

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

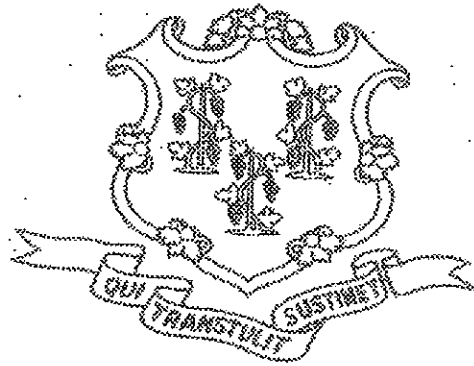
DRAFT

Arden House

Facility: 7
Page: 22
Date: 01/28/2016

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

State of Connecticut



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Annual Report of Long-Term Care Facility Cost Year 2015

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DEPT. OF SOCIAL SERVICES
OFFICE OF CON AND RATE SETTINGS

Name of Facility (as licensed) Arden House Care and Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 850 Mix Avenue, Hamden, CT 06514	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 2199-C	RHNS	(Specify)	Medicare Provider 07-5228
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Medicaid Provider Numbers:	CCNH 20371	RHNS	ICF-IID
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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

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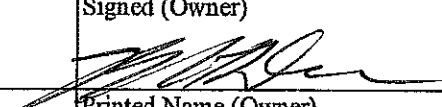

Administrator's/Owner's Certification

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

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

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
					11/12/2015
Printed Name (Administrator) McDonnell, Patrick Michael			Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare		
Subscribed and Sworn to before me:	State of PA	Date 11/13/15	Signed (Notary Public) 		Comm. Expires / /
Address of Notary Public					

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
 OLUSEGUN A. OMOLAJA, Notary Public
 Upper Darby Twp., Delaware County
 My Commission Expires May 28, 2017

(Notary Seal)

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General Information

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Arden House Care and Rehabilitation Center		Period Covered:	From 10/1/2014	To 9/30/2015
Address of Facility 850 Mix Avenue, Hamden, CT 06514				
Report Prepared By Thomas Farnan		Phone Number 978-247-5029	Date 12/20/2014	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$ 1,427,154	1,427,154		
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$ 10,463,605	10,463,605		
5. All other wages paid	\$ 1,263,971	1,263,971		
6. Total Wages Paid	\$ 13,154,731	13,154,731		
7. Total salaries paid	\$ 411,086	411,086		
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$ 13,565,817	13,565,817		

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-281-3500		Report for Year Ended 9/30/2015	Page 2	of 37
Name of Facility (as shown on license) Arden House Care and Rehabilitation Center		Address (No. & Street, City, State, Zip) 850 Mix Avenue, Hamden, CT 06514		
License Numbers:	CCNH 2199-C	RHNS (Specify)	Medicare Provider No. 07-5228	
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator McDonnell,Patrick Michael		Nursing Home Administrator's License No.:	1574	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

General Information and Questionnaire
Corporate Owners

Name of Facility Arden House Care and Rehabilitation Center	License No. 2199-C	Report for Year Ended 9/30/2015	Page 3A	of 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	
Arden 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				

General Information and Questionnaire Related Parties*

Name of Facility Arden House Care and Rehabilitation Center	License No. 2199-C	Report for Year Ended 9/30/2015	Page 4	of 37	
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No					
If "Yes," provide the following information:					
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Indicate Where Costs are Included in Annual Report Page # / Line #	Actual Cost to the Related Party
		Yes	No		
Genesis Health Ventures	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Home Office Pg 16/m12	1,263,639
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	63% PE/OT/ST- Direct and Indirect Cost Pg 13/B5, 9,10	1,442,382
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	55% Staffing Pool Pg 10/A12	63,569
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	85% Case Management Pg 13/B8, Pg 10/A12	113,563
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Staffing Pool Pg 13/B11 a,b,c	69,059
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>	43% Respiratory Therapy Pg 13/B12, Pg 20/C5E	94,273
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Insurance Pg 27/14	427,943
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Capital Interest Page 17, page 26-12A	119,003

* Use additional sheets if necessary.

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

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility Arden House Care and Rehabilitation Center	License No. 2199-C	Report for Year Ended 9/30/2015	Page 5	of 37
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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 (<i>See listing page 13</i>)
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.

- In the preparation of this Report, were all costs allocated as required? Yes No If "No," explain fully why such allocation was not made.
- Explain the allocation of related company expenses and attach copy of appropriate supporting data.
- 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.

