State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) Madison House Care and Rehabilitation Center		
Address (No. & Street, City, State, Zip Code) 34 Wildwood Avenue, Madison, CT 06443		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2201-C			07-5405

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	21444		

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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Madison House Care and Rehabilitation Center	2201-C	9/30/2017	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 Madison House Care and Rehabilitation Center [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, 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) Roessler,Cynthia Christine			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 Madison House Care and Rehabilitation Center	Period Covered:		From 10/1/2016	To 9/30/2017
Address of Facility 34 Wildwood Avenue, Madison, CT 06443				
Report Prepared By Thomas Farnan	Phone Number 978-247-5029		Date 12/20/2014	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$	194,691	194,691		
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$	2,258,424	2,258,424		
5. All other wages paid	$	413,048	413,048		
6. ***Total Wages Paid***	$	2,866,164	2,866,164		
7. Total salaries paid	$	209,449	209,449		
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	3,075,613	3,075,613		

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
203-245-8008	9/30/2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Madison House Care and Rehabilitation Center	34 Wildwood Avenue, Madison, CT 06443

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	2201-C			07-5405

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.:
Roessler,Cynthia Christine	1501

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
Harborside Health I Corporatic	101 Sun Ave. NE, Albuquerque, NM 87109		1
Harborside Healthcare Limited	101 Sun Ave. NE, Albuquerque, NM 87109		99

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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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
Madison House Care and Rehabilitation Center	101 East State Street, Kennett Square, PA 19348	PA

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

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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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	347,912	347,912
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	⊙	○	63%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	437,439	437,439
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	○	⊙		Staffing Pool	Pg 10/A12	12,120	12,120
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	⊙	○	83%	Medical Director /NP	Pg 13/B8, Pg 10/A12	51,472	51,472
Career Staffing	101 East State Street, Kennett Square, PA 19348	⊙	○	60%	Outside Agency	Pg 13/B11 a,b,c	197,526	197,526
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	⊙	○	44%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	18,233	18,233
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Insurance	Pg 27/14	162,297	162,297
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Capital Interest	Page 17, page 26-12A	27,156	27,156
		○	○					

* 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

Name of Facility	License No.	Report for Year Ended	Page	of
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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.

Name of Facility	License No.	Report for Year Ended	Page	of
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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
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						Total ***	

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

* 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

Name of Facility	License No.	Report for Year Ended	Page	of
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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 State of Connecticut - Court of Probate	203-787-4805
2 Bloom & Witkin	617 456-0500
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1 8 Meetinghouse Lane Madison, Ct 06443
2 470 Atlantic Ave - 3rd Fl Boston, MA 02210
3
4
5

Services Provided by This Firm (*describe fully*)

1	Probate Court Fees	$ 225
2	Real Estate Tax Abatement-reduced the assessment values of Real Estate Tax	$
3		$
4		$
5		$
		Charge for Services Provided $ 225

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	90	90			90	90			90	90		
B. On last day of THIS report period	90	90			90	90			90	90		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	72	72			72	72			66	66		
B. As of midnight of THIS report period	68	68			66	66			68	68		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,982	2,982			2,056	2,056			926	926		
B. Medicaid (Conn.)	18,331	18,331			13,907	13,907			4,424	4,424		
C. Medicaid (other states)												
D. Private Pay	1,744	1,744			1,409	1,409			335	335		
E. State SSI for RCH												
F. Other (Specify)	789	789			530	530			259	259		
G. Total Care Days During Period (3A thru F)	23,846	23,846			17,902	17,902			5,944	5,944		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	11	11			3	3			8	8		
B. Other Bed Reserve Days	1	1			1	1						
5. ***Total Resident Days*** **(3G + 4A + 4B)**	23,858	23,858			17,906	17,906			5,952	5,952		

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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	11	49		8				
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.	559.87	237.71		474.55				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	2,079	2,079		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	143	143		
C. Other	8,139	8,139		
D. ***Total Physical Therapy Treatments***	10,361	10,361		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	277	277		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	7	7		
C. Other	420	420		
D. ***Total Speech Therapy Treatments***	704	704		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,750	1,750		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	162	162		
C. Other	8,743	8,743		
D. ***Total Occupational Therapy Treatments***	10,655	10,655		

