State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) 35 Marc Drive Operations LLC, d/b/a Skyview Center	
Address (No. & Street, City, State, Zip Code) 35 Marc Drive, Wallingford, CT 06492	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2377			07-5057

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	000007427		

For Department Use Only

Sequence Number Assigned	Signed and Notarized	Date Received	Sequence Number Assigned	Signed and Notarized	Date Received

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General Information

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35 Marc Drive Operations LLC, d/b/a Skyview Center	2377	9/30/2016	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for 35 Marc Drive Operations LLC, d/b/a Skyview Center [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, 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
Printed Name (Administrator) Jeffrey E. Turner			Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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Department of Social Services
25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility 35 Marc Drive Operations LLC, d/b/a Skyview Center	Period Covered:		From 10/1/2015	To 9/30/2016
Address of Facility 35 Marc Drive, Wallingford, CT 06492				
Report Prepared By Thomas Farnan	Phone Number 978-247-5029		Date 12/20/2014	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$	315,396	315,396		
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$	2,626,983	2,626,983		
5. All other wages paid	$	444,290	444,290		
6. ***Total Wages Paid***	$	3,386,670	3,386,670		
7. Total salaries paid	$	200,285	200,285		
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	3,586,955	3,586,955		

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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-265-0981	9/30/2016	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
35 Marc Drive Operations LLC, d/b/a Skyview Center	35 Marc Drive, Wallingford, CT 06492

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2377			07-5057

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ◉ LLC ○ Partnership ○ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Jeffrey E. Turner	1613

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Skyvie	2377	9/30/2016	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
35 Marc Drive Operations LLC, d/b/a Skyview Center	101 East State Street, Kennett Square, PA 19348	PA

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
See Attached			
Names of Stockholders Owning at Least 10% of Shares			
See Attached			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Skyview Ce	2377	9/30/2016	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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 association to any of the owners, operators, or officials of this facility? ⊙ Yes ○ No

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Genesis Health Ventures	101 East State Street, Kennett Square, PA 19348	⊙	○		Home Office	Pg 16/m12	332,352	332,352
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	⊙	○	62%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	433,023	433,023
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	⊙	○	56%	Staffing Pool	Pg 10/A12	22,833	22,833
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	⊙	○	83%	Case Management	Pg 13/B8, Pg 10/A12	41,021	41,021
Career Staffing	101 East State Street, Kennett Square, PA 19348	⊙	○	80%	Staffing Pool	Pg 13/B11 a,b,c		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	⊙	○	51%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	15,904	15,904
Liberty Health (Insurance)	101 East State Street, Kennett Square, PA 19348	⊙	○		Insurance	Pg 27/14	147,924	147,924
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Capital Interest	Page 17, page 26-12A	29,043	29,043
		○	○					

* Use additional sheets if necessary.

** Provide the percentage amount of revenue received from non-related parties.

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General Information and Questionnaire
Basis for Allocation of Costs

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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

The preparer of this report must answer the following questions applicable to the cost information provided.

1. In the preparation of this Report, were all costs allocated as required? ⊙ Yes ○ No If "No," explain fully why such allocation was not made.

2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.

3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)

⊙ Yes ○ No If "No," explain fully why such allocation was not made.

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General Information and Questionnaire
Leases (Excluding Real Property)

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

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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No **Total ***

* 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.

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General Information and Questionnaire
Accounting Basis

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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period? ⊙ Yes ○ No If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 KPMG Peat Marwick	1600 Market Street, Philadelphia, PA 19103
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1	Year end financial audit	$
2		$
3		$
4		$

Charge for Services Provided $

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.

○ Yes ⊙ No

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Wallingford Probate District	
2 Sciacca Law Group LLC	8.7E+09
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)

1 45 South Main St, Wallingford CT 06492
2 PO Box 870126, Milton Village, MA 02187
3
4
5

Services Provided by This Firm (*describe fully*)

1	Probate Court Fees for the Conservatorship	$ 470
2	Review for the Uncollectable Account	$ 8,459
3		$
4		$
5		$

Charge for Services Provided $ 8,929

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.

