ -	\$ -	S -	\$ -
1020620010	Consulting Fees	\$ 409.70	n/a	\$ -	\$ -	\$ -	<u> </u>
1020620010	Consulting Fees	\$ 206.29	n/a	\$ -	\$ -	\$ -	\$ -
3010620020	Purchased Services	\$ 3,835.98	n/a	\$ -	\$ -	\$ -	\$ -
3010620020	Purchased Services	\$ (3,836.00)	n/a	\$ -	\$ -	S -	\$ -
3155620020	Purchased Services	\$ (0.87)	n/a	\$ -	\$ -	<u>s</u> -	\$ -
3155620020	Purchased Services	\$ 4,423.32	n/a	\$ -	\$ -	\$ -	S -
	0	0 \$ -	n/a	\$ -	\$ -	\$ -	Ø
	0	0 \$ -	\$ -	\$ -	\$ -	\$ -	3 -
Total		\$ 5,187.27	\$ -	\$ -	-	\$ -	

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*

(1) - (2) - (3) -			Ticense	Ticense No		Report for	Report for Year Ended		Page	10
Name of Facility	totion Cont.	t		2201-C		9/30/2015			11	37
Madison House Care and Renabilitation Center	Hanon Cent	77								
		Salary Paid	p.	Henore Benefits						
Name	CCNH	REINS	(Specify)		Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Soction I - Onerators/Owners										
To A Common of the Common of t			V							
							1000			
Section II - Other related parties of Operators/Owners				(4)						
employed in and paid by facility (EXCEPT those who may be the Administrator or										
are identified on Page 12).										
*										

^{*} No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

^{**} 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*

		V	ceretant	Administra	Assistant Administrators and Other Related Latines	NOTATION.	I altho			
		L.	Transferen	Times Me		Report for Year Ended	ar Ended		Page	ot
Name of Facility (as licensed)				License Inc.		9/30/2015			12	37
Madison House Care and Rehabilitation Center	ution Center			2201-C		270710016				
Madison modes care are		Salary Paid								
				Fringe Benefits			T ino Whore		Total	
				and/or Other Payments	Full Description of	w		Name and Address of All Other Employment**	Hours	Compensation Received
Name	CCNH	RHINS	(Specify)	(describe fully)	Services Rendered	WOIKEL	Lago 10			
Section III - Administrators***										
					Management of	292	7			
Roessler, Cynthia Christine	13,598				Center					
Aldo Napoletano 10/1/2014-	102 040	700			Management of Center	1,816	2			
8/27/2015	103,77									
Section IV - Assistant										
Administrators									2	
			T							
						,,				

*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include \underline{all} other employment worked during the cost year. *** If more than one Administrator is reported, include dates of employment for each.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

B. Report of Ex	License No.		Report for Y	ear Ended	Page 13	of 37
Tadison House Care and Rehabilitation Center	2201-	C	9/30/2015	1.77	13	- 31
			Total Cost a	nd Hours		
	COMI	Hours	RHNS	Hours	(Specify)	Hours
Item	CCNH	пошь	KIIND	1100	<u> </u>	
B. Direct care consultants paid on a fee						
for service basis in lieu of salary						
(For all such services complete Schedule B1)	716	19				
1. Dietitian	9,774	67				
2. Dentist	6,839	140				
3. Pharmacist	0,837	110				
4. Podiatrist						
5. Physical Therapy	965,321	13,224				
a. Resident Care	905,521	15,22 1				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians	39,348	208				
a. Medical Director (entire facility)	37,540	200				
b. Utilization Review						SE DICTION SOUTH
(Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility 1. Infection Control Committee						
(Quarterly meetings)						
2. Pharmaceutical Committee						
(Quarterly meetings)						
3. Staff Development Committee						
(Once annually)						
e. Other (Specify)						
4 000						
9. Speech Therapist	32,452	41	6			
a. Resident Care	32,					
b. Other						
10. Occupational Therapist	75,252	1,03	1			
a. Resident Care	,					
b. Other						
11. Nurses and aides and attendants						
a. RN						
Direct Care Administrative***						
b. LPN	30,810	72	28			
Direct Care Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	5,18					
B-13 Total Fees Paid in Lieu of Salaries	1,165,699	15,8	32			,

^{*} 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.

^{**} 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

^{***} Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such istrative - costs and notife accordance category for the purposes of rate setting.

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

T of Equility	License No.		Report for Y	ear Ended	Page	of 37
Name of Facility Madison House Care and Rehabilitation Cen			9/30/2015		14	31
Madison House care and a			to Owners,	Evnlo	nation of F	Relationship
Name & Address of Individual	Full Explanation of Service		s, Officers	Expla	пацоп от г	Clanonship
Name & Address of Mary Address		Yes	No	Common Ow	nomhin	
Genesis Eldercare Hospitality Services, 101 East	Dietary Services	•	0	Common Ow	nersmp	•
State Street, Kennett Square, PA 19348				Common Ow	nership	
Genesis Eldercare Rehabilitation Services, 101	Physical, Occupational, and Speech	O .	0	Collinon	Hermi	
East State Street, Kennett Square, PA 19348	Therapy			Common Ow	mership	
Genesis Eldercare Physician Services, 101 East	Medical Director	•	0	Common o		
State Street, Kennett Square, PA 19348				Common Ov	nership	
Genesis Eldercare Staffing Services, 101 East	Nursing Pool	•	0	Common o	1102	
State Street, Kennett Square, PA 19348		-		Common Ov	vnership	
Respiratory Health Services, 515 Fairmount Ave,	Respiratory and Oxygen Supplies	0	0	Common.c.v	Moromp	
6th Floor, Suite 600, Towson, MD 21286						
the Marine		0	0			
		0	0	1		
1.20 - 944		-				
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					_	

^{*} Use additional sheets if necessary.

^{**} Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

C. Expenditures Other Than Salaries	Re	port for Ye	ar Ended	Page	OI
me or racilly		30/2015		15	37
adison House Care and Rehabilitation Center 2201-C					
					(G :C)
Item		Total	CCNH	RHNS	(Specify)
Administrative and General					
D. Joseph & Welfare Benefits			246262		
Employee Health & Wehler Benefits Workmen's Compensation	\$	216,263	216,263		
2. Disability Insurance	\$		22.200		
3. Unemployment Insurance	\$	90,308	90,308		
4. Social Security (F.I.C.A.)	\$	302,104	302,104		-
5. Health Insurance	\$	264,437	264,437		
6. Life Insurance (employees only)					
(not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory)	\$				
(not-owners and not-operators)					
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>)	\$	13,107	13,107		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and	\$				
Profit Sharing Plans for Owners and					
Operators (Discriminatory)*					
Operators (Discriminatory)					
c. Bad Debts*	\$	188,162	188,162		
A accounting and Auditing	\$	3. 30.			
1 (9 since should be fully described on Page /)	\$	13,950	13,950)	
	\$				
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*					
Operators (Specify)	\$	26,171	26,17	1	
g. Office Supplies h. Telephone and Cellular Phones					
h. Telephone and Condian Frontis	\$	34,698			
1. Telephone & Pagers	\$	3,985	3,98	5	
2. Cellular Phones	\$				
i. Appraisal (Specify purpose and					
attach copy)*					
j. Corporation Business Taxes (franchise tax)	- \$				
k. Other Taxes (Not related to property - See Page 22)					
1. Income*	\$		7.2 No. 1	10	_
2. Other (<i>Specify</i>)	\$	1,04	8 1,04	18	
See Attached Schedule				-	
	\$		The second secon		
3. Resident Day User Fee	\$	1,593,06	2 1,593,06	52 btotals forwa	

* Facility should self-disallow the expense on Page 28 of the Cost Report.

