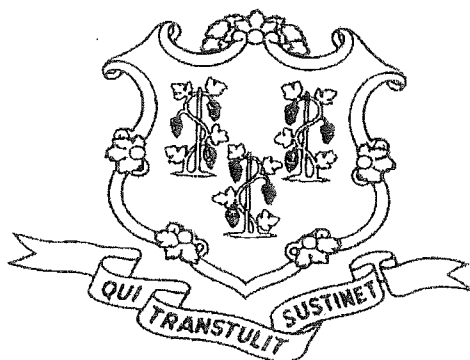


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2019

| | |
|--|--|
| Name of Facility (as licensed) 35 Marc Drive Operations, LLC, d/b/a Skyview Center | |
| Address (No. & Street, City, State, Zip Code) 35 Marc Drive, Wallingford, CT 06492 | |
| Type of Facility | |
| <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) | <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) |
| <input type="checkbox"/> (Specify) | |
| Report for Year Beginning 5/1/2019 | Report for Year Ending 9/30/2019 |

| | | | | |
|------------------|--------------|------|-----------|------------------------------|
| License Numbers: | CCNH 2377 | RHNS | (Specify) | Medicare Provider 07-5057 |
|------------------|--------------|------|-----------|------------------------------|

| | | | |
|----------------------------|--------------|------|---------|
| Medicaid Provider Numbers: | CCNH 7427 | RHNS | ICF-IID |
|----------------------------|--------------|------|---------|

For Department Use Only

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

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General Information

| | | | | |
|---|-------------|-----------------------|------|----|
| Name of Facility (as licensed) | License No. | Report for Year Ended | Page | of |
| 35 Marc Drive Operations, LLC, d/b/a Skyview Center | 2377 | 9/30/2019 | 1 | 37 |

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for 35 Marc Drive Operations, LLC, d/b/a Skyview Center [facility name], for the cost report period beginning May 1, 2019 and ending September 30, 2019, 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.

{a} Subject to Desk Audit Review

| | | | | | |
|---|----------|------|--|----------------------|------|
| Signed (Administrator) | | Date | Signed (Owner) | | Date |
| Printed Name (Administrator) Raymond Cyr | | | Printed Name (Owner) Shannon Mirlis | | |
| Subscribed and Sworn to before me: | State of | Date | Signed (Notary Public) | Comm. Expires / / | |
| Address of Notary Public | | | | | |

(Notary Seal)

State of Connecticut
Department of Social Services
 55 Farmington Avenue, Hartford, Connecticut 06105

| Data Required for Real Wage Adjustment | | | Page 1A | of 37 |
|---|------------------------------|------------------|-----------------|-----------|
| Name of Facility 35 Marc Drive Operations, LLC, d/b/a Skyview Center | Period Covered: | From 5/1/2019 | To 9/30/2019 | |
| Address of Facility 35 Marc Drive, Wallingford, CT 06492 | | | | |
| Report Prepared By Marcum LLP | Phone Number 203-781-9600 | Date 1/8/2020 | | |
| Item | Total | CCNH | RHNS | (Specify) |
| 1. Dietary wages paid | \$ | | | |
| 2. Laundry wages paid | \$ | | | |
| 3. Housekeeping wages paid | \$ | | | |
| 4. Nursing wages paid | \$ | | | |
| 5. All other wages paid | \$ | | | |
| 6. Total Wages Paid | \$ | | | |
| 7. Total salaries paid | \$ | | | |
| 8. Total Wages and Salaries Paid (As per page 10 of Report) | \$ | | | |

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

| | | | | |
|--|--------------|--|----------------------------------|----------|
| Phone No. of Facility 203-265-0981 | | Report for Year Ended 9/30/2019 | Page 2 | of 37 |
| Name of Facility (as shown on license) 35 Marc Drive Operations, LLC, d/b/a Skyview Center | | Address (No. & Street, City, State, Zip) 35 Marc Drive, Wallingford, CT 06492 | | |
| License Numbers: | CCNH 2377 | RHNS (Specify) | Medicare Provider No. 07-5057 | |
| Type of Facility (Check appropriate box(es)) | | | | |
| <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify) | | | | |
| Type of Ownership (Check appropriate box) | | | | |
| <input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust | | | | |
| If this facility opened or closed during report year provide: | | Date Opened | Date Closed | |
| Has there been any change in ownership or operation during this report year? <input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," explain fully. | | | | |
| Shannon Mirlis Purchased the facility and began operations as of 5/1/2019. | | | | |
| Administrator | | | | |
| Name of Administrator Raymond Cyr | | Nursing Home Administrator's License No.: | 567 | |
| Other Operators/Owners who are assistant administrators (full or part time) of this facility. | | | | |
| Name N/A | | License No.: | | |
| | | | | |
| | | | | |
| | | | | |

General Information and Questionnaire
Corporate Owners

| | | | | |
|---|---------------------|------------------------------------|------------|----------|
| Name of Facility 35 Marc Drive Operations, LLC, d/b/a Skyvic | License No. 2377 | Report for Year Ended 9/30/2019 | 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 | |
|---------------------------|------------------|--------------------------------|--|
| N/A | | | |

| Name of Directors, Officers | Business Address | Title | No. Shares Held by Each |
|-----------------------------|------------------|-------|-------------------------|
| N/A | | | |
| | | | |
| | | | |
| | | | |
| | | | |

| Names of Stockholders Owning at Least 10% of Shares | Business Address | Title | No. Shares Held by Each |
|---|------------------|-------|-------------------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

General Information and Questionnaire Individual Proprietorship

| | | | | |
|--|---------------------|------------------------------------|------------|----------|
| Name of Facility 35 Marc Drive Operations, LLC, d/b/a Skyview C | License No. 2377 | Report for Year Ended 9/30/2019 | Page 3B | of 37 |
|--|---------------------|------------------------------------|------------|----------|

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

N/A

General Information and Questionnaire
Related Parties*

| | | | | |
|---|---------------------|------------------------------------|-----------|----------|
| Name of Facility 35 Marc Drive Operations, LLC, d/b/a Skyview Center | License No. 2377 | Report for Year Ended 9/30/2019 | Page 4 | of 37 |
|---|---------------------|------------------------------------|-----------|----------|

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 | %** | | | | |
| RegalCare Rehab | 26 Firemens Memorial Drive, Suite 205, Pomona, NY 10970 | <input type="radio"/> | <input checked="" type="radio"/> | | Physical Therapy | Page 13 / Line 5a | 67,995 | 67,995 |
| RegalCare Rehab | 26 Firemens Memorial Drive, Suite 205, Pomona, NY 10970 | <input type="radio"/> | <input checked="" type="radio"/> | | Speech Therapy | Page 13 / Line 9a | 22,404 | 22,404 |
| RegalCare Rehab | 26 Firemens Memorial Drive, Suite 205, Pomona, NY 10970 | <input type="radio"/> | <input checked="" type="radio"/> | | Occupational Therapy | Page 13 / Line 10a | 71,277 | 71,277 |
| Skyview PropCo | 5 Barlow Road, Edison, NJ 08817 | <input type="radio"/> | <input checked="" type="radio"/> | | Rental Property | Page 22 / Line 9 | 200,000 | ***200000 |
| | | <input type="radio"/> | <input checked="" type="radio"/> | | Various Intercompany Loans | Page 34 / Line B3 | | |
| | | <input type="radio"/> | <input checked="" type="radio"/> | | | | | |
| | | <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.

*** N/A Medicaid reimbursement is based upon fair rental value system. Replaced during rate setting.

General Information and Questionnaire
Basis for Allocation of Costs

| | | | | |
|--|---------------------|------------------------------------|-----------|----------|
| Name of Facility 35 Marc Drive Operations, LLC, d/b/a Skyview | License No. 2377 | Report for Year Ended 9/30/2019 | Page 5 | of 37 |
|--|---------------------|------------------------------------|-----------|----------|

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

| Item | Method of Allocation |
|---|--|
| Dietary | Number of meals served to residents |
| Laundry | Number of pounds processed |
| Housekeeping | Number of square feet serviced |
| Nursing | Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants |
| Direct Resident Care Consultants | Number of hours of resident care provided by EACH specialist (<i>See listing page 13</i>) |
| Maintenance and operation of plant | Square feet |
| Property costs (depreciation) | Square feet |
| Employee health and welfare | Gross salaries |
| Management services | Appropriate cost center involved |
| All other General Administrative expenses | Total of Direct and Allocated Costs |

The preparer of this report must answer the following questions applicable to the cost information provided.

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

General Information and Questionnaire Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts.

| Name of Facility | | | License No. | Report for Year Ended | | | Page | of | |
|--|---|----------------------------------|-----------------------------|-----------------------|------------------|------------------------------|---------------------------|-------------------------------------|------------------|
| 35 Marc Drive Operations, LLC, d/b/a Skyview Center | | | 2377 | 9/30/2019 | | | 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 | | | | | | | |
| Balboa Capital Corporation- 575 Anton Blvd, 12th floor Costa Mesa, CA 92626 | <input type="radio"/> | <input checked="" type="radio"/> | Copier Lease | 05/20/19 | 63 Months | 2,034 | | 2,034 | |
| | <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 | Total *** |
| | | | | | | | | 2,034 | |

* 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.



e Copier Solutions

| | | | | |
|---|---------------------------------|---|---|--|
| Business Name ("You") 35 MARC DRIVE OPERATIONS LLC DBA Skyview Center | | Business Address 35 Marc Dr Wallingford, CT 06492 | | Equipment Location Address (if different than billing address of lessee) Same as Billing |
| Business Phone 203-265-0981 | | Business Tax ID | | |
| Monthly Rent ("Rent") (plus applicable taxes) \$330.00 | Base Term (months) 63 | Required Deposit 0 | Deposit Applied to First and Last 0 Monthly Rentals | Doc Fees: \$125.00 |
| 1 Kyocera TaskAlfa 5003i | | | | (2) ea. dual scan, 4,000 Finisher, dual 1500 trays, fax system |