⊙ Yes ○ No Legal Fees pg. 15 1-e

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	97	97			97	97			97	97		
B. On last day of THIS report period	97	97			97	97			97	97		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	90	90			90	90			76	76		
B. As of midnight of THIS report period	77	77			76	76			77	77		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,176	2,176			1,798	1,798			378	378		
B. Medicaid (Conn.)	24,725	24,725			18,526	18,526			6,199	6,199		
C. Medicaid (other states)												
D. Private Pay	1,944	1,944			1,642	1,642			302	302		
E. State SSI for RCH												
F. Other (Specify)	977	977			831	831			146	146		
G. Total Care Days During Period (3A thru F)	29,822	29,822			22,797	22,797			7,025	7,025		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	1	1			1	1						
B. Other Bed Reserve Days	3	3			1	1			2	2		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	29,826	29,826			22,799	22,799			7,027	7,027		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID
No. of Residents	4	67		6				
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.	567.86	198.00		390.04				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	2,346	2,346		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	826	826		
C. Other	8,437	8,437		
D. ***Total Physical Therapy Treatments***	11,609	11,609		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	220	220		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	37	37		
C. Other	772	772		
D. ***Total Speech Therapy Treatments***	1,029	1,029		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,522	1,522		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	530	530		
C. Other	7,000	7,000		
D. ***Total Occupational Therapy Treatments***	9,052	9,052		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	104,730	2,091				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	164,724	8,101				
5. Dietary Service						
a. Head Dietitian	19,043	566				
b. Food Service Supervisor	53,308	2,187				
c. Dietary Workers	243,046	17,607				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	54,641	2,127				
b. Other Maintenance Workers	20,102	1,168				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	95,555	2,101				
b. RN						
1. Direct Care	571,897	14,811				
2. Administrative**	103,445	2,589				
c. LPN						
1. Direct Care	738,096	24,979				
2. Administrative**						
d. Aides and Attendants	1,149,242	68,838				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	114,382	6,254				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	90,440	3,625				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	64,303	3,772				
A-13. Total Salary Expenditures	3,586,955	160,815				

* 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 private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10

		CCNH		RHNS		(Specify)	
Position		**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Ward Clerks	0	$ 27,816	1,667			$ -	-
Central Supply	0	$ 17,194	1,098			$ -	-
Medical Records	0	$ 19,292	1,006			$ -	-
0	0	$ -	-			$ -	-
0	0	$ -	-				
0	0	$ -	-				
0	0	$ -	-				
0	0	$ -	-				
0	0	$ -	-				
0	0	$ -	-				
0	0	$ -	-				
0	0	$ -	-				
0	0	$ -	-				
0	0	$ -	-				
0	0	$ -	-				
0	0	$ -	-				
0	0	$ -	-				
Total		$ 64,303	$ 3,772	$ -	-	$ -	-
		0	0				

Schedule of Other Fees (Page 13)

		CCNH		RHNS		(Specify)	
Service		**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
1020620010	Consulting Fees	$ 2,242	n/a			-	
3010620020	Purchased Services	$ 510	n/a				
3155620020	Purchased Services	$ (75)	n/a				
3155620020	Purchased Services	$ 2,469	n/a				
1020620010	Consulting Fees	$ 473	n/a				
0	0	$ -	n/a				
0	0	$ -	n/a				
0							
0							
0							
0							
Total		$ 5,620	0	$ -	-	$ -	-
		0					

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Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Related Parties*

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	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
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

* 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.

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Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Related Parties*

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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	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
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Jeffrey E. Turner	104,730				Management of Center	2,091	2			
Section IV - Assistant Administrators										

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

** Include **all** other employment worked during the cost year.

*** If more than one Administrator is reported, include dates of employment for each.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	615	17				
2. Dentist	13,534	93				
3. Pharmacist	5,704	116				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	402,311	5,511				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	35,400	187				
b. Utilization Review (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)						
9. Speech Therapist						
a. Resident Care	24,924	320				
b. Other						
10. Occupational Therapist						
a. Resident Care	59,836	820				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	678	10				
2. Administrative***						
b. LPN						
1. Direct Care	1,580	37				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	5,620					
B-13 Total Fees Paid in Lieu of Salaries	550,201	7,111				

* 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 be removed on Page 28.