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

Madison House Care and Rehabilitation Center 9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description			CCNH		RHNS		(Specify)		
	0	0	\$	-	\$	-			
3005520020	Union Health & Welfare		\$	456	\$	-			
3030520020	Union Health & Welfare		\$	2,714	\$	-			
3225520020	Union Health & Welfare		\$	10,067	\$	-			
5035520020	Union Health & Welfare		\$	64	\$	-			
3030520050	Other-Benefits		\$	(194)	\$	-			
	0	0	\$	-	\$				
	0	0	\$	-	\$	-			
	0	0	\$	-	\$	-			
	0	0	\$	-	\$	-			
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	0	0	\$	<u>-</u>	\$	-			
	0	0	\$	-	\$	-			
	0	0	\$	-	\$	-			
	0	C	\$	-	\$	-			
	0	(\$	-	\$	-			
	0	(\$	-	\$	1			
Total	7		\$	13,107	\$	-	\$ -		

Schedule of Other Taxes

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax	\$ 1,048	8 \$ -	\$ -
	0	0 \$ -	\$ -	\$ -
	0	0 \$ -	\$ -	\$ -
	0	0 \$ -	\$ -	\$ -
Tratal	0	\$ 1,04	8 \$ -	\$ -
Total				

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

Name of Facility	License No.	1	Report for Y	ear Ended	Page	of
Madison House Care and Rehabilitation Center	2201-C	g	9/30/2015		16	37
Tadison House Care and Rondometron Conso						
Item			Total	CCNH	RHNS	(Specify)
	ls Brought Forwar	d:	1,593,062	1,593,062		
1. Travel and Entertainment						
Resident Travel and Entertainment		\$		2000 A		
Holiday Parties for Staff		\$	250	250		
3. Gifts to Staff and Residents		\$				
4 Employee Travel		\$	2,934	2,934		
Education Expenses Related to Seminars a	nd Conventions	\$	413	413		
6. Automobile Expense (not purchase or depr	eciation)	\$				
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)***		\$	9,412	9,412		
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	rice)***					
7. Postage		\$	2,004	2,004		4
* 8. Dues and Membership Fees to Profession	al	\$	8,078	8,078		
Associations (Specify)						
See Attached Schedule						
8a. Dues to Chamber of Commerce & Other Non-	-Allowable Org.***	\$		205		
9. Subscriptions		\$		1,458		1
10. Contributions***		\$	1,246	1,246		
See Attached Schedule						
11. Services Provided by Contract Specify an	d Complete	\$	3,957	3,957		
Schedule C-2, Page 21 for each firm or in	ıdividual)					
12. Administrative Management Services**		\$	-	460,403		-
13. Other (Specify)	Me-	\$	87,771	87,771		
See Attached Schedule						
C-14 Total Administrative & General Expenditure	es	\$	2,171,192	2,171,192		

^{*} Do not include Subscriptions, which should go in item 9.

^{**} Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

^{***} 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 -	\$ -
0 0	\$ -	\$ -	s -
0 0	S -	S -	S -
0 0	\$ -	\$ -	\$ -
0 0) S -	S -	\$ -
0 () S -	\$ -	S -
0 () \$ -	\$ -	\$ -
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description		C	CNH	RE	INS	(Specify)		
020630020	Advertising	\$	1,225	\$		\$	•	
020630020	Advertising	S	385	\$		\$		
020630020	Advertising	\$	1,016	\$	•	\$		
020630330	Marketing Expense	S	1,355	\$	•	\$		
020630330	Marketing Expense	\$	26	S	•	\$		
020630330	Marketing Expense	S	139	\$		\$	-	
020630331	Marketing Exp- Corporate Spend	S	737	\$	_	S		
020630331	Marketing Exp- Corporate Spend	\$	4,530	S	•	\$		
		0 \$		\$	•	\$		
		0 \$		\$	-	\$		
		0 \$		\$	-	\$		
		0 \$		S	•	\$		
		0 \$		\$	•	\$	-	
		0 \$		\$		\$		
		0 \$		\$		\$		
		0 \$	-	S	<u>-</u>	\$		
	0	0 \$		S		\$		
	0	0 \$	÷	S		\$		
	0	0 \$	-	S	-	S		
	0	0 \$	•	\$		8		
	0	0 \$	-	S	•	\$		
	0	0 \$		\$	-	S		
	0	0 \$		\$		\$		
	0	0 \$		\$	-	\$		
	0	0 \$		S		\$		
Total Other	v	s	9,412	\$		S		

Schedule of Dues

Description		CCNH	RHNS	(Specify)
	Licenses and Certification fee	\$ 8,078	S -	\$ -
1020630310	0	\$ -	s -	\$ -
1020630310	0	\$ -	\$ -	\$ -
1020630310	0	\$ -	\$ -	\$ -
0	0	s -	s -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	s -
0	0	\$ -	S -	\$ -

			•	¢ .
0	0	ን	9	· Ψ
	0	% -	\$ -	\$ -
U				
		\$ 8,078	g -	8 -
Total Dues		Φ 0,010		

Schedule of Contributions

Description		CCNH	RHNS	(Specify)
Description 1020630135	Political Contributions	\$ 1,246	\$ -	s -
0	0	\$ -	\$ -	\$ -
C	0	\$ -	\$ -	8 -
Total Contrib	rtions	\$ 1,246	3 -	φ

Schedule of Other Administrative and General

Description			CNH	RHNS	(Specify)		
020630060	Bank Service Charges	\$	6,015	\$ -	\$		
020630120	Collection Fees	\$	43,337	self-disallowed	\$		
020630120	Collection Fees	\$	23	self-disallowed	\$		
020630120	Collection Fees	\$	66	self-disallowed	\$		
020630140	Education Expense	\$	112	s -	\$		
020630140	Education Expense	\$	39	\$ -	\$		
020630180	Employee Physicals	\$	10,318	\$ -	\$	*	
020630200	Employee Relations	\$	1,086	\$ -	\$		
1020630200	Employee Relations	\$	212	\$ -	\$		
1020630200	Employee Relations	8	50	\$ -	S	*	
1020630380	Printing	\$	18	\$ -	\$		
1020630380	Printing	\$	21	\$ -	\$		
1020630380	Printing	S	154	\$ -	\$		
1020630610	Training Expense	\$	87	\$ -	\$		
1020630610	Training Expense	\$	84	\$ -	\$		
1020630610	Training Expense	- \$	652	\$ -	\$		
1020630640	Uniforms	8	215	\$ -	S		
1020640080	Fines & Penalties	\$	10,155	self-disallowed			
1020640090	Miscellaneous	\$	235	\$ -	\$		
1020640090	Miscellaneous	\$	(1		S	8	
1020660990	Accrued Expense Estimation	\$	4,220		\$		
5095720020	Cap Stk/Franchise Tax	\$	1,151		S		
5095720090	Landlord Operating Taxes	\$	2,400	OF THE RESIDENCE OF THE PROPERTY.	\$		
1020630120	Collection Fees	\$	7,121				
	0	0 \$	-	\$ -	S		
	0	0 \$	<u>.</u>	\$ -	\$		
	0	0 \$		\$ -	\$		
	0	0 \$	-	S -	\$		
	0	0 \$	-	\$ -	\$		
	0	0 \$		\$ -	\$		
	0	0 \$		\$ -	\$		
	0	0 \$		S -	\$		
	0	0 \$	•	\$ -	S		
	0	0 \$		\$ -	5	8	
	0	0 \$	-	\$ -	\$		
	0	0 \$	-	S -	\$	8	
Trees Other	Administrative and General	\$	87,77	1 \$ -	\$		

State of Connecticut Annual Report of Long-Term Care Facility CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility		Report for Year Ended	Page of 17 37
Madison House Care and Rehabilitation C	2201-C	9/30/2015	17 37
Name & Address of Individual or Company Supplying Service Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	Cost of Management Service 387,911	Full Description of Mgmt. Service Provided Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	Indicate Where Costs are Included in Annual Report Page #/Line # pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	38,838	Capital Interest	pg 26 12-A-1

^{*} 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

S. Expenditures State			Page 5)		77 D. 1-1	Page of
ame of Facility	L	icense	2000000000	Report for 9/30/20	Year Ended	Page of 18 37
adison House Care and Rehabilitation Center		2	201-C	9/30/20	13	10 0
Item			Total	CCNH	RHNS	(Specify)
Dietary						
a. In-House Preparation & Service		_		100.5	0.5	
1. Raw Food	200	\$	138,595	138,5		
2. Non-Food Supplies		\$	14,254	14,2		
3. Other (Specify)		\$	(1,522)	(1,5	022)	
b. Purchased Services (by contract other		\$				
than through Management Services)						
(Complete Schedule C-2 att. Page 21)						
c. Management Services**		\$ \$				
d. Other (Specify)		Þ				
E_{total} E_{\text			151,327	151,	327	
2E. Total Dietary Expenditures $(2a+b+c+d)$	_		1			
			Total	CCN	H RHNS	(Specify)
2F. Dietary Questionnaire	r day	*				
G. Resident Meals: Total no. of meals served pe		Yes	0	No		
H. Is cost of employee meals included in 2E?		1 65			If yes, specify	I
I. Did you receive revenue from employees?		Yes) No	amt.	
J. Where is the revenue received reported in the	e Cos	t Repo	ort? (Page/Lin	e Item)		
Is cost of meals provided to persons other					If yes, specify	y
K. than employees or residents (i.e., Board	0	Yes	•) No	cost.	
Members, Guests) included in 2E?					If you one oif	iv.
	0	Yes	() No	If yes, specif	у
L. Is any revenue collected from these people?				Tr. N	aint.	
M. Where is the revenue received reported in the	e Co	st Repo	ort? (Page/Lin	ie Item)		
Is cost of food (other than meals, e.g., snacks N. at monthly staff meetings, board meetings)	0	Yes	(O No	If yes, specif cost.	ŷ
provided to employees included in 2E?						<u> </u>
O. Is any revenue collected from employees?	0	Yes	(O No	If yes, specif amt.	
P. Where is the revenue received reported in the	ne Co	st Rep	ort? (Page/Li	ne Item)		
P. Where is the revenue received reported in the					1000	en