See attached schedule for additional Equipment/Accories

1. LEASE: You agree to lease from us and we agree to lease to you, the Equipment. You unconditionally promise to pay us the sum of all the rent and other payments indicated above ("Rent"), plus the prorated rent as described in the next paragraph. We may insert in this Lease any information and adjust any payment or agreement in this Lease ("Obligations") by no more than 10% to reflect actual costs. We may accept a photocopy or electronically transmitted facsimile copy of this Lease or any other document but no such document(s) shall be binding upon us until signed by us. Any such document will, when executed by us, constitute an original document for the purpose of establishing the provisions thereof and shall be legally admissible under the best or original evidence rule and binding on the parties. 2. TERM OF LEASE: The first payment we will charge you shall be a daily charge of one-thirtieths (1/30th) of the Rent from the date the Equipment is accepted by you ("Commencement Date") to the first day of the Base Term (the "Prorated Rent") and shall be due and payable on a date selected by us. You acknowledge that a) we may charge up to thirty (30) days of Prorated Rent in our sole discretion, regardless of whether this Lease is characterized as an "operating" lease or a "candle" lease and b) the Prorated Rent is not credited against the monthly Rent due after the start of the Base Term. The Base Term of this Lease will begin on a date we choose not more than 30 days following the Commencement Date and terminate upon the expiration of the number of months stated under Base Term above. Following the Commencement Date, Rent and other payments are due on the same day of each month as the first day of the Base Term, payable to us at our offices in Irvine, CA. YOUR OBLIGATION TO PAY RENT IS UNCONDITIONAL AND NOT SUBJECT TO ANY REDUCTION, SET-OFF, DEFENSE, OR COUNTERCLAIM AND MAY NOT BE CANCELLED. 3. PAYMENT OF LEASE OBLIGATION: UNLESS WE AGREE OTHERWISE IN WRITING, you authorize us or our assignee to debit from the bank account on which your payment was drawn for Rent and other Obligations, or the account on which a cancelled or voided check you provided can be drawn. You understand and agree that this authorization to electronically withdraw funds from your account is irrevocable. If any part of any Obligation is not paid by you within three (3) days of its due date, you will pay us eighteen percent (18%) of each such late payment (to the extent permitted by law). 4. NO WARRANTIES: WE ARE LEASING THE EQUIPMENT TO YOU AS-IS, WHERE-IS AND WE MAKE NO WARRANTIES, EXPRESSED OR IMPLIED, INCLUDING WARRANTIES OF NON-INFRINGEMENT, MERCHANTABILITY, OR FITNESS FOR A PARTICULAR PURPOSE OR ORDINARY USE. You acknowledge that you have selected the Equipment and the vendor, manufacturer and/or supplier (collectively "Suppliers") of the Equipment. You acknowledge that the Supplier is not our agent. Any breach by the Supplier will not relieve or excuse your Obligations. We are not responsible for any service or maintenance of the Equipment. 5. UCC-ARTICLE 2A: You agree that this Lease is a "finance lease" under the UCC as adopted in California ("UCC"). YOU WAIVE ANY AND ALL RIGHTS AND REMEDIES CONFERRED UPON YOU UNDER ARTICLE 2A OF THE UCC. You will not assert any claim against us for any consequential, special or indirect damages. 6. ASSIGNMENT: You may not sell, transfer, assign or sublease the Equipment without our prior written approval. We may sell, assign or transfer this Lease and the Equipment or any interest therein without notifying you; and you agree that if we do, the new Lessor will have the same rights and benefits that we now have, and will not have to perform any of our obligations. You agree that the rights of the assignee will not be subject to any claims, defenses or setoffs that you may have against us. 7. OWNERSHIP, RIGHTS AND QUIET ENJOYMENT: We are the owner of and have title to the Equipment. You will, at your expense, protect and defend our rights to the Equipment and keep the Equipment free of liens. To the extent this Lease is deemed to be a "capital lease," you grants us a security interest in the Equipment and any proceeds thereof, including any insurance proceeds. You will have the right to quiet use and enjoyment of the Equipment for the term of this Lease, provided you are not in default. 8. CARE, USE AND LOCATION; LOSS OF EQUIPMENT: You are responsible for installing and keeping the Equipment in good working order and repair, only at your address shown on this Lease, only for business or commercial purposes and in compliance with all applicable laws. You will not make any alterations to the Equipment, nor will you attach the Equipment to real estate. If the Equipment is lost, stolen or damaged you will within one week: (a) repair or replace the Equipment or (b) pay to us all remaining Rent under this Lease and our residual interest in the Equipment, discounted to present value at 5%, plus any other Obligations ("Lost Value"). We may inspect the Equipment at your expense. 9. TAXES AND FEES: You will pay when due all taxes, fines and penalties and fees relating to this Lease or the Equipment. If we pay any of the above for you, you will reimburse us and pay us a processing fee. You will pay us any filing fees and reimburse us for all expenses in documenting and servicing this transaction. You will pay us an origination fee on or before the date the first payment is due. Such fees may not only cover our costs they may also include a profit. 10. INDEMNITY: You will reimburse us for and defend us against any claims for such losses or injuries, including, without limitation, those arising out of the negligence, tort or strict liability claims. This indemnity will continue after the term of this Lease has expired. 11. INSURANCE: You will maintain, at your expense, property insurance protecting the Equipment for its full replacement value, naming us as a loss payee and public liability insurance, in amounts acceptable to us, naming us as an additional insured (together "Required Insurance"). You must provide us satisfactory written evidence of Required Insurance within 30 days of the Commencement Date of this Lease or of any subsequent request. If you do not do so, we may obtain insurance from an insurer of our choosing in such forms and amounts as we deem reasonable to protect our interests ("Lease Insurance"). Lease Insurance covers the Equipment and us, not you. You will pay us periodic charges for Lease Insurance ("Insurance Charges") that include a premium that may be higher than if you maintained Required Insurance separately, a finance charge of up to

the implicit rate of the Lease on any premium advances made by us or our agents; and billing and processing fees; each of which may generate a profit to us and our agents. If you fail to pay billed Insurance Charges within 30 days of their due date, we may pay them by applying funds paid under the Lease or debiting your account under any previously authorized automatic payment. We will discontinue billing Insurance Charges upon receipt of satisfactory evidence of Required Insurance. You will arbitrate any dispute with us or our agents regarding Lease Insurance or Insurance Charges under the rules of the American Arbitration Association in Los Angeles, CA, provided however, such agreement does not authorize class action arbitration. At Lessor's election, in lieu of obtaining or continuing Lease Insurance, Lessor may require Lessee to pay a monthly additional fee up to 2% of the Equipment Cost. This fee is not calculated with reference to additional risk and constitutes additional profit for Lessor, but represents the basis on which Lessor is willing to forgo for exercising remedies and continue this Agreement without Required Insurance. Lessee will receive no insurance coverage and will not be released from any obligations. Lessor is not selling insurance. Lessor will cease charging the additional fee or billing for Lease Insurance 30 days after Lessee provides satisfactory proof of Required Insurance and compliance with this section. 12. DEFAULT AND REMEDIES: You will be in default if (A) you do not pay or perform any Obligation when due or misrepresent any fact, (B) more than 20% of your voting interests are transferred, (C) you change your name, state of incorporation, chief executive office and/or place of residence without 30 days prior written notice to us. In the event of a default by you, we can require that you return the Equipment to us and pay to us the remaining balance of all of the Rent due under this Lease, together with any other amounts due under this Lease, including late charges and interest. You are also required to pay us our residual interest in the Equipment. We will also be entitled to recover from you all damages caused by your default. Interest will accrue on all Obligations due to us from the date of default until paid at the rate of 18% per annum but only to the extent allowed by law. We can also use any of the remedies available to us under the UCC or any other law, including repossession of the Equipment or other Collateral. You agree to reimburse us for all charges, costs, expenses and attorney's fees that we have to pay to enforce this Lease, respond to any dispute, recover and sell the Equipment or collect the Obligations due from you to us under this Lease and in any lawsuit or other legal proceeding which we bring or defend. 13. RETURN OF EQUIPMENT; RENEWAL: If no default exists or has occurred under this Lease, you may, at the end of the original or any renewal term, purchase all of the Equipment for its Fair Market Value, plus any applicable taxes. At least 60 days but not more than 150 days prior to the original Lease term, you must give us written notice, via certified mail, that you will purchase the equipment for its fair market value, which we will determine in our reasonable judgment, or that you will return the equipment to us. If you do not give us such written notice or if you give us written notice, but do not purchase or deliver the Equipment in accordance with the terms and conditions of this Lease, then this Lease will automatically renew for a 90 day term, and thereafter renew for successive 90 day terms until you deliver the Equipment to us and all such Rent will be the highest Rent in this Lease. We may cancel the renewal by sending you written notice 90 days prior to such renewal term. Upon payment of the End of Term Option price, and if no default exists, we will transfer our interest in the Equipment to you "AS-IS, WHERE IS". If you return the Equipment, it will be freight and insurance prepaid, in good repair, condition and working order, ordinary wear and tear excepted, in a manner and to a location designated by us. Until the End of Term Option price is actually paid, or until you return the Equipment to us, you will be responsible to continue to pay Rent. 14. OTHER RIGHTS: Time is of the essence in this Lease. You agree that any delay or failure by us to enforce our rights under this Lease or any other agreements will not prevent us from enforcing any rights at a later time. If for any reason this Lease is not a true lease, then you also grant us a security interest in the Equipment and any proceeds of, accessions and attachments to the Equipment as security for your Obligations. We may file financing statements or other filings in our name or your name. This Lease as well as the Delivery and Acceptance receipt(s) for the Equipment constitute the entire agreement between the parties and supersede all prior negotiations, written or oral, including any written offer or proposal describing and/or summarizing the terms of any proposed lease/financing. This Lease cannot be modified except in writing signed by the party against whom enforcement is sought. You represent to us that you shall not allege in any court proceeding that the parties entered into an oral modification of any Lease, and further agree that in any event, any such oral modification shall not be enforceable unless it is reduced to a writing signed by the party against whom enforcement is sought. A limiting endorsement on a check or other form or payment will not be effective against us. 15. CHOICE OF LAW: THIS LEASE IS BINDING WHEN ACCEPTED IN WRITING BY US AT OUR OFFICES IN COSTA MESA, CA AND GOVERNED BY THE LAWS OF CALIFORNIA. YOU AND WE AGREE THAT THIS LEASE IS DEEMED TO HAVE BEEN MADE AND PERFORMED IN ORANGE COUNTY, CA. YOU AND WE EACH SUBMIT TO THE JURISDICTION OF CALIFORNIA AND AGREE THAT THE COURTS OF ORANGE COUNTY, CALIFORNIA AND/OR THE UNITED STATES DISTRICT COURT FOR THE CENTRAL DISTRICT OF CALIFORNIA, SANTA ANA DIVISION SHALL HAVE EXCLUSIVE AND MANDATORY JURISDICTION OVER THE DETERMINATION OF ALL DISPUTES ARISING OUT OF THIS LEASE. YOU WAIVE TRIAL BY JURY. You represent that all financial and other information furnished to us is true and correct. If this Lease was sent electronically, you warrant that it has not been altered in any way. To the extent that this Lease constitutes chattel paper under the UCC, a security interest may only be created by the signed copy marked "Original".



| | | |
|--------------------|--|---|
| Lessee Name: | 35 MARC DRIVE OPERATIONS LLC DBA Skyview Center | Balboa Capital Corporation ("We" or "Us") |
| Signature: | | By: |
| Print Name, Title: | Raymond Cyr Date: 4/20/19 | Vice President |



DELIVERY AND ACCEPTANCE CERTIFICATE

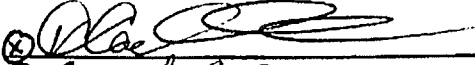
Lease Agreement # 295686-000

By signing below, you, the Lessee, agree:

- a. That all Equipment described in the Lease identified above has been delivered, inspected, installed and is unconditionally and irrevocably accepted by you as satisfactory for all purposes of the Lease; and
- b. That we, BALBOA CAPITAL CORPORATION, are authorized to purchase the Equipment and start billing you under the Lease Agreement as set forth in the above referenced lease.

