

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

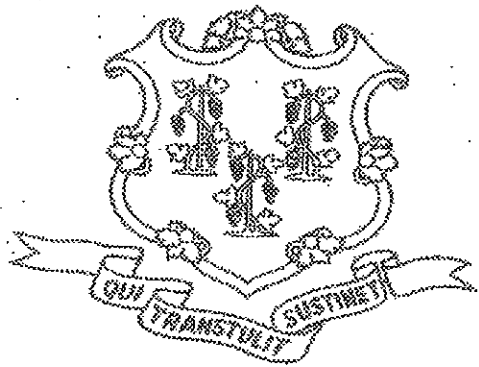
**DRAFT**

Skyview Center

Facility: 319  
Page: 22  
Date: 01/26/2016

<u>Page - Lic. Type - Rate Yr</u>	<u>Error Message</u>
2-CCH	(90), Sum of Total Care Days does not match Annual Report
2-CCH	(90), Sum of Total Resident Days does not match Annual Report
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
3-CCH	(3), Sum of salaries does not match Annual Report figure
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
5-CCH	(2), Sum of Admin and General Expense does not match value on Annual Report
11-CCH	(2), Total Expenses does not foot
16-CCH	(7,899), 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 (16,387) does not match Real Property Additions on pg. 18 of Rate Comp. (0)
RC-Nurs Fac-CCH	No Self Pay rates entered

# State of Connecticut

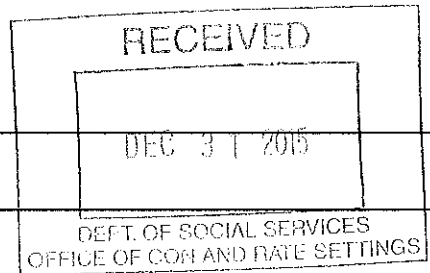


15-21

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## Annual Report of Long-Term Care Facility Cost Year 2015



Name of Facility (as licensed) 35 Marc Drive Operations LLC, d/b/a Skyview Center	
Address (No. & Street, City, State, Zip Code) 35 Marc Drive, Wallingford, CT 06492	
Type of Facility <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 2377	RHNS	(Specify)	Medicare Provider 07-5057
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Medicaid Provider Numbers:	CCNH 000007427	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

RECEIVED

JAN 05 2016

MYERS & STAUFFER LC

**General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Skyview Center	2377	9/30/2015	1	37

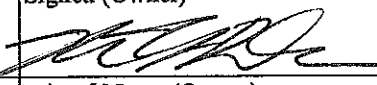
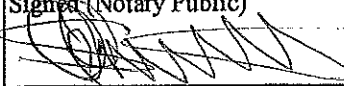
**Administrator's/Owner's Certification**

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 35 Marc Drive Operations LLC, d/b/a Skyview 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
					11/13/2015
Printed Name (Administrator) Jeffrey E. Turner			Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare		
Subscribed and Sworn to before me:	State of PA	Date 11/13/15	Signed (Notary Public) 		Comm. Expires 1 1
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)	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Skyview Center	2377	9/30/2015	1	37

#### Administrator's/Owner's Certification

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

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility 35 Marc Drive Operations LLC, d/b/a Skyview Center		Period Covered:	From 10/1/2014	To 9/30/2015
Address of Facility 35 Marc Drive, Wallingford, CT 06492				
Report Prepared By Thomas Farnan		Phone Number 978-247-5029	Date 12/20/2014	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$ 307,731	307,731		
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$ 2,716,519	2,716,519		
5. All other wages paid	\$ 422,283	422,283		
6. <b>Total Wages Paid</b>	<b>\$ 3,446,533</b>	<b>3,446,533</b>		
7. Total salaries paid	\$ 199,300	199,300		
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	<b>\$ 3,645,833</b>	<b>3,645,833</b>		

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 203-265-0981	Report for Year Ended 9/30/2015	Page 2	of 37
Name of Facility (as shown on license) 35 Marc Drive Operations LLC, d/b/a Skyview Center		Address (No. & Street, City, State, Zip ) 35 Marc Drive, Wallingford, CT 06492		
License Numbers:	CCNH 2377	RHNS (Specify)	Medicare Provider No. 07-5057	
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.				
<b>Administrator</b>				
Name of Administrator Jeffrey E. Turner		Nursing Home Administrator's License No.:	1613	
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 35 Marc Drive Operations LLC, d/b/a Skyvie	License No. 2377	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 35 Marc Drive Operations LLC, d/b/a Skyview Center	Business Address 101 East State Street, Kennett Square, PA 19348	State(s) in Which Incorporated PA		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
See Attached				
Names of Stockholders Owning at Least 10% of Shares				
See Attached				