^{*} Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

^{**} 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)

ame of Facility Iadison House Care and Rehabilitation Center	L	icense 22	No. :01-C		port for Y (/30/2015	ear Ended	Page 19		of 37
ladison House Care and Rehabilitation Center		Ŧ		T					
Item			Total		CCNH	RHNS	(5	Speci	fy)
 Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, 		Lbs.							
gowns and other resident care items washed, ironed, and/or processed.***	Ā	Amt. \$	3,574	1	3,574				-
 Employee items including uniforms, gowns, etc. washed, ironed and/or 	-	Lbs.							
processed.***	1	Amt. \$		_					
3. Personal clothing of residents	-	Lbs.		-					
washed, ironed, and/or processed.***	_	Amt. \$	-	-				-	
4. Repair and/or purchase of linens.***	-	Lbs.		_					
		Amt. \$		_	22,255			11	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	131,72	.0	131,720				
c. Management Services**		\$							
d. Other (Specify)		\$							
3E. Total Laundry Expenditures $(3a+b+c+d)$		\$	157,54	19	157,549				
3F. Laundry Questionnaire						TC			
G. Is cost of employee laundry included in 3E?	0	Yes	(O N	lo	If yes, specify cost			
H. Did you receive revenue from employees?		Yes		9 N		If yes, specify amt.		4 45	
I. Where is the revenue received reported in the 0	Cost	Repor	<u>t?</u>		(Page/Lin				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		Yes		9 N	No .	If yes, specify cost	•		
K. Did you receive revenue from these people?	8	Yes		0 I	724009-0-0	If yes, specify amt	•		
L. Where is the revenue received reported in the	Cost	Repor	t?		(Page/Lin	e Item)		1,500	

^{*} 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.

^{**} Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

^{***} 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)

	License No. F	Repor		ded	Page	of 37
Madison House Care and Rehabilitation Center	2201-C		9/30/2015	32	20	31
2				CONIT	RHNS	(Specify)
Item		_	Total	CCNH	MINS	(Specify)
Housekeeping	Sq. Ft. Serviced			1		
a. In-House Care	by Personnel	_	10.051	12.251		
 Supplies - Cleaning (Mops, 	Amt.	\$	12,351	12,351		
pails, brooms, etc.)						
b. Purchased Services (by contract other	Sq. Ft. Serviced	1				
than through Management Services)	by Personnel			106.021		
(Complete Schedule C-2 att.	Amt.	\$	196,931	196,931		
Page 21)						
c. Management Services*		\$				
d. Other (Specify)		\$				
COLOR TO COMMENT SHARE SEC			200.202	200.202		
4E. Total Housekeeping Expenditures (4a+	b+c+d	\$	209,282	209,282		
5. Resident Care (Supplies)**						
a. Prescription Drugs***	•	2				
1. Own Pharmacy		\$		206.070		+
2. Purchased from		\$	386,879	386,879		
				00.220		
 b. Medicine Cabinet Drugs 		\$	22,338	22,338		+
c. Medical and Therapeutic Supplies		\$	126,212	126,212		
d. Ambulance/Limousine***		\$	12,478	12,478		
e. Oxygen						
1. For Emergency Use		\$		12.417		
2. Other***		\$		13,417		
f. X-rays and Related Radiological		\$	11,990	11,990		
Procedures***						
g. Dental (Not dentists who should be in	cluded under	\$				
salaries or fees)				27.002		
h. Laboratory***		9		37,692		
i. Recreation		9				-
i. Other (Specify)****		9	89,379	89,379		
See Attached Schedule		×.		701.005		
5K. Total Resident Care Expenditures (5a-	- 5j)	9	721,005	721,005		

^{*} Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

^{**} Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

^{***} Facility should self-disallow the expense on Page 29 of the Cost Report.

^{****} ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description		CCNH	RHNS	(Specify)
Description 3060610160	Incontinency	\$ 39,850.03	\$ -	\$ -
3060610161	Incontinency - Rebates	\$ (2,310.99)	\$ -	\$ -
3080630030	Advertising-Help War	\$ 1,385.44	\$ -	\$ -
3080630030	Advertising-Help War	\$ 784.54	\$ -	\$ -
3080630080	Books, Dues & Subsc	\$ 96.90	\$ -	\$ -
3080630140	Education Expense	\$ 425,97	\$ -	\$ -
3080630140	Education Expense	\$ 151.08	\$ -	\$ -
3080630140	Education Expense	\$ 590.37		\$ -
3080630310	Licenses & Certificati	***************************************	\$ -	\$ -
3120630530	Supplies	\$ 330.33	\$ -	\$ -
3155630530	Supplies	\$ 5,406.90	c 1000000000000000000000000000000000000	\$ -
3155630530	Supplies	\$ 10,401.46		\$ -
3090630535	Office Supplies	\$ 484.30		\$ -
3165630535	Office Supplies	\$ 47,00		\$ -
3165630550	T&E-Lodging/Transp			\$ -
3120660080	Rental Expense	\$ 43.61	\$ -	\$ -
3155660080	Rental Expense	\$ (138.32		\$ -
3155660080	Rental Expense	\$ 10,858.04		\$ -
3010610300	Consolidated Billing	\$ 20,354.63		\$ -
Total Other Resident Care		\$ 89,379	\$ -	\$ -

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

Name of Facility	obilitation Center			License No. 2201-C	Report for Year Ended 9/30/2015			æ	Page of 21 37	4 5
Madison House Care and redamination Care	domination contra									
		Related ** to Owners,	Officers				Fotal Cost/	Total Cost/Page Ref.**	-	-
		Operators					6)			
Name of Individual or	Address	Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHINS	(Specify)	Pg Li	Line
Condimo.	Drive, Bensalem, PA	С	•	Vendor Contracted	Laundry Purchased Services	131,720			19 35	
Healthcare Services Group	Drive, Bensalem, PA	С	• •	Vendor Contracted	Housekeeping Purchased Services	196,931			20 4b	
Healthcare Services Group	17020	0 0	C							_
		0	0							
		0	0							T
		С	C							
)) (
		0	0							T
4		0	0							
		0	0							T
		0	0	•						
		0	0							
		0	0							
		С	0							
) .	3: 7: 1:	-						

^{*} List all contracted services over \$10,000. Use additional sheets if necessary. ** Refer to Page 4 for definition of related.

^{***} 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 Ye	ear Ended		Page 22	of 37
Madison House Care and Rehabilitation Cente 2201-C		9/30/2015			1 22	31
Item		Total	CCNH	RHNS	(S ₁	pecify)
6. Maintenance & Operation of Plant	1					
a. Repairs & Maintenance	\$	254,599	254,599			
b. Heat	\$	71,488	71,488			
c. Light & Power	\$	169,371	169,371			
d. Water	\$	68,159	68,159			
e. Equipment Lease (Provide detail on page 6)	\$					
f. Other (itemize)	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	563,616	563,616			
7. Depreciation (complete schedule page 23*)					Į.	
a. Land Improvements	\$	426	426			
b. Building & Building Improvements	\$	25,913	25,913			
c. Non-Movable Equipment	\$	24,468	24,468			
d. Movable Equipment	\$	12,119	12,119			
*7e. Total Depreciation Costs (7a+b+c+d)	\$	62,925	62,925			
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	\$	1,113,903	1,113,903			
10. Property Taxes			98			
a. Real estate taxes paid by owner	\$	3				
b. Real estate taxes paid by lessor	\$	157,118	157,118			
c. Personal property taxes	\$	3				
11. <i>Total Property Expenses</i> (7e + 8e + 9 + 10)	\$	1,333,946	1,333,946			

^{*} 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

	Deprec	Depreciation Schedule	nedule) - 100 	
Nome of Booility	License No.			Report for Year Ended	nded		Page	ot 22
Madison House Care and Rehabilitation Center	2201-C	ပု		9/30/2015			73	3/
AMMANDUM AND SIGN OF S	Historical			Accumulated	;			
	Cost Exclusive of	Less	Cost to Be	Depreciation to Beginning of	Method of Computing	Useful	Depreciation	
Property Item	Land	Value	Depreciated	Year's Operations	1	Life	for This Year	Totals
A. Land Improvements	2 141		3 141	393	S/L	Varions	314	
1. Acquired prior to this report period	7,141							
2. Disposals (attach schedule)	000		6 600				112	
 Acquired during this report period (attach schedule) 	6,699		0,099					426
4.								
B. Building and Building Improvements 1. Aconired prior to this report period	282,692		282,692	43,075	S/L	Various	24,662	
2 Disposals (attach schedule)								
3 Acomined during this report period (attach schedule)	125,012		125,012				1,250	25.012
B-4 Subtotal								23,913
C. Non-Movable Equipment			The state of the s				27.110	
	220,482		220,482	41,354	S/L	Various	74,110	
2. Disposals (attach schedule)							250	
3. Acquired during this report period (attach schedule)	7,323		7,323				000	24 468
								6
Is a mileage logbook Date of maintained? Acquisition	Historical Cost	Less		Accumulated Depreciation to	Method of			
>	EXC	Salvage Value	Cost to Be Depreciated	Beginning of Year's Operations	Computing Depreciation	Useful 1 Life	Depreciation for This Year	Totals
1. Motor Vehicles (Specify name, model								
and year of each vehicle)					S/L	Various		
b.								
ď								
d.								
2. Movable Equipment			03040	37.726	27	Varions	11.972	
a. Acquired prior to this report period	84,060		84,000			1 morns		
b. Disposals (attach schedule)								
c. Acquired during this report period	,		1 002				147	
(attach schedule)	1,923		1,925					12,119
D-3. Subtotal								62,925
E. Total Depreciation								