Date of Acceptance: 4/30/14

Lessee Name: 35 MARC DRIVE OPERATIONS LLC DBA Skyview Center

Sign Signature: 
 Name: Raymond Cyr
 Title: Administrator

I hereby authorize Raymond Cyr to orally verify my/our acceptance of the equipment subject to Lease Agreement # 295686-000 in my absence

"Delivery of this document bearing a facsimile signature or signatures shall have the same force and effect as if the document bore an original signature."

Account Setup:

Email address for invoices: esteey@hcs.com

Fax number for invoices: _____

Cell number: (973) 796-6175

Attention: _____



General Information and Questionnaire
Accounting Basis

| | | | | |
|--|---------------------|------------------------------------|-----------|----------|
| Name of Facility 35 Marc Drive Operations, LLC, d | License No. 2377 | Report for Year Ended 9/30/2019 | Page 7 | of 37 |
|--|---------------------|------------------------------------|-----------|----------|

The records of this facility for the period covered by this report were maintained on the following basis:
 Accrual Cash Modified Cash

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

N/A

Independent Accounting Firm

| | |
|-------------------------|---|
| Name of Accounting Firm | Address (No. & Street, City, State, Zip Code) |
| 1 N/A | |
| 2 | |
| 3 | |
| 4 | |

Services Provided by This Firm (*describe fully*)

| | |
|---|------------------------------|
| 1 | \$ |
| 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 Page 15, Line 1d

Legal Services Information

| | |
|--|------------------|
| Name of Legal Firm or Independent Attorney | Telephone Number |
| 1 Goldman, Gruder & Woods, LLC | 203-880-5333 |
| 2 Treasurer State of Connecticut | 860-702-3000 |
| 3 Cogency Global | 800-221-0102 |
| 4 Timothy S. Wall | 20-265-7173 |
| 5 | |

Address (*No. & Street, City, State, Zip Code*)

| |
|---|
| 1 105 Technology Dr, Trumbull, CT 06611 |
| 2 55 Elm St #2, Hartford, CT 06106 |
| 3 122 E 42nd St 18th FL, New York, NY 10168 |
| 4 PO Box 297 Wallingford CT 06492-0297 |
| 5 |

Services Provided by This Firm (*describe fully*)

| | | |
|---|------------------------------|-------|
| 1 General Legal Services | \$ | 5,991 |
| 2 Conservatorship (Disallowed on Pg 28) | \$ | 250 |
| 3 Statutory Representation | \$ | 103 |
| 4 Conservatorship (Disallowed on Pg 28) | \$ | 57 |
| 5 | \$ | |
| | Charge for Services Provided | |
| | \$ | 6,401 |

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

Schedule of Resident Statistics

| Name of Facility 35 Marc Drive Operations, LLC, d/b/a Skyview Center | | License No. 2377 | | | Report for Year Ended 9/30/2019 | | | | 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 | | | | | | | | | 97 | 97 | | | |
| B. On last day of THIS report period | 97 | 97 | | | 97 | 97 | | | 97 | 97 | | | |
| 2. Number of Residents | | | | | | | | | | | | | |
| A. As of midnight of PREVIOUS report period | | | | | | | | | 76 | 76 | | | |
| B. As of midnight of THIS report period | 76 | 76 | | | 76 | 76 | | | 76 | 76 | | | |
| 3. Total Number of Days Care Provided During Period | | | | | | | | | | | | | |
| A. Medicare | 1,073 | 1,073 | | | 216 | 216 | | | 857 | 857 | | | |
| B. Medicaid (Conn.) | 9,199 | 9,199 | | | 3,689 | 3,689 | | | 5,510 | 5,510 | | | |
| C. Medicaid (other states) | | | | | | | | | | | | | |
| D. Private Pay | 230 | 230 | | | 121 | 121 | | | 109 | 109 | | | |
| E. State SSI for RCH | | | | | | | | | | | | | |
| F. Other (Specify) HMO / Commercial Insurance / | 908 | 908 | | | 282 | 282 | | | 626 | 626 | | | |
| G. Total Care Days During Period (3A thru F) | 11,410 | 11,410 | | | 4,308 | 4,308 | | | 7,102 | 7,102 | | | |
| 4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds | | | | | | | | | | | | | |
| A. Medicaid Bed Reserve Days | | | | | | | | | | | | | |
| B. Other Bed Reserve Days | | | | | | | | | | | | | |
| 5. Total Resident Days (3G + 4A + 4B) | 11,410 | 11,410 | | | 4,308 | 4,308 | | | 7,102 | 7,102 | | | |

Schedule of Resident Statistics (Cont'd)

| | | | | |
|---|---------------------|------------------------------------|-----------|----------|
| Name of Facility 35 Marc Drive Operations, LLC, d/b/a Skyvid | License No. 2377 | Report for Year Ended 9/30/2019 | Page 9 | of 37 |
|---|---------------------|------------------------------------|-----------|----------|

4. Were there any changes in the certified bed capacity during the report year? Yes No
 If "YES", provide the following information:

| Date of Change | Place of Change | | | Change in Beds | | | | | | Capacity After Change | | | Reason for Change |
|----------------|-----------------|------|-----------|----------------|-----|-----|--------|-----|-----|-----------------------|------|-----------|-------------------|
| | CCNH | RHNS | (Specify) | Lost | | | Gained | | | CCNH | RHNS | (Specify) | |
| | (1) | (2) | (3) | (1) | (2) | (3) | (1) | (2) | (3) | | | | |
| N/A | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | | | | | | | | | | | | | |

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

| Change in Resident Days | CCNH | RHNS | (Specify) |
|-------------------------|------|------|-----------|
| 1st change | | | |
| 2nd change | | | |
| 3rd change | | | |
| 4th change | | | |

6. Number of Residents and Rates on September 30 of Cost Year

| Item | Medicare | Medicaid | | Self-Pay | | | Other State Assisted | |
|---------------------------|----------|----------|------|----------|------|-----------|----------------------|--------|
| | CCNH | CCNH | RHNS | CCNH | RHNS | (Specify) | R.C.H. | ICF-MR |
| No. of Residents | 8 | 66 | | 2 | | | | |
| Per Diem Rate | | | | | | | | |
| a. One bed rm. | Various | 209.14 | | 453.00 | | | | |
| b. Two bed rms. | Various | 209.14 | | 438.00 | | | | |
| c. Three or more bed rms. | | | | | | | | |

7. Total Number of Physical Therapy Treatments

| | TOTAL | CCNH | RHNS | (Specify) |
|--|-------|-------|------|-----------|
| A. Medicare - Part B | 611 | 611 | | |
| B. Medicaid (Exclusive of Part B) | | | | |
| 1. Maintenance Treatments | 59 | 59 | | |
| 2. Restorative Treatments | 536 | 536 | | |
| C. Other | 963 | 963 | | |
| D. Total Physical Therapy Treatments | 2,169 | 2,169 | | |
| 8. Total Number of Speech Therapy Treatments | | | | |
| A. Medicare - Part B | 128 | 128 | | |
| B. Medicaid (Exclusive of Part B) | | | | |
| 1. Maintenance Treatments | 21 | 21 | | |
| 2. Restorative Treatments | 193 | 193 | | |
| C. Other | 289 | 289 | | |
| D. Total Speech Therapy Treatments | 631 | 631 | | |
| 9. Total Number of Occupational Therapy Treatments | | | | |
| A. Medicare - Part B | 607 | 607 | | |
| B. Medicaid (Exclusive of Part B) | | | | |
| 1. Maintenance Treatments | 45 | 45 | | |
| 2. Restorative Treatments | 404 | 404 | | |
| C. Other | 966 | 966 | | |
| D. Total Occupational Therapy Treatments | 2,022 | 2,022 | | |

Report of Expenditures - Salaries & Wages

| Name of Facility | License No. | Report for Year Ended | Page | of | | |
|--|-------------|-----------------------|------|-------|-----------|-------|
| 35 Marc Drive Operations, LLC, d/b/a Skyview Center | 2377 | 9/30/2019 | 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) | 35,376 | 731 | | | | |
| 3. Assistant Administrator (Complete also Sec. IV of Schedule A1) | | | | | | |
| 4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.) | 31,553 | 1,866 | | | | |
| 5. Dietary Service | | | | | | |
| a. Head Dietitian | 3,193 | 128 | | | | |
| b. Food Service Supervisor | | | | | | |
| c. Dietary Workers | 93,957 | 6,234 | | | | |
| 6. Housekeeping Service | | | | | | |
| a. Head Housekeeper | 252 | 14 | | | | |
| b. Other Housekeeping Workers | 36,200 | 2,767 | | | | |
| 7. Repairs & Maintenance Services | | | | | | |
| a. Engineer or Chief of Maintenance | 22,145 | 878 | | | | |
| b. Other Maintenance Workers | 8,338 | 1,377 | | | | |
| 8. Laundry Service | | | | | | |
| a. Supervisor | | | | | | |
| b. Other Laundry Workers | 31,779 | 2,112 | | | | |
| 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 | 39,134 | 963 | | | | |
| b. RN | | | | | | |
| 1. Direct Care | 263,751 | 6,799 | | | | |
| 2. Administrative** | 8,487 | 207 | | | | |
| c. LPN | | | | | | |
| 1. Direct Care | 248,406 | 9,109 | | | | |
| 2. Administrative** | | | | | | |
| d. Aides and Attendants | 419,623 | 22,714 | | | | |
| e. Physical Therapists | | | | | | |
| f. Speech Therapists | | | | | | |
| g. Occupational Therapists | | | | | | |
| h. Recreation Workers | 34,009 | 1,670 | | | | |
| 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 | 18,693 | 699 | | | | |
| n. Marketing | 26,273 | 571 | | | | |
| o. Other (Specify) | | | | | | |
| See Attached Schedule | 22,885 | 779 | | | | |
| <i>A-13. Total Salary Expenditures</i> | 1,344,054 | 59,618 | | | | |

* 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 |
| | - | | | | | |
| Admissions | \$ 22,885 | 779 | | | | |
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| | | | | | | |
| Total | \$ 22,885 | 779 | \$ - | - | \$ - | - |

Schedule of Other Fees (Page 13)

| Service | CCNH | | RHNS | | (Specify) | |
|--|-----------------|------------|-------------|----------|-------------|----------|
| | \$ | Hours | \$ | Hours | \$ | Hours |
| | - | | | | | |
| Respiratory Therapist (Disallowed on Pg 28a) | \$ 410 | 6 | | | | |
| Peripheral Insertion (Disallowed on Pg 28a) | 1,155 | 9 | | | | |
| Clinical Consultant | 3,900 | 176 | | | | |
| | | | | | | |
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| | | | | | | |
| Total | \$ 5,465 | 191 | \$ - | - | \$ - | - |