## General Information and Questionnaire Related Parties\*

Name of Facility 35 Marc Drive Operations LLC, d/b/a Skyview Center	License No. 2377	Report for Year Ended 9/30/2015	Page 4	of 37
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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	<input checked="" type="radio"/>	<input type="radio"/>	Home Office	Pg 16/m12	357,808	357,808
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	63% PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	469,397	469,397
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	17,189	17,189
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	35,400	35,400
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	9,053	9,053
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	30,709	30,709
Liberty Health (Insurance)	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Insurance	Pg 27/14	121,169	121,169
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	33,792	33,792

\* 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 35 Marc Drive Operations LLC, d/b/a Skyview	License No. 2377	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 (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.

- 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 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			
35 Marc Drive Operations LLC, d/b/a Skyview Center	2377	9/30/2015	6	37			
Name and Address of Lessor	Related * to Owners, Operators, Officers		Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
	<input type="radio"/>	<input type="radio"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?					<input type="radio"/> Yes	<input type="radio"/> No	<b>Total ***</b>

\* 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.

### General Information and Questionnaire Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/	2377	9/30/2015	7	37

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	\$
<b>Charge for Services Provided</b>	
	\$

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 Bloom & Witkin	617-456-0500
2 Wiggin And Dana LLP	203-498-4400
3 Wallingford Probate District	
4 Sciacca Law Group LLC	9E+09
5	

Address ( <i>No. &amp; Street, City, State, Zip Code</i> )	
1	175 Federal Street Boston Ma 02110
2	One Century Tower, PO BOX 1832, New Harven, CT,06508
3	45 South Main St, Wallingford CT 06492
4	PO Box 870126, Milton Village, MA 02187
5	

Services Provided by This Firm (*describe fully*)

1 Real Estate Tax Abatement-reduced the assessment values of Real Estate Tax	\$	6,294
2	\$	
3	\$	
4	\$	
5	\$	
<b>Charge for Services Provided</b>		
	\$	6,294

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 35 Marc Drive Operations LLC, d/b/a Skyview Center	License No. 2377		Report for Year Ended 9/30/2015				Page 8	of 37
	Total All Levels		Period 10/1 Thru 6/30		Period 7/1 Thru 9/30			
	Total CCNH Level	Total RHNS Level	Total CCNH	Total RHNS (Specify)	Total CCNH	Total RHNS (Specify)		
1. Certified Bed Capacity								
A. On last day of PREVIOUS report period	97	97	97	97	97	97	97	97
B. On last day of THIS report period	97	97	97	97	97	97	97	97
2. Number of Residents								
A. As of midnight of PREVIOUS report period	92	92	92	92	85	85	85	85
B. As of midnight of THIS report period	90	90	85	85	90	90	90	90
3. Total Number of Days Care Provided During Period								
A. Medicare	2,073	2,073	1,536	1,536	537	537	537	537
B. Medicaid (Conn.)	26,566	26,566	19,883	19,883	6,683	6,683	6,683	6,683
C. Medicaid (other states)								
D. Private Pay	2,185	2,185	1,598	1,598	587	587	587	587
E. State SSI for RCH								
F. Other (Specify)	1,193	1,193	978	978	215	215	215	215
G. Total Care Days During Period (3A thru F)	32,017	32,017	23,995	23,995	8,022	8,022	8,022	8,022
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds								
A. Medicaid Bed Reserve Days	6	6	6	6				
B. Other Bed Reserve Days								
5. Total Resident Days (3G + 4A + 4B)	32,023	32,023	24,001	24,001	8,022	8,022	8,022	8,022

### Schedule of Resident Statistics (Cont'd)

Name of Facility 35 Marc Drive Operations LLC, d/b/a Skyvie			License No. 2377			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	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID				
No. of Residents	5	75			10								
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	519.31		195.45		383.92								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments							TOTAL	CCNH	RHNS	(Specify)			
A. Medicare - Part B							3,651	3,651					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments							895	895					
C. Other							7,676	7,676					
D. <b>Total Physical Therapy Treatments</b>							12,222	12,222					
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B							328	328					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments							28	28					
C. Other							1,041	1,041					
D. <b>Total Speech Therapy Treatments</b>							1,397	1,397					
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B							2,034	2,034					
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments							634	634					
C. Other							6,735	6,735					
D. <b>Total Occupational Therapy Treatments</b>							9,403	9,403					



