

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Arden House Care and Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 850 Mix Avenue, Hamden, CT 06514	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 2199-C	RHNS	(Specify)	Medicare Provider 07-5228
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Medicaid Provider Numbers:	CCNH 20371	RHNS	ICF-IID
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**For Department Use Only**

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

**General Information**

Name of Facility (as licensed) Arden House Care and Rehabilitation Center	License No. 2199-C	Report for Year Ended 9/30/2021	Page 1	of 37
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**Administrator's/Owner's Certification**

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Arden House Care and Rehabilitation Center [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator) Lathrop, Christopher George			Printed Name (Owner) Diane Morris - VP Reimbursement		
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**  
 55 Farmington Avenue, Hartford, Connecticut 06105

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Arden House Care and Rehabilitation Center	Period Covered:	From 10/1/2020	To 9/30/2021	
Address of Facility 850 Mix Avenue, Hamden, CT 06514				
Report Prepared By Rick Fink	Phone Number 410-494-7657	Date 12/28/2021		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$ 6,846,265	6,846,265		
5. All other wages paid	\$ 1,030,883	1,030,883		
6. <b>Total Wages Paid</b>	\$ 7,877,148	7,877,148		
7. Total salaries paid	\$ 420,299	420,299		
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$ 8,297,447	8,297,447		

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 9/30/2021	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.				
<b>Administrator</b>				
Name of Administrator Lathrop, Christopher George		Nursing Home Administrator's License No.:	1988	
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 9/30/2021	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address		State(s) in Which Incorporated	
Arden House Care and Rehabilitation Center	101 East State Street, Kennett Square, PA 19348		PA	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
See Attached				
Names of Stockholders Owning at Least 10% of Shares				
See Attached				





**General Information and Questionnaire  
Related Parties\***

Name of Facility Arden House Care and Rehabilitation Center	License No. 2199-C	Report for Year Ended 9/30/2021	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 Administrative Services LLC	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Home Office	Pg 16/m12	1,240,616	1,240,616
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	658,909	658,909
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input type="radio"/>	<input checked="" type="radio"/>		Staffing Pool	Pg 10/A12, p15-1		
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Medical Director /NP	Pg 13/B8, Pg 10/A12	16,884	16,884
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Outside Agency	Pg 13/B11 pg 10-12, 14		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>		Respiratory Therapy	Pg 13/B12, Pg 20/C5E	17,950	17,950
Genesis Healthcare Ins Program	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	551,227	551,227
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" 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 9/30/2021	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 9/30/2021		Page 6	of 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 checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes	<input checked="" 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 Arden House Care and Rehabilitati	License No. 2199-C	Report for Year Ended 9/30/2021	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:  
 Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

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

Services Provided by This Firm (*describe fully*)

1 Year end financial audit	\$
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    Included in Management Fee pg. 16 m-12

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 2 3 4 5	Telephone Number
---	------------------

Address (*No. & Street, City, State, Zip Code*)  
 1  
 2  
 3  
 4  
 5

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.  
 Yes     No    Legal Fees pg. 15 1-e

### Schedule of Resident Statistics

Name of Facility Arden House Care and Rehabilitation Center		License No. 2199-C			Report for Year Ended 9/30/2021				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						
B. On last day of THIS report period	360	360							360	360		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	173	173			173	173						
B. As of midnight of THIS report period	197	197							197	197		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,753	2,753			2,438	2,438			315	315		
B. Medicaid (Conn.)	60,253	60,253			44,683	44,683			15,570	15,570		
C. Medicaid (other states)												
D. Private Pay	1,569	1,569			988	988			581	581		
E. State SSI for RCH												
F. Other (Specify)	4,747	4,747			3,389	3,389			1,358	1,358		
G. Total Care Days During Period (3A thru F)	69,322	69,322			51,498	51,498			17,824	17,824		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	2	2							2	2		
5. <b>Total Resident Days (3G + 4A + 4B)</b>	69,324	69,324			51,498	51,498			17,826	17,826		