**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 | |
|---|-------------|------|-----------|--|---------------------------------------|--------------------|-------------------------------|--|--------------------|-----------------------|
| 35 Marc Drive Operations, LLC, d/b/a Skyview Center | | | | 2377 | 9/30/2019 | | | 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 | |
|---|-------------|------|-----------|--|---------------------------------------|--------------------|-------------------------------|--|--------------------|-----------------------|
| 35 Marc Drive Operations, LLC, d/b/a Skyview Center | | | | 2377 | 9/30/2019 | | | 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*** | | | | | | | | | | |
| Raymond Cyr (5/1/19-6/30/19) | 13,671 | | | Non Discriminatory | Administrator | 200 | A2 | | | |
| Elza Augustin (7/1/19-9/30/19) | 21,705 | | | Non Discriminatory | Administrator | 531 | A2 | | | |
| Section IV - Assistant Administrators | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |

*No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

** Include **all** other employment worked during the cost year.

*** If more than one Administrator is reported, include dates of employment for each.

Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

| Name of Facility | License No. | Report for Year Ended | Page | of | | |
|---|----------------|-----------------------|------|-------|-----------|-------|
| 35 Marc Drive Operations, LLC, d/b/a Skyview Cen | 2377 | 9/30/2019 | 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 | 2,157 | 74 | | | | |
| 3. Pharmacist | 1,722 | Monthly Fee | | | | |
| 4. Podiatrist | | | | | | |
| 5. Physical Therapy | | | | | | |
| a. Resident Care | 67,995 | 542 | | | | |
| b. Other | | | | | | |
| 6. Social Worker | | | | | | |
| 7. Recreation Worker | | | | | | |
| 8. Physicians | | | | | | |
| a. Medical Director (entire facility) | 12,500 | 48 | | | | |
| b. Utilization Review (Title 18 and 19 only) monthly meeting | | | | | | |
| c. Resident Care** | | | | | | |
| d. Administrative Services facility | | | | | | |
| 1. Infection Control Committee (Quarterly meetings) | | | | | | |
| 2. Pharmaceutical Committee (Quarterly meetings) | | | | | | |
| 3. Staff Development Committee (Once annually) | | | | | | |
| e. Other (Specify) | | | | | | |
| 9. Speech Therapist | | | | | | |
| a. Resident Care | 22,404 | 158 | | | | |
| b. Other | | | | | | |
| 10. Occupational Therapist | | | | | | |
| a. Resident Care | 71,277 | 506 | | | | |
| b. Other | | | | | | |
| 11. Nurses and aides and attendants | | | | | | |
| a. RN | | | | | | |
| 1. Direct Care | 29,590 | 269 | | | | |
| 2. Administrative*** | | | | | | |
| b. LPN | | | | | | |
| 1. Direct Care | | | | | | |
| 2. Administrative*** | | | | | | |
| c. Aides | | | | | | |
| d. Other | | | | | | |
| 12. Other (Specify) See Attached Schedule | 5,465 | 191 | | | | |
| B-13 Total Fees Paid in Lieu of Salaries | 213,110 | 1,788 | | | | |

* 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.

Report of Expenditures
Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis*

| Name of Facility 35 Marc Drive Operations, LLC, d/b/a Skyview Center | | License No. 2377 | Report for Year Ended 9/30/2019 | Page 14 | of 37 |
|---|---|--|------------------------------------|-----------------------------|----------|
| Name & Address of Individual | Full Explanation of Service | Related** to Owners, Operators, Officers | | Explanation of Relationship | |
| | | Yes | No | | |
| Deborah A Hardy, N/A | RN Services | <input type="radio"/> | <input checked="" type="radio"/> | N/A | |
| Channa Perera, MD, 755 Campbell Ave # 3, West Haven, CT 06516 | Medical Director | <input type="radio"/> | <input checked="" type="radio"/> | N/A | |
| Integra Scripts, 160 Airport Road, Lakewood, NJ 08701 | Pharmacist | <input type="radio"/> | <input checked="" type="radio"/> | N/A | |
| LTC Management, 174 Scott Road, Prospect, CT 06712 | Dentist | <input type="radio"/> | <input checked="" type="radio"/> | N/A | |
| Healthdrive Dental Group, 888 Worcester Street, Wellesley, MA 02482 | Dentist | <input type="radio"/> | <input checked="" type="radio"/> | N/A | |
| Technical Gas Products, 101 North Plains Industrial Road, 1B Suite 1, Wallingford, CT | Respiratory Therapist | <input type="radio"/> | <input checked="" type="radio"/> | N/A | |
| Regal Care Rehab, 26 Firemens Memorial Drive, Suite 205 Pomona, NY 10970 | Physical, Occupational and Speech Therapy | <input checked="" type="radio"/> | <input type="radio"/> | Common Ownership | |
| Michelle Cortina Quattrocchi, N/A | Clinical Consultant | <input type="radio"/> | <input checked="" type="radio"/> | N/A | |
| Medwiz Solutions, 167 Route 304, Bardonia, NY 10954 | Peripheral Insertion | <input type="radio"/> | <input checked="" type="radio"/> | N/A | |
| | | <input type="radio"/> | <input checked="" type="radio"/> | | |
| | | <input type="radio"/> | <input checked="" type="radio"/> | | |
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* Use additional sheets if necessary.
 ** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|-------------|-----------------------|------|-----------|
| 35 Marc Drive Operations, LLC, d/b/a Skyview C | 2377 | 9/30/2019 | 15 | 37 |
| Item | Total | CCNH | RHNS | (Specify) |
| 1. Administrative and General | | | | |
| a. Employee Health & Welfare Benefits | | | | |
| 1. Workmen's Compensation | \$ 21,091 | 21,091 | | |
| 2. Disability Insurance | \$ | | | |
| 3. Unemployment Insurance | \$ | | | |
| 4. Social Security (F.I.C.A.) | \$ 144,776 | 144,776 | | |
| 5. Health Insurance | \$ 160,852 | 160,852 | | |
| 6. Life Insurance (employees only) (not-owners and not-operators) | \$ | | | |
| 7. Pensions (Non-Discriminatory) (not-owners and not-operators) | \$ | | | |
| 8. Uniform Allowance | \$ | | | |
| 9. Other (<i>Specify</i>) Reclassified out of Fringes See Attached Schedule | \$ 2,009 | 2,009 | | |
| b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)* | \$ | | | |
| c. Bad Debts* | \$ 30,085 | 30,085 | | |
| d. Accounting and Auditing | \$ | | | |
| e. Legal (<i>Services should be fully described on Page 7</i>) | \$ 6,401 | 6,401 | | |
| f. Insurance on Lives of Owners and Operators (<i>Specify</i>)* | \$ | | | |
| g. Office Supplies | \$ 2,688 | 2,688 | | |
| h. Telephone and Cellular Phones | | | | |
| 1. Telephone & Pagers | \$ 3,449 | 3,449 | | |
| 2. Cellular Phones | \$ 434 | 434 | | |
| 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 | \$ | | | |
| 3. Resident Day User Fee | \$ 215,833 | 215,833 | | |
| Subtotal | \$ 587,618 | 587,618 | | |

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

(Carry Subtotals forward to next page)

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

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|-------------|-----------------------|------|-----------|
| 35 Marc Drive Operations, LLC, d/b/a Skyview Center | 2377 | 9/30/2019 | 16 | 37 |
| Item | Total | CCNH | RHNS | (Specify) |
| Subtotals Brought Forward: | 587,618 | 587,618 | | |
| I. Travel and Entertainment | | | | |
| 1. Resident Travel and Entertainment | \$ 2,602 | 2,602 | | |
| 2. Holiday Parties for Staff | \$ | | | |
| 3. Gifts to Staff and Residents | \$ | | | |
| 4. Employee Travel | \$ 3,288 | 3,288 | | |
| 5. Education Expenses Related to Seminars and Conventions | \$ 3,437 | 3,437 | | |
| 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>) | \$ 389 | 389 | | |
| 2. Advertising Telephone Directory (<i>all such expenses</i>)*** | \$ | | | |
| 3. Advertising Other (<i>Specify</i>)*** See Attached Schedule | \$ 6,323 | 6,323 | | |
| 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 | \$ 1,462 | 1,462 | | |
| * 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule | \$ 2,556 | 2,556 | | |
| 8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** | \$ | | | |
| 9. Subscriptions | \$ | | | |
| 10. Contributions*** See Attached Schedule | \$ | | | |
| 11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>) | \$ 87,767 | 87,767 | | |
| 12. Administrative Management Services** | \$ | | | |
| 13. Other (<i>Specify</i>) See Attached Schedule | \$ 5,146 | 5,146 | | |
| C-14 Total Administrative & General Expenditures | \$ 700,588 | 700,588 | | |

* 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) |
|---|-------------|-------------|-------------|
| | - | | |
| | | | |
| | | | |
| | | | |
| Total Other Travel and Entertainment | \$ - | \$ - | \$ - |

Schedule of Other Advertising

| Description | CCNH | RHNS | (Specify) |
|---|-----------------|-------------|-------------|
| | - | | |
| Marketing & Advertising (Disallowed on Pg 28) | \$ 6,323 | | |
| | | | |
| Total Other Advertising | \$ 6,323 | \$ - | \$ - |

Schedule of Dues

| Description | CCNH | RHNS | (Specify) |
|-------------------|-----------------|-------------|-------------|
| | - | | |
| CAHCF Dues | \$ 2,556 | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Total Dues | \$ 2,556 | \$ - | \$ - |

Schedule of Contributions

| Description | CCNH | RHNS | (Specify) |
|----------------------------|-------------|-------------|-------------|
| | - | | |
| | | | |
| Total Contributions | \$ - | \$ - | \$ - |

Schedule of Other Administrative and General

| Description | CCNH | RHNS | (Specify) |
|---|-----------------|-------------|-------------|
| | - | | |
| Licenses | \$ 100 | | |
| Late Fees (Disallowed on Pg 28) | 350 | | |
| Bank Fees (\$310 Disallowed on Pg 28) | 420 | | |
| Employee Food (Disallowed on Pg 28) | 1,644 | | |
| Employee Relations (Disallowed on Pg 28) | 206 | | |
| Discriminatory Bonus (Disallowed on Pg 28) | 2,000 | | |
| Pet Related Expense (Disallowed on Pg 28) | 426 | | |
| | | | |
| Total Other Administrative and General | \$ 5,146 | \$ - | \$ - |

Schedule C-1 - Management Services*

| Name of Facility 35 Marc Drive Operations, LLC, d/b/a Sk | License No. 2377 | Report for Year Ended 9/30/2019 | Page of 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 # |
| N/A | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