*** 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Skyview Center	2377	9/30/2016	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Genesis Eldercare Hospitality Services, 101 East State Street, Kennett Square, PA 19348	Dietary Services	⊙	○	Common Ownership
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	⊙	○	Common Ownership
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	⊙	○	Common Ownership
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	⊙	○	Common Ownership
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	⊙	○	Common Ownership
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
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		○	○	
		○	○	
		○	○	

* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Skyview C	2377	9/30/2016	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	155,494	155,494		
2. Disability Insurance	$				
3. Unemployment Insurance	$	52,713	52,713		
4. Social Security (F.I.C.A.)	$	263,433	263,433		
5. Health Insurance	$	346,151	346,151		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans forOwners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	48,562	48,562		
d. Accounting and Auditing	$				
e. Legal (*Services should be fully described on Page 7)*	$	8,929	8,929		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	24,451	24,451		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	20,024	20,024		
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*	$				
2. Other (*Specify*)	$	263	263		
See Attached Schedule					
3. Resident Day User Fee	$	560,184	560,184		
Subtotal	$	1,480,204	1,480,204		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description		CCNH	RHNS	(Specify)
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
Total		$ -	$ -	$ -

Schedule of Other Taxes

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax	263.00	0	0
1020640110	Sales Tax	-	0	0
1020640110	Sales Tax	-	0	0
0	0	-	0	0
Total		$ 263	$ -	$ -

0

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

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Skyview Cente	2377	9/30/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,480,204	1,480,204		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	233	233		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	1,910	1,910		
5. Education Expenses Related to Seminars and Conventions	$				
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	7,789	7,789		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	2,211	2,211		
* 8. Dues and Membership Fees to Professional Associations (*Specify*)	$	6,759	6,759		
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	964	964		
9. Subscriptions	$	197	197		
10. Contributions***	$	1,241	1,241		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	2,672	2,672		
12. Administrative Management Services**	$	314,005	314,005		
13. Other (*Specify*)	$	32,233	32,233		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,850,419	1,850,419		

* 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
				0
				0
				0
				0
Total Other Travel and Entertainment		$ -	$ -	$ -

Schedule of Other Advertising

Description		CCNH	RHNS	(Specify)
1020630020	Advertising	761.62	0	0
1020630020	Advertising	1155.54	0	0
1020630330	Marketing Expense	3918.22	0	0
1020630330	Marketing Expense	13.33	0	0
1020630331	Marketing Exp- Corpor	421.06	0	0
1020630331	Marketing Exp- Corpor	1518.9	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
Total Other Advertising		$ 7,789	$ -	$ -
		$ -		

Schedule of Dues

Description		CCNH	RHNS	(Specify)
1020630310	Licenses and Certificat	6759.38	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	-	0	0
1020630310	0	-	0	0
1020630310	0	-	0	0
1020630310	0	-	0	0
1020630310	0	-	0	0
Total Dues		$ 6,759	$ -	$ -
		$ -		

Schedule of Contributions

Description		CCNH	RHNS	(Specify)
0	0	0	0	0
1020630135	Political Contributions	1240.89	0	0
0	0	0	0	0
Total Contributions		$ 1,241	$ -	$ -
		$ -		

Schedule of Other Administrative and General

Description		CCNH	RHNS	(Specify)
1020630060	Bank Service Charges	3682.08	0	0
1020630120	Collection Fees	14574.5	self-disallowed	0
1020630120	Collection Fees	25.3	self-disallowed	0
1020630140	Education Expense	25.16	0	0
1020630140	Education Expense	3.44	0	0
1020630180	Employee Physicals	6431.56	0	0
1020630200	Employee Relations	3686.69	0	0
1020630380	Printing	146.16	0	0
1020630610	Training Expense	22.02	0	0
1020630610	Training Expense	710.16	0	0
1020630640	Uniforms	362.65	0	0
1020640090	Miscellaneous	-2.72	0	0
1020660080	Rental Expense	2256.95	0	0
1020660990	Accrued Expense Estin	221.52	self-disallowed	0
5095720020	Cap Stk/Franchise Tax	47.79	0	0
1020720070	State Tax Annual Repo	40	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
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Total Other Administrative and General		$ 32,233	$ -	$ -
		0		

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
35 Marc Drive Operations LLC, d/b/a Sky	2377	9/30/2016	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	332,352	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	29,043	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.**

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

Name of Facility	License No.	Report for Year Ended	Page of
35 Marc Drive Operations LLC, d/b/a Skyview Center	2377	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	139,556	139,556		
2. Non-Food Supplies	$	19,332	19,332		
3. Other (*Specify*)_____	$	(3,915)	(3,915)		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)_____	$	40	40		
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	155,013	155,013		