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

Name of Facility Arden House Care and Rehabilitation Center			License No. 2199-C			Report for Year Ended 9/30/2021			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <span style="float: right;"><input type="radio"/> Yes <input checked="" type="radio"/> No</span>													
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	(Specify)	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR			
No. of Residents	4		145			48							
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	636.28		255.97			479.66							
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									2,980	2,980			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									1,858	1,858			
C. Other													
D. <b>Total Physical Therapy Treatments</b>									4,838	4,838			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									506	506			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									516	516			
C. Other													
D. <b>Total Speech Therapy Treatments</b>									1,022	1,022			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									2,162	2,162			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									1,134	1,134			
C. Other													
D. <b>Total Occupational Therapy Treatments</b>									3,296	3,296			

**Annual Report of Long-Term Care Facility**

CSP-10 Rev. 9/2002

**Report of Expenditures - Salaries & Wages**

Name of Facility Arden House Care and Rehabilitation Center	License No. 2199-C	Report for Year Ended 9/30/2021	Page 10	of 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)	166,617	2,064				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	7,303	184				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	382,707	14,075				
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	100,998	2,658				
b. Other Maintenance Workers	100,316	5,340				
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	246,379	4,450				
b. RN						
1. Direct Care	883,854	19,210				
2. Administrative**	120,658	2,492				
c. LPN						
1. Direct Care	2,368,573	72,572				
2. Administrative**						
d. Aides and Attendants	3,272,173	158,170				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	227,946	10,920				
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	218,915	7,625				
n. Marketing						
o. Other (Specify) See Attached Schedule	201,008	8,626				
<i>A-13. Total Salary Expenditures</i>	8,297,447	308,386				

\* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

\*\* Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

\*\*\* This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Ward Clerks	\$ -	-	\$ -	-	\$ -	-
Central Supply	\$ 55,920	2,616	\$ -	-	\$ -	-
Medical Records	\$ 63,770	2,506	\$ -	-	\$ -	-
Coordinator-Staffing Centers	\$ 81,317	3,504	\$ -	-	\$ -	-
<b>Total</b>	\$ 201,008	8,626	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
1020620010 Consulting Fees	\$ 4,812	n/a	\$ -	-	\$ -	-
3010620020 Purchased Services	\$ 450	n/a	\$ -	-	\$ -	-
3015620020 Purchased Services	\$ -	n/a	\$ -	-	\$ -	-
3155620020 Purchased Services	\$ 17,710	n/a	\$ -	-	\$ -	-
3080620020 Purchased Services	\$ 351,282	n/a	\$ -	-	\$ -	-
<b>Total</b>	\$ 374,254	-	\$ -	-	\$ -	-



**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	9/30/2021				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)							
<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.

**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	9/30/2021			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>										
Lathrop, Christopher George 1/8/2019 - present	166,617				Management of Center	2,064	2			
<b>Section IV - Assistant Administrators</b>										
Serrano, Maria Ann 9/1/2021- 9/30/2021	7,303				Management of Center	184	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	9/30/2021	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	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						
2. Dentist	56,978	390				
3. Pharmacist	25,092	512				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	635,926	8,711				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	56,405	298				
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	57,114	732				
b. Other						
10. Occupational Therapist						
a. Resident Care	96,716	1,325				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	13,398	223				
2. Administrative***						
b. LPN						
1. Direct Care	51,150	1,208				
2. Administrative***						
c. Aides	8,886	364				
d. Other						
12. Other (Specify) See Attached Schedule	374,254					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>1,375,919</b>	<b>13,764</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
Arden House Care and Rehabilitation Center	2199-C	9/30/2021	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 783,019	783,019		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 76,118	76,118		
4. Social Security (F.I.C.A.)	\$ 610,385	610,385		
5. Health Insurance	\$ 877,538	877,538		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 470,019	470,019		
8. Uniform Allowance	\$			
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 59,328	59,328		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 133,448	133,448		
d. Accounting and Auditing	\$			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$			
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 32,991	32,991		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 16,453	16,453		
2. Cellular Phones	\$ 2,371	2,371		
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	\$ 575	575		
3. Resident Day User Fee	\$ 1,047,550	1,047,550		
<b>Subtotal</b>	\$ 4,109,794	4,109,794		

\* 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
Arden House Care and Rehabilitation Center	2199-C	9/30/2021		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>	4,109,794	4,109,794			
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	3,914	3,914		
5. Education Expenses Related to Seminars and Conventions	\$	339	339		
6. Automobile Expense ( <i>not purchase or depreciation</i> )	\$				
7. Other ( <i>Specify</i> ) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted ( <i>all such expenses</i> )	\$				
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	27,575	27,575		
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	\$	8,101	8,101		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	28,677	28,677		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	500	500		
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$	2,084	2,084		
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$	6,283	6,283		
12. Administrative Management Services**	\$	1,425,390	1,425,390		
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	117,306	117,306		
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$	5,729,964	5,729,964		

\* Do not include Subscriptions, which should go in item 9.