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

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

| Name of Facility | | License No. | Report for Year Ended | | Page | of |
|---|--|---------------------------|-------------------------------------|-----------------------|-----------|----|
| 35 Marc Drive Operations, LLC, d/b/a Skyview Center | | 2377 | 9/30/2019 | | 18 | 37 |
| Item | | Total | CCNH | RHNS | (Specify) | |
| 2. Dietary | | | | | | |
| a. In-House Preparation & Service | | | | | | |
| 1. | Raw Food | \$ 85,229 | 85,229 | | | |
| 2. | Non-Food Supplies | \$ 7,821 | 7,821 | | | |
| 3. | Other (Specify) _____ | \$ | | | | |
| b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21) | | \$ 32,497 | 32,497 | | | |
| c. Other (Specify) _____ | | \$ | | | | |
| 2D. Total Dietary Expenditures (2a + b + c + d) | | \$ 125,547 | 125,547 | | | |
| 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 35 Marc Drive Operations, LLC, d/b/a Skyview Center | | License No. 2377 | Report for Year Ended 9/30/2019 | Page 19 | of 37 |
|---|---------------------------|-------------------------------------|------------------------------------|------------|-----------|
| Item | | Total | CCNH | RHNS | (Specify) |
| 3. Laundry | | | | | |
| a. In-House Processing* | Lbs. | | | | |
| 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.*** | Amt. \$ | | | | |
| 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. \$ | | | | |
| b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21) | \$ | | | | |
| c. Other (<i>Specify</i>) Laundry Supplies | \$ | 4,439 | 4,439 | | |
| 3D. Total Laundry Expenditures (3a + b + c) | \$ | 4,439 | 4,439 | | |
| 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 |
|--|---|----------------------------------|-----------------------|---------|------|-----------|
| 35 Marc Drive Operations, LLC, d/b/a Skyview | | 2377 | 9/30/2019 | | 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. \$ | | | | |
| 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. \$ | 13,829 | 13,829 | | |
| C. Other (<i>Specify</i>) Housekeeping Supplies | | | \$ 10,296 | 10,296 | | |
| 4D. | Total Housekeeping Expenditures (4a + b + c) | | \$ 24,125 | 24,125 | | |
| 5. | Resident Care (Supplies)** | | | | | |
| a. | Prescription Drugs*** | | | | | |
| | 1. Own Pharmacy | \$ | | | | |
| | 2. Purchased from Medwiz | \$ | 90,330 | 90,330 | | |
| b. | Medicine Cabinet Drugs | \$ | 1,441 | 1,441 | | |
| c. | Medical and Therapeutic Supplies | \$ | | | | |
| d. | Ambulance/Limousine*** | \$ | | | | |
| e. | Oxygen | | | | | |
| | 1. For Emergency Use | \$ | | | | |
| | 2. Other*** | \$ | 1,039 | 1,039 | | |
| f. | X-rays and Related Radiological Procedures*** | \$ | 1,960 | 1,960 | | |
| g. | Dental (<i>Not dentists who should be included under salaries or fees</i>) | \$ | | | | |
| h. | Laboratory*** | \$ | 8,859 | 8,859 | | |
| i. | Recreation | \$ | 8,984 | 8,984 | | |
| j. | Direct Management Services* | \$ | | | | |
| k. | Indirect Management Services* | \$ | | | | |
| l. | Other (Specify)**** See Attached Schedule | \$ | 65,445 | 65,445 | | |
| 5M. | Total Resident Care Expenditures (5a - 5j) | \$ | 178,058 | 178,058 | | |

* 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) |
|--|------------------|-------------|-------------|
| | - | | |
| Supplies (\$10,065 Disallowed on Pg 29a) | \$ 48,343 | | |
| Sanitation & Incineration | 367 | | |
| Equipment Rental (Disallowed on Pg 29a) | 16,356 | | |
| Data Processing | 379 | | |
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| | | | |
| Total Other Resident Care | \$ 65,445 | \$ - | \$ - |

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

| Name of Facility 35 Marc Drive Operations, LLC, d/b/a Skyview Center | | License No. 2377 | | Report for Year Ended 9/30/2019 | | | 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 |
| LTC Consulting Services | 7 Randolph Road, Howell, NJ 07731 | <input type="radio"/> | <input checked="" type="radio"/> | N/A | Billing and Fiscal Services | 70,250 | | | 16 | m11 |
| Healthcare Services Group | 300 Bensalem, PA 19020 | <input type="radio"/> | <input checked="" type="radio"/> | N/A | Dietary Services | 32,497 | | | 18 | 2b |
| Healthcare Services Group | 300 Bensalem, PA 19020 | <input type="radio"/> | <input checked="" type="radio"/> | N/A | Housekeeping Services | 13,829 | | | 20 | 4b |
| | | <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 |
|--|-------------|-----------------------|------|-----------|------|----|
| 35 Marc Drive Operations, LLC, d/b/a Skyview | 2377 | 9/30/2019 | | | 22 | 37 |
| Item | Total | CCNH | RHNS | (Specify) | | |
| 6. Maintenance & Operation of Plant | | | | | | |
| a. Repairs & Maintenance | \$ 16,597 | 16,597 | | | | |
| b. Heat | \$ 8,447 | 8,447 | | | | |
| c. Light & Power | \$ 27,182 | 27,182 | | | | |
| d. Water | \$ 16,669 | 16,669 | | | | |
| e. Equipment Lease (<i>Provide detail on page 6</i>) | \$ 2,034 | 2,034 | | | | |
| f. Other (<i>itemize</i>) | \$ 26,911 | 26,911 | | | | |
| See Attached Schedule | | | | | | |
| 6g. Total Maint. & Operating Expense (6a - 6f) | \$ 97,840 | 97,840 | | | | |
| 7. Depreciation (<i>complete schedule page 23*</i>) | | | | | | |
| a. Land Improvements | \$ | | | | | |
| b. Building & Building Improvements | \$ | | | | | |
| c. Non-Movable Equipment | \$ | | | | | |
| d. Movable Equipment | \$ 1,520 | 1,520 | | | | |
| *7e. Total Depreciation Costs (7a + b + c + d) | \$ 1,520 | 1,520 | | | | |
| 8. Amortization (<i>Complete att. Schedule Page 24*</i>) | | | | | | |
| a. Organization Expense | \$ 22,555 | 22,555 | | | | |
| b. Mortgage Expense | \$ | | | | | |
| c. Leasehold Improvements | \$ 1,173 | 1,173 | | | | |
| d. Other (<i>Specify</i>) | \$ | | | | | |
| *8e. Total Amortization Costs (8a + b + c + d) | \$ 23,728 | 23,728 | | | | |
| 9. Rental payments on leased real property less real estate taxes included in item 10b | \$ 200,000 | 200,000 | | | | |
| 10. Property Taxes | | | | | | |
| a. Real estate taxes paid by owner | \$ | | | | | |
| b. Real estate taxes paid by lessor | \$ 21,284 | 21,284 | | | | |
| c. Personal property taxes | \$ 3,753 | 3,753 | | | | |
| 11. Total Property Expenses (7e + 8e + 9 + 10) | \$ 250,285 | 250,285 | | | | |

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

Schedule of Other Repairs and Maintenance

| Description | CCNH | RHNS | (Specify) |
|--|-----------|------|-----------|
| | - | | |
| Supplies | \$ 2,646 | | |
| Sanitation & Incineration | 8,242 | | |
| Landscaping | 7,650 | | |
| Contracted Services | 8,373 | | |
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| | | | |
| | | | |
| Total Other Repairs and Maintenance | \$ 26,911 | \$ - | \$ - |

Depreciation Schedule

| Name of Facility 35 Marc Drive Operations, LLC, d/b/a Skyview Center | | | License No. 2377 | | Report for Year Ended 9/30/2019 | | | 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 | | | | | | | | | | | | |
| 2. Disposals (attach schedule) | | | | | | | | | | | | |
| 3. Acquired during this report period (attach schedule) | | | | | | | | | | | | |
| A-4. Subtotal | | | | | | | | | | | | |
| B. Building and Building Improvements | | | | | | | | | | | | |
| 1. Acquired prior to this report period | | | | | | | | | | | | |
| 2. Disposals (attach schedule) | | | | | | | | | | | | |
| 3. Acquired during this report period (attach schedule) | | | | | | | | | | | | |
| B-4. Subtotal | | | | | | | | | | | | |
| C. Non-Movable Equipment | | | | | | | | | | | | |
| 1. Acquired prior to this report period | | | | | | | | | | | | |
| 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 | | | | | | | |
| D. Movable Equipment | | | | | | | | | | | | |
| 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) | | | | | Var | Var | 8,676 | | S/L | Various | 1,520 | |
| D-3. Subtotal | | | | | | | | | | | | 1,520 |
| E. Total Depreciation | | | | | | | | | | | | 1,520 |

NOTE: Facility was acquired as of 5/1/19. Assets reported on this cost report are additions during this fiscal period. See Facility rate computation report for historical assets.

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

| Acquisition Date | Description of Item | Cost | Useful Life | Depreciation |
|--|---------------------|------|-------------|--------------|
| Additions: | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Total additions for Building Improvements | | \$ - | | \$ - * |
| Deletions: | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| 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

Annual Report of Long-Term Care Facility

Amortization Schedule*

| Name of Facility | | | License No. | | Report for Year Ended | | | Page | of |
|---|---------------------|------|------------------------|----------------------|--|------------------------------------|---------|----------------------------|--------|
| 35 Marc Drive Operations, LLC, d/b/a Skyview Center | | | 2377 | | 9/30/2019 | | | 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 | | | | | | | |
| A. Organization Expense | | | | | | | | | |
| 1. Startup costs | 5 | 2019 | | 66,423 | | S/L | | 22,555 | |
| 2. | | | | | | | | | |
| 3. | | | | | | | | | |
| A-4. Subtotal | | | | | | | | | 22,555 |
| 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) | Var | Var | Various | 15,896 | | S/L | Various | 1,173 | |
| C-4. Subtotal | | | | | | | | | 1,173 |
| D. Total Amortization | | | | | | | | | 23,728 |

* 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.