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
7/31/2015	Braun Gear Box for mixer/sewer	\$ 6,698.98	10	\$ 111.65
Fotal additions for	Land Improvements	\$ 6,698.98		\$ 111.65
Deletions:				
Total deletions for	1 Land Improvements	\$ -		\$ -

^{*}Ties to Page 23, Line A3

Schedule of Building Improvements Acquired during this report period

	g Improvements Acquired during th	RV. 153-5		Useful	~	
Acquisition Date	Description of Item		Cost	Life	De	preciation
Additions:					*******	····
3/31/2015	Sprinkler repairs due to frozen pipes	S	11,996.28	20	\$	299.91
3/31/2015	Sprinkler repairs due to frozen pipes	\$	5,573.80	20	\$	139.35
3/31/2015	Repiped 8 sprinklers in front lobby	\$	2,765.10	20	-	69.13
4/30/2015	8 auxiliary drains on attic dry sprinkler	S	10,682.86	20		222.56
	Repair cooling system on generator	S	9,180.66	20	2000000	191,26
4/30/2015	2 hp compressor and dry pendant sprit	S	3,197.94	20		66.62
6/30/2015	Replace radiator core on generator	S	9,763.64	20	-	122.05
	Daikin WSHP	S	13,824.44	20		115.20
	New Watts 909-OS&Y backflow prev	\$	2,898,63	20		24.16
9/30/2015	Final install on backflow preventor	\$	2,893.63		S	-
9/30/2015	Sep Accruals	S	52,235.00	20	\$	•
Total additions for	Building Improvements	\$	125,012		S	1,250
Deletions:						
	0	\$		0	\$	
(0	s		0	\$	
(S		0	S	_
		s			s	
(P.4-1.4-1-41	Building Improvements	S			S	
Total deferious for	Dallating Furbrosements			***************************************		

^{*}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:				
3/31/2015	3 Daikin applied water source heat pur	\$ 6,992.51	10	\$ 349.63
	Sep Accruals	\$ 330,88	10	\$ -
Total additions for	Non-Movable Equipment	\$ 7,32 3		\$ 350
Deletions:				
Total deletions for	 Non-Movable Equipment	S -		\$ -

^{*}Ties to Page 23, Line C3

^{**}Ties to Page 23, Line A2

^{**}Ties to Page 23, Line B2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
3/31/2015	Tracer EX2 Wheelchair, Stock,	\$ 130.98	10	000000000000000000000000000000000000000
	Tracer IV Wheelchair w/Swingaw	\$ 353.98	10	\$ 17.70
	Tracer EX2 Wheelchair, Stock,	\$ 247.96	10	\$ 12,40
	Direct Choice Overbed Table	s 147.15	10	\$ 6.13
	Yard Machines 30" Two Stage	\$ 1,043.21	5	\$ 104,32
DIDALESTS.				
Total additions for	Movable Equipment	\$ 1,923		\$ 147
Deletions:				
(0	\$ -		\$ -
(0	s -	() S -
	0	s -	(\$ -
· · · · · · · · · · · · · · · · · · ·		s -	() S -
	Movable Equipment	\$ -		\$ -

^{*}Ties to Page 23, Line D2c

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
				s -
otal additions for Lea	asehold Improvement	S -		•
eletions:				
			+	
			+	
				en en
Cotal deletions for Le	asehold Improvement	\$ -		\$.

^{*}Ties to Page 24, Line C3

^{**}Ties to Page 23, Line D2b

^{**}Ties to Page 24, Line C2

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Amortization Schedule*

Nan	Name of Facility		License No. 2201-C	γ	Report for Year Ended 9/30/2015	r Ended		Page 24	of 37
Ma	Madison House Care and Rehabilitation Center				Accumulated				
		Date of			Amort. to Reginning of	Basis for			
		Acquisinon	I enoth of	Cost to Be	Year's	Computing	Rate	Rate Amortization	
	Item	Month Year	Æ	Amortized	Operations	Amortization**	%	for This Year	Totals
Ą.	Organization Expense								
	1.								
	2.								
	3.								
A-4.	1. Subtotal								
B.	Mortgage Expense								
	1.								
	2.								
	3.								
B-4.	4. Subtotal								
ت									
	1. Acquired prior to this report period								
	2. Disposals (attach schedule)								
	3. Acquired during this report period								
	(attach schedule)								
C-4	4. Subtotal								
D.	Total Amortization								
]	* Straight-line method mist 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.

State of Connecticut

Annual Report of Long-Term Care Facility

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

Name of Facility Madison House Care and Rehabilitatio	License No. 2201-	1	Report for Year End 9/30/2015	ed		Page 25	of 37
11. Property Questionnaire							
Part A	o Facility			0.3		If "Yes," compl	ete Part B.
Is the property either owned by th	e raciiity	0	Yes	⊙]	NO	If "No," comple	ete Part C.
or leased from a Related Party?*	1.4.11	haa famailee e	morriage ovenershin ah	ility to control or			
*If any owner or operator of this fa business association to any person	cility is related	from whom	huildings are leased, th	en it is considered	a		
business association to any person	or organization	Hom whom	, bundangs ,				
related party transaction. Description			Total				
Date Land Purchased Date Land Purchased							
2. Date Structure Completed	of Durchage						
3. If NOT Original Owner, Date	OI Fuichase						
4. Date of Initial Licensure			90				
Total Licensed Bed Capacity							
6. Square Footage							
Acquisition Cost							
a. Land							
b. Building				0.136 (2nd Mortgogo	e 4th Mor	taaae
Part B - Owner and Related Pa	rties		1st Mortgage	2nd Mortgage	310 Mortgage	5 4H IVIOI	igugo
1. Financing		20					
a. Type of Financing (e.g.,	ixed, variable	e)					
b. Date Mortgage Obtained							
c. Interest Rate for the Cost	Year						
d. Term of Mortgage (numb							***
e. Amount of Principal Bor	rowed						
f. Principal balance outstan	ding as of						******************
Complete if Mortgage was							
During Current Cost Y	ear						
g. Type of Financing (e.g.,	fixed variable	e)					
	naou, vuruor	<u> </u>					
h. Date of Refinancing i. New Interest Rate							
	or of ware)						
j. Term of Mortgage (num	oci oi years)						
k. Amount of Principal Bor	Note Poid O	ff					
Principal Outstanding or	1 Note Paid-O	Desays autor	Improvements Onl	v			
Part C - Arms-Length Lea	ses for Real	Property	Improvements On	Date of Lease	Term of Lea	se Annual Amo	unt of Leas
Name and Address of Less	or		operty Leased	11/15/10 - 6/3		THIRD THE	1,113,90
SABRA, 101 Sun Ave. NE, Albuque	rque, NM	Facility L	ease	11/13/10 - 0/3	d127 mondis		-,,
87107							
					1		
					-		

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 Year	r Ended		Page	of
Madison House Care and Rehabilitatio 2201-C		9/30/2015			26	37
Item		Total	CCNH	RHNS	(Sp	ecify)
 Interest A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage 	\$	38,838	38,838			
Name of Lender	Rate					
Address of Lender						
2. Second Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage	\$	8				
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage	(6				
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information			4			
1. Original Loan Amount		\$	4			
2. Loan Origination Date			_			
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$ 38,838	38,838			

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

ame of Facility License N			Report for Yo 9/30/2015	ear Ended		Page of 27 37
ladison House Care and Rehabilita 220	1-C		7/20/2020			
T - 000000			Total	CCNH	RHNS	(Specify)
Item	totala Prov	ight Forward		38,838		
	iotais Dioc	ight i orward.	00,000			
2. C. Movable Equipment		\$				
1. Automotive Equipment	Rate	Amount				
A. Item	Rate					
ender						
Address of Lender						
2. Other (Specify)		9	3			
A. Item	Rate	Amount				
Lender						
School						
Address of Lender						
	Rate	Amount	\dashv			
B. Item	Rate	Timount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Into	erest					
Expense $(C1 + 2)$			\$			
12. D. Other Interest Expense (Specify)			\$			
	A.					
13. Total All Interest Expense (12B7 + 1	2C3 + 12I	O)	\$ 38,83	38,838		
14 Ingurance			01.40	21 407		
a. Insurance on Property (buildings	only)		\$ 21,49	7 21,497		
b Insurance on Automobiles		1	\$			
c. Insurance other than Property (as	specified	above)	\$ 103,54	6 103,546		1
1. Umbrella (Blanket Coverage)		\$ 103,54 \$	103,340		
2. Fire and Extended Coverage			\$			
3. Other (Specify)			φ			
14d. Total Insurance Expenditures (14a	± h ± a)		\$ 125,04	3 125,043		
11 A.1 Total Incurance Evnenditures [140]	TUTU		\$ 10,757,59			