		Total	CCNH	RHNS	(Specify)
2F.	Dietary Questionnaire				
G.	Resident Meals: Total no. of meals served per day:*				

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page of
35 Marc Drive Operations LLC, d/b/a Skyview Center	2377	9/30/2016	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	3,894	3,894		
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $	6,264	6,264		
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	113,735	113,735		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	123,893	123,893		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Skyview	2377	9/30/2016	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	11,487	11,487		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	170,277	170,277		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	181,764	181,764		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	112,818	112,818		
b. Medicine Cabinet Drugs		$	31,638	31,638		
c. Medical and Therapeutic Supplies		$	79,812	79,812		
d. Ambulance/Limousine***		$	1,442	1,442		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	5,037	5,037		
f. X-rays and Related Radiological Procedures***		$	6,114	6,114		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	16,807	16,807		
i. Recreation		$	28,212	28,212		
j. Other (Specify)**** See Attached Schedule		$	49,756	49,756		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	331,635	331,635		

* 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)
3060610160	Incontinency	32817.89	0	0
3060610161	Incontinency - Rebate	-87.54	0	0
3060610161	Incontinency - Rebate	-4778.01	0	0
3080630030	Advertising-Help Wan	494.42	0	0
3080630030	Advertising-Help Wan	281.1	0	0
3080630140	Education Expense	76.96	0	0
3080630140	Education Expense	1067.07	0	0
3120630530	Supplies	44.82	0	0
3155630530	Supplies	1892.75	0	0
3155630530	Supplies	1554.5	0	0
3170630530	Supplies	63.25	0	0
3120660080	Rental Expense	1848.42	0	0
3120660080	Rental Expense	616.14	0	0
3155660080	Rental Expense	79.03	0	0
3155660080	Rental Expense	7028.02	0	0
3010610300	Consolidated Billing	6757.45	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
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Total Other Resident Care		$ 49,756	$ -	$ -
		0		

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Laundry Purchased Services	113,735			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	○	○	Vendor Contracted	Housekeeping Purchased Services	170,277			20	4b
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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).

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

Name of Facility	License No.	Report for Year Ended	Page of
35 Marc Drive Operations LLC, d/b/a Skyview	2377	9/30/2016	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	108,214	108,214		
b. Heat	$	25,964	25,964		
c. Light & Power	$	96,216	96,216		
d. Water	$	35,275	35,275		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	265,669	265,669		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	9,432	9,432		
b. Building & Building Improvements	$	363,905	363,905		
c. Non-Movable Equipment	$	568	568		
d. Movable Equipment	$	7,467	7,467		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	381,372	381,372		
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	$	176,181	176,181		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	59,184	59,184		
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	616,737	616,737		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Total Other Repairs and Maintenance	$ -	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Skyview Center	2377	9/30/2016	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	102,937		102,937	17,018	S/L	Various	9,432	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								9,432
B. **Building and Building Improvements**								
1. Acquired prior to this report period	1,911,990		1,911,990	1,357,224	S/L	Various	363,857	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	5,944		5,944				48	
B-4. Subtotal								363,905
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	5,675		5,675	1,321	S/L	Various	568	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								568

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.									S/L	Various		
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					52,832		52,832	28,166	S/L	Various	3,733	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					28,276		28,276				3,735	
D-3. Subtotal												7,467
E. ***Total Depreciation***												381,372

35 Marc Drive Operations LLC, d/b/a Skyview Center
9/30/2016

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Land Improvements		$ -		$ -
Deletions:				
Total deletions for Land Improvements		$ -		$ -

***Ties to Page 23, Line A3**

****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
5/31/2016	4 accordian doors	1,950.00	20	32.50
8/31/2016	Watlow block heater	1,198.73	20	4.99
8/31/2016	Gutters	1,914.30	15	10.64
9/30/2016	Sep 2016 Accrual -Cummins Power Systems, LLC	881.42	-	-
Total additions for Building Improvements		$ 5,944		$ 48
Deletions:				
Total deletions for Building Improvements		$ -		$ -

***Ties to Page 23, Line B3**

****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report perio

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Non-Movable Equipment		$ -		$ -
Deletions:				
Total deletions for Non-Movable Equipment		$ -		$ -

