

General Information

Name of Facility (as licensed) Arden House Care and Rehabilitation Center	License No. 2199-C	Report for Year Ended 9/30/2018	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 , for the cost report period beginning October 1, 2017 and ending September 30, 2018, 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 o this Facility in accordance with the Reporting Requirements of the State of Connecticut for the year ended as specified above.

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

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) 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)

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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 10/1/2017	To 9/30/2018
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	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$	8,313,555	8,313,555	
5. All other wages paid	\$	1,104,015	1,104,015	
6. Total Wages Paid	\$	9,417,569	9,417,569	
7. Total salaries paid	\$	370,129	370,129	
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$	9,787,698	9,787,698	

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 9/30/2018	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 9/30/2018	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation Arden House Care and Rehabilitation 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	
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 9/30/2018		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 checked="" type="radio"/> Yes <input 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			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 Healthcare	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Home Office	Pg 16/m12	1,014,446	1,014,446
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	825,054	825,054
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input type="radio"/>	<input checked="" type="radio"/>	50%	Staffing Pool	Pg 10/A12, p15-1	2,417	2,417
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	85%	Medical Director /NP	Pg 13/B8, Pg 10/A12	59,053	59,053
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	91%	Outside Agency	Pg 13/B11 pg 10-12, 15-1	16,677	16,677
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>	40%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E2, Pg 20/C5	9,389	9,389
Genesis Healthcare	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	546,411	546,411
Genesis Healthcare	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Capital Interest	Page 17, page 26-12A	96,713	96,713
		<input type="radio"/>	<input type="radio"/>					

* 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 9/30/2018	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.

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

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

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

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

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 Arden House Care and Rehabilitation Center			License No. 2199-C			Report for Year Ended 9/30/2018		Page of 6 37		
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	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"/>								
Is a Mileage Log Book Maintained for All Leased Vehicles ?								<input type="radio"/> Yes	<input type="radio"/> No	Total ***

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

** Attach copies of newly acquired leases.

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

General Information and Questionnaire
Accounting Basis

Name of Facility Arden House Care and Rehabilitati	License No. 2199-C	Report for Year Ended 9/30/2018	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
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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 Court of Probate 3 Timothy S Wall State Marshall - Probate Court Fees 4 Bloom & Witkin 5	Telephone Number 203-287-7082 203-265-7173 617 456-0500
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Address (*No. & Street, City, State, Zip Code*)

- 1 45 Notch Rd Bolton, CT 06043
 2 2750 Dixwell Ave Hamden, CT 06518
 3 P O Box 297 Wallingford, CT 06492
 4 470 Atlantic Ave - 3rd Fl Boston, MA 02210
 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 Citation/Appointment of Conservator	\$
3 Citation and Return/Appointment of Conservator, Probate Court Fees	\$ 5,557
4 Saving the Real Estate Tax - R.E Tax Abatement	\$
5	\$
	Charge for Services Provided
	\$ 5,557

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 Arden House Care and Rehabilitation Center			License No. 2199-C			Report for Year Ended 9/30/2018				Page 8		of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30				
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)	
1. Certified Bed Capacity													
A. On last day of PREVIOUS report period	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	256	256			256	256			242	242			
B. As of midnight of THIS report period	241	241			242	242			241	241			
3. Total Number of Days Care Provided During Period													
A. Medicare	2,427	2,427			1,918	1,918			509	509			
B. Medicaid (Conn.)	83,544	83,544			62,501	62,501			21,043	21,043			
C. Medicaid (other states)													
D. Private Pay	2,419	2,419			2,071	2,071			348	348			
E. State SSI for RCH													
F. Other (Specify)	1,488	1,488			1,204	1,204			284	284			
G. Total Care Days During Period (3A thru F)	89,878	89,878			67,694	67,694			22,184	22,184			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	1	1			1	1							
B. Other Bed Reserve Days													
5. Total Resident Days (3G + 4A + 4B)	89,879	89,879			67,695	67,695			22,184	22,184			

Schedule of Resident Statistics (Cont'd)