D. Adjustments to Statement of Expenditures

ame	of Fa	cility	1 I Dehabilitation Center	Lic	ense No. 2201-C	Report for Yea 9/30/2015	r Ended	Page of 28 37
ladis	son Ho	ouse C	are and Rehabilitation Center	┰	Total			
				- 1	Amount of	1		
	Page		T. D. Lulius	1	Decrease	CCNH	RHNS	(Specify)
No.	No.	No.	Item Description	-	Decrease	CCIVII		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
age	10 - S	alarie	es and Wages	6				
1.			Outpatient Service Costs	\$ \$				
2.			Salaries not related to Resident Care					
3.			Occupational Therapy	\$	102.050	182,059		
4.	-		Other - See attached Schedule	\$	182,059	162,039		
Page	13 - 1	Profes	sional Fees					
5.	13	В-8-с	Resident Care Physicians **	\$			_	
6.		B-10	Occupational Therapy	\$	1 2 2 2 1 4 2	1.077.447		
7.			Other - See attached Schedule	\$	1,077,447	1,077,447		
Page	s 15 d	£ 16 -	Administrative and General					
8.			Discriminatory Benefits	\$		100 1 50		
9.	_	1-c	Bad Debts	\$		188,162		
10.	_		Accounting & Legal	\$				
11.	_	-	Telephone	\$				
12.	_	_	Cellular Telephone	\$				
13.	_	-	Life insurance premiums on the life					
13	1		of Owners, Partners, Operators	\$				
14	-	-	Gifts, flowers and coffee shops	\$				
15	_	-	Education expenditures to colleges or					
13	•		universities for tuition and related costs					
			for owners and employees	\$	3			
10		-	Travel for purposes of attending					
16			conferences or seminars outside the					
			continental U.S. Other out-of-state					
			travel in excess of one representative	5	S			
1.5		4	Automobile Expense (e.g. personal use)		B			
17	<u>'. </u>		& Unallowable Advertising *		9,41	2 9,412		
18		m-2	Income Tax / Corporate Business Tax		\$			
19		_	Fund Raising / Contributions		\$ 1,24	6 1,246		
20	-	-	Unallowable Management Fees	_	\$ 499,24	- 1 2 2 2		
21	_	-			\$			
22			Barber and Beauty Other - See attached Schedule		\$ 71,72	8 71,728		
23					Ψ 7237=	,		
-		- Dieta	ary Expenditures		+			
24	4.		Meals to employees, guests and others		\$			
			who are not residents		φ			
Pag	ge 19 .	- Laur	ndry Expenditures		+			
2	5.		Laundry services to employees, guests		6			
			and others who are not residents		\$			
Pa	ge 20	- Hou	sekeeping Expenditures					
_	6.		Housekeeping services to employees, gues	sts				
			and others who are not residents		\$ 2000.00	2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	-	
-			Subtotal (Items 1 - 2	26)	\$ 2,029,29	95 2,029,295 (Carry Subtotal)		

^{*} All except "Help Wanted".

^{**} 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

D. C. T.L. Dof		Description	CCNH	RHNS	(Specify)
age Ref Line Ref	Administrator's salary disallowed		0 \$ 36,959.00	S -	\$ -
			0 \$ 145,099.64	s -	\$ -
	Child Care Wages		0 \$ -	\$	s -
10 A-12d	unallowed C.N.A no license period	s	0 \$ -	\$ -	S -
0 0	9		0.8 -	\$ -	\$ -
0 0	0	 	0.8 -	S -	s -
0 0	1 9	-	0.5 -	s -	\$ -
0 () (1	\$ 182,059	s -	\$ -

Schedule of Fees Adjustments

~ c	T . D.C		Description	CCNH	RHNS	(Specify)
		Rehabilitation Services	3120620020	\$ 87,888,55	\$ -	S -
13		Rehabilitation Services	3195620020	\$ 877,431.99	\$	\$ -
13	200000000000000000000000000000000000000	Speech Therapist	3170620020	\$ 32,452.03	\$ -	\$ -
13	***************************************	Occupational Therapist	3105620020	\$ 75,252.46	\$ -	\$ -
13			3010620020	\$ (0.02)	\$	\$ -
13		Other	3015620020	\$ -	\$ -	\$ -
13		Other Respiratory Purchased Servies	3155620020	\$ 4,422.45	\$ -	\$ -
13	12	Respiratory r trenased our red				
	 					
	er Fees Ad			\$ 1,077,447	\$ -	\$.

Schedule of Other A&G Adjustments

	* . n.e		Description	CCNH	RHNS	(Specify)
age Ref	Ref Line Ref 16 m-13 Collection Fees 16 m-8a Chamber of Commerce 16 m-13 Estimated Accrual 16 m-12 Management Fee disall 16 m-13 Non-recurring Charges 16 m-13 Penalty and Fines 15 1a3 Child Care SUTA 15 1a4 Child Care; FICA 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Calladian Voor	1020630120	\$ 50,548.12	\$ -	\$ -
		6-22-00-00-00-00-00-00-00-00-00-00-00-00-	1020630310	\$ 205.00	\$ -	\$ -
			1020660990	\$ 4,219.71	\$ -	\$ -
			CBO service Fee	\$ -	\$ -	\$ -
			7010800030	\$ -	\$ -	\$ -
			1020640080	\$ 10,155.00	\$ -	\$ -
	***************		Child Care; SUTA	\$ 1,518.91	s -	\$ -
			Child Care; FICA	\$ 5,081.14	\$ -	\$ -
		Cliffd Care, Freez		\$ -	\$ -	S -
U			0 0	\$ -	\$ -	\$ -
0	V.		0 0	\$ -	\$ -	\$ -
0			0 0	\$ -	\$ -	S -
U		1	0 0	\$ -	\$ -	S -
104	A P (* A	ljustments		\$ 71,728	\$ -	\$ -

State of Connecticut

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

			D. Adjustments to Statemen	at (of Expend	itures (co	nt'd)	-	
Jame	of Fa	cility		Lic	ense No.	Report for Y	ear Ended	Page	of
Madie	on H	onice C	are and Rehabilitation Center		2201-C	9/30/2015		29	37
Viaux	3011 110	Juse			Total				
tom	Page	Line			Amount of				1010 811
No.	No.		Item Description		Decrease	CCNH	RHNS	(S ₁	ecify)
INO.	140.	140.	Subtotals Brought Forward	\$	2,029,295	2,029,295			The service of
Daga	20 - 1	Posido	nt Care Supplies***					- A	
27.	20-1	5-2-2	Prescription Drugs	\$	386,879	386,879			
28.		5-d	Ambulance/Limousine	\$	12,478	12,478			
29.			X-rays, etc	\$	11,990	11,990			
30.			Laboratory	\$	37,692	37,692			
31.	20		Medical Supplies	\$					
32.	20		Oxygen (non emergency)	\$	13,417	13,417	25		
33.	20	3-6-2	Occupational Therapy	\$					
34.			Other - See Attached Schedule	\$		58,679			
34.	22	Maint	enance and Property						
	22-1	Laini	Excess Movable Equipment Depreciation						
35.			See Attached Schedule	\$					
26		-	Depreciation on Unallowable	100					
36.			Motor Vehicles	\$					
27		-	Unallowable Property and Real						
37	•		Estate Taxes	\$					
20		-	Rental of Building Space or Rooms	9					
38			Other - See Attached Schedule			5,197			
39		<u> </u>							
		Insur	ance	5	8				
40	_	+	Mortgage Insurance		8				
41			Property Insurance						
_		iscella	ineous	-	\$				
42		_	Research or Experimental Activities		\$			1	
43			Radio and Television Revenue		\$				
44	_	_	Vending Machine Revenue		\$				
45			Purchase Discounts and Allowances		\$				
46	ó.		Duplications of functions or services		φ.				
47	7.		Expenditures made for the protection,						
			enhancement or promotion of the		\$	one has a second with the	_		A
			providers interest	_	\$				
48			Interest Income on Accounts Rec		Φ				
49	9.		Other (include personnel and other						
			costs unrelated to resident care) - See		\$ 97,62	5 97,625	AN INCLUSION AND A STATE OF THE PARTY OF THE	District Control of the Control	THE RESERVE
			Attached Schedule		\$ 91,02	77,023			
		Profit	Providers Only	-					
- 50	0.		Building/Non Movable Eq. Depreciation						
			Unallowable Building Interest -		¢			Lyse Mawalan	SAV SAME AND ADDRESS.
1			See Attached Schedule		\$ 2,653,25	3 2,653,253	3	_	
5	1. Tot	al Am	ount of Decrease (Items 1 - 50)		\$ 2,653,25	3 4,033,233	1		

^{***} 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.