General Information and Questionnaire
Accounting Basis

Name of Facility Arden House Care and Rehabilitati	License No. 2199-C	Report for Year Ended 9/30/2015	Page 7	of 37
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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 1 KPMG Peat Marwick 2 3 4	Address (No. & Street, City, State, Zip Code) 1600 Market Street, Philadelphia, PA 19103
---	---

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 1 American Arbitration Association 2 Hamden Government Center Cout of Probate 3 Timothy S Wall State Marshall 4 5	Telephone Number 203-287-7082 203-265-7173
---	--

Address (<i>No. & Street, City, State, Zip Code</i>) 1 45 Notch Rd Bolton, CT 06043 2 2750 Dixwell Ave Hamden, CT 06518 3 P O Box 297 Wallingford, CT 06492 4 5
--

Services Provided by This Firm (*describe fully*)

1 Arbitrator Compensation regarding lawsuit with nursing agency union -NE Healthcare Employees Union, District 1199, SEIU	\$
2 Probate Court Fees	\$
3 Citation and Return/Appointment of Conservator	\$
4	\$
5	\$
	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 Fees pg. 15 1-e

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended		Page	of										
		9/30/2015				8	37								
		Period 10/1 Thru 6/30	Period 7/1 Thru 9/30												
Arden House Care and Rehabilitation Center	2199-C	Total CCNH Level	Total RHNS Level	Total	CCNH	RHNS	Total	CCNH	RHNS	Total	CCNH	RHNS	Total	(Specify)	
1. Certified Bed Capacity															
A. On last day of PREVIOUS report period		360	360					360	360			360	360		
B. On last day of THIS report period		360	360					360	360			360	360		
2. Number of Residents															
A. As of midnight of PREVIOUS report period		296	296					296	296			305	305		
B. As of midnight of THIS report period		298	298					305	305			298	298		
3. Total Number of Days Care Provided During Period															
A. Medicare		8,710	8,710					7,055	7,055			1,655	1,655		
B. Medicaid (Conn.)		97,793	97,793					72,946	72,946			24,847	24,847		
C. Medicaid (other states)															
D. Private Pay		4,814	4,814					3,683	3,683			1,131	1,131		
E. State SSI for RCH															
F. Other (Specify)		2,982	2,982					2,527	2,527			455	455		
G. Total Care Days During Period (3A thru F)		114,299	114,299					86,211	86,211			28,088	28,088		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds															
A. Medicaid Bed Reserve Days															
B. Other Bed Reserve Days		5	5									5	5		
5. Total Resident Days (3G + 4A + 4B)		114,304	114,304					86,211	86,211			28,093	28,093		

Schedule of Resident Statistics (Cont'd)

Name of Facility Arden House Care and Rehabilitation Center			License No. 2199-C			Report for Year Ended 9/30/2015			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> 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			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
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	15		268			15							
Per Diem Rate													
a. One bed rm.						435.00							
b. Two bed rms.	520.21		213.80			413.01							
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								7,296	7,296				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								2,537	2,537				
C. Other								23,393	23,393				
D. Total Physical Therapy Treatments								33,226	33,226				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								994	994				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								259	259				
C. Other								2,291	2,291				
D. Total Speech Therapy Treatments								3,544	3,544				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								4,464	4,464				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								2,127	2,127				
C. Other								20,059	20,059				
D. Total Occupational Therapy Treatments								26,650	26,650				

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Arden House Care and Rehabilitation Center	2199-C	9/30/2015	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> 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)	153,398	2,597				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	57,983	1,502				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	396,695	16,381				
5. Dietary Service						
a. Head Dietitian	71,246	2,225				
b. Food Service Supervisor	189,029	7,403				
c. Dietary Workers	1,166,880	66,881				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	120,796	4,436				
b. Other Maintenance Workers	154,244	8,817				
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	199,706	3,851				
b. RN						
1. Direct Care	1,461,164	39,655				
2. Administrative**	91,738	2,478				
c. LPN						
1. Direct Care	3,624,855	122,606				
2. Administrative**						
d. Aides and Attendants	5,059,285	281,862				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	294,226	16,046				
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	298,010	12,788				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	226,562	10,537				
A-13. Total Salary Expenditures	13,565,817	600,065				

* 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.