***Ties to Page 23, Line C3**

****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report perioc

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
11/30/2015	Quick-Ship Panacea 6300 Bariatric Bed	3,806.78	10	317.23
12/31/2015	Slicer, Compact Manual, Heavy	1,991.91	10	149.39
1/31/2016	Direct Choice Overbed Table, S	397.33	10	26.49
3/31/2016	3 CUSHION,W/C,18X16 ROHO HIGH PR	1,648.50	10	82.43
11/30/2015	Ariens snow blower	1,312.36	5	218.73
11/30/2015	GENESIS ONLY: DermaFloat LAL 3	6,255.80	3	1,737.72
4/30/2016	25 MATTRESS,GENESIS VISCO	7,962.00	3	1,105.83
4/30/2016	1 APC SmartUPS	698.19	3	96.97
9/30/2016	2 DermaFloat Alternating Pressure Air Ma	4,203.08	3	-
Total additions for Movable Equipment		$ 28,276		$ 3,735
Deletions:				
Total deletions for Movable Equipment		$ -		$ -

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report perioc

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Leasehold Improvement		$ -		$ -
Deletions:				
Total deletions for Leasehold Improvement		$ -		$ -

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Skyview Center	2377	9/30/2016	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									

* Straight-line method must be used.

** 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a	2377	9/30/2016	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	97
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
Well Tower /Healthcare REIT, Inc	Building and Equipment	04/01/11	20	176,181
Address: One Seagate Suite 1500				
Toledo, OH 43603-1475				

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.

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

Name of Facility	License No.	Report for Year Ended	Page of
35 Marc Drive Operations LLC, d/b/a	2377	9/30/2016	26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	29,043	29,043		
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage	$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount	$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5)	$	29,043	29,043		

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
35 Marc Drive Operations LLC, d/	2377	9/30/2016	27 | 37

Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:			29,043	29,043		
12. C. Movable Equipment						
1. Automotive Equipment		$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (*Specify*)		$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		$				
12. D. Other Interest Expense (*Specify*)		$				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D)		$	29,043	29,043		
14. Insurance						
a. Insurance on Property (buildings only)		$	4,155	4,155		
b. Insurance on Automobiles		$				
c. Insurance other than Property (as specified above)						
1. Umbrella (*Blanket Coverage*)		$	143,768	143,768		
2. Fire and Extended Coverage		$				
3. Other (*Specify*)		$				
14d. ***Total Insurance Expenditures (14a + b + c)***		$	147,923	147,923		
15. ***Total All Expenditures (A-13 thru C-14)***		$	7,839,253	7,839,253		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
35 Marc Drive Operations LLC, d/b/a Skyview Center	2377	9/30/2016	28 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages								
1.			Outpatient Service Costs	$				
2.			Salaries not related to Resident Care	$				
3.			Occupational Therapy	$				
4.			Other - See attached Schedule	$	20,308	20,308		
Page 13 - Professional Fees								
5.	13	B-8-c	Resident Care Physicians **	$				
6.		B-10	Occupational Therapy	$				
7.			Other - See attached Schedule	$	489,975	489,975		
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	1-c	Bad Debts	$	48,562	48,562		
10.			Accounting & Legal	$				
11.			Telephone	$				
12.			Cellular Telephone	$				
13.			Life insurance premiums on the life of Owners, Partners, Operators	$				
14.			Gifts, flowers and coffee shops	$				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	$				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	$				
17.			Automobile Expense (e.g. personal use)	$				
18.	16	m-2 &	Unallowable Advertising *	$	7,789	7,789		
19.			Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$	1,241	1,241		
21.			Unallowable Management Fees	$	343,048	343,048		
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	(341,059)	(341,059)		
Page 18 - Dietary Expenditures								
24.			Meals to employees, guests and others who are not residents	$				
Page 19 - Laundry Expenditures								
25.			Laundry services to employees, guests and others who are not residents	$				
Page 20 - Housekeeping Expenditures								
26.			Housekeeping services to employees, guests and others who are not residents	$				
			Subtotal (Items 1 - 26)	$	569,863	569,863		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
10	2	Administrator's salary disallowed	0	$ 20,308	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
Total Other Salaries Adjustment				$ 20,308	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	91324.07	0	0
13	5	Rehabilitation Services	3195620020	310986.88	0	0
13	9	Speech Therapist	3170620020	24924.03	0	0
13	10	Occupational Therapist	3105620020	59835.68	0	0
13	12	Other	3010620020	510	0	0
13	12	Other	3015620020	0	0	0
13	12	Respiratory Purchased Servies	3155620020	2394.18	0	0
					0	0
					0	0
					0	0
					0	0
					0	0
Total Other Fees Adjustments				$ 489,975	$ -	$ -
				$ -		