Name of Facility Arden House Care and Rehabilitation Center			License No. 2199-C			Report for Year Ended 9/30/2018			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)	CCNH	RHNS	(Specify)	
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID				
No. of Residents	6		228		7								
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	546.24		222.96		446.35								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									4,787	4,787			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									1,895	1,895			
C. Other									9,373	9,373			
D. Total Physical Therapy Treatments									16,055	16,055			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									711	711			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									565	565			
C. Other									1,791	1,791			
D. Total Speech Therapy Treatments									3,067	3,067			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									6,981	6,981			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									2,291	2,291			
C. Other									9,834	9,834			
D. Total Occupational Therapy Treatments									19,106	19,106			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Arden House Care and Rehabilitation Center	2199-C	9/30/2018	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)	134,652	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	39,151	1,103				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	343,449	13,846				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers						
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	118,572	4,268				
b. Other Maintenance Workers	122,577	7,083				
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	196,326	3,935				
b. RN						
1. Direct Care	1,387,031	34,136				
2. Administrative**	80,842	2,128				
c. LPN						
1. Direct Care	2,595,227	87,382				
2. Administrative**						
d. Aides and Attendants	4,026,886	219,412				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	288,868	13,590				
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	230,549	9,022				
n. Marketing						
o. Other (Specify) See Attached Schedule	223,569	10,253				
<i>A-13. Total Salary Expenditures</i>	9,787,698	408,243				

* 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				License No.	Report for Year Ended			Page	of	
Arden House Care and Rehabilitation Center				2199-C	9/30/2018			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section 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.

**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	
Arden House Care and Rehabilitation Center				2199-C	9/30/2018			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
McDonnell,Patrick Michael	134,652				Management of Center	2,086	2			
					Management of Center					
Section IV - Assistant Administrators										
Vitko-Aniolek,Stephanie Margaret	39,151				Assists in Overseeing Facility	1,103	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	9/30/2018	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. Dentist	36,986	253				
3. Pharmacist	23,845	487				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	570,077	7,809				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	70,216	372				
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	99,728	1,279				
b. Other						
10. Occupational Therapist						
a. Resident Care	276,109	3,782				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	16,677	278				
2. Administrative***						
b. LPN						
1. Direct Care	1,160	27				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	723					
B-13 Total Fees Paid in Lieu of Salaries	1,095,521	14,287				

* 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	9/30/2018		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 306,136	306,136			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 142,087	142,087			
4. Social Security (F.I.C.A.)	\$ 717,945	717,945			
5. Health Insurance	\$ 906,832	906,832			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 541,367	541,367			
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 68,296	68,296			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 264,602	264,602			
d. Accounting and Auditing	\$				
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 5,557	5,557			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 39,903	39,903			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 19,768	19,768			
2. Cellular Phones	\$ 959	959			
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	\$ 1,376	1,376			
3. Resident Day User Fee	\$ 1,385,017	1,385,017			
Subtotal	\$ 4,399,844	4,399,844			

* 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
9/30/2018

Attachment Page 15

Schedule of Other Employee Benefits

Description		CCNH	RHNS	(Specify)
1020520020	Union Health & Welfare	\$ 754	\$ -	
3005520020	Union Health & Welfare	\$ 17	\$ -	
3210520020	Union Health & Welfare	\$ 31	\$ -	
3080520020	Union Health & Welfare	\$ 1,426	\$ -	
3215520020	Union Health & Welfare	\$ 24,873	\$ -	
3225520020	Union Health & Welfare	\$ 39,973	\$ -	
5035520020	Union Health & Welfare	\$ 1,222	\$ -	
-	-	\$ -	\$ -	
-	-	\$ -	\$ -	
-	-	\$ -	\$ -	
-	-	\$ -	\$ -	
-	-	\$ -	\$ -	
-	-	\$ -	\$ -	
-	-	\$ -	\$ -	
-	-	\$ -	\$ -	
-	-	\$ -	\$ -	
-	-	\$ -	\$ -	
-	-	\$ -	\$ -	
Total		\$ 68,296	\$ -	\$ -

Schedule of Other Taxes

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax	\$ 1,376	\$ -	\$ -
-	-	\$ -	\$ -	\$ -
-	-	\$ -	\$ -	\$ -
-	-	\$ -	\$ -	\$ -
Total		\$ 1,376	\$ -	\$ -

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	9/30/2018		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	4,399,844	4,399,844			
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 1,165	1,165			
5. Education Expenses Related to Seminars and Conventions	\$ 772	772			
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>)	\$ 25	25			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 16,196	16,196			
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	\$ 7,730	7,730			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 21,085	21,085			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 1,850	1,850			
9. Subscriptions	\$ 100	100			
10. Contributions*** See Attached Schedule	\$ 4,681	4,681			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 5,205	5,205			
12. Administrative Management Services**	\$ 871,661	871,661			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 89,069	89,069			
C-14 Total Administrative & General Expenditures	\$ 5,419,381	5,419,381			