**Report of Expenditures - Salaries & Wages**

Name of Facility	License No.	Report for Year Ended	Page	of		
35 Marc Drive Operations LLC, d/b/a Skyview Center	2377	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
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	102,482	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	149,471	7,212				
5. Dietary Service						
a. Head Dietitian	21,202	640				
b. Food Service Supervisor	43,462	1,709				
c. Dietary Workers	243,066	18,886				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	51,478	2,064				
b. Other Maintenance Workers	22,158	1,316				
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	96,817	2,111				
b. RN						
1. Direct Care	692,849	18,281				
2. Administrative**	98,782	2,525				
c. LPN						
1. Direct Care	694,205	23,869				
2. Administrative**						
d. Aides and Attendants	1,154,533	73,830				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	114,406	6,251				
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	84,770	3,159				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	76,149	4,616				
<i>A-13. Total Salary Expenditures</i>	3,645,833	168,554				

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

Name of Facility 35 Marc Drive Operations LLC, d/b/a Skyview Center		License No. 2377		Report for Year Ended 9/30/2015		Page 11	of 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	RENS (Specify)							
<b>Section I - Operators/Owners</b>									
<b>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).</b>									

\* 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		
35 Marc Drive Operations LLC, d/b/a Skyview Center		2377		9/30/2015		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)							
<b>Section III - Administrators***</b>									
Jeffrey E. Turner	102,482			Management of Center	2,086	2			
<b>Section IV - Assistant Administrators</b>									

\*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		
35 Marc Drive Operations LLC, d/b/a Skyview Cent	2377	9/30/2015	13	37		
<b>Total Cost and Hours</b>						
Item	CCNH	Hours	RFNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian	694	19				
2. Dentist	15,560	107				
3. Pharmacist	7,568	154				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	389,570	5,337				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	35,400	187				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	28,095	360				
b. Other						
10. Occupational Therapist						
a. Resident Care	85,249	1,168				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	9,053	139				
2. Administrative***						
b. LPN						
1. Direct Care	643	15				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	3,688					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>575,519</b>	<b>7,486</b>				

\* 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
35 Marc Drive Operations LLC, d/b/a Skyview Ce	2377	9/30/2015	15	37
Item	Total	CCNH	RHNS	(Specify)
<b>1. Administrative and General</b>				
<b>a. Employee Health &amp; Welfare Benefits</b>				
1. Workmen's Compensation	\$ 162,236	162,236		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 82,282	82,282		
4. Social Security (F.I.C.A.)	\$ 264,594	264,594		
5. Health Insurance	\$ 372,288	372,288		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$			
9. Other ( <i>Specify</i> ) See Attached Schedule	\$			
<b>b. Personal Retirement Plans, Pensions, and        Profit Sharing Plans for Owners and        Operators (Discriminatory)*</b>	\$			
c. Bad Debts*	\$ 249,315	249,315		
d. Accounting and Auditing	\$			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 6,294	6,294		
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 21,406	21,406		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 16,989	16,989		
2. Cellular Phones	\$			
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	\$ 360	360		
3. Resident Day User Fee	\$ 610,211	610,211		
<b>Subtotal</b>	\$ 1,785,975	1,785,975		

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

(Carry Subtotals forward to next page)





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

Name of Facility	License No.	Report for Year Ended		Page	of
35 Marc Drive Operations LLC, d/b/a Skyview Center	2377	9/30/2015		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>	1,785,975	1,785,975			
<b>l. Travel and Entertainment</b>					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 251	251			
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 1,599	1,599			
5. Education Expenses Related to Seminars and Conventions	\$ 120	120			
6. Automobile Expense (not purchase or depreciation)	\$				
7. Other (Specify) See Attached Schedule	\$				
<b>m. Other Administrative and General Expenses</b>					
1. Advertising Help Wanted (all such expenses)	\$				
2. Advertising Telephone Directory (all such expenses)***	\$ 1,067	1,067			
3. Advertising Other (Specify)*** See Attached Schedule	\$ 8,284	8,284			
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 2,454	2,454			
* 8. Dues and Membership Fees to Professional Associations (Specify) See Attached Schedule	\$ 6,029	6,029			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 917	917			
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$ 1,098	1,098			
11. Services Provided by Contract (Specify and Complete Schedule C-2, Page 21 for each firm or individual)	\$ 2,716	2,716			
12. Administrative Management Services**	\$ 327,963	327,963			
13. Other (Specify) See Attached Schedule	\$ 32,982	32,982			
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 2,171,453	2,171,453			