\*\* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

## Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

## Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
1020630020 Advertising	\$ 21,808	\$ -	\$ -
1020630330 Marketing Expense	\$ 2,761	\$ -	\$ -
1020630331 Marketing Exp- Corporate Spend	\$ 3,007	\$ -	\$ -
3165630330 Marketing Exp- Corporate Spend	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
<b>Total Other Advertising</b>	\$ 27,575	\$ -	\$ -

## Schedule of Dues

Description	CCNH	RHNS	(Specify)
1020630310 Licenses & Certifications	\$ 29,177	\$ -	\$ -
1020630310 Dues to Chamber of Commerce	\$ (500)	\$ -	\$ -
1020630310	\$ -	\$ -	\$ -
1020630310	\$ -	\$ -	\$ -
1020630310	\$ -	\$ -	\$ -
<b>Total Dues</b>	\$ 28,677	\$ -	\$ -

## Schedule of Contributions

Description	CCNH	RHNS	(Specify)
1020630130 Contributions	\$ -	\$ -	\$ -
1020630135 Political Contributions	\$ 2,084	\$ -	\$ -
<b>Total Contributions</b>	\$ 2,084	\$ -	\$ -

## Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
1020630060 Bank Service Charges	\$ 5,856	\$ -	\$ -
1020630120 Collection Fees	\$ 38,954	self-disallowed	\$ -
1020630140 Education Expense	\$ -	\$ -	\$ -
1020630180 Employee Physicals	\$ 20,042	\$ -	\$ -
1020630200 Employee Relations	\$ 3,786	\$ -	\$ -
1020630380 Printing	\$ 4,477	\$ -	\$ -
1020630610 Training Expense	\$ 80	\$ -	\$ -
1020640080 Fines & Penalties	\$ 36,000	self-disallowed	\$ -
1020640090 Miscellaneous	\$ 1,186	\$ -	\$ -
1020660080 Rental Expense	\$ 7,976	\$ -	\$ -
1020660990 Accrued Expense Estimation	\$ (1,051)	self-disallowed	\$ -
5095720090 Landlord Operating Taxes	\$ -	\$ -	\$ -
1020720070 State Tax Annual Report Filing	\$ -	\$ -	\$ -
3080630440 Recruiting Fees	\$ -	\$ -	\$ -
3080630441 Recruiting Fees	\$ -	\$ -	\$ -
7010800030 Non-recurring Charges	\$ -	\$ -	\$ -
<b>Total Other Administrative and General</b>	\$ 117,306	\$ -	\$ -



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

Name of Facility	License No.	Report for Year Ended	Page of
Arden House Care and Rehabilitation Cen	2199-C	9/30/2021	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 Administrative Services LLC, 101 East St., Kennett Square, PA 19348	1,240,616	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12

**\* 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	9/30/2021	18	37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 348,649	348,649		
2.	Non-Food Supplies	\$ 65,360	65,360		
3.	Other ( <i>Specify</i> ) _____	\$ 438	438		
b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )					
		\$ 1,737,847	1,737,847		
c. Other ( <i>Specify</i> ) _____					
		\$			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>		<b>\$ 2,152,294</b>	<b>2,152,294</b>		
2E. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
F.	Resident Meals: Total no. of meals served per day:*				
G.	Is cost of employee meals included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		
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 meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.
K.	Is any revenue collected 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)				
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify cost.
N.	Is any revenue collected from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No		If yes, specify amt.
O.	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	9/30/2021		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. \$	16,526	16,526		
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. \$	11,312	11,312		
b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )		\$	710,163	710,163		
c. Other ( <i>Specify</i> )		\$				
<b>3D. Total Laundry Expenditures (3a + b + c)</b>		\$	738,001	738,001		
3E. Laundry Questionnaire						
F. Is cost of employee laundry included in 3D?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?		(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K. 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 3D.