* 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
Arden House Care and Rehabilitation Cen	2199-C	9/30/2018	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 Healthcare , 101 East St., Kennett Square, PA 19348	1,014,446	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Healthcare , 101 East St., Kennett Square, PA 19348	96,713	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	9/30/2018	18	37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$ 463,984	463,984			
2. Non-Food Supplies	\$ 56,782	56,782			
3. Other (Specify) _____	\$ (15)	(15)			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 1,821,887	1,821,887			
c. Other (Specify) _____	\$				
2D. Total Dietary Expenditures (2a + b + c)	\$ 2,342,638	2,342,638			
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.

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
Arden House Care and Rehabilitation Center		2199-C	9/30/2018		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. \$	16,296	16,296		
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. \$	30,579	30,579		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	726,175	726,175		
c. Other (Specify)		\$				
3D. Total Laundry Expenditures (3a + b + c)		\$	773,049	773,049		
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.

*** 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	9/30/2018		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. \$	27,856	27,856		
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. \$	1,088,179	1,088,179		
c.	Other (<i>Specify</i>)		\$			
4D.	Total Housekeeping Expenditures (4a + b + c)		\$ 1,116,035	1,116,035		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	118,879	118,879		
b.	Medicine Cabinet Drugs	\$	55,494	55,494		
c.	Medical and Therapeutic Supplies	\$	185,723	185,723		
d.	Ambulance/Limousine***	\$	13,739	13,739		
e.	Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	5,883	5,883		
f.	X-rays and Related Radiological Procedures***	\$	3,467	3,467		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	32,785	32,785		
i.	Recreation	\$	47,351	47,351		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	160,674	160,674		
5M.	Total Resident Care Expenditures (5a - 5l)		\$ 623,996	623,996		

* 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 Arden House Care and Rehabilitation Center			License No. 2199-C		Report for Year Ended 9/30/2018			Page of 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	726,175			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	1,088,179			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Dietary Purchased Services	1,814,936			18	2b
		<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
Arden House Care and Rehabilitation Center	2199-C	9/30/2018			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 336,077	336,077				
b. Heat	\$ 99,905	99,905				
c. Light & Power	\$ 309,706	309,706				
d. Water	\$ 176,786	176,786				
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)	\$ 922,474	922,474				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 1,866	1,866				
b. Building & Building Improvements	\$ 813,162	813,162				
c. Non-Movable Equipment	\$ 154,558	154,558				
d. Movable Equipment	\$ 50,206	50,206				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 1,019,793	1,019,793				
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	\$ 1,953,002	1,953,002				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 669,620	669,620				
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 3,642,415	3,642,415				

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

Depreciation Schedule

Name of Facility Arden House Care and Rehabilitation Center				License No. 2199-C			Report for Year Ended 9/30/2018			Page 23	of 37	
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
A. Land Improvements												
1. Acquired prior to this report period				3,163		3,163	1,298	S/L	Various	1,866		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal											1,866	
B. Building and Building Improvements												
1. Acquired prior to this report period				1,077,006		1,077,006	263,844	S/L	Various	813,162		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
B-4. Subtotal											813,162	
C. Non-Movable Equipment												
1. Acquired prior to this report period				307,633		307,633	153,075	S/L	Various	154,558		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal											154,558	
		Is a mileage logbook maintained?	Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year							
D. Movable Equipment												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.						4,900		4,900	4,900	S/L	Various	
b. Total Current Assets (Lines A1 thru												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period						520,292		520,292	338,907	S/L	Various	49,138
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)						31,067		31,067				1,069
D-3. Subtotal												50,206
E. Total Depreciation												1,019,793

Total deletions for Building Improvements		\$ -		\$ -

** \$ - \$ - \$ -

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

* \$ - \$ - \$ -

** \$ - \$ - \$ -

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Amortization Schedule*

Name of Facility Arden House Care and Rehabilitation Center			License No. 2199-C		Report for Year Ended 9/30/2018			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	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 9/30/2018	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	1,953,002	

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	9/30/2018			26	37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$ 96,713	96,713				
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)		\$ 96,713	96,713				