Lighthouse Nursing Care Center Summary of Proposed FYE June 30, 2016 Budget Changes

DSCR Requirement Summary: 10/31/2015 11/30/2015 Proforma* 543,661 512,807 722,601 Required Margin Through 1.25 DSCR. 10/31/2015 11/30/2015 708,083 Required Margin to achieve 1.25 DSCR: 1.08,083 708,083 1.08,783 108,783							
ortunities below.							To the second se
Proposed Operational Opportunities:	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	otal
Additional Revenue 1) 1 Additional Medicaid ADC over budgeted levels @ \$197 ppd less Bed Tax Room & Board - Medicaid	6,107	5,713	6,107	5,910	6,107	5,910 (552)	35,854 (3,351)
- CLess> User / Bed Tax - State Net Change	5,536	5,179	5,536	5,358	5,536	5,358	32,503
Expense Reductions 2) Nursing Staffing Adjustments per week eff 2/1/16: (Excludes Empl Taxes & Benefits) L.P.N		34.5					
CNA		(20,681)	(22,108)	(21,394)	(22,108)	(21,394)	(107,685)
3) Eliminated Admissions Screener Position (Connie Sullivan). Service to be provided by Genesis (Excludes Empl Taxes & Benefits) Departmental Support Staff (24 Hrs/week @ \$40/hour budgeted, has been working 40 Hrs/wk)	(3,840)	(3,840)	(3,840)	(3,840)	(3,840)	(3,840)	(23,040)
4) Eliminated Director of Professional Development (Nancy Lattin), less 3 mos severance. (Excludes Empl Taxes & Benefits) Departmental Support Staff	0	0	0	(6,923)	(6,923)	(6,923)	(20,769)
5) Raw Food savings due to pricing and possible menu changes due to be implemented within 90 days (\$1 ppd savings) Food, Raw:Diet	/s (\$1 ppd sav 0	ings) 0	0	(3,510)	(3,627)	(3,510)	(10,647)
6) Payroll Tax savings from Salary changes above at: 10% Payroll Tax	(384)	(2,452)	(2,595)	(3,216)	(3,287)	(3,216)	(15,149)
7) Computer/Software Maintenance expense reduction? Computer/Software Maintenance	0	0	0	0	0	0	0
8) Consultant Fees reductions? Consultant/Professional Services	0	0	0	0	0	0	0
9) Supplies pricing/formulary expense reductions? Supplies - Departmental	0	0	0	0	0	0	0
10) Other opportunities	0	0	0	0	0	0	0
Grand Total of Operational Improvements:	9,760	32,152	34,079	44,241	45,321	44,241	209,794

Madison House Care and Rehabilitation Center 9/30/2015

Schedule of Other Ancillary Costs

n.c	n	CCNH	RHNS	(Specify)
		\$ 20,354.63	3010610300	\$ -
				\$ -
				S -
5-j	Respiratory Rental			allow \$3600
5-i	Cable TV	\$ 11,730.23	6	8 -
0-Jan		0 \$ -	Ф -	φ r
0-Jan		0 \$ -	3 -	Φ 7
		0 \$ -	\$ -	ъ -
		0 \$ -	\$ -	\$ -
		0 \$ -	\$ -	\$ -
		0 \$ -	\$ -	\$ -
	1	\$ 58,679	\$ -	\$ -
	5-j 5-j 5-j 5-i 0-Jan 0-Jan 0-Jan 0-Jan 0-Jan 0-Jan 0-Jan 0-Jan 0-Jan	5-j Respiratory Supplies 5-j Respiratory Rental	Line Ref Description \$ 20,354.63 5-j Consolidated Billing \$ 15,808.36 5-j Respiratory Supplies \$ 10,719.72 5-j Respiratory Rental \$ 11,796.25 5-j Cable TV 0 \$ - 0-Jan 0 \$ -	Line Ref Description \$ 20,354.63 3010610300 5-j Consolidated Billing \$ 15,808.36 3155630530 5-j Respiratory Supplies \$ 10,719.72 3155660080 5-j Respiratory Rental \$ 11,796.25 3005660130 5-i Cable TV 0 \$ - \$ - 0-Jan 0 \$ - \$ -

Schedule of Excess Movable Equipment Depreciation

~ ~ 6	T D . C	Description	CCNH	RHNS	(Specify)
'age Kei	Line Kei	Description			
				<u> </u>	-
			œ .	ς -	S -
Total Exc	ess Movab	le Equipment Depreciation	Φ	· · · · · · · · · · · · · · · · · · ·	60 Accessor

Schedule of Other Property Adjustments

	~. n.c	Description	CCNH	RHNS	(Specify)
	10.000.000.0000.0000.0000.0000	Description	1202.367847	0	
22		Adult day care -heat	2848.673003	0	
22	6c	Adult day care -electricity	1146.368376	0	
22	6d	Adult day care -water	0 0	0	
0	0-Jan		0 0	0	
0	0-Jan		0 0	0	
0	0-Jan		0 0	- 0	
0	0-Jan		0 0	ę .	ς -
0	0-Jan		0 8	φ	ς -
0	0-Jan		9 5.197	g _	s -

Dof	Line Dof	Description	CCNH	RHNS	(Specify)
Avenue de la company de la com	Lille Kei	General liability Insurance Adjust	97625.24906	0	
21			0 0	0	
0	0-Jan		0 0	0	
0	0-Jan		0 0	0	
0	0-Jan		0 0	0	
0	0-Jan		0 0	0	
0	0-Jan		0 0	0	o o
0	0-Jan		0 \$ -	Э -	φ <u> </u>
0	0-Jan		0 \$ -	S -	ቅ
0	0-Jan		0 \$ -	S -	S -
n.	0-Jan		0 \$ -	\$ -	\$ -
104	er Adjustm		\$ 97,625	\$ -	\$ -

Schedule of Unallowable Building Interest

- n-c	Li. Def Description	CCNH	RHNS	(Specify)
ge Rei	Line Ref Description	0 \$ -	\$ -	S -
U	0-Jan	0 8 -	S -	\$ -
0	0-Jan	0.8 -	\$ -	\$ -
0	0-Jan	0 2 -	\$ -	s -
0	0-Jan	0 0	e _	¢ .
0	0-Jan	U 5 +	φ	s -
0	0-Jan	0 \$ -	3 -	9
0	0-Jan	0 \$ -	5 -	3
0	0-Jan	0 \$ -	\$ -	5 -
n	0-Jan	0 \$ -	\$ -	S -
0	0-Jan	0 \$ -	\$ -	S -
2 1 Tie al	lowable Building Interest	\$ -	S -	\$ -

F. Statement of Revenue

F. Statement of Reve	enu	e			In.	o.f.
ame of Facility License No.		Report for Ye	ar Ended		Page 30	of 37
adison House Care and Rehabilitation (2201-C	19	0/30/2015			1 30 1	31
			COMI	RHNS	(Sne	cify)
Item	-	Total	CCNH	KEINS	(Spc	ZIIY)
Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (CT only)	\$	8,541,351	8,541,351	-		
b. Medicaid Room and Board Contractual Allowance **	\$	(4,411,314)	(4,411,314)		-	-
2. a. Medicaid (All other states)	\$				-	-
b. Other States Room and Board Contractual Allowance **	\$	V			-	
3. a. Medicare Residents (all inclusive)	\$	4,052,656	4,052,656		+	
b. Medicare Room and Board Contractual Allowance **	\$	(1,377,206)	(1,377,206)		-	
4. a. Private-Pay Residents and Other	\$	1,730,852	1,730,852		-	
b. Private-Pay Room and Board Contractual Allowance **	\$	(664,207)	(664,207)			
. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$	315,221	315,221	-	+	
b. Prescription Drugs - Medicare Contractual Allowance **	\$	(107,121)	(107,121		-	
c. Prescription Drugs - Non-Medicare	\$	110,570	110,570	A 1752 ST.		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(43,715)	(43,715	_		
2. a. Medical Supplies - Medicare	\$	233	233	1000		
b. Medical Supplies - Medicare Contractual Allowance **	\$	(79)	(79		_	
c. Medical Supplies - Non-Medicare	\$	353	353			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$	(143)	(143)	_	
3. a. Physical Therapy - Medicare	\$	1,118,139	1,118,139			
b. Physical Therapy - Medicare Contractual Allowance **	\$	(379,975)	(379,975	5)		
c. Physical Therapy - Non-Medicare	\$	249,524	249,524			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$	(98,767)	(98,76	7)		
4. a. Speech Therapy - Medicare	\$	235,820	235,820			
b. Speech Therapy - Medicare Contractual Allowance **	\$	(80,138)	(80,13	3)		
c. Speech Therapy - Non-Medicare	\$			507		_
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$	(20,299	(20,29	9)		
5. a. Occupational Therapy - Medicare	\$	1,150,607	1,150,60	7		
b. Occupational Therapy - Medicare Contractual Allowance **	9	(391,008	(391,00	8)		
c. Occupational Therapy - Non-Medicare	5	250,691				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	9	(99,657	(99,65	7)		
6. a. Other (Specify) - Medicare	9	30,131	30,13	1		
b. Other (Specify) - Non-Medicare		8,234	8,23	4		
III. Total Resident Revenue (Section I. thru Section II.)		\$ 10,171,609	10,171,60	9		
IV. Other Revenue *						
	ì	\$	200000000000000000000000000000000000000		971778 25177587177783	
Meals sold to guests, employees & others	_	\$				
2. Rental of rooms to non-residents		\$				
3. Telephone	_	\$ 2,592	2 2,59)2		
4. Rental of Television and Cable Services	_	\$ 515				
5. Interest Income (Specify)		\$				
6. Private Duty Nurses' Fees		\$				
7. Barber, Coffee, Beauty and Gift shops		\$ 165,83	6 165,83	36		
8. Other (Specify)		\$ 168,94	100000000000000000000000000000000000000			
V. Total Other Revenue (1 thru 8)	-					
VI. Total All Revenue (III +V)		\$ 10,340,55	2 10,340,5	52		