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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)	109,380	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	141,943	7,281				
5. Dietary Service						
a. Head Dietitian	5,129	176				
b. Food Service Supervisor	22,454	694				
c. Dietary Workers	167,109	10,992				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	63,592	2,287				
b. Other Maintenance Workers	1,213	71				
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	100,069	1,778				
b. RN						
1. Direct Care	596,593	15,915				
2. Administrative**	4,798	87				
c. LPN						
1. Direct Care	600,925	21,053				
2. Administrative**						
d. Aides and Attendants	1,017,907	57,803				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	72,154	3,921				
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	134,146	5,082				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	38,201	2,665				
A-13. Total Salary Expenditures	3,075,613	131,891				

* 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	$ -	-	$ -	-	$ -	-
Other	0	$ -	-	$ -	-	$ -	-
0	0	$ -	-	$ -	-	$ -	-
0	0	$ -	-	$ -	-	$ -	-
0	0	$ -	-	$ -	-	$ -	-
0	0	$ -	-	$ -	-	$ -	-
Central Supply	0	$ 3,921.35	276.24	$ -	-	$ -	-
Medical Records	0	$ 34,279.51	2,388.74	$ -	-	$ -	-
0	0	$ -	-	$ -	-	$ -	-
0	0	$ -	-	$ -	-	$ -	-
0	0	$ -	-	$ -	-	$ -	-
0	0	$ -	-	$ -	-	$ -	-
0	0	$ -	-	$ -	-	$ -	-
0	0	$ -	-	$ -	-	$ -	-
0	0	$ -	-	$ -	-	$ -	-
0	0	$ -	-	$ -	-	$ -	-
0	0	$ -	-	$ -	-	$ -	-
Total		$ 38,200.85	$ 2,664.98	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

		CCNH		RHNS		(Specify)	
Service		**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
1020620010	Consulting Fees	$ 480.52	n/a	$ -	$ -	$ -	$ -
3015620020	Purchased Services	$ 13,947.00	n/a	$ -	$ -	$ -	$ -
3155620020	Purchased Services	$ 1,976.00	n/a	$ -	$ -	$ -	$ -
3010620020	Purchased Services	$ 20.00	n/a	$ -	$ -	$ -	$ -
1020620010	Consulting Fees	$ 528.81	n/a	$ -	$ -	$ -	$ -
0	0	$ -	n/a	$ -	$ -	$ -	$ -
0	0	$ -	n/a	$ -	$ -	$ -	$ -
0	0	$ -	n/a	$ -	$ -	$ -	$ -
0	0	$ -	$ -	$ -	$ -	$ -	$ -
Total		$ 16,952.33	$ -	$ -	-	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
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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*

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Madison House Care and Rehabilitation Center	2201-C	9/30/2017	12	37

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* **										
Roessler,Cynthia Christine	109,380				Management of Center	2,086	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						
2. Dentist	10,235	70				
3. Pharmacist	5,922	121				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	362,722	4,969				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	41,900	222				
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	22,280	286				
b. Other						
10. Occupational Therapist						
a. Resident Care	54,031	740				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	188,047	3,136				
2. Administrative***						
b. LPN						
1. Direct Care	4,113	97				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	16,952					
B-13 Total Fees Paid in Lieu of Salaries	706,202	9,641				

* 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
Madison House Care and Rehabilitation Center	2201-C	9/30/2017	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
		⊙	○	
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
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

* 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
Madison House Care and Rehabilitation Center	2201-C	9/30/2017	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	127,285	127,285		
2. Disability Insurance	$				
3. Unemployment Insurance	$	50,781	50,781		
4. Social Security (F.I.C.A.)	$	226,847	226,847		
5. Health Insurance	$	238,445	238,445		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	113,583	113,583		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	12,634	12,634		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	113,459	113,459		
d. Accounting and Auditing	$				
e. Legal (*Services should be fully described on Page 7)*	$	225	225		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	8,503	8,503		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	20,221	20,221		
2. Cellular Phones	$	1,779	1,779		
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*)	$	281	281		
See Attached Schedule					
3. Resident Day User Fee	$	426,559	426,559		
Subtotal	$	1,340,602	1,340,602		

* 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	$ -	$ -	
3005520020	Union Health & Welfare	$ 302	$ -	
3030520020	Union Health & Welfare	$ 1,853	$ -	
3225520020	Union Health & Welfare	$ 9,693	$ -	
5035520020	Union Health & Welfare	$ 12	$ -	
3080520000	Elimination-Benefits	$ 773	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
Total		$ 12,634	$ -	$ -