State of Connecticut
 Annual Report of Long-Term Care Facility
 CSP-11 Rev. 10/2005

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

Name of Facility	License No.	Report for Year Ended	Page	of						
					2199-C	9/30/2015	11	37		
Name	Name of Facility and Rehabilitation Center		Line Where Claimed on Page 10	Total Hours Worked	Full Description of Services Rendered	Fringe Benefits and/or Other Payments (describe fully)	Total Hours Worked	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	REHNS								
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.

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

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

Name of Facility (as licensed) Arden House Care and Rehabilitation Center		License No. 2199-C		Report for Year Ended 9/30/2015		Page 12	of 37			
Name	CCNH	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
		RHNS	(Specify)							
Section III - Administrators***										
McDonnell, Patrick Michael 6/15/15-9/30/15	39,201				Management of Center	630	2			
Kevin Cleary 10/1/14-5/27/15	91,552				Management of Center	1,320	2			
Vitko-Aniolek, Stephanie Margaret 4/26/15-8/27/15	22,645				Management of Center	647	2			
Section IV - Assistant Administrators										
Vitko-Aniolek, Stephanie Margaret 8/27/15-9/30/15	6,753				Assists in Overseeing Facility	190	3			
Jona C. Tamowicz 10/1/2014-8/5/2015	51,230				Assists in Overseeing Facility	1,312	3			

*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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Arden House Care and Rehabilitation Center	2199-C	9/30/2015	13	37		
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	2,217	60				
2. Dentist	46,792	320				
3. Pharmacist	26,684	545				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	1,106,881	15,163				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	113,563	601				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	125,022	1,603				
b. Other						
10. Occupational Therapist						
a. Resident Care	222,008	3,041				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	83,180	1,387				
2. Administrative***						
b. LPN						
1. Direct Care	93,995	2,219				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	11,810					
B-13 Total Fees Paid in Lieu of Salaries	1,832,151	24,939				

* 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.

C. Expenditures Other Than Salaries - Administrative and General

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

* 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**

Arden House Care and Rehabilitation Center
9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
Arden House Care and Rehabilitation Center	2199-C	9/30/2015		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	5,297,864	5,297,864			
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 3,703	3,703			
5. Education Expenses Related to Seminars and Conventions	\$ 554	554			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$				
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 12,402	12,402			
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	\$ 11,169	11,169			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 21,178	21,178			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 4,702	4,702			
9. Subscriptions	\$ 151	151			
10. Contributions*** See Attached Schedule	\$ 4,837	4,837			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 7,072	7,072			
12. Administrative Management Services**	\$ 1,305,736	1,305,736			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 127,893	127,893			
C-14 Total Administrative & General Expenditures	\$ 6,797,260	6,797,260			

* 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.

0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
Total Dues		\$ 21,178	\$ -	\$ -

Schedule of Contributions

Description		CCNH	RHNS	(Specify)
Total Contributions	0	\$ 4,837	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
0	0	\$ -	\$ -	\$ -
Total Contributions		\$ 4,837	\$ -	\$ -

Schedule of Other Administrative and General

Description		CCNH	RHNS	(Specify)
1020630060	Bank Service Charges	\$ 7,888	\$ -	\$ -
1020630060	Bank Service Charges	\$ 32	self-disallowed	\$ -
1020630120	Collection Fees	\$ 43,840	self-disallowed	\$ -
1020630120	Collection Fees	\$ 23	self-disallowed	\$ -
1020630120	Collection Fees	\$ 66	self-disallowed	\$ -
1020630120	Collection Fees	\$ 11,773	self-disallowed	\$ -
1020630140	Education Expense	\$ 134	\$ -	\$ -
1020630140	Education Expense	\$ 39	\$ -	\$ -
1020630180	Employee Physicals	\$ 19,893	\$ -	\$ -
1020630200	Employee Relations	\$ 6,390	\$ -	\$ -
1020630200	Employee Relations	\$ 212	\$ -	\$ -
1020630380	Printing	\$ 112	\$ -	\$ -
1020630380	Printing	\$ 154	\$ -	\$ -
3210630440	Recruiting Fees	\$ 4,041	\$ -	\$ -
1020630610	Training Expense	\$ 87	\$ -	\$ -
1020630610	Training Expense	\$ 84	\$ -	\$ -
1020630610	Training Expense	\$ 652	\$ -	\$ -
1020630640	Uniforms	\$ 242	\$ -	\$ -
1020640080	Fines & Penalties	\$ 13,628	self-disallowed	\$ -
1020640090	Miscellaneous	\$ 746	\$ -	\$ -
1020640090	Miscellaneous	\$ (8)	\$ -	\$ -
1020660080	Rental Expense	\$ 14,157	\$ -	\$ -
1020660990	Accrued Expense Estimation	\$ 2,135	self-disallowed	\$ -
5095720020	Cap Stk/Franchise Tax	\$ 1,151	\$ -	\$ -
5095720090	Landlord Operating Taxes	\$ 2,400	\$ -	\$ -
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		\$ 127,893	\$ -	\$ -