(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 Rehabilitat		2199-C		9/30/2018		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				96,713	96,713		
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)				\$ 96,713	96,713		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 10,500	10,500		
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)			\$ 535,911	535,911			
2. Fire and Extended Coverage			\$				
3. Other (Specify)			\$				
14d. Total Insurance Expenditures (14a + b + c)				\$ 546,411	546,411		
15. Total All Expenditures (A-13 thru C-14)				\$ 26,366,332	26,366,332		

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	9/30/2018	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	\$ 7,818	7,818		
Page 13 - Professional Fees							
5.	13	B-8-c	Resident Care Physicians **	\$			
6.		B-10	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 945,985	945,985		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 264,602	264,602		
10.			Accounting	\$			
10a.			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 *	\$ 16,196	16,196		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 4,681	4,681		
21.			Unallowable Management Fees	\$ (142,785)	(142,785)		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ (75,499)	(75,499)		
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)				\$ 1,020,996	1,020,996		

* 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	\$ 7,817.63	\$ - \$ -
-	-	-	-	\$ -	\$ - \$ -
-	-	-	-	\$ -	\$ - \$ -
-	-	-	-	\$ -	\$ - \$ -
-	-	-	-	\$ -	\$ - \$ -
-	-	-	-	\$ -	\$ - \$ -
-	-	-	-	\$ -	\$ - \$ -
Total Other Salaries Adjustment				\$ 7,818	\$ - \$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	\$ 197,967.00	\$ - \$ -
13	5	Rehabilitation Services	3195620020	\$ 372,109.77	\$ - \$ -
13	9	Speech Therapist	3170620020	\$ 99,727.95	\$ - \$ -
13	10	Occupational Therapist	3105620020	\$ 276,108.63	\$ - \$ -
13	12	Other	3010620020	\$ (929.47)	\$ - \$ -
13	12	Other	3015620020	\$ 20.00	\$ - \$ -
13	12	Respiratory Purchased Servies	3155620020	\$ 981.02	\$ - \$ -
Total Other Fees Adjustments				\$ 945,985	\$ - \$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	1020630120	\$ 32,298.27	\$ - \$ -
16	m-8a	Chamber of Commerce	1020630310	\$ 1,850.00	\$ - \$ -
16	m-13	Estimated Accrual	1020660990	\$ 1,514.52	\$ - \$ -
16	m-13	Fines & Penalties	1020640080	\$ 22,698.50	\$ - \$ -
16	m-13	Non-recurring Charges	7010800030	\$ -	\$ - \$ -
16	m-12		0	\$ -	\$ - \$ -
15	1-a-1	adj workers comp	0	\$ (133,860.54)	\$ - \$ -
0	0		0	\$ -	\$ - \$ -
0	0		0	\$ -	\$ - \$ -
0	0		0	\$ -	\$ - \$ -
0	0		0	\$ -	\$ - \$ -
0	0		0	\$ -	\$ - \$ -
0	0		0	\$ -	\$ - \$ -
Total Other A&G Adjustments				\$ (75,499)	\$ - \$ -

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	9/30/2018	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,020,996	1,020,996		
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs	\$ 118,879	118,879		
28.	20	5-d	Ambulance/Limousine	\$ 13,739	13,739		
29.	20	5-f	X-rays, etc	\$ 3,467	3,467		
30.	20	5-h	Laboratory	\$ 32,785	32,785		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 5,883	5,883		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 26,757	26,757		
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.			Other - Indirect	\$ 31,355	31,355		
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ (75,275)	(75,275)		
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49.	Total Amount of Decrease (Items 1 - 48)			\$ 1,178,586	1,178,586		

*** 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
9/30/2018

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	9796	3010610300	\$ -
20	5-j	Respiratory Supplies	8405	3155630530	\$ -
20	5-j	Respiratory Rental	8556	3155660080	\$ -
-	-	-	-	\$ -	\$ -
-	-	-	-	\$ -	\$ -
-	-	-	-	\$ -	\$ -
-	-	-	-	\$ -	\$ -
-	-	-	-	\$ -	\$ -
-	-	-	-	\$ -	\$ -
Total Other Ancillary Costs			26757	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Other - Miscellaneous- In Direct

Page Ref	Line Ref	Description	CCNH	RHNS	0
20	5-i	Cable TV	31355	3005660130	allow \$3600

Schedule of Other -Miscellaneous

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14 c1	General liability Insurance Adjust	-75275	\$ -	\$ -
-	-	-	-	\$ -	\$ -
-	-	-	-	\$ -	\$ -
-	-	-	-	\$ -	\$ -
-	-	-	-	\$ -	\$ -
-	-	-	-	\$ -	\$ -
-	-	-	-	\$ -	\$ -
-	-	-	-	\$ -	\$ -
-	-	-	-	\$ -	\$ -
-	-	-	-	\$ -	\$ -
Total Other Adjustments			-75275	\$ -	\$ -