Skyview Center
FIXED ASSET / DEPRECIATION SCHEDULE

| Asset Type | Description | Date In Service | Method | Life | Historical Cost | 2018 A/D | 2019 Deprec. | 2019 A/D | NBV |
|---------------------------------------|-----------------------------------|-----------------|--------|------|-----------------|----------|---------------|---------------|----------------|
| LEASEHOLD IMPROVEMENTS | | | | | | | | | |
| 2019 Additions | | | | | | | | | |
| LI | phone repair- cross connect wires | 5/20/2019 | S/L | 10 | 1,063 | - | 106 | 106 | 957 |
| LI | phone ports | 5/9/2019 | S/L | 10 | 1,435 | - | 144 | 144 | 1,291 |
| LI | AC repair | 7/10/2019 | S/L | 20 | 3,660 | - | 183 | 183 | 3,477 |
| LI | Fax repair-new T/R card installed | 7/17/2019 | S/L | 10 | 922 | - | 92 | 92 | 830 |
| LI | phone ports | 5/9/2019 | S/L | 10 | 91 | - | 9 | 9 | 82 |
| LI | phone repair- cross connect wires | 5/20/2019 | S/L | 10 | 67 | - | 7 | 7 | 60 |
| LI | Fax repair-new T/R card installed | 7/17/2019 | S/L | 10 | 59 | - | 6 | 6 | 53 |
| LI | replaced fan motor on AC | 8/14/2019 | S/L | 20 | 2,571 | - | 129 | 129 | 2,442 |
| LI | hvac repair | 10/10/2019 | S/L | 15 | 1,595 | - | 106 | 106 | 1,489 |
| LI | aquastat repair | 8/16/2019 | S/L | 10 | 1,331 | - | 133 | 133 | 1,198 |
| LI | Fridge repair-replace valve | 10/1/2019 | S/L | 15 | 1,559 | - | 104 | 104 | 1,455 |
| LI | AC repair-heat pump switch | 9/3/2019 | S/L | 10 | 792 | - | 79 | 79 | 713 |
| LI | equipment service-slicer repair | 9/18/2019 | S/L | 10 | 751 | - | 75 | 75 | 676 |
| TOTAL LEASEHOLD IMPROVEMENTS | | | | | 15,896 | - | 1,173 | 1,173 | 14,723 |
| MOVABLE EQUIPMENT | | | | | | | | | |
| 2019 Additions | | | | | | | | | |
| FFE | food processor | 5/22/2019 | S/L | 10 | 1,323 | - | 132 | 132 | 1,191 |
| FFE | Refridgerator | 9/30/2019 | S/L | 15 | 586 | - | 39 | 39 | 547 |
| Medical Equipment | Bed controls | 9/4/2019 | S/L | 12 | 823 | - | 69 | 69 | 754 |
| Computer Hardware | Tablets | 5/31/2019 | S/L | 3 | 684 | - | 228 | 228 | 456 |
| Computer Hardware | Scanner | 6/17/2019 | S/L | 5 | 500 | - | 100 | 100 | 400 |
| Computer Hardware | Printer | 6/30/2019 | S/L | 5 | 638 | - | 128 | 128 | 510 |
| Computer Software | tvS | 8/13/2019 | S/L | 5 | 784 | - | 157 | 157 | 627 |
| Computer Software | tvS | 8/29/2019 | S/L | 5 | 1,057 | - | 211 | 211 | 846 |
| Sales Use Tax | Various Sales Use Tax | 5/31/2019 | S/L | 5 | 2,281 | - | 456 | 456 | 1,825 |
| TOTAL MOVABLE EQUIPMENT | | | | | 8,676 | - | 1,520 | 1,520 | 7,156 |
| Org Expense | Startup Costs | 5/1/2019 | S/L | 3 | 66,423 | - | 22,555 | 22,555 | 43,868 |
| TOTAL ASSETS PER CR SCHEDULE | | | | | 90,995 | - | 25,248 | 25,248 | 65,747 |
| TOTAL ASSETS PER TRIAL BALANCE | | | | | 90,995 | - | 23,208 | 23,209 | 67,786 |
| VARIANCE | | | | | - | - | 2,040 | 2,039 | (2,039) |

F/S vs C/R NBV - Page 31, Line B9
F/S vs C/R Depreciation - Page 36, Line F1

2,039
(2,040)

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

| | | | | | |
|---|---------------------|------------------------------------|-------------------------------------|---|--------------|
| Name of Facility 35 Marc Drive Operations, LLC, d/b/a | License No. 2377 | Report for Year Ended 9/30/2019 | 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 | 97 | | | | |
| 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 | |
| SV Propco | Building | 05/01/19 | Ongoing | 200,000 | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

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

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

| Name of Facility | | License No. | Report for Year Ended | | Page | of |
|--|--|-------------|-----------------------|------|------|-----------|
| 35 Marc Drive Operations, LLC, d/b/a | | 2377 | 9/30/2019 | | 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. Total Building Interest Expense (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 |
|---|--|-------------|--------|-----------------------|-----------|-----------|-----------|
| 35 Marc Drive Operations, LLC, d/ | | 2377 | | 9/30/2019 | | 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) Interest on Loan / Credit Card | | | | \$ | 2,525 | 2,525 | |
| 13. Total All Interest Expense (12B7 + 12C3 + 12D) | | | | \$ | 2,525 | 2,525 | |
| 14. Insurance | | | | | | | |
| a. Insurance on Property (buildings only) | | | | \$ | 4,923 | 4,923 | |
| b. Insurance on Automobiles | | | | \$ | | | |
| c. Insurance other than Property (as specified above) | | | | | | | |
| 1. Umbrella (Blanket Coverage) | | | | \$ | | | |
| 2. Fire and Extended Coverage | | | | \$ | | | |
| 3. Other (Specify) General Liability / EPLI / Surety Bond | | | | \$ | 21,732 | 21,732 | |
| 14d. Total Insurance Expenditures (14a + b + c) | | | | \$ | 26,655 | 26,655 | |
| 15. Total All Expenditures (A-13 thru C-14) | | | | \$ | 2,967,226 | 2,967,226 | |

D. Adjustments to Statement of Expenditures

| Name of Facility | | | License No. | Report for Year Ended | Page | of | |
|---|----------|----------|---|--------------------------|---------|------|-----------|
| 35 Marc Drive Operations, LLC, d/b/a Skyview Center | | | 2377 | 9/30/2019 | 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 | \$ 26,273 | 26,273 | | |
| Page 13 - Professional Fees | | | | | | | |
| 5. | | | Resident Care Physicians ** | \$ | | | |
| 6. | 13 | b10a | Occupational Therapy | \$ 71,277 | 71,277 | | |
| 7. | | | Other - See attached Schedule | \$ 31,155 | 31,155 | | |
| Pages 15 & 16 - Administrative and General | | | | | | | |
| 8. | | | Discriminatory Benefits | \$ | | | |
| 9. | 15 | 1c | Bad Debts | \$ 30,085 | 30,085 | | |
| 10. | | | Accounting | \$ | | | |
| 10a. | 15 | 1e | Legal | \$ 307 | 307 | | |
| 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. | 16 | L3 | Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative | \$ 2,337 | 2,337 | | |
| 17. | | | Automobile Expense (e.g. personal use) | \$ | | | |
| 18. | 16 | m2/3 | Unallowable Advertising * | \$ 6,323 | 6,323 | | |
| 19. | | | Income Tax / Corporate Business Tax | \$ | | | |
| 20. | | | Fund Raising / Contributions | \$ | | | |
| 21. | | | Unallowable Management Fees | \$ | | | |
| 22. | | | Barber and Beauty | \$ | | | |
| 23. | | | Other - See attached Schedule | \$ 10,910 | 10,910 | | |
| 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) | | | | \$ 178,667 | 178,667 | | |

(Carry Subtotal forward to next page)

* All except "Help Wanted".

** 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 | 12n | Marketing Salary | \$ 26,273 | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Total Other Salaries Adjustment | | | \$ 26,273 | \$ - | \$ - |

Schedule of Fees Adjustments

| Page Ref | Line Ref | Description | CCNH | RHNS | (Specify) |
|-------------------------------------|----------|--------------------------------|-----------|------|-----------|
| 13 | 12o | Respiratory Therapist | \$ 410 | | |
| 13 | 12o | Peripheral Insertion | 1,155 | | |
| 13 | B11a1 | CHOW Consent Order Contract RN | 29,590 | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Total Other Fees Adjustments | | | \$ 31,155 | \$ - | \$ - |

Schedule of Other A&G Adjustments

| Page Ref | Line Ref | Description | CCNH | RHNS | (Specify) |
|--|----------|--|-----------|------|-----------|
| 16 | m13 | Non Allowable Bank Fees | \$ 310 | | |
| 16 | m13 | Employee Food | 1,644 | | |
| 16 | m13 | Employee Relations | 206 | | |
| 16 | m13 | Discriminatory Bonus | 2,000 | | |
| 16 | m13 | Pet Related Expense | 426 | | |
| 16 | m13 | Late Fees | 350 | | |
| 15 | Var | Benefits Relating to Marketing Salary (See Attached) | 5,974 | | |
| Total Other A&G Adjustments | | | \$ 10,910 | \$ - | \$ - |

Skyview Center
September 30, 2019
Benefits Disallowance

Marketing Benefits Disallowance

| | | |
|--|------------------|--------------------|
| Marketing Salary | 26,273 | Page 10 |
| Total Salaries | <u>1,344,054</u> | TB Linked |
| Percent to Total Salaries | 1.95% | |
| | | |
| Total Benefits (Pg 15, Line 1a3 - 1a6) | 305,628 | TB Linked |
| | | |
| Marketing Benefits Disallowed | 5,974 | Page 28 attachment |

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

| Name of Facility | | | | License No. | Report for Year Ended | Page | of |
|---|----------|----------|---|--------------------------|-----------------------|------|-----------|
| 35 Marc Drive Operations, LLC, d/b/a Skyview Center | | | | 2377 | 9/30/2019 | 29 | 37 |
| Item No. | Page No. | Line No. | Item Description | Total Amount of Decrease | CCNH | RHNS | (Specify) |
| Subtotals Brought Forward | | | | \$ 178,667 | 178,667 | | |
| Page 20 - Resident Care Supplies*** | | | | | | | |
| 27. | 20 | 5a2 | Prescription Drugs | \$ 90,330 | 90,330 | | |
| 28. | | | Ambulance/Limousine | \$ | | | |
| 29. | 20 | 5f | X-rays, etc | \$ 1,960 | 1,960 | | |
| 30. | 20 | 5h | Laboratory | \$ 8,859 | 8,859 | | |
| 31. | | | Medical Supplies | \$ | | | |
| 32. | 20 | 5e2 | Oxygen (non emergency) | \$ 1,039 | 1,039 | | |
| 33. | | | Occupational Therapy | \$ | | | |
| 34. | | | Other - See Attached Schedule | \$ 31,295 | 31,295 | | |
| 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 | \$ 22,555 | 22,555 | | |
| Page 27 - Insurance | | | | | | | |
| 40. | | | Mortgage Insurance | \$ | | | |
| 41. | | | Property Insurance | \$ | | | |
| Other - Miscellaneous | | | | | | | |
| 42. | | | Other - Indirect | \$ | | | |
| 43. | | | Interest Income on Account Rec. | \$ | | | |
| 44. | | | Other - Miscellaneous Administrative | \$ | | | |
| 45. | | | Management Fees Direct | \$ | | | |
| 46. | | | Management Fees Indirect | \$ | | | |
| 47. | | | Other - Direct | \$ 20 | 20 | | |
| 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) | | | | \$ 334,725 | 334,725 | | |

*** 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 | 5l | Non Allowable Nursing Supplies | \$ 10,065 | | |
| 27 | 12d | Interest on Credit Card | 25 | | |
| 20 | 5l | Nursing Equipment Rental | 16,356 | | |
| 20 | 5i | Cable Television Disallowance (See Attached) | 4,849 | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Total Other Ancillary Costs | | | \$ 31,295 | \$ - | \$ - |