Schedule C-1 - Management Services*

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

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Arden House Care and Rehabilitation Center		2199-C	9/30/2015		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 545,910	545,910			
2.	Non-Food Supplies	\$ 69,754	69,754			
3.	Other (Specify) _____	\$ (3,880)	(3,880)			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)						
c. Management Services**						
d. Other (Specify) _____						
2E. Total Dietary Expenditures (2a + b + c + d)		\$ 611,784	611,784			
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)	
G.	Resident Meals: Total no. of meals served per day:*					
H.	Is cost of employee meals included in 2E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No			
I.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.	
L.	Is any revenue collected from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.	
O.	Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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.

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

Name of Facility Arden House Care and Rehabilitation Center		License No. 2199-C	Report for Year Ended 9/30/2015	Page 19	of 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. \$	19,365	19,365		
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. \$	24,972	24,972		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	774,721	774,721		
c. Management Services**	\$				
d. Other (Specify)	\$				
3E. Total Laundry Expenditures (3a + b + c + d)	\$	819,058	819,058		
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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.

**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
Arden House Care and Rehabilitation Center		2199-C	9/30/2015		20	37
Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt.	\$ 48,394	48,394			
b. Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel					
	Amt.	\$ 1,163,065	1,163,065			
c. Management Services*		\$				
d. Other (<i>Specify</i>)		\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)		\$ 1,211,459	1,211,459			
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		\$				
2. Purchased from		\$ 405,587	405,587			
b. Medicine Cabinet Drugs		\$ 23,509	23,509			
c. Medical and Therapeutic Supplies		\$ 299,470	299,470			
d. Ambulance/Limousine***		\$ 38,985	38,985			
e. Oxygen						
1. For Emergency Use		\$				
2. Other****		\$ 26,126	26,126			
f. X-rays and Related Radiological Procedures***		\$ 15,198	15,198			
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$				
h. Laboratory****		\$ 42,633	42,633			
i. Recreation		\$ 45,025	45,025			
j. Other (<i>Specify</i>)**** See Attached Schedule		\$ 220,437	220,437			
5K. Total Resident Care Expenditures (5a - 5j)		\$ 1,116,971	1,116,971			

* 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.

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

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

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

Amortization Schedule*

Name of Facility Arden House Care and Rehabilitation Center	License No. 2199-C		Report for Year Ended 9/30/2015		Page 24	of 37	
	Date of Acquisition		Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**			Rate %
	Month	Year					
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.

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

Name of Facility Arden House Care and Rehabilitation	License No. 2199-C	Report for Year Ended 9/30/2015	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> 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		360			
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
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	163 months	2,001,958	

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Arden House Care and Rehabilitation		2199-C	9/30/2015		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$ 119,003	119,003		
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
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)			\$ 119,003	119,003		

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page	of
Arden House Care and Rehabilitatid	2199-C	9/30/2015	27	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	119,003	119,003		
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)	\$	119,003	119,003	
14. Insurance				
a. Insurance on Property (buildings only)	\$	10,755	10,755	
b. Insurance on Automobiles	\$			
c. Insurance other than Property (as specified above)				
1. Umbrella (Blanket Coverage)	\$	417,188	417,188	
2. Fire and Extended Coverage	\$			
3. Other (Specify)	\$			
14d. Total Insurance Expenditures (14a + b + c)	\$	427,943	427,943	
15. Total All Expenditures (A-13 thru C-14)	\$	30,200,269	30,200,269	

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
Arden House Care and Rehabilitation Center			2199-C	9/30/2015	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	\$ 7,171	7,171		
Page 13 - Professional Fees							
5.	13	B-8-c	Resident Care Physicians **	\$			
6.		B-10	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 1,465,169	1,465,169		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 281,734	281,734		
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 *	\$ 12,402	12,402		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 4,837	4,837		
21.			Unallowable Management Fees	\$ 1,424,739	1,424,739		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 74,167	74,167		
Page 18 - 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)				\$ 3,270,219	3,270,219		

