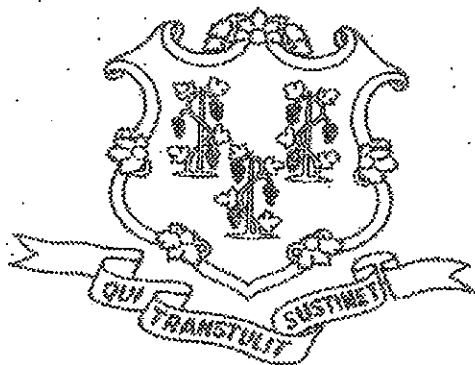


State of Connecticut



15-15

Annual Report of Long-Term Care Facility Cost Year 2015

RECEIVED

DEC 24 2015

DEPT. OF SOCIAL SERVICES
OFFICE OF CON AND RATE SETTINGS

Name of Facility (as licensed) 1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center	
Address (No. & Street, City, State, Zip Code) One Emerson Drive, Windsor, CT 06095	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH 2369	RHNS	(Specify)	Medicare Provider 07-5237
------------------	--------------	------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH 000010751	RHNS	ICF-IID
----------------------------	-------------------	------	---------

For Department Use Only

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

RECEIVED

JAN 05 2016

MYERS & STAUFFER LC

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC, d/b/a Kimber	2369	9/30/2015	1	37

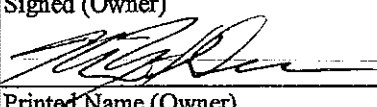
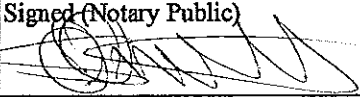
Administrator's/Owner's Certification

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

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

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
				11/13/2015
Printed Name (Administrator) Tamowicz, Jona			Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare	
Subscribed and Sworn to before me:	State of PA	Date 11/13/15	Signed (Notary Public) 	Comm. Expires 1 1
Address of Notary Public				

(Notary Seal)

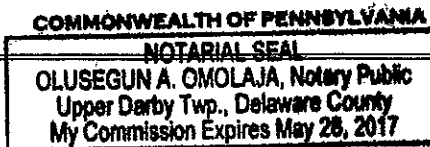


Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Leases	6
General Information and Questionnaire - Accounting Basis	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC, d/b/a Kimber	2369	9/30/2015	1	37

Administrator's/Owner's Certification

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

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

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

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

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

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center		Period Covered:	From 10/1/2014	To 9/30/2015
Address of Facility One Emerson Drive, Windsor, CT 06095				
Report Prepared By Thomas Farnan		Phone Number 978-247-5029	Date 12/21/2015	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$ 461,701	461,701		
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$ 26,503	26,503		
4. Nursing wages paid	\$ 3,866,880	3,866,880		
5. All other wages paid	\$ 597,733	597,733		
6. Total Wages Paid	\$ 4,952,816	4,952,816		
7. Total salaries paid	\$ 252,249	252,249		
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$ 5,205,065	5,205,065		

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 860-688-6443		Report for Year Ended 9/30/2015	Page 2	of 37
Name of Facility (as shown on license) 1 Emerson Drive South Operations LLC, d/b/a Kimberly South		Address (No. & Street, City, State, Zip) One Emerson Drive, Windsor, CT 06095		
License Numbers:	CCNH 2369	RHNS	(Specify)	Medicare Provider No. 07-5237
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Tarnowicz, Jona		Nursing Home Administrator's License No.:	2020	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

**General Information and Questionnaire
 Corporate Owners**

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a	License No. 2369	Report for Year Ended 9/30/2015	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address	State(s) in Which Incorporated		
1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center	101 East State Street, Kennett Square, PA 19348	PA		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
See Attached				
Names of Stockholders Owning at Least 10% of Shares				
See Attached				

General Information and Questionnaire Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of		
1 Emerson Drive South Operations LLC, d/b/a Kimber	2369	9/30/2015	4	37		
<p>Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>If "Yes," provide the Name/Address and complete the information on Page 11 of the report.</p>						
<p>Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? <input type="radio"/> Yes <input checked="" type="radio"/> No</p> <p>If "Yes," provide the following information:</p>						
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties		Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No			
Genesis Health Ventures	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Home Office	503,863	503,863
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	63% PT/OT/ST- Direct and Indirect Cost	1,614,988	1,614,988
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	55% Staffing Pool	6,317	6,317
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	85% Case Management	28,680	28,680
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Staffing Pool	1,294	1,294
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>	43% Respiratory Therapy	154,507	154,507
Liberty Health (Insurance)	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Insurance	155,367	155,367
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Capital Interest	49,653	49,653

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a	License No. 2369	Report for Year Ended 9/30/2015	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.				
1. In the preparation of this Report, were all costs allocated as required? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				
2. Explain the allocation of related company expenses and attach copy of appropriate supporting data.				
3. Did the Facility appropriately allocate and self-disallow direct and indirect costs to non-nursing home cost centers? (e.g., Assisted Living, Home Health, Outpatient Services, Adult Day Care Services, etc.)				
<input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain fully why such allocation was not made.				