0

Schedule of Other Taxes

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax	$ 215	$ -	$ -
1020640110	Sales Tax	$ 66	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
Total		$ 281	$ -	$ -

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
Madison House Care and Rehabilitation Center	2201-C	9/30/2017	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,340,602	1,340,602		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	20	20		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	3,335	3,335		
5. Education Expenses Related to Seminars and Conventions	$	311	311		
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*)***	$	11,311	11,311		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	0	0		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	1,345	1,345		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	7,305	7,305		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	205	205		
9. Subscriptions	$	100	100		
10. Contributions***	$	1,140	1,140		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	2,912	2,912		
12. Administrative Management Services**	$	300,611	300,611		
13. Other (*Specify*)	$	49,913	49,913		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,719,110	1,719,110		

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

Schedule of Other Advertising

Description		CCNH	RHNS	(Specify)
1020630020	Advertising	$ 121	$ -	$ -
1020630020	Advertising	$ 1,401	$ -	$ -
1020630330	Marketing Expense	$ 4,468	$ -	$ -
1020630330	Marketing Expense	$ 71	$ -	$ -
3165630330	Marketing Expense	$ 66	$ -	$ -
1020630331	Marketing Exp- Corporate Spend	$ 32	$ -	$ -
1020630331	Marketing Exp- Corporate Spend	$ 457	$ -	$ -
1020630331	Marketing Exp- Corporate Spend	$ 4,695	$ -	$ -
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		$ 11,311	$ -	$ -

Schedule of Dues

Description		CCNH	RHNS	(Specify)
1020630310	Licenses and Certification fee	$ 7,305	$ -	$ -
1020630310	0	$ -	$ -	$ -
1020630310	0	$ -	$ -	$ -
1020630310	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -

Total Dues		$ 7,305	$ -	$ -

Schedule of Contributions

Description		**CCNH**	**RHNS**	**(Specify)**
1020630135	Political Contributions	$ 1,140	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
Total Contributions		$ 1,140	$ -	$ -

Schedule of Other Administrative and General

Description		**CCNH**	**RHNS**	**(Specify)**
1020630060	Bank Service Charges	$ 2,888	$ -	$ -
1020630120	Collection Fees	$ 2,800	self-disallowed	$ -
1020630120	Collection Fees	$ 115	self-disallowed	$ -
1020630140	Education Expense	$ 130	$ -	$ -
1020630140	Education Expense	$ 18	$ -	$ -
1020630180	Employee Physicals	$ 8,387	$ -	$ -
1020630200	Employee Relations	$ 2,049	$ -	$ -
1020630380	Printing	$ 158	$ -	$ -
3080630440	Recruiting Fees	$ 5,318	$ -	$ -
1020630610	Training Expense	$ 76	$ -	$ -
1020630610	Training Expense	$ 533	$ -	$ -
1020640080	Fines & Penalties	$ 21,693	$ -	$ -
1020640090	Miscellaneous	$ 582	$ -	$ -
1020640090	Miscellaneous	$ (1)	$ -	$ -
1020660080	Rental Expense	$ 11	$ -	$ -
1020660990	Accrued Expense Estimation	$ 498	self-disallowed	$ -
5095720090	Landlord Operating Taxes	$ 2,400	$ -	$ -
1020630120	Collection Fees	$ 2,258	self-disallowed	$ -
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 Administrative and General		$ 49,913	$ -	$ -
		0		

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Madison House Care and Rehabilitation C	2201-C	9/30/2017	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	347,912	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	27,156	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
Madison House Care and Rehabilitation Center	2201-C	9/30/2017	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	117,870	117,870		
2. Non-Food Supplies	$	16,132	16,132		
3. Other (*Specify*)_____	$	(1,795)	(1,795)		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	147,426	147,426		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	279,634	279,634		

		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
Madison House Care and Rehabilitation Center	2201-C	9/30/2017	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. $	3,431	3,431		
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. $	6,947	6,947		
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	129,330	129,330		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	139,708	139,708		

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
Madison House Care and Rehabilitation Center	2201-C	9/30/2017	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.	$	8,290	8,290		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	195,044	195,044		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	203,334	203,334		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	147,793	147,793		
b. Medicine Cabinet Drugs		$	16,777	16,777		
c. Medical and Therapeutic Supplies		$	44,269	44,269		
d. Ambulance/Limousine***		$	1,750	1,750		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	8,559	8,559		
f. X-rays and Related Radiological Procedures***		$	4,112	4,112		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	15,749	15,749		
i. Recreation		$	28,903	28,903		
j. Other (Specify)**** See Attached Schedule		$	51,684	51,684		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	319,596	319,596		