^{*} Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

^{**} Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare

Related Exp

Paga Ref	Description		CCNH	RHNS	(Specify)
I-6-a	Medicare Part A	X-Ray	8,901.53	-	. 0
I-6-a	Medicare Part A	Radiology Service		-	0
II-6-a	Medicare Part A	Outpatient Therapy Program	-	-	0
I-6-a	Medicare Part A	Laboratory	26,596.33		0
I-6-a	Medicare Part A	Respiratory Therapy & Supplie	5,935,41	-	0
I-6-a	Medicare Part A	Nursing Treatment Supplies	-	-	0
II-6-a	Medicare Part A	Audiology	-	-	0
I-6-a	Medicare Part A	Incontinency	•		(
II-6-a	Medicare Part A	Oxygen & Supplies	1,955.10	-	(
П-6-а	Medicare Part A	Physician Visit	-		(
II-6-a	Medicare Part A	Ambulance	-	-	(
II-6-a	Medicare Part A	Flu Shot	2,253,43		(
II-6-a	Contractuals-Medicare	X-Ray	(3,024.99)	<u> </u>	
II-6-a	Contractuals-Medicare	Radiology Service	-	<u> </u>	
II-6-a	Contractuals-Medicare	Outpatient Therapy Program	-	-	
II-6-a	Contractuals-Medicare	Laboratory	(9,038.18)		
П-6-а	Contractuals-Medicare	Respiratory Therapy & Supplie	(2,017.02)		
П-6-а	Contractuals-Medicare	Nursing Treatment Supplies	-		
II-6-a	Contractuals-Medicare	Audiology		-	
II-6-a	Contractuals-Medicare	Incontinency		-	
II-6-a	Contractuals-Medicare	Oxygen & Supplies	(664,40)	-	
II-6-a	Contractuals-Medicare	Physician Visit	-	-	
II-6-a	Contractuals-Medicare	Ambulance		ļ	
∏-6-а	Contractuals-Medicare	Flu Shot	(765.78)		\$ -
Total O	ther Resident Revenue - N	ledicare	\$ 30,131	5 -	ð -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Related E	An-		CCNH	RHNS	(Specify)	
	Description	Tar D		0	0	
II-6-b	Medicaid	X-Ray		0	0	
II-6-b	Medicaid	Radiology Service	-	0	0	
II-6-b	Medicaid	Outpatient Therapy Program	-	0	0	
∐-6-b	Medicaid	Laboratory	124.17	0	0	
П-6-Б	Medicaid	Respiratory Therapy & Supplie	1,492.44	0	0	
П-6-в	Medicaid	Nursing Treatment Supplies	-	0	0	
П-6-Ъ	Medicaid	Audiology	-	0	0	
II-6-b	Medicaid	Incontinency		0	, <u>, , , , , , , , , , , , , , , , , , </u>	
II-6-b	Medicaid	Oxygen & Supplies	2,565.00	0		
II-6-b	Medicaid	Physician Visit	-	0	(
∐-6-b	Medicaid	Ambulance	-	0	(
II-6-b	Medicaid	Flu Shot	-	0	(
II-6-b	Contractuals Medicaid	X-Ray	-	0	(
П-6-ь	Contractuals Medicaid	Radiology Service	-	0	(
П-6-в	Contractuals Medicaid	Outpatient Therapy Program	-	0	(
II-6-b	Contractuals Medicaid	Laboratory	(64.13)	0	l	
II-6-b	Contractuals Medicaid	Respiratory Therapy & Supplie	(770,79)	0	- (
II-6-b	Contractuals Medicaid	Nursing Treatment Supplies	-	0	(
	Contractuals Medicaid	Audiology	-	0	(
II-6-b	Contractuals Medicaid	Incontinency	-	0		
II-6-b		Oxygen & Supplies	(1,324.73)	0		
II-6-b	Contractuals Medicaid			0		
П-6-Б	Contractuals Medicaid	Physician Visit	**************************************			

I-6-b	Contractuals Medicaid	Ambulance		0	0
П-6-b	Contractuals Medicaid	Flu Shot		0	0
II-6-b	Private and Other	X-Ray	1,896.00	0	0
II-6-b	Private and Other	Radiology Service	-	0	0
II-6-b	Private and Other	Outpatient Therapy Program		0	0
II-6-b	Private and Other	Laboratory	5,929.91	0	0
П-6-b	Private and Other	Respiratory Therapy & Supplie	1,550.63	0	0
Ц-6-b	Private and Other	Nursing Treatment Supplies	-	0	0
П-6-b	Private and Other	Audiology	-	0	0
II-6-b	Private and Other	Incontinency	-	0	0
II-6-b	Private and Other	Oxygen & Supplies	757.80	0	0
II-6-b	Private and Other	Physician Visit	-	0	0
II-6-b	Private and Other	Ambulance	-	0	0
II-6-b	Private and Other	Flu Shot	(53.43)	0	0
II-6-b	Private and Other	Capitation Contracts		0	0
II-6-b	Contractuals-Non-Medic	aid X-Ray	(727.58)	0	0
П-6-Ь	Contractuals-Non-Medic	aid Radiology Service	-	0	0
П-6-Ь	Contractuals-Non-Medic	aid Outpatient Therapy Program	-	0	
II-6-b	Contractuals-Non-Medic	aid Laboratory	(2,275.58)	0	0
II-6-b	Contractuals-Non-Medic	aid Respiratory Therapy & Supplie	(595,05)	0	0
II-6-b	Contractuals-Non-Medic	aid Nursing Treatment Supplies	-	0	0
II-6-b	Contractuals-Non-Medic	aid Audiology	-	0	0
II-6-b	Contractuals-Non-Medic	aid Incontinency		0	0
П-6-b	Contractuals-Non-Medic	aid Oxygen & Supplies	(290.80)	0	0
П-6-Ь	Contractuals-Non-Medic	eaid Physician Visit	-	0	0
П-6-b	Contractuals-Non-Medic			0	
II-6-b	Contractuals-Non-Medi	aid Flu Shot	20.50	0	0
II-6-b	Contractuals-Non-Medi	caid Capitation Contracts	ļ	0	
Total C	Other Resident Revenue		\$ 8,234	\$	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
1 age Rei	71000				
Pg 30 line	430055	Interest On Overdue Accounts	\$ 515	\$ -	\$ -
<u> </u>					
Total Inte	rest Income		\$ 515	\$ -	3

Schedule of Other Revenue

Dage Dof	Description		CCNH	RHNS	(Specify)
rage Kei	Description Medical records	0	\$ 2,225.34	\$ -	\$ -
***************	Donation	0	\$ 150,00	\$ -	\$ -
0	n	0	\$ -	\$ -	\$ -
0	Child Care	0	\$ 163,461.00	\$ -	\$ -
0	0	0	\$ -	S -	\$ -
					-
					
				+	
			\$ 165,836	s -	\$ -
Total Oth	er Revenue		***************************************		