General Information and Questionnaire
Accounting Basis

Name of Facility 1 Emerson Drive South Operations	License No. 2369	Report for Year Ended 9/30/2015	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.

Independent Accounting Firm

Name of Accounting Firm 1 Wells fargo institutional Retirement and Trust 2 3 4	Address (No. & Street, City, State, Zip Code) PO BOX 563957 Charlotte NC 28556
--	--

Services Provided by This Firm (*describe fully*)

1 401K plan auditing for collective bargaining unit employees	\$ (65)
2	\$
3	\$
4	\$
Charge for Services Provided	
	\$ (65)

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

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Morrow Morgan Smith, Inc. 2 Bloom Witkin 3 4 5	Telephone Number 860-678-1530
--	----------------------------------

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

1 11 Talcott Notch Road 2nd Fl Farmington, CT 06032
2 470 Atlantic Ave 3rd Fl Boston, MA 02210
3
4
5

Services Provided by This Firm (*describe fully*)

1 Review the report for Tax Appeal (Revaluation R.E)	\$ 2,000
2 Saving on R.E tax reduction based on the tax assessment	\$ 11,281
3 Dispute with an employee/case still pending	\$ 275
4	\$
5	\$
Charge for Services Provided	
	\$ 13,556

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

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended		Page	of									
		9/30/2015				8	37							
		2369												
1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center	Total All Levels	Total CCNH Level	Total RHINS Level	Total (Specify)	Period 10/1 Thru 6/30	Period 7/1 Thru 9/30								
					Total	CCNH	RHINS	CCNH	RHINS	Total	CCNH	RHINS	Total	(Specify)
1. Certified Bed Capacity														
A. On last day of PREVIOUS report period	180	180	180		180	180		180		180	180		180	
B. On last day of THIS report period	180	180	180		180	180		180		180	180		180	
2. Number of Residents														
A. As of midnight of PREVIOUS report period	105	105	105		105	105		105		105	105		105	
B. As of midnight of THIS report period	99	99	99		99	103		103		99	99		99	
3. Total Number of Days Care Provided During Period														
A. Medicare	7,134	7,134			5,996	5,996		5,996		1,138	1,138		1,138	
B. Medicaid (Conn.)	21,880	21,880			16,117	16,117		16,117		5,763	5,763		5,763	
C. Medicaid (other states)														
D. Private Pay	3,526	3,526			2,697	2,697		2,697		829	829		829	
E. State SSI for RCH														
F. Other (Specify)	5,487	5,487			4,413	4,413		4,413		1,074	1,074		1,074	
G. Total Care Days During Period (3A thru F)	38,027	38,027			29,223	29,223		29,223		8,804	8,804		8,804	
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds														
A. Medicaid Bed Reserve Days														
B. Other Bed Reserve Days	2	2			2	2		2						
5. Total Resident Days (3G + 4A + 4B)	38,029	38,029			29,225	29,225		29,225		8,804	8,804		8,804	

Schedule of Resident Statistics (Cont'd)

Name of Facility 1 Emerson Drive South Operations LLC, d/b/			License No. 2369			Report for Year Ended 9/30/2015			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days								CCNH	RHNS	(Specify)			
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID				
No. of Residents	14		62		23								
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	543.35		201.93		352.20								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								4,765	4,765				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								1,490	1,490				
C. Other								33,510	33,510				
D. Total Physical Therapy Treatments								39,765	39,765				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								703	703				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								77	77				
C. Other								31,075	31,075				
D. Total Speech Therapy Treatments								31,855	31,855				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								2,657	2,657				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								1,163	1,163				
C. Other								3,204	3,204				
D. Total Occupational Therapy Treatments								7,024	7,024				

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
1 Emerson Drive South Operations LLC, d/b/a Kimberly So	2369	9/30/2015	10	37		
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No				
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	125,759	2,046				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	170,871	8,004				
5. Dietary Service						
a. Head Dietitian	31,524	943				
b. Food Service Supervisor	51,725	2,171				
c. Dietary Workers	378,452	24,062				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	26,503	1,756				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	37,675	1,592				
b. Other Maintenance Workers	32,486	2,073				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	126,490	2,062				
b. RN						
1. Direct Care	1,055,252	29,024				
2. Administrative**	155,305	4,080				
c. LPN						
1. Direct Care	1,056,849	32,968				
2. Administrative**						
d. Aides and Attendants	1,556,161	91,220				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	123,935	6,217				
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	232,766	7,832				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	43,313	2,575				
<i>A-13. Total Salary Expenditures</i>	5,205,065	218,625				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
 ** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
 *** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

Position		CCNH		RHNS		(Specify)	
		\$	Hours	\$	Hours	\$	Hours
Ward Clerks	0	5264	404				
Central Supply	0	18886	1079				
Medical Records	0	19163	1092				
	0	0	0				
	0	0	0				
	0	0	0				
	0	0	0				
	0	0	0				
	0	0	0				
	0	0	0				
	0	0	0				
	0	0	0				
	0	0	0				
	0	0	0				
	0	0	0				
	0	0	0				
	0	0	0				
Total		43313	2575	\$ -		\$ -	