* 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	$ 28,824.96	$ -	$ -
3080630030	Advertising-Help Wan	$ 203.73	$ -	$ -
3080630030	Advertising-Help Wan	$ 753.81	$ -	$ -
3080630140	Education Expense	$ 1,026.12	$ -	$ -
3080630140	Education Expense	$ 675.88	$ -	$ -
3080630200	Employee Relations	$ 42.52	$ -	$ -
3120630530	Supplies	$ 250.35	$ -	$ -
3155630530	Supplies	$ 2,563.83	$ -	$ -
3155630530	Supplies	$ 2,426.08	$ -	$ -
3165630530	Supplies	$ 58.43	$ -	$ -
3170630530	Supplies	$ 123.14	$ -	$ -
3090630535	Office Supplies	$ 167.16	$ -	$ -
3120630535	Office Supplies	$ 239.56	$ -	$ -
3165630535	Office Supplies	$ 6.37	$ -	$ -
3120660080	Rental Expense	$ 169.98	$ -	$ -
3155660080	Rental Expense	$ (69.36)	$ -	$ -
3155660080	Rental Expense	$ 8,230.00	$ -	$ -
3010610300	Consolidated Billing	$ 5,991.85	$ -	$ -
0	0	$ -	$ -	$ -
Total Other Resident Care		$ 51,684	$ -	$ -
		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
Madison House Care and Rehabilitation Center	2201-C	9/30/2017	21	37

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	129,330			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Housekeeping Purchased Services	195,044			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Dietary Purchased Services	146,065			18	2b
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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
Madison House Care and Rehabilitation Cente	2201-C	9/30/2017	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	215,196	215,196		
b. Heat	$	39,432	39,432		
c. Light & Power	$	151,213	151,213		
d. Water	$	48,109	48,109		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	453,951	453,951		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	1,770	1,770		
b. Building & Building Improvements	$	35,081	35,081		
c. Non-Movable Equipment	$	39,902	39,902		
d. Movable Equipment	$	16,017	16,017		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	92,770	92,770		
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	$	653,846	653,846		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	157,353	157,353		
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	903,969	903,969		

* 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

Account	Description	CCNH	RHNS	(Specify)
5035630310	Connecticut Depar	$ -	$ -	$ -
5035630310	State of Connecticu	$ -	$ -	$ -
Total Other Repairs and Mainte		$ -	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Madison House Care and Rehabilitation Center	2201-C	9/30/2017	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	25,569		25,569	2,065	S/L	Various	1,770	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								1,770
B. **Building and Building Improvements**								
1. Acquired prior to this report period	381,438		381,438	97,756	S/L	Various	24,759	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	125,289		125,289				10,322	
B-4. Subtotal								35,081
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	355,648		355,648	100,801	S/L	Various	36,663	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	47,490		47,490				3,239	
C-4. Subtotal								39,902

	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					134,144		134,144	59,740	S/L	Various	15,034	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					15,287		15,287				983	
D-3. Subtotal												16,017
E. ***Total Depreciation***												92,770

Madison House Care and Rehabilitation Center
9/30/2017

Schedule of Land Improvements Acquired during this report period

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

***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:									
10/31/2016	Mannington plank flooring	$ 34,530.41	7	$ 4,521.84					
9/30/2017	Vinyl plank flooring seam taoe cove ba	$ 23,053.46	7	$ -					
11/30/2016	8 water heat souece heat pumps	$ 18,400.00	7	$ 2,190.48					
1/31/2017	1st payment on 8 water source heat pu	$ 18,400.00	7	$ 1,752.38					
5/31/2017	Daikin WSHP	$ 15,394.16	7	$ 733.06					
4/30/2017	Plank flooring cove bases adhesive and	$ 7,708.18	7	$ 458.82					
1/31/2017	Final payment on 8 water souece heat p	$ 4,085.00	7	$ 389.05					
3/31/2017	ROUNDED HANDRAILS	$ 2,824.66	7	$ 201.76					
2/28/2017	Waste water treatment motor	$ 893.12	7	$ 74.43					
Total additions for Building Improvemen		$ 125,289		$ 10,322	*	$ -	$ -	$ -	
Deletions:									
0	0	$ -	0	$ -					
0	0	$ -	0	$ -					
0	0	$ -	0	$ -					
0	0	$ -	0	$ -					
Total deletions for Building Improvement		$ -		$ -	**	$ -	$ -	$ -	