\* 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 C-1 - Management Services\***

Name of Facility	License No.	Report for Year Ended	Page of
35 Marc Drive Operations LLC, d/b/a Sky	2377	9/30/2015	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	357,808	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	33,792	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
35 Marc Drive Operations LLC, d/b/a Skyview Center		2377	9/30/2015		18	37
Item		Total	CCNH	RHNS	(Specify)	
2. Dietary						
a. In-House Preparation & Service						
1.	Raw Food	\$ 152,097	152,097			
2.	Non-Food Supplies	\$ 19,395	19,395			
3.	Other (Specify) _____	\$ (2,928)	(2,928)			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)						
		\$				
c. Management Services**						
		\$				
d. Other (Specify) _____						
		\$				
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>		<b>\$ 168,564</b>	<b>168,564</b>			
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		License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Skyview Center		2377	9/30/2015	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. \$	4,236	4,236	
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. \$	6,755	6,755	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	116,226	116,226	
c. Management Services**		\$			
d. Other (Specify)		\$			
<b>3E. Total Laundry Expenditures (3a + b + c + d)</b>		\$	<b>127,216</b>	<b>127,216</b>	
<b>3F. Laundry Questionnaire</b>					
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
35 Marc Drive Operations LLC, d/b/a Skyview		2377	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. \$	16,191	16,191			
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. \$	171,872	171,872			
c. Management Services*	\$					
d. Other ( <i>Specify</i> )	\$					
<b>4E. Total Housekeeping Expenditures (4a + b + c + d)</b>	\$	188,063	188,063			
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy	\$					
2. Purchased from	\$	131,357	131,357			
b. Medicine Cabinet Drugs	\$	22,965	22,965			
c. Medical and Therapeutic Supplies	\$	103,717	103,717			
d. Ambulance/Limousine***	\$	410	410			
e. Oxygen						
1. For Emergency Use	\$					
2. Other***	\$	14,615	14,615			
f. X-rays and Related Radiological Procedures***	\$	9,127	9,127			
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$					
h. Laboratory***	\$	20,831	20,831			
i. Recreation	\$	26,415	26,415			
j. Other (Specify)**** See Attached Schedule	\$	60,209	60,209			
<b>5K. Total Resident Care Expenditures (5a - 5j)</b>	\$	389,645	389,645			

\* 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.







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

Name of Facility		License No.		Report for Year Ended		Page of			
35 Marc Drive Operations LLC, d/b/a Skyview Center		2377		9/30/2015		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	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Laundry Purchased Services	116,226		19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	171,872		20	4b
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						
		<input type="radio"/>	<input type="radio"/>						

\* List all contracted services over \$10,000. Use additional sheets if necessary.  
 \*\* Refer to Page 4 for definition of related.  
 \*\*\* Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended			Page	of
35 Marc Drive Operations LLC, d/b/a Skyview	2377	9/30/2015			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 109,666	109,666				
b. Heat	\$ 40,411	40,411				
c. Light & Power	\$ 100,178	100,178				
d. Water	\$ 37,161	37,161				
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$					
f. Other <i>(itemize)</i> See Attached Schedule	\$					
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	\$ 287,417	287,417				
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$ 8,202	8,202				
b. Building & Building Improvements	\$ 363,846	363,846				
c. Non-Movable Equipment	\$ 568	568				
d. Movable Equipment	\$ 3,543	3,543				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	\$ 376,158	376,158				
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 182,455	182,455				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 54,891	54,891				
c. Personal property taxes	\$					
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	\$ 613,504	613,504				

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





35 Marc Drive Operations LLC, d/b/a Skyview Center  
9/30/2015

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
6/30/2015	Upgrade front stairs from park lot to fi	\$ 9,556	10	\$ 239
7/31/2015	Iron railings front stairway	\$ 3,084	10	\$ 51
7/31/2015	50 ton 1 3/4 inch crushed stone	\$ 3,084	10	\$ 51
<b>Total additions for Land Improvements</b>		\$ 15,724		\$ 342 *
<b>Deletions:</b>				
<b>Total deletions for Land Improvements</b>		\$ -		\$ - **