* 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 \$ 7,171.00	\$ -	\$ -
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			\$ 7,171	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020 \$ 305,728.60	\$ -	\$ -
13	5	Rehabilitation Services	3195620020 \$ 801,152.71	\$ -	\$ -
13	9	Speech Therapist	3170620020 \$ 125,021.55	\$ -	\$ -
13	10	Occupational Therapist	3105620020 \$ 222,007.65	\$ -	\$ -
13	12	Other	3010620020 \$ (0.28)	\$ -	\$ -
13	12	Other	3015620020 \$ 130.00	\$ -	\$ -
13	12	Respiratory Purchased Services	3155620020 \$ 11,108.72	\$ -	\$ -
Total Other Fees Adjustments			\$ 1,465,169	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	1020630120 \$ 55,702.50	\$ -	\$ -
16	m-3a	Chamber of Commerce	1020630310 \$ 4,702.00	\$ -	\$ -
16	m-13	Estimated Accrual	1020660990 \$ 2,135.42	\$ -	\$ -
16	m-13	Fines & Penalties	1020640080 \$ 11,627.50	\$ -	\$ -
16	m-13	Non-recurring Charges	7010800030 \$ -	\$ -	\$ -
16	m-12	0	0 \$ -	\$ -	\$ -
0	0	0	0 \$ -	\$ -	\$ -
0	0	0	0 \$ -	\$ -	\$ -
0	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			\$ 74,167	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Arden House Care and Rehabilitation Center				2199-C	9/30/2015	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 3,270,219	3,270,219		
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs	\$ 405,587	405,587		
28.	20	5-d	Ambulance/Limousine	\$ 38,985	38,985		
29.	20	5-f	X-rays, etc	\$ 15,198	15,198		
30.	20	5-h	Laboratory	\$ 42,633	42,633		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 26,126	26,126		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 103,277	103,277		
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	\$ 295,711	295,711		
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)				\$ 4,197,736	4,197,736		

*** 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.

Arden House Care and Rehabilitation Center
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	\$ 14,428.64	3010610300	\$ -
20	5-j	Respiratory Supplies	\$ 29,642.44	3155630530	\$ -
20	5-j	Respiratory Rental	\$ 33,766.93	3155660080	\$ -
20	5-j	Cable TV	\$ 25,438.91	3005660130	allow \$3600
0	0-Jan		0 \$	\$ -	\$ -
0	0-Jan		0 \$	\$ -	\$ -
0	0-Jan		0 \$	\$ -	\$ -
0	0-Jan		0 \$	\$ -	\$ -
0	0-Jan		0 \$	\$ -	\$ -
0	0-Jan		0 \$	\$ -	\$ -
0	0-Jan		0 \$	\$ -	\$ -
Total Other Ancillary Costs			\$ 103,277	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

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 Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

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 Other Property Adjustments			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14.c1	General liability Insurance Adjust	\$ 295,711.37	\$ -	\$ -
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 Other Adjustments			\$ 295,711	\$ -	\$ -

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 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
Total Unallowable Building Interest			\$ -	\$ -	\$ -

F. Statement of Revenue

Name of Facility		License No.	Report for Year Ended		Page	of
Arden House Care and Rehabilitation Ce		2199-C	9/30/2015		30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 38,563,162	38,563,162				
b. Medicaid Room and Board Contractual Allowance **	\$ (18,008,875)	(18,008,875)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 3,763,019	3,763,019				
b. Medicare Room and Board Contractual Allowance **	\$ (976,809)	(976,809)				
4. a. Private-Pay Residents and Other	\$ 3,618,262	3,618,262				
b. Private-Pay Room and Board Contractual Allowance **	\$ (646,821)	(646,821)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 314,228	314,228				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (81,568)	(81,568)				
c. Prescription Drugs - Non-Medicare	\$ 125,747	125,747				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (28,392)	(28,392)				
2. a. Medical Supplies - Medicare	\$ 252	252				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (65)	(65)				
c. Medical Supplies - Non-Medicare	\$ 468	468				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (160)	(160)				
3. a. Physical Therapy - Medicare	\$ 1,247,417	1,247,417				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (323,806)	(323,806)				
c. Physical Therapy - Non-Medicare	\$ 508,516	508,516				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (129,042)	(129,042)				
4. a. Speech Therapy - Medicare	\$ 309,688	309,688				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (80,389)	(80,389)				
c. Speech Therapy - Non-Medicare	\$ 127,813	127,813				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (31,929)	(31,929)				
5. a. Occupational Therapy - Medicare	\$ 1,049,416	1,049,416				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (272,409)	(272,409)				
c. Occupational Therapy - Non-Medicare	\$ 453,175	453,175				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (115,723)	(115,723)				
6. a. Other (<i>Specify</i>) - Medicare	\$ 39,727	39,727				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 26,179	26,179				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 29,451,081	29,451,081				
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	\$ 25,575	25,575				
5. Interest Income (<i>Specify</i>)	\$ 1,305	1,305				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 2,838	2,838				
V. Total Other Revenue (1 thru 8)	\$ 29,719	29,719				
VI. Total All Revenue (III +V)	\$ 29,480,800	29,480,800				