Schedule of Other Fees (Page 13)

Service		CCNH		RHNS		(Specify)	
		\$	Hours	\$	Hours	\$	Hours
1020620010	Consulting Fees	148.85	n/a				
1020620010	Consulting Fees	409.70	n/a				
3010620020	Purchased Services	440.00	n/a				
3015620020	Purchased Services	10,048.75	n/a				
3155620020	Purchased Services	(97.07)	n/a				
3155620020	Purchased Services	81,873.18	n/a				
1020620010	Consulting Fees	1,312.12	n/a				
	0	0	n/a				
	0						
	0						
	0						
Total		94136	0	\$ -		\$ -	

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		
1 Emerson Drive South Operations LLC, d/b/a Kimberly South Cent		2369		9/30/2015		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		
1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center		2369		9/30/2015		12	37		
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS (Specify)							
Section III - Administrators***									
Tarnowicz, Jona 8/9/2015-9/30/2015	11,897			Management of Center	286	2			
Heather Rodriguez 10/1/2014-8/1/2015	113,862			Management of Center	1,760	2			
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.

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
1 Emerson Drive South Operations LLC, d/b/a Kim	2369	9/30/2015	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian	699	19				
2. Dentist	14,261	98				
3. Pharmacist	14,409	294				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	1,432,863	19,628				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	82,830	438				
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	93,178	1,195				
b. Other						
10. Occupational Therapist						
a. Resident Care	131,572	1,802				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	926	15				
2. Administrative***						
b. LPN						
1. Direct Care	31,031	733				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	94,136					
B-13 Total Fees Paid in Lieu of Salaries	1,895,905	24,222				

* 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		License No.	Report for Year Ended		Page	of
1 Emerson Drive South Operations LLC, d/b/a Kimberly		2369	9/30/2015		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Genesis Eldercare Hospitality Services, 101 East State Street, Kennett Square, PA 19348	Dietary Services	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			

* 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
1 Emerson Drive South Operations LLC, d/b/a Ki	2369	9/30/2015	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 210,046	210,046		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 102,023	102,023		
4. Social Security (F.I.C.A.)	\$ 382,738	382,738		
5. Health Insurance	\$ 477,120	477,120		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 15,512	15,512		
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 28,186	28,186		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 339,044	339,044		
d. Accounting and Auditing	\$ (65)	(65)		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 13,556	13,556		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 33,901	33,901		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 9,182	9,182		
2. Cellular Phones	\$ 1,199	1,199		
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$ 1,520	1,520		
3. Resident Day User Fee	\$ 572,416	572,416		
Subtotal	\$ 2,186,378	2,186,378		

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

(Carry Subtotals forward to next page)

***** DO NOT Include Holiday Parties / Awards / Gifts to Staff**

1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center
9/30/2015

Attachment Page 15

Schedule of Other Employee Benefits

Description		CCNH	RHNS	(Specify)
3005520020	Union Health & Welfare	647.28	0	
3030520020	Union Health & Welfare	3,834.01	0	
3040520020	Union Health & Welfare	428.18	0	
3060520020	Union Health & Welfare	106.67	0	
3080520020	Union Health & Welfare	353.95	0	
3225520020	Union Health & Welfare	17,673.56	0	
5035520020	Union Health & Welfare	320.25	0	
3030520050	Employee Benefits-Other	2,290.39	0	
3080520050	Employee Benefits-Other	430.19	0	
3225520050	Employee Benefits-Other	2,101.86	0	
	0	0	-	0
Total		\$ 28,186	\$ -	\$ -

Schedule of Other Taxes

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax	564.00		
1020640110	Sales Tax	956.00		
	0	0	-	
	0	0	-	
Total		\$ 1,520	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC, d/b/a Kimbe	2369	9/30/2015	16	37
Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	2,186,378	2,186,378		
1. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$ 100	100		
3. Gifts to Staff and Residents	\$			
4. Employee Travel	\$ 2,029	2,029		
5. Education Expenses Related to Seminars and Conventions	\$ 355	355		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$			
7. Other (<i>Specify</i>) See Attached Schedule	\$			
m. Other Administrative and General Expenses				
1. Advertising Help Wanted (<i>all such expenses</i>)	\$			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$			
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 7,429	7,429		
4. Fund-Raising***	\$			
5. Medical Records	\$			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$			
7. Postage	\$ 2,798	2,798		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 12,380	12,380		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 510	510		
9. Subscriptions	\$ 440	440		
10. Contributions*** See Attached Schedule	\$ 2,469	2,469		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 2,410	2,410		
12. Administrative Management Services**	\$ 514,928	514,928		
13. Other (<i>Specify</i>) See Attached Schedule	\$ 40,663	40,663		
C-14 Total Administrative & General Expenditures	\$ 2,772,890	2,772,890		

* 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)
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
Total Other Travel and Entertainment	\$	\$	\$