\*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
<b>Additions:</b>				
1/31/2015	Emergency stop switch on generator	663.40	20.00	22.11
<b>Total additions for Building Improvements</b>		\$ 663		\$ 22 *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
<b>Total additions for Non-Movable Equipment</b>		\$ -		\$ - *
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ - **

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
4/30/2015	Sales and Use Tax April 2015	209.00	7.00	12.44
10/31/2014	Direct Choice Overbed Table, S	152.55	10.00	13.98
10/31/2014	Food Processor, 3-1/2 Quart	1,339.14	10.00	122.75
12/31/2014	1.6 cu ft medical grade refrigerator	527.54	10.00	39.57
3/31/2015	OmniCycle Elite Rehab System	6,327.83	10.00	316.39
3/31/2015	3 CUSHION, W/C 18X16 ROHO HIC	1,648.50	10.00	82.43
3/31/2015	3 CUSHION, W/C 18X16 ROHO HIC	1,648.50	10.00	82.43
8/31/2015	Nancy McAlister credit card - projects	488.14	3.00	13.56
Total additions for Movable Equipment		\$ 12,341		\$ 684 *
<b>Deletions:</b>				
Total deletions for Movable Equipment		\$ -		\$ - **

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
Total additions for Leasehold Improvement		\$ -		\$ - *
<b>Deletions:</b>				
Total deletions for Leasehold Improvement		\$ -		\$ - **

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

**Amortization Schedule\***

Name of Facility 35 Marc Drive Operations LLC, d/b/a Skyview Center	Date of Acquisition		License No. 2377	Report for Year Ended 9/30/2015		Page 24	of 37
	Month	Year		Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**		
Item			Length of Amortization	Cost to Be Amortized			Totals
<b>A. Organization Expense</b>							
1.							
2.							
3.							
A-4. Subtotal							
<b>B. Mortgage Expense</b>							
1.							
2.							
3.							
B-4. Subtotal							
<b>C. Leasehold Improvements and Other</b>							
1. Acquired prior to this report period							
2. Disposals (attach schedule)							
3. Acquired during this report period (attach schedule)							
C-4. Subtotal							
<b>D. Total Amortization</b>							

\* 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 35 Marc Drive Operations LLC, d/b/a	License No. 2377	Report for Year Ended 9/30/2015	Page 25	of 37	
<b>11. Property Questionnaire</b>					
<b>Part A</b>					
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 <b>NOT</b> Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	97				
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
<b>Part B - Owner and Related Parties</b>		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					
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>					
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					
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	
Healthcare REIT, Inc	Building and Equipment	04/01/11	20	182,455	
Address: One Seagate Suite 1500					
Toledo, OH 43603-1475					

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



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

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a	2377	9/30/2015	26	37
Item	Total	CCNH	RHNS	(Specify)
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage	\$ 33,792	33,792		
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				
<b>12 B7. Total Building Interest Expense (A1 - A4 + B5)</b>	<b>\$ 33,792</b>	<b>33,792</b>		

(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	
35 Marc Drive Operations LLC, d/b/a	2377	9/30/2015	27	37	
Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		33,792	33,792		
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)		\$ 33,792	33,792		
14. Insurance					
a. Insurance on Property (buildings only)					
b. Insurance on Automobiles					
c. Insurance other than Property (as specified above)					
1. Umbrella (Blanket Coverage)					
2. Fire and Extended Coverage					
3. Other (Specify)					
14d. Total Insurance Expenditures (14a + b + c)		\$ 121,169	121,169		
15. Total All Expenditures (A-13 thru C-14)		\$ 8,322,177	8,322,177		

### D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
35 Marc Drive Operations LLC, d/b/a Skyview Center			2377	9/30/2015	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 39,729	39,729		
<b>Page 13 - Professional Fees</b>							
5.	13	B-8-c	Resident Care Physicians **	\$			
6.		B-10	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 505,790	505,790		
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 249,315	249,315		
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 *	\$ 9,351	9,351		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 1,098	1,098		
21.			Unallowable Management Fees	\$ 361,755	361,755		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 14,260	14,260		
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
<b>Subtotal (Items 1 - 26)</b>				<b>\$ 1,181,298</b>	<b>1,181,298</b>		

\* 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	39,729	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
<b>Total Other Salaries Adjustment</b>			\$ 39,729	\$ -	\$ -