\*\*\* 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	9/30/2021		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. \$	28,263	28,263		
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. \$	963,755	963,755		
C.	Other ( <i>Specify</i> )	\$				
<b>4D.</b>	<b>Total Housekeeping Expenditures (4a + b + c)</b>	\$	992,018	992,018		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from	\$	255,219	255,219		
b.	Medicine Cabinet Drugs	\$	13,496	13,496		
c.	Medical and Therapeutic Supplies	\$	235,892	235,892		
d.	Ambulance/Limousine***	\$	7,005	7,005		
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	696	696		
f.	X-rays and Related Radiological Procedures***	\$	8,851	8,851		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h.	Laboratory***	\$	64,933	64,933		
i.	Recreation	\$	36,386	36,386		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	120,608	120,608		
<b>5M.</b>	<b>Total Resident Care Expenditures (5a - 5j)</b>	\$	743,084	743,084		

\* Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

\*\* Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

\*\*\* Facility should self-disallow the expense on Page 29 of the Cost Report.

\*\*\*\* ICFMR's should provide a detailed schedule of all Day Program Costs.

## Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
3060610160 Incontinency	\$ 77,806	\$ -	\$ -
3060610161 Advertising-Help Wanted	\$ (219)	\$ -	\$ -
3080630030 Advertising-Help Wanted	\$ 4,172	\$ -	\$ -
3080630080 Books, Dues & Subscriptions	\$ -	\$ -	\$ -
3080630140 Education Expense	\$ 237	\$ -	\$ -
3120630530 Supplies	\$ 363	\$ -	\$ -
3155630530 Supplies	\$ 12,487	\$ -	\$ -
3170630530 Supplies	\$ 179	\$ -	\$ -
3090630535 Office Supplies	\$ -	\$ -	\$ -
3120630535 Office Supplies	\$ -	\$ -	\$ -
3165630535 Office Supplies	\$ -	\$ -	\$ -
3080630610 Training Expense	\$ -	\$ -	\$ -
3120660080 Rental Expense	\$ 630	\$ -	\$ -
3155660080 Rental Expense	\$ 7,632	\$ -	\$ -
3010610300 Consolidated Billing	\$ 17,322	\$ -	\$ -
3080630630 Tuition Reimbursement	\$ -	\$ -	\$ -
3210630630 Tuition Reimbursement	\$ -	\$ -	\$ -
3225630630 Tuition Reimbursement	\$ -	\$ -	\$ -
Miscellaneous	\$ -	\$ -	\$ -
3080630310 Licenses & Certifications	\$ -	\$ -	\$ -
3165630530 Supplies	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
<b>Total Other Resident Care</b>	<b>\$ 120,608</b>	<b>\$ -</b>	<b>\$ -</b>

**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 9/30/2021			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	710,163			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	963,755			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Dietary Purchased Services	1,732,051			18	2b
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" 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	9/30/2021			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 383,051	383,051				
b. Heat	\$ 50,853	50,853				
c. Light & Power	\$ 205,475	205,475				
d. Water	\$ 153,040	153,040				
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>	\$ 792,419	792,419				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 984	984				
b. Building & Building Improvements	\$ 7,531	7,531				
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 11,546	11,546				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	\$ 20,062	20,062				
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	\$ 1,848,253	1,848,253				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 536,690	536,690				
c. Personal property taxes	\$					
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	\$ 2,405,005	2,405,005				

\* 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 9/30/2021			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		
<b>A. Land Improvements</b>												
1. Acquired prior to this report period							S/L	Various	(0)			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)			245,343		245,343				984			
A-4. Subtotal										984		
<b>B. Building and Building Improvements</b>												
1. Acquired prior to this report period			17,972		17,972	217	S/L	Various	3,637			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)			69,494		69,494				3,893			
B-4. Subtotal										7,531		
<b>C. Non-Movable Equipment</b>												
1. Acquired prior to this report period							S/L	Various				
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal												
	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								
<b>D. Movable Equipment</b>												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period												
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												
<b>E. Total Depreciation</b>												

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
8/31/2021	New Pavement, curbs, and striping for parking lot - Deposit	\$ 80,714	06 10	\$ 984
9/30/2021	September 2021 Accrual	\$ 3,200	-	\$ -
9/30/2021	September 2021 Accrual	\$ 161,429	-	\$ -
<b>Total additions for Land Improvement</b>		\$ 245,343		\$ 984 *
<b>Deletions:</b>				
<b>Total deletions for Land Improvement</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>				
6/30/2021	Deposit - New Flooring in Rec Room, B wing, & Offices	\$ 28,226	7	\$ 1,008
6/30/2021	New Flooring in B Wing - remaining materials/labor	\$ 28,918	7	\$ 1,033
12/31/2020	Final Install - New AO Smith Hot Water Heater	\$ 12,350	5	\$ 1,853
<b>Total additions for Building Improvement</b>		\$ 69,494		\$ 3,893 *
<b>Deletions:</b>				
<b>Total deletions for Building Improvement</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