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
1020630020 Advertising	240.5	0	0
1020630020 Advertising	372.38	0	0
1020630020 Advertising	1015.57	0	0
1020630330 Marketing Expense	3203.18	0	0
1020630330 Marketing Expense	25.57	0	0
1020630330 Marketing Expense	481.06	0	0
1020630330 Marketing Expense	48.91	0	0
1020630331 Marketing Exp. Corps	606.79	0	0
1020630331 Marketing Exp. Corps	1435.19	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
0	0	0	0
Total Other Advertising	\$ 7,429	\$	\$

Schedule of Dues

Description	CCNH	RHNS	(Specify)
1020630310 CT ASSOCIATION C	9,690.24	0	0
1020630310 State of Connecticut	1,380.00	0	0
1020630310 ACHCA	325.00	0	0
1020630310 Town of Windsor	279.77	0	0
1020630310 Russell Phillips & Ass	350	0	0
1020630310 Greisler, Christina Lys	85	0	0
1020630310 Walth, Gregory C.	100	0	0
1020630310 O'reba, Cathy B.	85	0	0
1020630310 Attmore	85	0	0
1020630310 0	0	0	0
1020630310 0	0	0	0
1020630310 0	0	0	0
1020630310 0	0	0	0
1020630310 0	0	0	0
1020630310 0	0	0	0
1020630310 0	0	0	0
1020630310 0	0	0	0
Total Dues	\$ 12,380	\$	\$

Schedule of Contributions

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
1 Emerson Drive South Operations LLC, c	2369	9/30/2015	17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	503,863	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	49,653	Capital Interest	pg 26 12-A-1

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC, d/b/a Kimberl	2369	9/30/2015	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 178,154	178,154		
2. Non-Food Supplies	\$ 19,957	19,957		
3. Other (Specify) _____	\$ (3,462)	(3,462)		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$			
c. Management Services**	\$			
d. Other (Specify) _____	\$			
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 194,649	194,649		
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*				
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility		License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC, d/b/a Kimberly		2369	9/30/2015	19	37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***		Amt. \$	4,805	4,805	
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***		Lbs.			
		Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***		Lbs.			
		Amt. \$			
4. Repair and/or purchase of linens.***		Lbs.			
		Amt. \$	6,766	6,766	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	155,539	155,539	
c. Management Services**		\$			
d. Other (Specify)		\$			
3E. Total Laundry Expenditures (3a + b + c + d)		\$	167,110	167,110	
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
 All allocations should add to total recorded in 3E.

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

*** Pounds of Laundry only required for multi-level facilities.

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

Name of Facility		License No.	Report for Year Ended		Page	of
1 Emerson Drive South Operations LLC, d/b/a K		2369	9/30/2015		20	37
Item		Total	CCNH	RHNS	(Specify)	
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	23,064	23,064			
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. \$	232,034	232,034			
c. Management Services*		\$				
d. Other (<i>Specify</i>)		\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)		\$	255,098	255,098		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy	\$					
2. Purchased from	\$	637,951	637,951			
b. Medicine Cabinet Drugs	\$	23,257	23,257			
c. Medical and Therapeutic Supplies	\$	154,050	154,050			
d. Ambulance/Limousine***	\$	10,568	10,568			
e. Oxygen						
1. For Emergency Use	\$					
2. Other****	\$	23,444	23,444			
f. X-rays and Related Radiological Procedures***	\$	29,446	29,446			
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$					
h. Laboratory***	\$	49,367	49,367			
i. Recreation	\$	28,999	28,999			
j. Other (Specify)***** See Attached Schedule	\$	119,121	119,121			
5K. Total Resident Care Expenditures (5a - 5j)		\$	1,076,204	1,076,204		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)	
3060610160	Incontinency	37078.07	0	0
3060610161	Incontinency - Rebates	-2977.26	0	0
3165630020	Advertising	12.5	0	0
3080630030	Advertising-Help War	1385.44	0	0
3080630030	Advertising-Help War	784.47	0	0
3080630140	Education Expense	1009.21	0	0
3080630140	Education Expense	155.71	0	0
3080630140	Education Expense	604.36	0	0
3120630530	Supplies	4345.62	0	0
3155630530	Supplies	12973.68	0	0
3155630530	Supplies	27331.28	0	0
3090630535	Office Supplies	1640.39	0	0
3120660080	Rental Expense	2424.26	0	0
3120660080	Rental Expense	2452.31	0	0
3155660080	Rental Expense	-85.17	0	0
3155660080	Rental Expense	21414.04	0	0
3010610300	Consolidated Billing	8571.92	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
Total Other Resident Care		\$ 119,121	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended	Page of	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	Pg	Line
				Yes	No							
1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center	2369	9/30/2015	21									37
Name of Individual or Company	Address											
Healthcare Services Group	Drive, Bensalem, PA 19020	Vendor Contracted		<input checked="" type="radio"/>	<input type="radio"/>	Vendor Contracted	Laundry Purchased Services	155,539				19 3b
Healthcare Services Group	Drive, Bensalem, PA 19020	Vendor Contracted		<input checked="" type="radio"/>	<input type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	232,034				20 4b
				<input type="radio"/>	<input type="radio"/>							
				<input type="radio"/>	<input type="radio"/>							
				<input type="radio"/>	<input type="radio"/>							
				<input type="radio"/>	<input type="radio"/>							
				<input type="radio"/>	<input type="radio"/>							
				<input type="radio"/>	<input type="radio"/>							
				<input type="radio"/>	<input type="radio"/>							
				<input type="radio"/>	<input type="radio"/>							
				<input type="radio"/>	<input type="radio"/>							
				<input type="radio"/>	<input type="radio"/>							
				<input type="radio"/>	<input type="radio"/>							
				<input type="radio"/>	<input type="radio"/>							