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	127,021.96	0
13	5	Rehabilitation Services	3195620020	262,548.27	0
13	9	Speech Therapist	3170620020	28,094.56	0
13	10	Occupational Therapist	3105620020	85,248.73	0
13	12	Other	3010620020	340.08	0
13	12	Other	3015620020	0	0
13	12	Respiratory Purchased Services	3155620020	2,536.69	0
				0	0
				0	0
				0	0
				0	0
				0	0
<b>Total Other Fees Adjustments</b>			\$ 505,790	\$ -	\$ -

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	1020630120	13,898.7	0
16	m-3a	Chamber of Commerce	1020630310	917	0
16	m-13	Estimated Accrual	1020660990	-555.58	0
16	m-13	Penalty and Fines	1020640080	0	0
16	m-13	Non-recurring Charges	7010800030	0	0
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
<b>Total Other A&amp;G Adjustments</b>			\$ 14,260	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
35 Marc Drive Operations LLC, d/b/a Skyview Center			2377	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,181,298	1,181,298		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5-a-2	Prescription Drugs	\$ 131,357	131,357		
28.	20	5-d	Ambulance/Limousine	\$ 410	410		
29.	20	5-f	X-rays, etc	\$ 9,127	9,127		
30.	20	5-h	Laboratory	\$ 20,831	20,831		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 14,615	14,615		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 33,137	33,137		
<b>Page 22 - Maintenance and Property</b>							
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	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
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	\$ 96,179	96,179		
<b>Not For Profit Providers Only</b>							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>51. Total Amount of Decrease (Items 1 - 50)</b>				\$ 1,486,953	1,486,953		

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

35 Marc Drive Operations LLC, d/b/a Skyview Center  
9/30/2015

#### Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	1997.51	3010610300	0
20	5-j	Respiratory Supplies	6076.09	3155630530	0
20	5-j	Respiratory Rental	9203.77	3155660080	0
20	5-i	Cable TV	13859.22	3005660130	allow \$3600
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
Total Other Ancillary Costs			\$ 33,137	\$ -	\$ -

#### Schedule of Excess Movable Equipment Depreciation

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



Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	1401	General liability Insurance Adjust	96178.70218	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
<b>Total Other Adjustments</b>			\$ 96,179	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended			Page	of
35 Marc Drive Operations LLC, d/b/a Sk 2377		9/30/2015			30	37
Item	Total	CCNH	RHNS	(Specify)		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 10,181,133	10,181,133				
b. Medicaid Room and Board Contractual Allowance **	\$ (5,050,946)	(5,050,946)				
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 794,490	794,490				
b. Medicare Room and Board Contractual Allowance **	\$ (217,864)	(217,864)				
4. a. Private-Pay Residents and Other	\$ 1,305,810	1,305,810				
b. Private-Pay Room and Board Contractual Allowance **	\$ (279,407)	(279,407)				
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 90,561	90,561				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (24,833)	(24,833)				
c. Prescription Drugs - Non-Medicare	\$ 56,668	56,668				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (16,383)	(16,383)				
2. a. Medical Supplies - Medicare	\$ 98	98				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (27)	(27)				
c. Medical Supplies - Non-Medicare	\$ 111	111				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (54)	(54)				
3. a. Physical Therapy - Medicare	\$ 431,794	431,794				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (118,406)	(118,406)				
c. Physical Therapy - Non-Medicare	\$ 210,078	210,078				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (57,910)	(57,910)				
4. a. Speech Therapy - Medicare	\$ 73,622	73,622				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (20,189)	(20,189)				
c. Speech Therapy - Non-Medicare	\$ 47,757	47,757				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (11,200)	(11,200)				
5. a. Occupational Therapy - Medicare	\$ 338,916	338,916				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (92,937)	(92,937)				
c. Occupational Therapy - Non-Medicare	\$ 181,468	181,468				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (47,086)	(47,086)				
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 11,947	11,947				
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 100,075	100,075				
<b>III. Total Resident Revenue (Section I. thru Section II.)</b>	\$ 7,887,286	7,887,286				
<b>IV. Other Revenue *</b>						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$ 7,899	7,899				
5. Interest Income ( <i>Specify</i> )	\$ 23	23				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other ( <i>Specify</i> )	\$ 1,561	1,561				
<b>V. Total Other Revenue (1 thru 8)</b>	\$ 9,483	9,483				
<b>VI. Total All Revenue (III +V)</b>	\$ 7,896,769	7,896,769				