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

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

Schedule of Non-Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation					
Additions:									
11/30/2016	Hot water tank	$ 13,090.00	7	$ 1,558.33					
3/31/2017	Walk in cooler/freezer	$ 9,092.93	7	$ 649.50					
5/31/2017	Walk in cooler/freezer	$ 18,185.85	7	$ 865.99					
7/31/2017	Sheetrock for Walk-in Freezer	$ 244.30	7	$ 5.82					
7/31/2017	Electric for Walk-in Freezer	$ 2,734.64	7	$ 65.11					
7/31/2017	New Sheetrock for Walk-in Freezer	$ 3,110.00	7	$ 74.05					
7/31/2017	Electrical Work-Refridgeration Unit	$ 635.12	7	$ 15.12					
7/31/2017	Sheetrock for Walk-in Freezer	$ 96.18	7	$ 2.29					
42947	Supplies-Walk-in Freezer Project	$ 108.02	7	$ 2.57					
42947	Sheetrock for Walk-in Freezer	$ 26.73	7	$ 0.64					
	Sep 2017 Accruals	$ 166.65		$ -					
Total additions for Non-Movable Equipmen		$ 47,490		$ 3,239	*	$ -	$ -	$ -	
Deletions:									

Total deletions for Non-Movable Equipmen		$ -		$ -	**	$ -	$ -	$ -	

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report perio

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation					
Additions:									
6/30/2017	Thurmaduke Steam Table	$ 5,657.80	7	$ 202.06					
3/31/2017	Camshelving Elements Stationary Ven	$ 3,178.48	7	$ 227.03					
1/31/2017	10 MATTRESS,GENESIS VISCO SE	$ 3,137.33	7	$ 298.79					
1/31/2017	Food Processor, 3 qt., 1 HP	$ 1,010.71	7	$ 96.26					
2/28/2017	5 Tracer EX2 Wheelchair	$ 629.90	7	$ 52.49					
2/28/2017	2 Attendant Handheld Pulse Oximeter	$ 600.07	7	$ 50.01					
4/30/2017	Brother IntelliFax 4100e Laser FAX	$ 319.04	7	$ 18.99					
5/31/2017	Sales and Use Tax	$ 266.00	7	$ 12.67					
8/31/2017	Sales & Use Tax	$ 197.00	7	$ 2.35					
2/28/2017	2 Direct Choice Overbed Table	$ 148.85	7	$ 12.40					
3/31/2017	LED HDTV	$ 141.45	7	$ 10.10					
Total additions for Movable Equipmen		$ 15,287		$ 983	*	$ (0)	$ -	$ -	
Deletions:									
0	0	$ -	0	$ -					
0	0	$ -	0	$ -					
0	0	$ -	0	$ -					
0	0	$ -	0	$ -					
Total deletions for Movable Equipmen		$ -		$ -	**	$ -	$ -	$ -	

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

Schedule of Leasehold Improvements Acquired during this report perio

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

***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
Madison House Care and Rehabilitation Center	2201-C	9/30/2017	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
Madison House Care and Rehabilitatio	2201-C	9/30/2017	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	90
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
SABRA, 101 Sun Ave. NE, Albuquerque, NM 87107	Facility Lease	11/15/10 - 6/30	127 months	653,846

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
Madison House Care and Rehabilitati	2201-C	9/30/2017	26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	27,156	27,156		
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)	$	27,156	27,156		

(*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
Madison House Care and Rehabilita	2201-C	9/30/2017	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	27,156	27,156		
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) $	27,156	27,156		
14. Insurance				
a. Insurance on Property (buildings only) $	18,940	18,940		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	143,357	143,357		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	162,297	162,297		
15. ***Total All Expenditures (A-13 thru C-14)*** $	7,990,570	7,990,570		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Madison House Care and Rehabilitation Center	2201-C	9/30/2017	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 $	25,709	25,709		
Page 13 - Professional Fees							
5.	13	B-8-c	Resident Care Physicians ** $				
6.		B-10	Occupational Therapy $				
7.			Other - See attached Schedule $	454,976	454,976		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1-c	Bad Debts $	113,459	113,459		
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 * $	11,311	11,311		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $	1,140	1,140		
21.			Unallowable Management Fees $	327,767	327,767		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	(54,686)	(54,686)		
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) $	879,676	879,676		