* 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
1 Emerson Drive South Operations LLC, d/b/a	2369	9/30/2015			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 152,278	152,278				
b. Heat	\$ 67,187	67,187				
c. Light & Power	\$ 132,246	132,246				
d. Water	\$ 59,245	59,245				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 410,955	410,955				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 190	190				
b. Building & Building Improvements	\$ 529,286	529,286				
c. Non-Movable Equipment	\$ 1,327	1,327				
d. Movable Equipment	\$ 42,376	42,376				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 573,180	573,180				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 437,284	437,284				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 108,645	108,645				
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,119,109	1,119,109				

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

Depreciation Schedule

Name of Facility		License No.		Report for Year Ended		Page		of	
1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center		2369		9/30/2015		23		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	
								Yes	No
A. Land Improvements									
1. Acquired prior to this report period	1,900		1,900	459	S/L	Various	190		
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
A-4. Subtotal									190
B. Building and Building Improvements									
1. Acquired prior to this report period	3,540,558		3,540,558	1,405,764	S/L	Various	525,163		
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	353,428		353,428				4,124		
B-4. Subtotal									529,286
C. Non-Movable Equipment									
1. Acquired prior to this report period	12,104		12,104	2,913	S/L	Various	1,327		
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									1,327
D. Movable Equipment									
1. Motor Vehicles (Specify name, model and year of each vehicle)	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
a.									
b.									
c.									
d.									
2. Movable Equipment									
a. Acquired prior to this report period	377,977		377,977	119,901	S/L	Various	41,995		
b. Disposals (attach schedule)									
c. Acquired during this report period (attach schedule)									
D-3. Subtotal									381
E. Total Depreciation									
									42,376
									573,179

1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center
9/30/2015

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
		0	0	0
		0	0	0
		0	0	0
		0	0	0
		0	0	0
		0	0	0
		0	0	0
Total additions for Land Improvements		0		0
Deletions:				
0	0	0.00	0.00	0.00
0	0	0.00	0.00	0.00
0	0	0.00	0.00	0.00
0	0	0.00	0.00	0.00
0	0	0.00	0.00	0.00
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:				
1/31/2015	6 sidewall sprinklers	3482.96	20.00	116.10
2/28/2015	Property Management Time Allocatio	2918.03	20.00	85.11
3/31/2015	Property Management Time Allocatio	1651.19	20.00	41.28
4/30/2015	Property Management Time Allocatio	9960.68	20.00	207.51
5/31/2015	Property Management Time Allocatio	13998.17	20.00	233.30
5/31/2015	Property Management Time Allocatio	817.29	20.00	13.62
5/31/2015	Roof replacement deposit	86010.00	20.00	1433.50
6/30/2015	Property Management Time Allocatio	13878.42	20.00	173.48
6/30/2015	Additional services for roof replacem	1911.79	20.00	23.90
7/31/2015	Property Management Time Allocatio	7165.21	20.00	59.71
8/31/2015	Property Management Time Allocatio	16629.28	20.00	69.29
8/31/2015	Full roof replacement	64860.00	20.00	270.25
8/31/2015	Full roof replacement	92954.00	20.00	387.31
9/30/2015	Property Time Management Allocatio	2620.33	20.00	0.00
5/31/2015	Paint and wallcoverings	20000.00	10.00	666.67
6/30/2015	Roam Alert Wander and mag lock sys	13714.90	10.00	342.87
9/30/2015	Sep Accrual - PPE Building Improver	239.29	0.00	0.00
9/30/2015	Sep Accrual - PPE Building Improver	616.83	0.00	0.00
Total additions for Building Improvements		\$ 353,428		\$ 4,124

Amortization Schedule*

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kimberly Sou	Date of Acquisition		License No. 2369	Report for Year Ended 9/30/2015	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	of 37
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.
 ** Specify which of the following bases were used:
 A. Minimum of 5 years or 60 months.
 B. Life of mortgage; OR
 C. Remaining Life of Lease; OR
 D. Actual Life if owned by Related Party.