\* 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	1,841.44	-	0
II-6-a	Medicare Part A	Laboratory	9,512.59	-	0
II-6-a	Medicare Part A	Respiratory Therapy & Supplies	807.62	-	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	1,054.50	-	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	3,245.00	-	0
II-6-a	Contractuals-Medicare	X-Ray	(504.96)	-	0
II-6-a	Contractuals-Medicare	Laboratory	(2,608.53)	-	0
II-6-a	Contractuals-Medicare	Respiratory Therapy & Supplies	(221.46)	-	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	(289.16)	-	0
II-6-a	Contractuals-Medicare	Physician Visit	-	-	0
II-6-a	Contractuals-Medicare	Ambulance	-	-	0
II-6-a	Contractuals-Medicare	Flu Shot	(889.84)	-	0
<b>Total Other Resident Revenue - Medicare</b>			<b>\$ 11,947</b>	<b>\$ -</b>	<b>\$ -</b>

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

**Related Exp**

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	-	-	0
II-6-b	Medicaid	Laboratory	103.90	-	0
II-6-b	Medicaid	Respiratory Therapy & Supplies	1,459.84	-	0
II-6-b	Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Medicaid	Audiology	-	-	0
II-6-b	Medicaid	Incontinency	-	-	0
II-6-b	Medicaid	Oxygen & Supplies	4,525.80	-	0
II-6-b	Medicaid	Physician Visit	-	-	0
II-6-b	Medicaid	Ambulance	-	-	0
II-6-b	Medicaid	Flu Shot	-	-	0
II-6-b	Contractuals Medicaid	X-Ray	-	-	0
II-6-b	Contractuals Medicaid	Laboratory	(51.55)	-	0
II-6-b	Contractuals Medicaid	Respiratory Therapy & Supplies	(724.24)	-	0
II-6-b	Contractuals Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Contractuals Medicaid	Audiology	-	-	0
II-6-b	Contractuals Medicaid	Incontinency	-	-	0
II-6-b	Contractuals Medicaid	Oxygen & Supplies	(2,245.29)	-	0
II-6-b	Contractuals Medicaid	Physician Visit	-	-	0
II-6-b	Contractuals Medicaid	Ambulance	-	-	0
II-6-b	Contractuals Medicaid	Flu Shot	-	-	0
II-6-b	Private and Other	X-Ray	504.00	-	0

II-6-b	Private and Other	Laboratory	8,420.23	-	0
II-6-b	Private and Other	Respiratory Therapy & Supplie	389.60	-	0
II-6-b	Private and Other	Nursing Treatment Supplies	-	-	0
II-6-b	Private and Other	Audiology	-	-	0
II-6-b	Private and Other	Incontinency	-	-	0
II-6-b	Private and Other	Oxygen & Supplies	741.00	-	0
II-6-b	Private and Other	Physician Visit	-	-	0
II-6-b	Private and Other	Ambulance	-	-	0
II-6-b	Private and Other	Flu Shot	-	-	0
II-6-b	Private and Other	Capitation Contracts	113,359.00	-	0
II-6-b	Contractuals-Non-Medicaid	X-Ray	(107.84)	-	0
II-6-b	Contractuals-Non-Medicaid	Laboratory	(1,801.70)	-	0
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplie	(83.36)	-	0
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Contractuals-Non-Medicaid	Audiology	-	-	0
II-6-b	Contractuals-Non-Medicaid	Incontinency	-	-	0
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplies	(158.55)	-	0
II-6-b	Contractuals-Non-Medicaid	Physician Visit	-	-	0
II-6-b	Contractuals-Non-Medicaid	Ambulance	-	-	0
II-6-b	Contractuals-Non-Medicaid	Flu Shot	-	-	0
II-6-b	Contractuals-Non-Medicaid	Capitation Contracts	(24,255.70)	-	0
<b>Total Other Resident Revenue</b>			<b>\$ 100,075</b>	<b>\$ -</b>	<b>\$ -</b>

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 30 line 1	430055	Interest On Overdue Accounts	22.69	-	-
0	0	0	0	-	0
0	0	0	0	-	0
<b>Total Interest Income</b>			<b>\$ 23</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Revenue**

Page Ref	Description		CCNH	RHNS	(Specify)
Pg 30 line 1	Hair Dressing	430060	1,050.29	-	-
0	Suspense Reclasses	0	510.55	-	-
0	0	0	-	-	-
<b>Total Other Revenue</b>			<b>\$ 1,561</b>	<b>\$ -</b>	<b>\$ -</b>