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

| Page Ref | Line Ref | Description | CCNH | RHNS | (Specify) |
|---|----------|-------------------------------|------------------|-------------|-------------|
| 22 | 8a | Amortization of Startup Costs | \$ 22,555 | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Total Other Property Adjustments | | | \$ 22,555 | \$ - | \$ - |

Schedule of Other - Indirect Adjustments

| Page Ref | Line Ref | Description | CCNH | RHNS | (Specify) |
|----------|----------|-------------|------|------|-----------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| | | | | | |
|--------------------------------|--|--|------|------|------|
| | | | | | |
| | | | | | |
| Total Other Adjustments | | | \$ - | \$ - | \$ - |

Schedule of Other - Miscellaneous Administrative Adjustments

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

| Page Ref | Line Ref | Description | CCNH | RHNS | (Specify) |
|--------------------------------|----------|------------------------|-------|------|-----------|
| 30 | IV 8 | Medical Record Revenue | \$ 20 | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Total Other Adjustments | | | \$ 20 | \$ - | \$ - |

Schedule of Unallowable Building Interest

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

**Skyview Center
Disallowance Schedule for Cable TV
September 30, 2019**

| | <u>Amount</u> |
|--|-------------------------------|
| Total Cable TV Expense acct #80-232-00 | \$ 6,358 TB Linked |
| Monthly Allowable amount | \$ 300 |
| Months in Year | 12 |
| % of Actual Days in Cost Year (153 Days) | <u>42%</u> |
| Total Allowable Cost | \$ 1,509 |
| | |
| Disallowed Cable TV | <u><u>\$ 4,849</u></u> |

F. Statement of Revenue

| Name of Facility | | License No. | | Report for Year Ended | | Page | of |
|--|--|--|----|-----------------------|-----------|-----------|-----------|
| 35 Marc Drive Operations, LLC, d/b/a St 2377 | | | | 9/30/2019 | | 30 | 37 |
| Item | | | | Total | CCNH | RHNS | (Specify) |
| I. Resident Room, Board & Routine Care Revenue | | | | | | | |
| 1. | a. | Medicaid Residents (<i>CT only</i>) | \$ | 1,892,963 | 1,892,963 | | |
| | b. | Medicaid Room and Board Contractual Allowance ** | \$ | | | | |
| 2. | a. | Medicaid (<i>All other states</i>) | \$ | | | | |
| | b. | Other States Room and Board Contractual Allowance ** | \$ | | | | |
| 3. | a. | Medicare Residents (<i>all inclusive</i>) | \$ | 688,141 | 688,141 | | |
| | b. | Medicare Room and Board Contractual Allowance ** | \$ | (3,756) | (3,756) | | |
| 4. | a. | Private-Pay Residents and Other | \$ | 357,995 | 357,995 | | |
| | b. | Private-Pay Room and Board Contractual Allowance ** | \$ | (332) | (332) | | |
| II. Other Resident Revenue | | | | | | | |
| 1. | a. | Prescription Drugs - Medicare | \$ | 55,708 | 55,708 | | |
| | b. | Prescription Drugs - Medicare Contractual Allowance ** | \$ | (55,708) | (55,708) | | |
| | c. | Prescription Drugs - Non-Medicare | \$ | 14 | 14 | | |
| | d. | Prescription Drugs - Non-Medicare Contractual Allowance ** | \$ | (14) | (14) | | |
| 2. | a. | Medical Supplies - Medicare | \$ | | | | |
| | b. | Medical Supplies - Medicare Contractual Allowance ** | \$ | | | | |
| | c. | Medical Supplies - Non-Medicare | \$ | | | | |
| | d. | Medical Supplies - Non-Medicare Contractual Allowance ** | \$ | | | | |
| 3. | a. | Physical Therapy - Medicare | \$ | 82,316 | 82,316 | | |
| | b. | Physical Therapy - Medicare Contractual Allowance ** | \$ | (67,318) | (67,318) | | |
| | c. | Physical Therapy - Non-Medicare | \$ | 39,539 | 39,539 | | |
| | d. | Physical Therapy - Non-Medicare Contractual Allowance ** | \$ | (27,387) | (27,387) | | |
| 4. | a. | Speech Therapy - Medicare | \$ | 31,937 | 31,937 | | |
| | b. | Speech Therapy - Medicare Contractual Allowance ** | \$ | (22,273) | (22,273) | | |
| | c. | Speech Therapy - Non-Medicare | \$ | 29,062 | 29,062 | | |
| | d. | Speech Therapy - Non-Medicare Contractual Allowance ** | \$ | (21,955) | (21,955) | | |
| 5. | a. | Occupational Therapy - Medicare | \$ | 85,644 | 85,644 | | |
| | b. | Occupational Therapy - Medicare Contractual Allowance ** | \$ | (73,907) | (73,907) | | |
| | c. | Occupational Therapy - Non-Medicare | \$ | 41,961 | 41,961 | | |
| | d. | Occupational Therapy - Non-Medicare Contractual Allowance ** | \$ | (26,843) | (26,843) | | |
| 6. | a. | Other (<i>Specify</i>) - Medicare | \$ | | | | |
| | b. | Other (<i>Specify</i>) - Non-Medicare | \$ | 2,642 | 2,642 | | |
| III. Total Resident Revenue (Section I. thru Section II.) | | | | \$ | 3,008,429 | 3,008,429 | |
| IV. Other Revenue* | | | | | | | |
| 1. | Meals sold to guests, employees & others | | | \$ | | | |
| 2. | Rental of rooms to non-residents | | | \$ | | | |
| 3. | Telephone | | | \$ | | | |
| 4. | Rental of Television and Cable Services | | | \$ | | | |
| 5. | Interest Income (<i>Specify</i>) | | | \$ | | | |
| 6. | Private Duty Nurses' Fees | | | \$ | | | |
| 7. | Barber, Coffee, Beauty and Gift shops | | | \$ | | | |
| 8. | Other (<i>Specify</i>) | | | \$ | 20 | 20 | |
| V. Total Other Revenue (1 thru 8) | | | | \$ | 20 | 20 | |
| VI. Total All Revenue (III + V) | | | | \$ | 3,008,449 | 3,008,449 | |

* 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) |
|--|-------------|------|------|-----------|
| | | - | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Total Other Resident Revenue - Medicare | | \$ - | \$ - | \$ - |

Schedule of Other Non-Medicare Resident Revenue

Related Exp

| Page Ref | Description | CCNH | RHNS | (Specify) |
|-------------------------------------|-------------------------------|----------|------|-----------|
| | | - | | |
| 30 II 6b | Revenue Adjustments>HMO | \$ 13 | | |
| 30 II 6b | Revenue Adjustments>Medicaid | 5,404 | | |
| 30 II 6b | Revenue Adjustments>Ancillary | (2,775) | | |
| | | | | |
| Total Other Resident Revenue | | \$ 2,642 | \$ - | \$ - |

Interest Income

Account

| Page Ref | Account | Balance | CCNH | RHNS | (Specify) |
|------------------------------|---------|---------|------|------|-----------|
| | | | - | | |
| | | | | | |
| | | | | | |
| Total Interest Income | | | \$ - | \$ - | \$ - |

Schedule of Other Revenue

| Page Ref | Description | CCNH | RHNS | (Specify) |
|----------------------------|--|-------|------|-----------|
| | | - | | |
| 30 IV 8 | Medical Records Revenue (Disallowed on Pg 29a) | \$ 20 | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| Total Other Revenue | | \$ 20 | \$ - | \$ - |

G. Balance Sheet

| Name of Facility | License No. | Report for Year Ended | Page | of |
|--|----------------------------------|-----------------------|--------|-----------|
| 35 Marc Drive Operations, LLC, d/b/a | 2377 | 9/30/2019 | 31 | 37 |
| Account | | | Amount | |
| Assets | | | | |
| A. Current Assets | | | | |
| 1. Cash (<i>on hand and in banks</i>) | | | \$ | 14,265 |
| 2. Resident Accounts Receivable (Less Allowance for Bad Debts) | | | \$ | 1,286,573 |
| 3. Other Accounts Receivable (Excluding Owners or Related Parties) | | | \$ | |
| 4. Inventories | | | \$ | |
| 5. Prepaid Expenses | | | \$ | 91,241 |
| a. _____ | | | | |
| b. _____ | | | | |
| c. _____ | | | | |
| d. See Schedule | | 91,241 | | |
| 6. Interest Receivable | | | \$ | |
| 7. Medicare Final Settlement Receivable | | | \$ | |
| 8. Other Current Assets (<i>itemize</i>) | | | \$ | |
| _____ | | | | |
| _____ | | | | |
| See Schedule | | | | |
| A-9. Total Current Assets (Lines A1 thru 8) | | | \$ | 1,392,079 |
| B. Fixed Assets | | | | |
| 1. Land | | | \$ | |
| 2. Land Improvements | *Historical Cost _____ | | \$ | |
| | Accum. Depreciation _____ | Net | | |
| 3. Buildings | *Historical Cost _____ | | \$ | |
| | Accum. Depreciation _____ | Net | | |
| 4. Leasehold Improvements | *Historical Cost <u>15,896</u> | | \$ | 14,723 |
| | Accum. Depreciation <u>1,173</u> | Net | | |
| 5. Non-Movable Equipment | *Historical Cost _____ | | \$ | |
| | Accum. Depreciation _____ | Net | | |
| 6. Movable Equipment | *Historical Cost <u>8,676</u> | | \$ | 7,156 |
| | Accum. Depreciation <u>1,520</u> | Net | | |
| 7. Motor Vehicles | *Historical Cost _____ | | \$ | |
| | Accum. Depreciation _____ | Net | | |
| 8. Minor Equipment-Not Depreciable | | | \$ | |
| 9. Other Fixed Assets (<i>itemize</i>) | | | \$ | 2,039 |
| F/S vs CR NBV | | 2,039 | | |
| See Schedule | | | | |
| B-10. Total Fixed Assets (Lines B1 thru 9) | | | \$ | 23,918 |

* 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 Expenses | \$ 4,154 |
| 31 | A5 | Prepaid Expenses>Insurance | 37,970 |
| 31 | A5 | Prepaid Expenses>Taxes | 15,143 |
| 31 | A5 | Prepaid Expenses>Workers Comp | 33,974 |
| Total Prepaid Expenses | | | \$ 91,241 |

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

| Page Ref | Line Ref | Description | |
|---|----------|-------------|-------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Total Other Current Assets (Itemize) | | | \$ - |

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

| Page Ref | Line Ref | Description | |
|---|----------|-------------|-------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Total Other Fixed Assets (Itemize) | | | \$ - |

Schedule of Other Assets Page 32 Line D7

| Page Ref | Line Ref | Description | |
|---------------------------|----------|-------------|-------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Total Other Assets | | | \$ - |

Schedule of Notes Payable (Itemize) Page 33 Line A2

| Page Ref | Line Ref | Description | |
|----------------------------|----------|-------------|-------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Total Notes Payable | | | \$ - |