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

Name of Facility 1 Emerson Drive South Operations LL	License No. 2369	Report for Year Ended 9/30/2015	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*			<input type="radio"/> Yes	<input checked="" type="radio"/> No
			If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description		Total		
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity		180		
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd 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
Healthcare REIT, Inc	Building and Equipment	04/01/11	20	437,284
Address: One Seagate Suite 1500				
Toledo, OH 43603-1475				

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
1 Emerson Drive South Operations LL		2369	9/30/2015		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$ 49,653	49,653		
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)			\$ 49,653	49,653		

(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
1 Emerson Drive South Operations		2369		9/30/2015		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				49,653	49,653		
12. C. Movable Equipment							
1. Automotive Equipment \$							
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify) \$							
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) \$							
12. D. Other Interest Expense (Specify) \$							
13. Total All Interest Expense (12B7 + 12C3 + 12D) \$				49,653	49,653		
14. Insurance							
a. Insurance on Property (buildings only) \$				6,661	6,661		
b. Insurance on Automobiles \$							
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)			\$ 148,706	148,706			
2. Fire and Extended Coverage			\$				
3. Other (Specify)			\$				
14d. Total Insurance Expenditures (14a + b + c) \$				155,367	155,367		
15. Total All Expenditures (A-13 thru C-14) \$				13,302,005	13,302,005		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
1 Emerson Drive South Operations LLC, d/b/a Kimberly South			2369	9/30/2015	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 18,952	18,952		
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 1,749,877	1,749,877		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$ 339,044	339,044		
10.			Accounting & Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.			Unallowable Advertising *	\$ 7,429	7,429		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 2,469	2,469		
21.			Unallowable Management Fees	\$ 564,581	564,581		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 14,203	14,203		
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)				\$ 2,696,555	2,696,555		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	2	Administrator's salary disallowed	0	18952	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
Total Other Salaries Adjustment			\$ 18,952	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	187671.13	0
13	5	Rehabilitation Services	3195620020	1245191.93	0
13	9	Speech Therapist	3170620020	93177.54	0
13	10	Occupational Therapist	3105620020	131571.75	0
13	12	Other	3010620020	440	0
13	12	Other	3015620020	10048.75	0
13	12	Respiratory Purchased Services	3155620020	81776.11	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
Total Other Fees Adjustments			\$ 1,749,877	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Collection Fees	1020630120	12677.35	0
16	m13	Estimated Accrual	1020660990	519.56	0
16	m8a	Chamber of Commerce License Fee		510	0
16	m13	Non-recurring charges	7010800030	0	0
16	m-12	0	0	0	0
16	m-13	Penalty and Fines	1020640080	1535	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
Total Other A&G Adjustments			\$ 14,203	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
1 Emerson Drive South Operations LLC, d/b/a Kimberly Sou			2369	9/30/2015	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 2,696,555	2,696,555		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$ 637,951	637,951		
28.			Ambulance/Limousine	\$ 10,568	10,568		
29.			X-rays, etc	\$ 29,446	29,446		
30.			Laboratory	\$ 49,367	49,367		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$ 23,444	23,444		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 88,801	88,801		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$ 108,612	108,612		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51. Total Amount of Decrease (Items 1 - 50)				\$ 3,644,745	3,644,745		

*** 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.

1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-	Consolidated Billing	8571.92	3010610300	0
20	5-	Respiratory Supplies	40304.96	3155630530	0
20	5-	Respiratory Rental	21328.87	3155660080	0
20	5-	Cable TV	18594.96	3005660130	allow \$3600
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
Total Other Ancillary Costs			\$ 88,801	\$	\$

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14c1	General liability Insurance Adjust	108612.2812	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
Total Other Adjustments			\$ 108,612	\$ -	\$ -