Schedule of Other A&G Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	1020630120	14599.8	0	0
16	m-8a	Chamber of Commerce	1020630310	964	0	0
16	m-13	Estimated Accrual	1020660990	221.52	0	0
16	m-13	Penalty and Fines	1020640080	0	0	0
16	m-13	Non-recurring Charges	7010800030	0	0	0
16	m-12	0	0	0	0	0
15	1-a-1	adj workers comp	0	-356844.65	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
Total Other A&G Adjustments				$ (341,059)	$ -	$ -
				$ -		

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

Name of Facility	License No.	Report for Year Ended	Page of
35 Marc Drive Operations LLC, d/b/a Skyview Center	2377	9/30/2016	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	569,863	569,863		
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs $	112,818	112,818		
28.	20	5-d	Ambulance/Limousine $	1,442	1,442		
29.	20	5-f	X-rays, etc $	6,114	6,114		
30.	20	5-h	Laboratory $	16,807	16,807		
31.			Medical Supplies $				
32.	20	5-e-2	Oxygen (non emergency) $	5,037	5,037		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	35,823	35,823		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.			Radio and Television Revenue $				
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $	136,510	136,510		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.			***Total Amount of Decrease (Items 1 - 50)*** $	884,413	884,413		

*** 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.

35 Marc Drive Operations LLC, d/b/a Skyview Center
9/30/2016

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	6757.45	3010610300	0
20	5-j	Respiratory Supplies	3447.25	3155630530	0
20	5-j	Respiratory Rental	7107.05	3155660080	0
20	5-i	Cable TV	18511.6	3005660130	allow $3600
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Other Ancillary Costs			$ 35,823	$ -	$ -
			$ -		

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Excess Movable Equipment Depreciation			$ -	$ -	$ -

Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0	0	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Other Property Adjustments			$ -	$ -	$ -

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14c1	General liability Insurance Adjust	136510.0442	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Other Adjustments			$ 136,510	$ -	$ -
			$ -		

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Sky	2377	9/30/2016	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	9,703,311	9,703,311		
b. Medicaid Room and Board Contractual Allowance **	$	(4,862,348)	(4,862,348)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	855,959	855,959		
b. Medicare Room and Board Contractual Allowance **	$	(205,591)	(205,591)		
4. a. Private-Pay Residents and Other	$	1,159,011	1,159,011		
b. Private-Pay Room and Board Contractual Allowance **	$	(230,347)	(230,347)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	88,597	88,597		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(21,280)	(21,280)		
c. Prescription Drugs - Non-Medicare	$	32,953	32,953		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(9,555)	(9,555)		
2. a. Medical Supplies - Medicare	$	20	20		
b. Medical Supplies - Medicare Contractual Allowance **	$	(5)	(5)		
c. Medical Supplies - Non-Medicare	$	640	640		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(196)	(196)		
3. a. Physical Therapy - Medicare	$	397,655	397,655		
b. Physical Therapy - Medicare Contractual Allowance **	$	(95,512)	(95,512)		
c. Physical Therapy - Non-Medicare	$	209,498	209,498		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(54,904)	(54,904)		
4. a. Speech Therapy - Medicare	$	81,708	81,708		
b. Speech Therapy - Medicare Contractual Allowance **	$	(19,625)	(19,625)		
c. Speech Therapy - Non-Medicare	$	38,258	38,258		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(8,953)	(8,953)		
5. a. Occupational Therapy - Medicare	$	368,443	368,443		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(88,496)	(88,496)		
c. Occupational Therapy - Non-Medicare	$	137,821	137,821		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(36,395)	(36,395)		
6. a. Other *(Specify)* - Medicare	$	12,349	12,349		
b. Other *(Specify)* - Non-Medicare	$	174,913	174,913		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	7,627,929	7,627,929		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	63	63		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	1,727	1,727		
V. Total Other Revenue (1 thru 8)	$	1,790	1,790		
VI. Total All Revenue (III +V)	$	7,629,719	7,629,719		