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

| Page Ref | Line Ref | Description | |
|--|----------|-------------|-------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Total Other Current Liabilities (Itemize) | | | \$ - |

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

| Page Ref | Line Ref | Description | |
|--|----------|-------------|-------------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Total Other Long-Term Liabilities (Itemize) | | | \$ - |

G. Balance Sheet (cont'd)

| Name of Facility | License No. | Report for Year Ended | Page | of |
|--|---------------------|-----------------------|-----------|-----------|
| 35 Marc Drive Operations, LLC, d/b/a S | 2377 | 9/30/2019 | 32 | 37 |
| Account | | | Amount | |
| Total Brought Forward: | | | \$ | 1,415,997 |
| 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 | 66,423 | | |
| | Accum. Depreciation | 22,555 | Net | \$ |
| 43,868 | | | | |
| 4. Goodwill (Purchased Only) | | | | |
| \$ | | | | |
| 5. Investments Related to Resident Care (<i>itemize</i>) | | | | |
| \$ | | | | |
| | | | | |
| 6. Loans to Owners or Related Parties (<i>itemize</i>) | | | | |
| \$ | | | | |
| 84,206 | | | | |
| Name and Address | | Amount | Loan Date | |
| Due from Partners | | 84,206 | | |
| 7. Other Assets (<i>itemize</i>) | | | | |
| \$ | | | | |
| | | | | |
| See Schedule | | | | |
| D-8. Total Investments and Other Assets (Lines D1 thru 7) | | | | |
| \$ | | | | |
| 129,439 | | | | |
| D-9. Total All Assets (Lines A9 + B10 + C8 + D8) | | | | |
| \$ | | | | |
| 1,545,436 | | | | |

* 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 35 Marc Drive Operations, LLC, d/b/a Skyview | | License No. 2377 | Report for Year Ended 9/30/2019 | Page 33 | of 37 |
|--|--|---------------------|------------------------------------|------------|----------|
| Account | | | | Amount | |
| Liabilities | | | | | |
| A. Current Liabilities | | | | | |
| 1. Trade Accounts Payable | | | | \$ | 588,174 |
| 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>) | | | | \$ | 120,985 |
| 5. Accrued Payroll (<i>Owners and/or Stockholders only</i>) | | | | \$ | |
| 6. Accrued Payroll Taxes Payable | | | | \$ | |
| 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>) | | | | \$ | 220,353 |
| Accrued Expenses | | 163,002 | Accrued Expenses>Work | 27,179 | |
| Accrued Expenses>Insurance - Gene | | 24,110 | | | |
| Accrued Expenses>Insurance - Suret | | 154 | | | |
| Accrued Expenses>Insurance - Propri | | 5,908 | See Schedule | | |
| A-13. Total Current Liabilities (Lines A1 thru 12) | | | | \$ | 929,512 |

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

| | | | | | |
|--|---------|---------------------|------------------------------------|--------------|----------|
| Name of Facility 35 Marc Drive Operations, LLC, d/b/a Skyv | | License No. 2377 | Report for Year Ended 9/30/2019 | Page 34 | of 37 |
| Account | | | | Amount | |
| Total Brought Forward: | | | | 929,512 | |
| 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>) | | | | \$ 547,120 | |
| Name and Address of Lender | Amount | Loan Date | | | |
| Salmon Brook, Realty Sky View, Wtrbry, RCMG, RC Holdings, Nor, NL, | 547,120 | | | | |
| 4. Other Long-Term Liabilities (<i>itemize</i>) | | | | \$ 25,541 | |
| Due From>Old Owner | | 453 | | | |
| Due To/(From)>Maplewood | | 25,088 | | | |
| See Schedule | | | | | |
| B-5. Total Long-Term Liabilities (Lines B1 thru 4) | | | | \$ 572,661 | |
| C. Total All Liabilities (Lines A-13 + B-5) | | | | \$ 1,502,173 | |

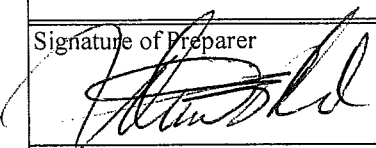
G. Balance Sheet (cont'd)
Reserves and Net Worth

| Name of Facility | License No. | Report for Year Ended | Page | of |
|---|-------------|-----------------------|--------|-----------|
| 35 Marc Drive Operations, LLC, d/b/a | 2377 | 9/30/2019 | 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 | | | \$ | |
| 6. Gain or Loss for Period | | | \$ | 43,263 |
| | 5/1/2019 | thru 9/30/2019 | | |
| 7. Total Net Worth | | | \$ | 43,263 |
| C. Total Reserves and Net Worth | | | \$ | 43,263 |
| D. Total Liabilities, Reserves, and Net Worth | | | \$ | 1,545,436 |

H. Changes in Total Net Worth

| Name of Facility | License No. | Report for Year Ended | Page | of | | |
|---|-------------|-----------------------|--------------|----|----|--|
| 35 Marc Drive Operations, LLC, d/b/a Sk | 2377 | 9/30/2019 | 36 | 37 | | |
| Account | | | Amount | | | |
| A. Balance at End of Prior Period as shown on Report of 09/30/2018 | | | \$ | | | |
| B. Total Revenue (<i>From Statement of Revenue Page 30</i>) | | | \$ 3,008,449 | | | |
| C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>) | | | \$ 2,965,186 | | | |
| D. Net Income or Deficit | | | \$ 43,263 | | | |
| E. Balance | | | \$ 43,263 | | | |
| F. Additions | | | | | | |
| 1. Additional Capital Contributed (<i>itemize</i>) | | | | | | |
| Expenses Per Page 27 \$2,967,226 | | | | | | |
| F/S vs C/R Depreciation (2,040) | | | | | | |
| Expenses Per F/S \$2,965,186 | | | | | | |
| 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 | | | \$ 43,263 | | | |
| 09/30/19 | | | | | | |

I. Preparer's/Reviewer's Certification

| | | | | |
|--|---|------------------------------------|------------|----------|
| Name of Facility 35 Marc Drive Operations, LLC, d/b/a | License No. 2377 | Report for Year Ended 9/30/2019 | 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 Principal | Date Signed 2/6/20 | | |
| Printed Name of Preparer Matthew S. Bovolack | | | | |
| Address Address 555 Long Wharf Drive, New Haven, CT 06511 | | Phone Number 203-781-9600 | | |
| Contacted Person Regarding Additional Information Needed Regarding This Report Yael Zabłudowski | | Phone Number 732-961-8571 | | |
| Contact Email Address yaelz@ltccs.com | | | | |

ACCOUNTANTS' CONSULTING REPORT

Management is responsible for the accompanying Annual Report of Long-Term Care Facility (the "Cost Report") for Skyview Center for the year ended September 30, 2019, included in the accompanying prescribed form. We have prepared the Cost Report in accordance with the American Institute of Certified Public Accountants' Statements on Standards for Consulting Services. The Cost Report was prepared in conformity with regulations prescribed by The State of CT Department of Social Services (DSS) from data provided to us by the management of Skyview Center. We did not audit or review the Cost Report included in the accompanying prescribed form, nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on the Cost Report included in the accompanying prescribed form.

Management is responsible for maintaining its records in accordance with accounting principles generally accepted in the United States of America and in accordance with reimbursement regulations set forth by DSS. Management is also responsible for designing, implementing, and maintaining internal control relevant to the preparation and fair presentation of the financial data and supplemental information included in the Cost Report.

This report is intended solely for the information and use of the management of Skyview Center and DSS and is not intended to be, and should not be, used by anyone other than these specified parties.

MARCUM LLP

New Haven, CT
February 5, 2020

Annual Report of Long-Term Care Facility Cost Year 2019 Checklist

This checklist is not required to be submitted with the Annual Report

Facility Name 35 Marc Drive Operations, LLC, d/b/a Skyview Center

Complete the following check list. **Provide an explanation for any "No" answers.** Attach additional sheets to explain further, if necessary.

Yes No

1. Have all related parties been properly disclosed on Pages 4, 11, 12, 14, 17 and 21?

Explanation: _____

Yes No

2. Are the methods of allocating costs consistent with prior year? If not, explain the reporting change.

Explanation: _____

Yes No

3. Are costs allocated based on the methods prescribed on Page 5 of the Annual Report? If not, provide the basis of your allocation.

Explanation: _____

Yes No

4. Do equipment leases listed on Page 6 agree with equipment leases reported on Page 22, Line 6e? If not, state where these costs are included in the Annual Report.

Explanation: _____

Yes No

5. Do accounting and legal fees reported on Page 7 agree with Page 15, Lines 1d and 1e, respectively?

Explanation: _____

Yes No

6. During cost year, did you report all certified bed changes on Page 9? Do the bed change dates agree to the license issued by the Department of Health?

Explanation: _____

Yes No

7. If there has been a change in Administrators, have the dates of employment and applicable hours for each Administrator been reported on Page 12?

Explanation: _____

Yes No

8. Have hours been reported for all expenses claimed on Page 13? Hours must be actual rather than estimated.

Explanation: _____

Yes No

9. Has resident day user fee expense been properly reported on Page 15, Line 1k3?

Explanation: _____

Yes No

10. Have purchased services greater than \$10,000 reported on Pages 16, 18, 19, 20 and 22 been detailed on Page 21?

Explanation: _____

Yes No

11. Have the dietary and laundry questionnaires on Pages 18 and 19 been completed?

Explanation: _____

Yes No

12. Has the personal use portion of automobile expense been disallowed, including, depreciation, lease payments, insurance and taxes?

Explanation: _____

Yes No

13. Does historical cost and accumulated depreciation of all assets reported on Pages 23 and 24 roll forward from the prior cost year?

Explanation: _____

Yes No

14. Does the net book value of all assets reported on Pages 23 and 24 agree with the net book value reported on Pages 31 and 32?

Explanation: _____

Yes No

15. Has asset useful life been reported in accordance with the 2013 edition of the American Hospital Association guidelines?

Explanation: _____

Yes No

16. Have all assets been categorized between movable and fixed in accordance with the 2013 edition of the American Hospital Association guidelines?

Explanation: _____

Yes No

17. Have all contractual allowances been properly reported on Page 30?

Explanation: _____

Yes No

18. Were all discrepancies on the Error Page addressed?

Explanation: _____

Yes No

19. Have Pages 1 and 37 been signed? *Cost reports without a signed Page 1 and 37 will not be accepted.*

Explanation: _____

Yes No

20. Have detailed schedules been provided for all "other" line items, fixed asset and movable equipment additions? *If detail is not provided, appropriate disallowances will be made.*

Explanation: _____

Yes No

21. Have all costs associated with non-nursing home businesses (i.e., Adult Daycare, Meals on Wheels, Outpatient Therapy Services, etc.) been disallowed on Pages 28 and/or 29 of the Annual Report?

Explanation: _____

Yes No

22. Has all required documentation been submitted to the Annual Report review and audit contractor?

Explanation: _____