**Annual Report of Long-Term Care Facility**

CSP-24 Rev. 10/2006

**Amortization Schedule\***

Name of Facility			License No.		Report for Year Ended			Page	of
Arden House Care and Rehabilitation Center			2199-C		9/30/2021			24	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							
<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 Arden House Care and Rehabilitation	License No. 2199-C	Report for Year Ended 9/30/2021	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		n/a			
2. Date Structure Completed		n/a			
3. If <b>NOT</b> Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity		360			
6. Square Footage					
7. Acquisition Cost					
a. Land		n/a			
b. Building		n/a			
<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
GMF-CT		Facility Lease	12/21/2018-12	10 years	1,848,253
650 Madison Avenue New York, NY 10022					

**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	9/30/2021			26	37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$					
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. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$					

(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 Rehabilitatio		2199-C		9/30/2021		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:							
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. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$			
14. Insurance							
a. Insurance on Property (buildings only)				\$ 32,957	32,957		
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$ 518,270	518,270		
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$ 551,227	551,227		
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$ 23,777,376	23,777,376		

### 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	9/30/2021	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	\$ 31,717	31,717		
<b>Page 13 - Professional Fees</b>							
5.	13	B-8-c	Resident Care Physicians **	\$			
6.		B-10	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 807,916	807,916		
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 133,448	133,448		
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 *	\$ 27,575	27,575		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 2,084	2,084		
21.			Unallowable Management Fees	\$ 184,774	184,774		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 613,834	613,834		
<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	\$			
Subtotal (Items 1 - 26)				\$ 1,801,348	1,801,348		

\* 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	\$ 31,717	\$ -	\$ -
<b>Total Other Salaries Adjustment</b>			\$ 31,717	\$ -	\$ -

## Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	\$ 188,879	\$ -	\$ -
13	5	Rehabilitation Services	\$ 447,047	\$ -	\$ -
13	9	Speech Therapist	\$ 57,114	\$ -	\$ -
13	10	Occupational Therapist	\$ 96,716	\$ -	\$ -
13	12	Other	\$ 450	\$ -	\$ -
13	12	Other	\$ -	\$ -	\$ -
13	12	Respiratory Purchased Servies	\$ 17,710	\$ -	\$ -
<b>Total Other Fees Adjustments</b>			\$ 807,916	\$ -	\$ -

## Schedule of Other A&amp;G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	\$ 38,954	\$ -	\$ -
16	m-13	Estimated Accrual	\$ (1,051)	\$ -	\$ -
16	m-13	Non-recurring Charges	\$ -	\$ -	\$ -
16	m-13	Dues to Chamber of Commerce	\$ 500	\$ -	\$ -
16	m-13	Penalty	\$ 36,000	\$ -	\$ -
16	m-12		0 \$ -	\$ -	\$ -
15	1-a-1	adj workers comp	\$ 201,756	\$ -	\$ -
13	B12	Disallowed The SNAP Strike Cost	\$ 337,674	\$ -	\$ -
0	0		0 \$ -	\$ -	\$ -
<b>Total Other A&amp;G Adjustments</b>			\$ 613,834	\$ -	\$ -

**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	9/30/2021	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,801,348	1,801,348		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5-a-2	Prescription Drugs	\$ 255,219	255,219		
28.	20	5-d	Ambulance/Limousine	\$ 7,005	7,005		
29.	20	5-f	X-rays, etc	\$ 8,851	8,851		
30.	20	5-h	Laboratory	\$ 64,933	64,933		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 696	696		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 37,441	37,441		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ (79,449)	(79,449)		
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.			Other - Indirect	\$ 28,749	28,749		
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 443,599	443,599		
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 2,568,391	2,568,391		

\*\*\* 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.

## Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	\$ 17,322	\$ -	\$ -
20	5-j	Respiratory Supplies	\$ 12,487	\$ -	\$ -
20	5-j	Respiratory Rental	\$ 7,632	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
<b>Total Other Ancillary Costs</b>			<b>\$ 37,441</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Page 22	7a	Land Imp	\$ (3,642)	\$ -	\$ -
Page 22	7b	Bldg Imp	\$ (9,178)	\$ -	\$ -
Page 22	7c	Non Movable Equip	\$ (1,647)	\$ -	\$ -
Page 22	7d	Movable Equip	\$ (64,982)	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
<b>Total Excess Movable Equipment Depreciation</b>			<b>\$ (79,449)</b>	<b>\$ -</b>	<b>\$ -</b>

## Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Property Adjustments</b>			<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-i	Cable TV - Allowable \$3,600 Account#3005660130	\$ 28,749	\$ -	\$ -
<b>Total Other Adjustments</b>			\$ 28,749	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14c1	General liability Insurance Adjust	\$ 443,599	\$ -	\$ -
<b>Total Other Adjustments</b>			\$ 443,599	\$ -	\$ -

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

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

## F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Arden House Care and Rehabilitation	Cen 2199-C	9/30/2021		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> )	\$ 26,745,577	26,745,577			
b. Medicaid Room and Board Contractual Allowance **	\$ (11,575,550)	(11,575,550)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,338,568	1,338,568			
b. Medicare Room and Board Contractual Allowance **	\$ (164,453)	(164,453)			
4. a. Private-Pay Residents and Other	\$ 3,152,814	3,152,814			
b. Private-Pay Room and Board Contractual Allowance **	\$ (893,263)	(893,263)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 82,364	82,364			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (10,119)	(10,119)			
c. Prescription Drugs - Non-Medicare	\$ 182,033	182,033			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (54,906)	(54,906)			
2. a. Medical Supplies - Medicare	\$ 123	123			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (15)	(15)			
c. Medical Supplies - Non-Medicare	\$ 78	78			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (34)	(34)			
3. a. Physical Therapy - Medicare	\$ 342,888	342,888			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (42,126)	(42,126)			
c. Physical Therapy - Non-Medicare	\$ 330,836	330,836			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (109,403)	(109,403)			
4. a. Speech Therapy - Medicare	\$ 112,681	112,681			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (13,844)	(13,844)			
c. Speech Therapy - Non-Medicare	\$ 157,785	157,785			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (56,310)	(56,310)			
5. a. Occupational Therapy - Medicare	\$ 312,009	312,009			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (38,333)	(38,333)			
c. Occupational Therapy - Non-Medicare	\$ 312,142	312,142			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (99,319)	(99,319)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 50,551	50,551			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 228,419	228,419			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 20,291,193	20,291,193			
<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	\$				
5. Interest Income ( <i>Specify</i> )	\$ 41	41			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 619,640	619,640			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 619,681	619,681			
<b>VI. Total All Revenue</b> (III +V)	\$ 20,910,874	20,910,874			

\* 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.



### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Arden House Care and Rehabilitation C	2199-C	9/30/2021	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	5,880
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,528,261
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(301,933)
4. Inventories			\$	29,126
5. Prepaid Expenses			\$	#VALUE!
a. Prepaid Expenses				
b. Prepaid Property Tax	96,896			
c. Prepaid Personal Property Tax	10,258			
d. See Schedule	#VALUE!			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	#VALUE!
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	245,343	\$	244,359
	Accum. Depreciation	984		Net
3. Buildings	*Historical Cost	87,466	\$	79,718
	Accum. Depreciation	7,748		Net
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
5. Non-Movable Equipment	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
6. Movable Equipment	*Historical Cost	98,954	\$	87,408
	Accum. Depreciation	11,546		Net
7. Motor Vehicles	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
_____				
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	411,485

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description		
31	A5	Prepaid Escrow Real Estate	145280	#VALUE!
31	A5	Prepaid Escrow Insurance	145290	#VALUE!
31	A5	Prepaid Escrow Replace Reserve	145300	#VALUE!
<b>Total Prepaid Expenses</b>				#VALUE!

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref	Line Ref	Description		
<b>Total Other Current Assets (Itemize)</b>				\$ -

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Page Ref	Line Ref	Description		
<b>Total Other Fixed Assets (Itemize)</b>				\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description		
32	D7	ROU Bldg Asset-Oper Lease	150510	#VALUE!
32	D7	AccumAmort-ROU Bldg OprLease	150511	#VALUE!
<b>Total Other Assets</b>				#VALUE!