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Arden House Care and Rehabilitation Cen	2199-C	9/30/2018			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 36,318,998	36,318,998				
b. Medicaid Room and Board Contractual Allowance **	\$ (17,850,056)	(17,850,056)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,110,381	1,110,381				
b. Medicare Room and Board Contractual Allowance **	\$ (344,711)	(344,711)				
4. a. Private-Pay Residents and Other	\$ 1,725,277	1,725,277				
b. Private-Pay Room and Board Contractual Allowance **	\$ (408,460)	(408,460)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 57,523	57,523				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (17,858)	(17,858)				
c. Prescription Drugs - Non-Medicare	\$ 72,769	72,769				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (21,419)	(21,419)				
2. a. Medical Supplies - Medicare	\$ 1,233	1,233				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (383)	(383)				
c. Medical Supplies - Non-Medicare	\$ 1	1				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 509,365	509,365				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (158,129)	(158,129)				
c. Physical Therapy - Non-Medicare	\$ 336,515	336,515				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (102,931)	(102,931)				
4. a. Speech Therapy - Medicare	\$ 187,395	187,395				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (58,176)	(58,176)				
c. Speech Therapy - Non-Medicare	\$ 174,374	174,374				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (56,394)	(56,394)				
5. a. Occupational Therapy - Medicare	\$ 667,247	667,247				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (207,143)	(207,143)				
c. Occupational Therapy - Non-Medicare	\$ 418,050	418,050				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (129,916)	(129,916)				
6. a. Other (<i>Specify</i>) - Medicare	\$ 36,813	36,813				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 296,395	296,395				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 22,556,760	22,556,760				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$ 255	255				
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 122	122				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 4,357	4,357				
V. Total Other Revenue (1 thru 8)	\$ 4,734	4,734				
VI. Total All Revenue (III +V)	\$ 22,561,494	22,561,494				

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-a	Medicare Part A	X-Ray	2,521.12	-	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	12,170.78	-	0
II-6-a	Medicare Part A	Respiratory Therapy & Supplies	307.50	-	0
II-6-a	Medicare Part A	Nursing Treatment Supplies	-	-	0
II-6-a	Medicare Part A	Audiology	56.65	-	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	38,331.00	-	0
II-6-a	Contractuals-Medicare	X-Ray	(782.67)	-	0
II-6-a	Contractuals-Medicare	Radiology Service	-	-	0
II-6-a	Contractuals-Medicare	Outpatient Therapy Program	-	-	0
II-6-a	Contractuals-Medicare	Laboratory	(3,778.34)	-	0
II-6-a	Contractuals-Medicare	Respiratory Therapy & Supplies	(95.46)	-	0
II-6-a	Contractuals-Medicare	Nursing Treatment Supplies	-	-	0
II-6-a	Contractuals-Medicare	Audiology	(17.59)	-	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	(11,899.63)	-	0
Total Other Resident Revenue - Medicare			\$ 36,813	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	-	-	-
II-6-b	Medicaid	Radiology Service	-	-	-
II-6-b	Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Medicaid	Laboratory	48.07	-	-
II-6-b	Medicaid	Respiratory Therapy & Supplies	444.93	-	-
II-6-b	Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Medicaid	Audiology	-	-	-
II-6-b	Medicaid	Incontinency	-	-	-
II-6-b	Medicaid	Oxygen & Supplies	-	-	-
II-6-b	Medicaid	Physician Visit	-	-	-
II-6-b	Medicaid	Ambulance	-	-	-
II-6-b	Medicaid	Flu Shot	-	-	-
II-6-b	Contractuals Medicaid	X-Ray	-	-	-
II-6-b	Contractuals Medicaid	Radiology Service	-	-	-
II-6-b	Contractuals Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Contractuals Medicaid	Laboratory	(23.63)	-	-
II-6-b	Contractuals Medicaid	Respiratory Therapy & Supplies	(218.67)	-	-
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	-	-	-
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	1,631.85	-	-
II-6-b	Private and Other	Radiology Service	-	-	-
II-6-b	Private and Other	Outpatient Therapy Program	-	-	-
II-6-b	Private and Other	Laboratory	6,869.02	-	-
II-6-b	Private and Other	Respiratory Therapy & Supplie	328.00	-	-
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	-	-	-
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	379,175.00	-	-
II-6-b	Contractuals-Non-Medicaid	X-Ray	(386.34)	-	-
II-6-b	Contractuals-Non-Medicaid	Radiology Service	-	-	-
II-6-b	Contractuals-Non-Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Contractuals-Non-Medicaid	Laboratory	(1,626.24)	-	-
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplie	(77.65)	-	-
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	-	-	-
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	(89,769.71)	-	-
Total Other Resident Revenue			\$ 296,395	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 30 line	430055	Interest On Overdue Accounts	\$ 121.97	\$ -	\$ -
Pg 30 line	430050		\$ -	\$ -	\$ -
	0	0	\$ -	\$ -	\$ -
Total Interest Income			\$ 122	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
Pg 30 line	Rental Income	0	\$45.00	-
	0 Emedeon Test Payment	0	\$28.70	-
	0 Rehab Screen	0	2,740.00	-
	0 Record escrow receipts inter	0	1,543.51	-
	0	0	-	-
Total Other Revenue			\$ 4,357	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Arden House Care and Rehabilitation C	2199-C	9/30/2018	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	20,714
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,183,683
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(0)
4. Inventories			\$	18,307
5. Prepaid Expenses			\$	1,711,370
a. Prepaid Escrow Replace Reserve	1,319,755			
b. Prepaid Personal Property Tax	88,536			
c. Prepaid Personal Property Tax	12,990			
d. Prepaid Escrow Insurance	40,095			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