* 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	$ 25,708.56	$ -	$ -
10	A-12d	unallowed C.N.A no license period sa	0	$ -	$ -	$ -
10	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
Total Other Salaries Adjustment				$ 25,709	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	$ 60,687.13	$ -	$ -
13	5	Rehabilitation Services	3195620020	$ 302,034.88	$ -	$ -
13	9	Speech Therapist	3170620020	$ 22,279.51	$ -	$ -
13	10	Occupational Therapist	3105620020	$ 54,031.42	$ -	$ -
13	12	Other	3010620020	$ 20.00	$ -	$ -
13	12	Other	3015620020	$ 13,947.00	$ -	$ -
13	12	Respiratory Purchased Servies	3155620020	$ 1,976.00	$ -	$ -
Total Other Fees Adjustments				$ 454,976	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	1020630120	$ 5,173.18	$ -	$ -
16	m-8a	Chamber of Commerce	1020630310	$ 205.00	$ -	$ -
16	m-13	Estimated Accrual	1020660990	$ 497.50	$ -	$ -
16	m-12	Management Fee disallowed	CBO service Fee	$ -	$ -	$ -
16	m-13	Non-recurring Charges	7010800030	$ -	$ -	$ -
16	m-13	Penalty and Fines	1020640080	$ 21,693.00	$ -	$ -
15	1	0	0	$ -	$ -	$ -
15	1a4	0	0	$ -	$ -	$ -
15	1-a-1	adj workers comp	0	$ (82,254.68)	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
Total Other A&G Adjustments				$ (54,686)	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Madison House Care and Rehabilitation Center	2201-C	9/30/2017	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	879,676	879,676		
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs $	147,793	147,793		
28.	20	5-d	Ambulance/Limousine $	1,750	1,750		
29.	20	5-f	X-rays, etc $	4,112	4,112		
30.	20	5-h	Laboratory $	15,749	15,749		
31.			Medical Supplies $				
32.	20	5-e-2	Oxygen (non emergency) $	8,559	8,559		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	31,692	31,692		
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 $	135,300	135,300		
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)*** $	1,224,629	1,224,629		

*** 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.

Attachment Page 29

Madison House Care and Rehabilitation Center
9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	$ 5,991.85	3010610300	$ -
20	5-j	Respiratory Supplies	$ 4,989.91	3155630530	$ -
20	5-j	Respiratory Rental	$ 8,160.64	3155660080	$ -
20	5-i	Cable TV	$ 12,549.17	3005660130	allow $3600
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
Total Other Ancillary Costs			$ 31,692	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14 c1	General liability Insurance Adjust	130,300.02	0	0
27	14c1	General liability Insurance Adjust	5,000.00	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-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
Total Other Adjustments			$ 135,300	$ -	$ -

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Madison House Care and Rehabilitation C	2201-C	9/30/2017	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	8,884,771	8,884,771		
b. Medicaid Room and Board Contractual Allowance **	$	(4,542,649)	(4,542,649)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,644,404	1,644,404		
b. Medicare Room and Board Contractual Allowance **	$	(587,018)	(587,018)		
4. a. Private-Pay Residents and Other	$	1,254,925	1,254,925		
b. Private-Pay Room and Board Contractual Allowance **	$	(255,291)	(255,291)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	120,504	120,504		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(43,017)	(43,017)		
c. Prescription Drugs - Non-Medicare	$	36,715	36,715		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(8,377)	(8,377)		
2. a. Medical Supplies - Medicare	$	1,387	1,387		
b. Medical Supplies - Medicare Contractual Allowance **	$	(495)	(495)		
c. Medical Supplies - Non-Medicare	$	379	379		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(155)	(155)		
3. a. Physical Therapy - Medicare	$	459,722	459,722		
b. Physical Therapy - Medicare Contractual Allowance **	$	(164,111)	(164,111)		
c. Physical Therapy - Non-Medicare	$	95,464	95,464		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(22,349)	(22,349)		
4. a. Speech Therapy - Medicare	$	55,025	55,025		
b. Speech Therapy - Medicare Contractual Allowance **	$	(19,643)	(19,643)		
c. Speech Therapy - Non-Medicare	$	20,097	20,097		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(4,886)	(4,886)		
5. a. Occupational Therapy - Medicare	$	491,459	491,459		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(175,441)	(175,441)		
c. Occupational Therapy - Non-Medicare	$	110,124	110,124		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(27,028)	(27,028)		
6. a. Other *(Specify)* - Medicare	$	12,073	12,073		
b. Other *(Specify)* - Non-Medicare	$	3,798	3,798		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	7,340,387	7,340,387		
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	$	136	136		
5. Interest Income *(Specify)*	$	(90)	(90)		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	14,883	14,883		
8. Other (*Specify*)	$	1,484	1,484		
V. Total Other Revenue (1 thru 8)	$	16,413	16,413		
VI. Total All Revenue (III +V)	$	7,356,800	7,356,800		