* *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

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-a	Medicare Part A	X-Ray	3,614.80	-	0
II-6-a	Medicare Part A	Laboratory	9,725.82	-	0
II-6-a	Medicare Part A	Respiratory Therapy & Supplies	15.44	-	0
II-6-a	Medicare Part A	Nursing Treatment Supplies	-	-	0
II-6-a	Medicare Part A	Audiology	-	-	0
II-6-a	Medicare Part A	Incontinency	-	-	0
II-6-a	Medicare Part A	Oxygen & Supplies	119.70	-	0
II-6-a	Medicare Part A	Physician Visit	-	-	0
II-6-a	Medicare Part A	Ambulance	-	-	0
II-6-a	Medicare Part A	Flu Shot	2,777.00	-	0
II-6-a	Contractuals-Medicare	X-Ray	(868.23)	-	0
II-6-a	Contractuals-Medicare	Laboratory	(2,336.02)	-	0
II-6-a	Contractuals-Medicare	Respiratory Therapy & Supplies	(3.71)	-	0
II-6-a	Contractuals-Medicare	Nursing Treatment Supplies	-	-	0
II-6-a	Contractuals-Medicare	Audiology	-	-	0
II-6-a	Contractuals-Medicare	Incontinency	-	-	0
II-6-a	Contractuals-Medicare	Oxygen & Supplies	(28.75)	-	0
II-6-a	Contractuals-Medicare	Physician Visit	-	-	0
II-6-a	Contractuals-Medicare	Ambulance	-	-	0
II-6-a	Contractuals-Medicare	Flu Shot	(667.00)	-	0
Total Other Resident Revenue - Medicare			$ 12,349	$ -	$ -
			$ 0		

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	-	-	0
II-6-b	Medicaid	Laboratory	30.29	-	0
II-6-b	Medicaid	Respiratory Therapy & Supplies	(15.44)	-	0
II-6-b	Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Medicaid	Audiology	-	-	0
II-6-b	Medicaid	Incontinency	-	-	0
II-6-b	Medicaid	Oxygen & Supplies	(119.70)	-	0
II-6-b	Medicaid	Physician Visit	-	-	0
II-6-b	Medicaid	Ambulance	-	-	0
II-6-b	Medicaid	Flu Shot	-	-	0
II-6-b	Contractuals Medicaid	X-Ray	-	-	0
II-6-b	Contractuals Medicaid	Laboratory	(15.18)	-	0
II-6-b	Contractuals Medicaid	Respiratory Therapy & Supplies	7.74	-	0
II-6-b	Contractuals Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Contractuals Medicaid	Audiology	-	-	0
II-6-b	Contractuals Medicaid	Incontinency	-	-	0
II-6-b	Contractuals Medicaid	Oxygen & Supplies	59.98	-	0
II-6-b	Contractuals Medicaid	Physician Visit	-	-	0
II-6-b	Contractuals Medicaid	Ambulance	-	-	0
II-6-b	Contractuals Medicaid	Flu Shot	-	-	0
II-6-b	Private and Other	X-Ray	1,121.02	-	0
II-6-b	Private and Other	Laboratory	9,012.69	-	0

II-6-b	Private and Other	Respiratory Therapy & Supplies	-	-	0
II-6-b	Private and Other	Nursing Treatment Supplies	-	-	0
II-6-b	Private and Other	Audiology	-	-	0
II-6-b	Private and Other	Incontinency	-	-	0
II-6-b	Private and Other	Oxygen & Supplies	-	-	0
II-6-b	Private and Other	Physician Visit	-	-	0
II-6-b	Private and Other	Ambulance	-	-	0
II-6-b	Private and Other	Flu Shot	1,568.00	-	0
II-6-b	Private and Other	Capitation Contracts	206,662.00	-	0
II-6-b	Contractuals-Non-Medicaid	X-Ray	(222.80)	-	0
II-6-b	Contractuals-Non-Medicaid	Laboratory	(1,791.22)	-	0
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplies	-	-	0
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Contractuals-Non-Medicaid	Audiology	-	-	0
II-6-b	Contractuals-Non-Medicaid	Incontinency	-	-	0
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplies	-	-	0
II-6-b	Contractuals-Non-Medicaid	Physician Visit	-	-	0
II-6-b	Contractuals-Non-Medicaid	Ambulance	-	-	0
II-6-b	Contractuals-Non-Medicaid	Flu Shot	(311.63)	-	0
II-6-b	Contractuals-Non-Medicaid	Capitation Contracts	(41,072.93)	-	0
Total Other Resident Revenue			$ 174,913	$ -	$ -
			$ (0)		