A-9. Total Current Assets (Lines A1 thru 8)			\$	3,934,074
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	3,163		
	Accum. Depreciation	3,163		
		Net	\$	
3. Buildings	*Historical Cost	1,077,006		
	Accum. Depreciation	1,077,006		
		Net	\$	
4. Leasehold Improvements	*Historical Cost			
	Accum. Depreciation			
		Net	\$	
5. Non-Movable Equipment	*Historical Cost	307,633		
	Accum. Depreciation	307,633		
		Net	\$	
6. Movable Equipment	*Historical Cost	551,360		162,246
	Accum. Depreciation	389,114		
		Net	\$	
7. Motor Vehicles	*Historical Cost	4,900		
	Accum. Depreciation	4,900		
		Net	\$	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

B-10. Total Fixed Assets (Lines B1 thru 9)			\$	162,246

* 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
Arden House Care and Rehabilitation C	2199-C	9/30/2018	32	37
Account			Amount	
Total Brought Forward:			\$	4,096,320
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 (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	(7,849,333)
	I/C Due to/Due From Owned	(7,849,333)		
	I/C Due to/Due From Multicare			
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	(7,849,333)
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	(3,753,013)

* 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 9/30/2018	Page 34	of 37
Account				Amount	
Total Brought Forward:				2,002,320	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					\$
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable					\$
3. Loans from Owners or Related Parties (<i>itemize</i>)					\$
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities (<i>itemize</i>)					\$
LT Debt-Financing Obligation		1,950,556			1,950,556
B-5. Total Long-Term Liabilities (Lines B1 thru 4)					\$ 1,950,556
C. Total All Liabilities (Lines A-13 + B-5)					\$ 3,952,876

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	2199-C	9/30/2018	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 (<i>Equity</i>)			\$	
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			\$	(3,901,050)
6. Gain or Loss for Period	10/1/2017	thru 9/30/2018	\$	(3,804,838)
7. Total Net Worth			\$	(7,705,888)
C. Total Reserves and Net Worth			\$	(7,705,888)
D. Total Liabilities, Reserves, and Net Worth			\$	(3,753,012)

H. Changes in Total Net Worth

Name of Facility Arden House Care and Rehabilitation Ce	License No. 2199-C	Report for Year Ended 9/30/2018	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2017			\$	(3,901,050)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	22,561,494
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	26,366,332
D. Net Income or Deficit			\$	(3,804,838)
E. Balance			\$	(7,705,888)
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. Balance at End of Period			\$	(7,705,888)

I. Preparer's/Reviewer's Certification

Name of Facility Arden House Care and Rehabilitation	License No. 2199-C	Report for Year Ended 9/30/2018	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)		
Preparer/Reviewer Certification				
<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	Date Signed		
Printed Name of Preparer				
Thomas Farnan -Sr. Director of Reimbursement				
Address Address		Phone Number		
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