* *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	2,028.00	-	0
II-6-a	Medicare Part A	Radiology Service	-	-	0
II-6-a	Medicare Part A	Outpatient Therapy Program	-	-	0
II-6-a	Medicare Part A	Laboratory	11,230.77	-	0
II-6-a	Medicare Part A	Respiratory Therapy & Supplies	1,356.30	-	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	-	-	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	4,160.00	-	0
II-6-a	Contractuals-Medicare	X-Ray	(723.95)	-	0
II-6-a	Contractuals-Medicare	Radiology Service	-	-	0
II-6-a	Contractuals-Medicare	Outpatient Therapy Program	-	-	0
II-6-a	Contractuals-Medicare	Laboratory	(4,009.15)	-	0
II-6-a	Contractuals-Medicare	Respiratory Therapy & Supplies	(484.17)	-	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	-	-	0
II-6-a	Contractuals-Medicare	Physician Visit	-	-	0
II-6-a	Contractuals-Medicare	Ambulance	-	-	0
II-6-a	Contractuals-Medicare	Flu Shot	(1,485.03)	-	0
Total Other Resident Revenue - Medicare			$ 12,073	$ -	$ -
			$ (0)		

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	581.09	0	0
II-6-b	Medicaid	Radiology Service	-	0	0
II-6-b	Medicaid	Outpatient Therapy Program	-	0	0
II-6-b	Medicaid	Laboratory	375.04	0	0
II-6-b	Medicaid	Respiratory Therapy & Supplies	1,487.52	0	0
II-6-b	Medicaid	Nursing Treatment Supplies	-	0	0
II-6-b	Medicaid	Audiology	-	0	0
II-6-b	Medicaid	Incontinency	-	0	0
II-6-b	Medicaid	Oxygen & Supplies	-	0	0
II-6-b	Medicaid	Physician Visit	-	0	0
II-6-b	Medicaid	Ambulance	-	0	0
II-6-b	Medicaid	Flu Shot	-	0	0
II-6-b	Contractuals Medicaid	X-Ray	(297.10)	0	0
II-6-b	Contractuals Medicaid	Radiology Service	-	0	0
II-6-b	Contractuals Medicaid	Outpatient Therapy Program	-	0	0
II-6-b	Contractuals Medicaid	Laboratory	(191.75)	0	0
II-6-b	Contractuals Medicaid	Respiratory Therapy & Supplies	(760.55)	0	0
II-6-b	Contractuals Medicaid	Nursing Treatment Supplies	-	0	0
II-6-b	Contractuals Medicaid	Audiology	-	0	0
II-6-b	Contractuals Medicaid	Incontinency	-	0	0
II-6-b	Contractuals Medicaid	Oxygen & Supplies	-	0	0
II-6-b	Contractuals Medicaid	Physician Visit	-	0	0
II-6-b	Contractuals Medicaid	Ambulance	-	0	0
II-6-b	Contractuals Medicaid	Flu Shot	-	0	0