* 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	11,570.83	-	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	21,830.59	-	0
II-6-a	Medicare Part A	Respiratory Therapy & Supplies	8,792.86	-	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	11,460.71	-	0
II-6-a	Contractuals-Medicare	X-Ray	(3,003.57)	-	0
II-6-a	Contractuals-Medicare	Radiology Service	-	-	0
II-6-a	Contractuals-Medicare	Outpatient Therapy Program	-	-	0
II-6-a	Contractuals-Medicare	Laboratory	(5,666.81)	-	0
II-6-a	Contractuals-Medicare	Respiratory Therapy & Supplies	(2,282.46)	-	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	(2,974.99)	-	0
Total Other Resident Revenue - Medicare			\$ 39,727	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	158.00	-	-
II-6-b	Medicaid	Radiology Service	-	-	-
II-6-b	Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Medicaid	Laboratory	338.22	-	-
II-6-b	Medicaid	Respiratory Therapy & Supplies	15,107.33	-	-
II-6-b	Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Medicaid	Audiology	-	-	-
II-6-b	Medicaid	Incontinency	-	-	-
II-6-b	Medicaid	Oxygen & Supplies	1,537.50	-	-
II-6-b	Medicaid	Physician Visit	-	-	-
II-6-b	Medicaid	Ambulance	-	-	-
II-6-b	Medicaid	Flu Shot	-	-	-
II-6-b	Contractuals Medicaid	X-Ray	(73.79)	-	-
II-6-b	Contractuals Medicaid	Radiology Service	-	-	-
II-6-b	Contractuals Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Contractuals Medicaid	Laboratory	(157.95)	-	-
II-6-b	Contractuals Medicaid	Respiratory Therapy & Supplies	(7,053.08)	-	-
II-6-b	Contractuals Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Contractuals Medicaid	Audiology	-	-	-
II-6-b	Contractuals Medicaid	Incontinency	-	-	-
II-6-b	Contractuals Medicaid	Oxygen & Supplies	(718.01)	-	-
II-6-b	Contractuals Medicaid	Physician Visit	-	-	-

II-6-b	Contractuals Medicaid	Ambulance			
II-6-b	Contractuals Medicaid	Flu Shot			
II-6-b	Private and Other	X-Ray	2,471.87		
II-6-b	Private and Other	Radiology Service			
II-6-b	Private and Other	Outpatient Therapy Program			
II-6-b	Private and Other	Laboratory	8,556.34		
II-6-b	Private and Other	Respiratory Therapy & Supplies	9,108.82		
II-6-b	Private and Other	Nursing Treatment Supplies			
II-6-b	Private and Other	Audiology			
II-6-b	Private and Other	Incontinency			
II-6-b	Private and Other	Oxygen & Supplies	615.00		
II-6-b	Private and Other	Physician Visit			
II-6-b	Private and Other	Ambulance			
II-6-b	Private and Other	Flu Shot			
II-6-b	Private and Other	Capitation Contracts			
II-6-b	Contractuals-Non-Medicaid	X-Ray	(441.89)		
II-6-b	Contractuals-Non-Medicaid	Radiology Service			
II-6-b	Contractuals-Non-Medicaid	Outpatient Therapy Program			
II-6-b	Contractuals-Non-Medicaid	Laboratory	(1,529.58)		
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplies	(1,628.34)		
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment Supplies			
II-6-b	Contractuals-Non-Medicaid	Audiology			
II-6-b	Contractuals-Non-Medicaid	Incontinency			
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplies	(109.94)		
II-6-b	Contractuals-Non-Medicaid	Physician Visit			
II-6-b	Contractuals-Non-Medicaid	Ambulance			
II-6-b	Contractuals-Non-Medicaid	Flu Shot			
II-6-b	Contractuals-Non-Medicaid	Capitation Contracts			
Total Other Resident Revenue			\$ 26,179	\$	\$