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility 1 Emerson Drive South Operations LLC, 2369		License No.		Report for Year Ended 9/30/2015		Page of 30 37	
Item				Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue							
1.	a.	Medicaid Residents (CT only)	\$	7,418,308	7,418,308		
	b.	Medicaid Room and Board Contractual Allowance **	\$	(3,130,987)	(3,130,987)		
2.	a.	Medicaid (All other states)	\$				
	b.	Other States Room and Board Contractual Allowance **	\$				
3.	a.	Medicare Residents (all inclusive)	\$	2,754,483	2,754,483		
	b.	Medicare Room and Board Contractual Allowance **	\$	(815,433)	(815,433)		
4.	a.	Private-Pay Residents and Other	\$	3,350,161	3,350,161		
	b.	Private-Pay Room and Board Contractual Allowance **	\$	(1,155,961)	(1,155,961)		
II. Other Resident Revenue							
1.	a.	Prescription Drugs - Medicare	\$	365,041	365,041		
	b.	Prescription Drugs - Medicare Contractual Allowance **	\$	(108,066)	(108,066)		
	c.	Prescription Drugs - Non-Medicare	\$	345,239	345,239		
	d.	Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(121,048)	(121,048)		
2.	a.	Medical Supplies - Medicare	\$	1,560	1,560		
	b.	Medical Supplies - Medicare Contractual Allowance **	\$	(462)	(462)		
	c.	Medical Supplies - Non-Medicare	\$	840	840		
	d.	Medical Supplies - Non-Medicare Contractual Allowance **	\$	(342)	(342)		
3.	a.	Physical Therapy - Medicare	\$	1,217,022	1,217,022		
	b.	Physical Therapy - Medicare Contractual Allowance **	\$	(360,286)	(360,286)		
	c.	Physical Therapy - Non-Medicare	\$	945,688	945,688		
	d.	Physical Therapy - Non-Medicare Contractual Allowance **	\$	(332,771)	(332,771)		
4.	a.	Speech Therapy - Medicare	\$	361,636	361,636		
	b.	Speech Therapy - Medicare Contractual Allowance **	\$	(107,058)	(107,058)		
	c.	Speech Therapy - Non-Medicare	\$	221,046	221,046		
	d.	Speech Therapy - Non-Medicare Contractual Allowance **	\$	(77,377)	(77,377)		
5.	a.	Occupational Therapy - Medicare	\$	1,139,206	1,139,206		
	b.	Occupational Therapy - Medicare Contractual Allowance **	\$	(337,249)	(337,249)		
	c.	Occupational Therapy - Non-Medicare	\$	838,133	838,133		
	d.	Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(294,276)	(294,276)		
6.	a.	Other (Specify) - Medicare	\$	75,434	75,434		
	b.	Other (Specify) - Non-Medicare	\$	114,727	114,727		
III. Total Resident Revenue (Section I. thru Section II.)				\$	12,307,208	12,307,208	
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			\$	11,685	11,685	
5.	Interest Income (Specify)			\$	611	611	
6.	Private Duty Nurses' Fees			\$			
7.	Barber, Coffee, Beauty and Gift shops			\$	11,986	11,986	
8.	Other (Specify)			\$	944	944	
V. Total Other Revenue (1 thru 8)				\$	25,226	25,226	
VI. Total All Revenue (III +V)				\$	12,332,434	12,332,434	

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-a	Medicare Part A	X-Ray	21,073.46	0	0
II-6-a	Medicare Part A	Laboratory	29,062.40	0	0
II-6-a	Medicare Part A	Respiratory Therapy & Supplie	46,875.37	0	0
II-6-a	Medicare Part A	Nursing Treatment Supplies	-	0	0
II-6-a	Medicare Part A	Audiology	54.10	0	0
II-6-a	Medicare Part A	Incontinency	-	0	0
II-6-a	Medicare Part A	Oxygen & Supplies	4,742.40	0	0
II-6-a	Medicare Part A	Physician Visit	1,074.30	0	0
II-6-a	Medicare Part A	Ambulance	-	0	0
II-6-a	Medicare Part A	Flu Shot	4,274.16	0	0
II-6-a	Contractuals-Medicare	X-Ray	(6,238.56)	0	0
II-6-a	Contractuals-Medicare	Laboratory	(8,603.59)	0	0
0	Contractuals-Medicare	Respiratory Therapy & Supplie	(13,876.92)	0	0
0	Contractuals-Medicare	Nursing Treatment Supplies	-	0	0
0	Contractuals-Medicare	Audiology	(16.02)	0	0
0	Contractuals-Medicare	Incontinency	-	0	0
0	Contractuals-Medicare	Oxygen & Supplies	(1,403.93)	0	0
0	Contractuals-Medicare	Physician Visit	(318.03)	0	0
0	Contractuals-Medicare	Ambulance	-	0	0
0	Contractuals-Medicare	Flu Shot	(1,265.32)	0	0
Total Other Resident Revenue - Medicare			\$ 75,434	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	311.00	0	0
II-6-b	Medicaid	Laboratory	503.05	0	0
II-6-b	Medicaid	Respiratory Therapy & Supplie	12,130.03	0	0
II-6-b	Medicaid	Nursing Treatment Supplies	-	0	0
II-6-b	Medicaid	Audiology	-	0	0
II-6-b	Medicaid	Incontinency	-	0	0
II-6-b	Medicaid	Oxygen & Supplies	5,614.50	0	0
II-6-b	Medicaid	Physician Visit	-	0	0
II-6-b	Medicaid	Ambulance	-	0	0
II-6-b	Medicaid	Flu Shot	-	0	0
II-6-b	Contractuals Medicaid	X-Ray	(131.26)	0	0
II-6-b	Contractuals Medicaid	Laboratory	(212.32)	0	0
II-6-b	Contractuals Medicaid	Respiratory Therapy & Supplie	(5,119.63)	0	0
II-6-b	Contractuals Medicaid	Nursing Treatment Supplies	-	0	0
II-6-b	Contractuals Medicaid	Audiology	-	0	0
II-6-b	Contractuals Medicaid	Incontinency	-	0	0
II-6-b	Contractuals Medicaid	Oxygen & Supplies	(2,369.67)	0	0
II-6-b	Contractuals Medicaid	Physician Visit	-	0	0
II-6-b	Contractuals Medicaid	Ambulance	-	0	0
II-6-b	Contractuals Medicaid	Flu Shot	-	0	0
II-6-b	Private and Other	X-Ray	13,939.94	0	0