II-6-b	Private and Other	X-Ray	390.00	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	2,591.75	0	0
II-6-b	Private and Other	Respiratory Therapy & Supplies	153.12	0	0
II-6-b	Private and Other	Nursing Treatment Supplies	-	0	0
II-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	-	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	134.00	0	0
II-6-b	Private and Other	Capitation Contracts	-	0	0
II-6-b	Contractuals-Non-Medicaid	X-Ray	(79.34)	0	0
II-6-b	Contractuals-Non-Medicaid	Radiology Service	-	0	0
II-6-b	Contractuals-Non-Medicaid	Outpatient Therapy Program	-	0	0
II-6-b	Contractuals-Non-Medicaid	Laboratory	(527.24)	0	0
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplies	(31.15)	0	0
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment Supplies	-	0	0
II-6-b	Contractuals-Non-Medicaid	Audiology	-	0	0
II-6-b	Contractuals-Non-Medicaid	Incontinency	-	0	0
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplies	-	0	0
II-6-b	Contractuals-Non-Medicaid	Physician Visit	-	0	0
II-6-b	Contractuals-Non-Medicaid	Ambulance	-	0	0
II-6-b	Contractuals-Non-Medicaid	Flu Shot	(27.26)	0	0
II-6-b	Contractuals-Non-Medicaid	Capitation Contracts	-	0	0
Total Other Resident Revenue			$ 3,798	$ -	$ -
			$ 0		

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 30 line I	430055	Interest On Overdue Accounts	$ (90)	$ -	$ -
Total Interest Income			$ (90)	$ -	$ -
			$ (0)		

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
Pg 30 line I	Medical records	0	$ 316.55	$ -	$ -
Pg 30 line I	Medicare B Refund	0	$ 109.11	$ -	$ -
Pg 30 line I	Donation	0	$ 133.34	$ -	$ -
Pg 30 line I	Madison School for Yong Cl	0	$ 500.00	$ -	$ -
Pg 30 line I	Beach Babies Larning center	0	$ 425.00	$ -	$ -
Total Other Revenue			$ 1,484	$ -	$ -
			$ -		

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Madison House Care and Rehabilitation	2201-C	9/30/2017	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 8,163
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 855,271
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (100,367)
4 Inventories				$ 23,185
5. Prepaid Expenses				$ 48,290
a. Prepaid Expenses		5,275		
b. Prepaid Personal Property Tax				
c. Prepaid Personal Property Tax		4,645		
d. Interest Receivable				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
Total Current Assets (Lines A1 thru 8)				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 834,542
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	25,569		$ 21,734
	Accum. Depreciation	3,835	Net	
3. Buildings	*Historical Cost	506,727		$ 373,891
	Accum. Depreciation	132,836	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	403,139		$ 262,436
	Accum. Depreciation	140,703	Net	
6. Movable Equipment	*Historical Cost	149,431		$ 73,674
	Accum. Depreciation	75,757	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)				$ 731,735

* 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
Madison House Care and Rehabilitation	2201-C	9/30/2017	32	37

Account				Amount
			Total Brought Forward:	$ 1,566,277
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*)			$ (2,547,643)
	I/C Due to/Due From Owned		(2,547,643)	
	I/C Due to/Due From Multicare			
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)			$ (2,547,643)
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$ (981,366)

* 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
Madison House Care and Rehabilitation Cente	2201-C	9/30/2017	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 341,604
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*)					$ 117,115
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 644
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*)					$ 309,973
Accrued Provider/Bed Tax	100,034	Accr Exp Electricity	5,107		
A/R Credit Gross Up Liability	150,602	Deferred Revenue	22,609		
Accr Exp Water and Sewer	3,789	Accr Exp Other and Accı	9,331		
Accr Exp Gas	1,573	Accr Gross Rec Tax-FY1	16,928		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 769,336

* 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
Madison House Care and Rehabilitation Cen	2201-C	9/30/2017	34	37

Account	Amount
Total Brought Forward:	769,336
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*)		$ 156,324
LT Debt-Financing Obligation	156,324	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 156,324
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 925,660

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

Name of Facility	License No.	Report for Year Ended	Page	of
Madison House Care and Rehabilitatio	2201-C	9/30/2017	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	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ (1,273,261)
	6. Gain or Loss for Period 10/1/2016 thru 9/30/2017	$ (633,768)
	7. Total Net Worth	$ (1,907,029)
C.	***Total Reserves and Net Worth***	$ (1,907,029)
D.	***Total Liabilities, Reserves, and Net Worth***	$ (981,369)

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Madison House Care and Rehabilitation	2201-C	9/30/2017	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2016			$ (1,273,260)
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 7,356,800
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 7,990,569
D.	Net Income or Deficit			$ (633,769)
E.	Balance			$ (1,907,029)
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*** 09/30/17			$ (1,907,029)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Madison House Care and Rehabilitation	2201-C	9/30/2017	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 - Sr Director of Reimbursement

Addres Address	Phone Number
200 Brickstone Square, Andover, MA 01810	978-247-5029