G. Balance Sheet

		Facility 1 Published	License No. 2201-C		ort for Year 20/2015	Ended	Page 31	of 37
Mad	ison	House Care and Rehabilitation		19/30	7/2013			nount
A ===	ta.		Account				All	nount
Asse A.		rrent Assets						
A.	1	Cash (on hand and in banks)			9))	8,036
	2	Resident Accounts Receivab		for Bad	Debts)	9		1,273,255
		Other Accounts Receivable				9		1,167
	4	Inventories	Dividing 0 Wiles		,	, 9		34,797
	- 27	Prepaid Expenses				9		24,762
	٥.	a. Prepaid Expenses						,
		b. Prepaid Personal Property	Tax					
		c. Prepaid Personal Property			2,984			
		d. Interest Receivable						
	6.	Interest Receivable				9	S	
	7.		eceivable			9	3	
		Other Current Assets (itemiz				9	3	
		•	21					
		Total Current Assets (Lines A1	thru 8)					
A-9.	To	tal Current Assets (Lines A1				9	\$	1,342,018
B.	_	ced Assets					*	
	1.	Land				9		
	2.	Land Improvements	*Historical Cost		9,840		\$	9,022
		Transportations de son de product de fact de la vivil	Accum. Deprecia	tion	818	Net		- 2
	3.	Buildings	*Historical Cost		407,704	_	\$	338,717
		501 1941 - 501 - 1	Accum. Deprecia	tion	68,987			
	4.	Leasehold Improvements	*Historical Cost			_	\$	
			Accum. Deprecia	tion		Net		- 4-4-4
	5.	Non-Movable Equipment	*Historical Cost		227,805	•	\$	161,983
		7070 - 1369	Accum. Deprecia	tion	65,822	Net		
	6.	Movable Equipment	*Historical Cost		85,984	-	\$	39,109
		400	Accum. Deprecia	tion	46,875			
	7.	Motor Vehicles	*Historical Cost			E	\$	
			Accum. Deprecia	tion		Net		
	8.	Minor Equipment-Not Depr	eciable				\$	
	9.	Other Fixed Assets (itemize)				\$	
					-			
B-1	0.	Total Fixed Assets (Lines I	31 thru 9)				\$	548,83

^{*} Historical Costs must agree with Historical Cost reported in Schedules on Depreciation and Amortization (Pages 23 and 24).

G. Balance Sheet (cont'd)

Name	e of	Facility	License No.	Report for Year Ended	Page 32	e	of 37
Madi	son	House Care and Rehabilitation		9/30/2015	32	Amount	31
			Account			Amount	0.040
				Total Brought Forward	d: \$	1,89	0,849
C.	Lea	asehold or like property record	ed for Equity Purpos	ses.	φ.		
	1.	Land			\$		
	2.	Land Improvements	*Historical Cost		φ.		
			Accum. Depreciation	on Net	\$		
	3.	Buildings	*Historical Cost		0		
			Accum. Depreciati	on Net	\$		
	4.	Non-Movable Equipment	*Historical Cost				
			Accum. Depreciati	on Net	\$		
	5.	Movable Equipment	*Historical Cost				
			Accum. Depreciati	on Net	\$		
	6.	Motor Vehicles	*Historical Cost				
			Accum. Depreciati	on Net	\$		
	7.	Minor Equipment-Not Depre	ciable		\$		
C-8	To	tal Leasehold or Like Propert	ties (C1 thru 7)		\$		
D.		vestment and Other Assets					
	1.	Deferred Deposits			\$		
		Escrow Deposits			\$	-	
	3.	Organization Expense	*Historical Cost				
1		3	Accum. Depreciat	ion Net	\$		
	4.	Goodwill (Purchased Only)			\$		
	5.	Investments Related to Resid	lent Care (temize)		\$		
			*		_		
	6.	Loans to Owners or Related	Parties (temize)		\$		
	2570.5	Name and Address	Amount	Loan Date			
	7.	Other Assets (itemize)			\$	(1,6	89,662
ł		I/C Due to/Due From Ow	ned	(1,689,662)	_		
		I/C Due to/Due From Mu		1			
(36)							
D-8	3. T	otal Investments and Other A	ssets (Lines D1 thru	7)	\$		89,662
D-0	T	total All Assets (Lines A9 + B)	10 + C8 + D8)		\$	2	201,187

^{*} 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	cility		License No.	200	Report for Year En	ded	Page	of
Madison Ho	use C	are and Rehabilitation Cente	· 2201-C	9)/30/2015		33	37
			Account				Aı	mount
Liabilities								
Α.	Cu	rrent Liabilities						
	1.	Trade Accounts Payable	5				\$	444,926
	2.	Notes Payable (itemize)					\$	
							d.	
	3.	Loans Payable for Equipme			emize)		\$	
		Name of Lender	Purpose		Amount	Date Due		
				1				
					1/4			
			30					
		Accrued Payroll(Exclusive	of Owners and	or Stock	holders only)		\$	189,402
	4.	10 00 00 00 00 00 00 00 00 00 00 00 00 0	and/or Stockhold	ers only)		\$	
	5.			cis Oney)		\$	731
	6.						\$	
	7.						\$	
	8.	72 2 72 22					\$	
	9.). Interest Payable (Exclusive	of Owner and/o	r Relate	od Parties)		\$	
		1. Accrued Income Taxes*	e of Owner unaro	Tician	a i a ii o j		\$	
			itomiza)				\$	228,557
	13	2. Other Current Liabilities (uemize)	112 163	Accr Exp Electricity	8,450	000000000000000000000000000000000000000	
		Accrued Provider/Bed Tax			Deferred Revenue	1,998	┪᠁	
		A/R Credit Gross Up Liability			Accr Exp Other	109	┪	
		Accr Exp Water and Sewer			Accr Sales and Use Tax			
A 1	12 7	Accr Exp Gas Total Current Liabilities (Lin	nes A1 thru 12)	7,733	Tion builds and old the		\$	863,616
A-1	13. 1	oun Current Linoutines (Lin						

^{*} 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. Report for Year Ended		Ended	Page	of
Madison House Care and Rehabilitation Cer	2201-C 9/30/2015			34	37
F	Account			An	ount
	Total Brought Forwar		nt Forward:		863,616
Liabilities (cont'd)					
B. Long-Term Liabilities					
Loans Payable-Equipment			\$		
Name of Lender	Purpose	Amount	Date Due		
		18 38			
	9				
2. Mortgages Payable					
Loans from Owners or Rel	\$				
Name and Address of Lender	Amount	Loan Date			
	<u>.</u>				
,					
9		19			
			\$		402 655
4. Other Long-Term Liabilities (temize)					182,603
LT Debt-Financing Obligation 182,603					
20 C C C C C C C C C C C C C C C C C C C	\$		192 602		
B-5. Total Long-Term Liabilities (Lines B1 thru 4) C. Total All Liabilities (Lines A-13 + B-5)					182,603 1,046,219
C. Total All Liabilities (Lines A-	\$		1,040,419		

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

	ne of Facility License No. Report for Year Ended	Page 35	of
Mac	lison House Care and Rehabilitatio 2201-C 9/30/2015 Account		37 Amount
A.	Reserves	1	
	1. 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	\$	
	6. Total Reserves	\$	
В.	Net Worth 1. Owner's Capital	\$	6
	2. Capital Stock	\$	
	3. Paid-in Surplus	\$	
	4. Treasury Stock	\$	
	5. Cumulated Earnings	\$	(565,005)
	6. Gain or Loss for Period 10/1/2014 thru 9/30/2015	\$	(280,028)
	7. Total Net Worth	\$	(845,033)
C.	Total Reserves and Net Worth	\$	(845,033)
D.	Total Liabilities, Reserves, and Net Worth	\$	201,186

H. Changes in Total Net Worth

Name of Facility	■ 0 - 200 Wiles	ense No.	Report for Year	Ended		age	of
Madison House C	are and Rehabilitation (2201-C	9/30/2015			36	37
Account						Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014					\$		7,992)
B. Total Revenue (From Statement of Revenue Page 30)					\$		0,551
	ditures (From Statement of	Expenditures Pa	ige 27)		\$		7,592
D. Net Income	or Deficit				\$		7,041)
E. Balance			100000		\$	(84	5,033)
F. Additions 1. Additional Capital Contributed (temize) 2. Other (itemize)							
F-3. Total Addit	ons	2			\$		
G. Deductions							
	Drawings of Owners/Operators/Partners(Specify)						
	and Address (No., City, Stat		Title	Amount			
	a .				\$		
2. Other Withdrawings (Specify)							
Purpose Amount				-			
3. Total Deductions					\$		
H. Balance at	End of Period	09/30/1	5		\$	(84	15,033)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility			License No.		Report for Year Ended	Page	of	
Madison House Care and Rehabilitation			2201-C	9/30/2015	37	37		
	Check appropriate category							
Ø	Chronic and Convalescent Nursing Home only (CCNH)	П	Rest Home with Nursing Supervision only (RHNS)	□ (Specify)				
Preparer/Reviewer Certification								
I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in 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.								
Signat	ure of Preparer		Title		Date Signed			
	Thomas & Farner		St. Director of Resimbusion	unt	12/28/	201	5	
Printed Name of Preparer								
Thomas Farnan - Sr Director of Reimbursement								
Addres Address				Phone Number				
200 B	rickstone Square Andover MA 0181	0			978-247-5029			