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a S	2377	9/30/2015	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	4,030
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	787,006
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	5,795
4 Inventories			\$	41,138
5. Prepaid Expenses			\$	13,911
a. Prepaid Expenses				
b. Prepaid Property Tax	11,537			
c. Prepaid Personal Property Tax				
d. Prepaid Personal Property Tax	2,374			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
_____				
<b>A-9. Total Current Assets (Lines A1 thru 8)</b>			\$	851,880
B. Fixed Assets				
1. Land			\$	491,532
2. Land Improvements	*Historical Cost	102,937		
	Accum. Depreciation	17,018	Net	\$ 85,919
3. Buildings	*Historical Cost	1,911,990		
	Accum. Depreciation	1,357,224	Net	\$ 554,766
4. Leasehold Improvements	*Historical Cost			
	Accum. Depreciation		Net	\$
5. Non-Movable Equipment	*Historical Cost	5,675		
	Accum. Depreciation	1,321	Net	\$ 4,354
6. Movable Equipment	*Historical Cost	52,832		
	Accum. Depreciation	28,166	Net	\$ 24,666
7. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	\$
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
_____				
<b>B-10. Total Fixed Assets (Lines B1 thru 9)</b>			\$	1,161,237

\* 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	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a S	2377	9/30/2015	32	37
Account			Amount	
Total Brought Forward:			\$ 2,013,117	
<b>C. Leasehold or like property recorded for Equity Purposes.</b>				
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			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	
<b>D. Investment and Other Assets</b>				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			\$	
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>temize</i> )			\$	
_____			\$	
6. Loans to Owners or Related Parties ( <i>temize</i> )			\$	
Name and Address	Amount	Loan Date	\$	
			\$	
7. Other Assets ( <i>itemize</i> )			\$ 225,831	
	I/C Due to/Due From Owned	225,831		
	I/C Due to/Due From Multicare	_____		
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$ 225,831	
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$ 2,238,948	

\* 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		License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Skyview		2377	9/30/2015	33	37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	224,266
2. Notes Payable ( <i>itemize</i> )				\$	
_____					
_____					
_____					
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$	
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$	138,153
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	126
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable ( <i>Current Portion</i> )				\$	
10. Interest Payable ( <i>Exclusive of Owner and/or Related Parties</i> )				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities ( <i>itemize</i> )				\$	311,295
Accrued Provider/Bed Tax		154,833	Accr Exp Electricity	6,527	
Accr Exp Other		2,957	Deferred Revenue	25,890	
Accr Exp Water and Sewer		12,479	Accr Exp Suspense	(769)	
A/R Credit Gross Up Liability		109,378	Accr Sales and Use Tax -		
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				<b>\$</b>	<b>673,840</b>

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

(Carry Total forward to next page)

**G. Balance Sheet (cont'd)**

Name of Facility 35 Marc Drive Operations LLC, d/b/a Skyv		License No. 2377	Report for Year Ended 9/30/2015	Page 34	of 37
Account				Amount	
Total Brought Forward:				673,840	
<b>Liabilities (cont'd)</b>					
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		1,813,336			
Escheatable Funds		68			
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 1,813,404	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 2,487,244	

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

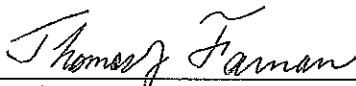
Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a	2377	9/30/2015	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property <del>(equity)</del>			\$	
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>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	1,127,912
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(950,799)
6. Gain or Loss for Period			\$	(425,408)
	10/1/2014	thru	9/30/2015	
7. Total Net Worth			\$	(248,295)
<b>C. Total Reserves and Net Worth</b>			\$	(248,295)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	2,238,949

### H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
35 Marc Drive Operations LLC, d/b/a Sk	2377	9/30/2015	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	177,112
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	7,896,769
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	8,322,176
D. Net Income or Deficit			\$	(425,407)
E. Balance			\$	(248,295)
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. <b>Balance at End of Period</b>			\$	(248,295)
	09/30/15			



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

Name of Facility 35 Marc Drive Operations LLC, d/b/a	License No. 2377	Report for Year Ended 9/30/2015	Page 37	of 37
<i>Check appropriate category</i>				
<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)		
<b>Preparer/Reviewer Certification</b>				
<p>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.</p>				
Signature of Preparer 	Title <i>Sr. Director of Reimbursement</i>	Date Signed <i>12/28/2015</i>		
Printed Name of Preparer Thomas Farnan Title -Sr. Director of Reimbursement				
Address Address 200 Brickstone Square, Andover, MA 01810		Phone Number 978-247-5029		