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 30 line 1	430055	Interest On Overdue Accounts	\$ 1,305.46	\$	\$
Pg 30 line 1	430050		0	\$	\$
	0	0	0	\$	\$
Total Interest Income			\$ 1,305	\$	\$

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
Pg 30 line 1	430060 Telephone rental charge	1,569.55		
Pg 30 line 1	400010-1020 MEDICAL RECORDS	863.84		
0	0 Donation	150.00		
0	0 rent	255.00		
0	0	0		
Total Other Revenue			\$ 2,838	\$

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Arden House Care and Rehabilitation C	2199-C	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	33,224
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,528,753
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	109
4 Inventories			\$	58,460
5. Prepaid Expenses			\$	1,452,301
a. Prepaid Escrow Replace Reserve	1,073,424			
b. Prepaid Personal Property Tax	92,379			
c. Prepaid Personal Property Tax	20,152			
d. Prepaid Escrow Insurance	34,187			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

A-9. Total Current Assets (Lines A1 thru 8)			\$	4,072,847
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	3,163	\$	2,478
	Accum. Depreciation	685		Net
3. Buildings	*Historical Cost	985,337	\$	855,175
	Accum. Depreciation	130,162		Net
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation			Net
5. Non-Movable Equipment	*Historical Cost	282,322	\$	194,810
	Accum. Depreciation	87,512		Net
6. Movable Equipment	*Historical Cost	438,272	\$	204,275
	Accum. Depreciation	233,997		Net
7. Motor Vehicles	*Historical Cost	4,900	\$	1,429
	Accum. Depreciation	3,471		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

B-10. Total Fixed Assets (Lines B1 thru 9)			\$	1,258,167

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Arden House Care and Rehabilitation Center		2199-C	9/30/2015	32	37
Account				Amount	
Total Brought Forward:				\$	5,331,014
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)					
		I/C Due to/Due From Owned	(1,009,289)		
		I/C Due to/Due From Multicare			
\$ (1,009,289)					
D-8. Total Investments and Other Assets (Lines D1 thru 7)					
\$ (1,009,289)					
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)					
\$ 4,321,726					

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

G. Balance Sheet (cont'd)

Name of Facility Arden House Care and Rehabilitation Center		License No. 2199-C	Report for Year Ended 9/30/2015	Page 34	of 37
Account				Amount	
Total Brought Forward:				2,383,045	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment <i>(temize)</i>					
\$					
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable					
\$					
3. Loans from Owners or Related Parties <i>(temize)</i>					
\$					
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities <i>(temize)</i>					
LT Debt-Financing Obligation		2,260,792	\$ 2,260,792		
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 2,260,792	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 4,643,837	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Arden House Care and Rehabilitation C	2199-C	9/30/2015	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			\$	397,359
6. Gain or Loss for Period			\$	(719,472)
10/1/2014 thru 9/30/2015				
7. Total Net Worth			\$	(322,113)
C. Total Reserves and Net Worth			\$	(322,113)
D. Total Liabilities, Reserves, and Net Worth			\$	4,321,724

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Arden House Care and Rehabilitation Center	2199-C	9/30/2015	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	397,357
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	29,480,799
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	30,200,269
D. Net Income or Deficit			\$	(719,470)
E. Balance			\$	(322,113)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <i>Balance at End of Period</i>			\$	(322,113)
				09/30/15

I. Preparer's/Reviewer's Certification

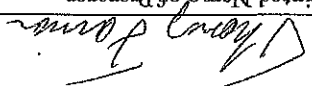
Name of Facility	Arden House Care and Rehabilitation
License No.	2199-C
Report for Year Ended	9/30/2015
Page of	37 of 37

Check appropriate category

<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)
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Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	
Title	Sr. Director of Reimbursement
Date Signed	12/29/2015
Printed Name of Preparer	Thomas Farnan - Sr. Director of Reimbursement
Address	200 Brickstone Square, Andover, MA 01810
Phone Number	978-247-5029