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description		
<b>Total Notes Payable</b>				\$ -

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref	Line Ref	Description		
33	A12	Accr Exp Other	210010	#VALUE!
33	A12	Accr Exp Water and Sewer	210090	#VALUE!
33	A12	Accr Exp Gas	210100	#VALUE!
33	A12	Accr Exp Electricity	210110	#VALUE!
33	A12	Accr Exp Nursing Purchased Ser	210310	#VALUE!
33	A12	Accr Exp Due to Prior Owner	210330	#VALUE!
33	A12	Deferred Revenue	210340	#VALUE!
33	A12	A/R Credit Gross Up Liability	210345	#VALUE!
33	A12	Accrued Provider/Bed Tax	210350	#VALUE!
33	A12	Accr Gross Rec Tax-FY11	215311	#VALUE!
33	A12	Accr Gross Rec Tax-FY12	215312	#VALUE!
33	A12	Accr Gross Rec Tax-FY13	215313	#VALUE!
33	A12	Accr Gross Rec Tax-FY14	215314	#VALUE!
33	A12	Accr Gross Rec Tax-FY15	215315	#VALUE!
33	A12	Accr Gross Rec Tax-FY16	215316	#VALUE!
33	A12	Accr Gross Rec Tax-FY17	215317	#VALUE!
33	A12	Accr Gross Rec Tax-FY18	215318	#VALUE!
33	A12	Accr Sales and Use Tax - FY18	215418	#VALUE!
33	A12			
<b>Total Other Current Liabilities (Itemize)</b>				#VALUE!

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

Page Ref	Line Ref	Description		
<b>Total Other Current Liabilities (Itemize)</b>				\$ -



**Annual Report of Long-Term Care Facility**

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

Name of Facility Arden House Care and Rehabilitation C	License No. 2199-C	Report for Year Ended 9/30/2021	Page 32	of 37
Account			Amount	
Total Brought Forward:			\$ #VALUE!	
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 <b>Total Leasehold or Like Properties</b> (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> )			\$ #VALUE!	
I/C Due to/Due From Owned			(12,767,727)	
I/C Due to/Due From Multicare				
See Schedule			#VALUE!	
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$ #VALUE!	
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$ #VALUE!	

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

**Annual Report of Long-Term Care Facility**

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

Name of Facility		License No.	Report for Year Ended	Page	of
Arden House Care and Rehabilitation Center		2199-C	9/30/2021	33	37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	1,398,281
2. Notes Payable ( <i>itemize</i> )				\$	
_____					
_____					
See Schedule					
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> )				\$	282,037
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	5,301
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> )				\$	#VALUE!
_____					
_____					
_____					
See Schedule				#VALUE!	
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)				\$	#VALUE!

\* 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 Arden House Care and Rehabilitation Center		License No. 2199-C	Report for Year Ended 9/30/2021	Page 34	of 37
Account				Amount	
Total Brought Forward:				#VALUE!	
<b>Liabilities (cont'd)</b>					
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> )				\$ 9,923,625	
LT Debt-Financing Obligation		9,923,625			
Escheatable Funds					
See Schedule					
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 9,923,625	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ #VALUE!	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Arden House Care and Rehabilitation C	2199-C	9/30/2021	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 ( <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>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(9,181,514)
6. Gain or Loss for Period			\$	(2,164,658)
	10/1/2020	thru 9/30/2021		
7. Total Net Worth			\$	(11,346,172)
<b>C. Total Reserves and Net Worth</b>			\$	(11,346,172)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	#VALUE!

### H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Arden House Care and Rehabilitation Ce	2199-C	9/30/2021	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2020			\$	(8,479,669)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	20,910,874
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	23,777,377
D. Net Income or Deficit			\$	(2,866,503)
E. Balance			\$	(11,346,172)
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>			\$	(11,346,172)

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

Name of Facility Arden House Care and Rehabilitation	License No. 2199-C	Report for Year Ended 9/30/2021	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		Date Signed
Printed Name of Preparer				
Rick Fink				
Address Address			Phone Number	
200 Brickstone Square, Andover, MA 01810			410-494-7657	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Rick Fink			410-494-7657	
Contact Email Address				
Rick.Fink@genesishcc.com				