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 30 line1(	430055	Interest On Overdue Accounts	62.53	-	-
0	0	0	0	-	0
0	0	0	0	-	0
Total Interest Income			$ 63	$ -	$ -
			$ (0)		

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
Pg 30 line1(	Hair Dressing	430060	1,727.35	-	-
0	Suspense Reclasses	0	-	-	-
0	0	0	-	-	-
Total Other Revenue			$ 1,727	$ -	$ -
			$ 0		

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Sk	2377	9/30/2016	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 4,550
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 552,194
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (21,501)
4 Inventories				$ 35,334
5. Prepaid Expenses				$ 21,259
a. Prepaid Expenses		3,910		
b. Prepaid Property Tax		15,023		
c. Prepaid Personal Property Tax				
d. Prepaid Personal Property Tax		2,326		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 591,835
B. Fixed Assets				
1. Land				$ 491,532
2. Land Improvements	*Historical Cost	102,937		$ 76,487
	Accum. Depreciation	26,450	Net	
3. Buildings	*Historical Cost	1,917,934		$ 196,805
	Accum. Depreciation	1,721,129	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	5,675		$ 3,786
	Accum. Depreciation	1,889	Net	
6. Movable Equipment	*Historical Cost	81,108		$ 45,475
	Accum. Depreciation	35,633	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 814,085

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Sk	2377	9/30/2016	32	37

Account				Amount
			Total Brought Forward:	$ 1,405,920
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 628,757
I/C Due to/Due From Owned			628,757	
I/C Due to/Due From Multicare				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 628,757
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 2,034,677

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Skyview	2377	9/30/2016	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 257,000
2. Notes Payable (*itemize*)					$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 102,115
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 126
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 274,325
Accrued Provider/Bed Tax	136,840	Accr Exp Electricity	6,233		
Accr Exp Other	2,957	Deferred Revenue	14,907		
Accr Exp Water and Sewer	12,267	Accr Exp Suspense	(769)		
A/R Credit Gross Up Liability	101,890	Accr Sales and Use Tax			
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 633,566

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Skyvi	2377	9/30/2016	34	37

Account	Amount
Total Brought Forward:	633,566
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 1,850,851
LT Debt-Financing Obligation	1,850,851	
Escheatable Funds		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 1,850,851
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 2,484,417

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

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a S	2377	9/30/2016	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. 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	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$
	3. Paid-in Surplus	$ 1,127,912
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (1,368,120)
	6. Gain or Loss for Period 10/1/2015 thru 9/30/2016	$ (209,533)
	7. Total Net Worth	$ (449,741)
C.	***Total Reserves and Net Worth***	$ (449,741)
D.	***Total Liabilities, Reserves, and Net Worth***	$ 2,034,676

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Sk	2377	9/30/2016	36	37

Account		Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2015	$ (240,207)
B.	Total Revenue (*From Statement of Revenue Page 30*)	$ 7,629,719
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$ 7,839,253
D.	Net Income or Deficit	$ (209,534)
E.	Balance	$ (449,741)
F.	Additions	
	1. Additional Capital Contributed (*itemize*)	
	2. Other (*itemize*)	
F-3.	Total Additions	$
G.	Deductions	
	1. Drawings of Owners/Operators/Partners (*Specify*)	$

Name and Address (*No., City, State, Zip*)	Title	Amount

	2. Other Withdrawings *(Specify)*	$

Purpose	Amount

	3. Total Deductions		$
H.	***Balance at End of Period***	09/30/16	$ (449,741)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a	2377	9/30/2016	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ 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. 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.

Signature of Preparer	Title	Date Signed

Printed Name of Preparer	
Thomas Farnan Title -Sr. Director of Reimbursement	
Addres Address	Phone Number
200 Brickstone Square, Andover, MA 01810	978-247-5029