II-6-b	Private and Other	Laboratory	17,767.50	0	0
II-6-b	Private and Other	Respiratory Therapy & Supplies	32,468.77	0	0
II-6-b	Private and Other	Nursing Treatment Supplies	-	0	0
II-6-b	Private and Other	Audiology	-	0	0
II-6-b	Private and Other	Incontinency	-	0	0
II-6-b	Private and Other	Oxygen & Supplies	2,992.50	0	0
II-6-b	Private and Other	Physician Visit	-	0	0
II-6-b	Private and Other	Ambulance	-	0	0
II-6-b	Private and Other	Flu Shot	-	0	0
II-6-b	Private and Other	Capitation Contracts	91,623.50	0	0
II-6-b	Contractuals-Non-Medicaid	X-Ray	(4,809.93)	0	0
II-6-b	Contractuals-Non-Medicaid	Laboratory	(6,130.61)	0	0
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplies	(11,203.24)	0	0
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment Supplies	-	0	0
II-6-b	Contractuals-Non-Medicaid	Audiology	-	0	0
II-6-b	Contractuals-Non-Medicaid	Incontinency	-	0	0
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplies	(1,032.55)	0	0
II-6-b	Contractuals-Non-Medicaid	Physician Visit	-	0	0
II-6-b	Contractuals-Non-Medicaid	Ambulance	-	0	0
II-6-b	Contractuals-Non-Medicaid	Flu Shot	-	0	0
II-6-b	Contractuals-Non-Medicaid	Capitation Contracts	(31,614.37)	0	0
Total Other Resident Revenue			\$ 114,727	\$	\$

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
IV-5	Interest On Overdue Account	0000100250	611.25	0	0
0	0	0	-	0	0
0	0	0	-	0	0
Total Interest Income			\$ 611	\$	\$

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
IV-8	Medical Record	430060	944.19	0	0
0	0	0	-	0	0
0	0	0	-	0	0
0	0	0	-	0	0
0	0	0	-	0	0
0	0	0	-	0	0
0	0	0	-	0	0
0	0	0	-	0	0
0	0	0	-	0	0
0	0	0	-	0	0
0	0	0	-	0	0
0	0	0	-	0	0
0	0	0	-	0	0
0	0	0	-	0	0
IV-8	0	0	-	0	0
Total Other Revenue			\$ 944	\$	\$

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC	2369	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	18,041
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,247,073
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	7,734
4 Inventories			\$	57,029
5. Prepaid Expenses			\$	87,272
a. Prepaid Expenses				
b. Prepaid Property Tax	74,564			
c. Prepaid Personal Property Tax				
d. Prepaid Personal Property Tax	12,708			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,417,150
B. Fixed Assets				
1. Land			\$	549,850
2. Land Improvements	*Historical Cost	1,900	\$	1,251
	Accum. Depreciation	649		Net
3. Buildings	*Historical Cost	3,893,986	\$	1,958,935
	Accum. Depreciation	1,935,051		Net
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation			Net
5. Non-Movable Equipment	*Historical Cost	12,104	\$	7,864
	Accum. Depreciation	4,240		Net
6. Movable Equipment	*Historical Cost	385,610	\$	223,333
	Accum. Depreciation	162,277		Net
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation			Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
PPE CIP				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	2,741,233

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC	2369	9/30/2015	32	37
Account			Amount	
Total Brought Forward:			\$	4,158,382
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
3. Buildings			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
4. Non-Movable Equipment			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
5. Movable Equipment			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
6. Motor Vehicles			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			*Historical Cost _____	
			Accum. Depreciation _____ Net	
			\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>temize</i>)			\$	
6. Loans to Owners or Related Parties (<i>temize</i>)			\$	
Name and Address		Amount	Loan Date	
7. Other Assets (<i>itemize</i>)			\$	(2,653,651)
I/C Due to/Due From Owned		(2,653,651)		
I/C Due to/Due From Multicare				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	(2,653,651)
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	1,504,731

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC, d/b/a		2369	9/30/2015	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	431,043
2. Notes Payable (<i>itemize</i>)				\$	

3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	178,968
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>)				\$	366,382
Accr Exp Other		14	Accr Exp Water and Sew	7,815	
A/R Credit Gross Up Liability		167,796	Deferred Revenue	28,241	
Accr Exp Gas		3,625	Accrued Provider/Bed Te	147,981	
Accr Exp Electricity		9,866	Accr Exp Suspense	1,044	
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	976,393

* 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 1 Emerson Drive South Operations LLC, d/b/a		License No. 2369	Report for Year Ended 9/30/2015	Page 34	of 37
Account				Amount	
Total Brought Forward:				976,393	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment <i>(temize)</i>					
Name of Lender		Purpose	Amount	Date Due	\$
2. Mortgages Payable					
\$					
3. Loans from Owners or Related Parties <i>(temize)</i>					
\$					
Name and Address of Lender		Amount	Loan Date		
4. Other Long-Term Liabilities <i>(temize)</i>					
LT Debt-Financing Obligation			2,558,029	\$ 2,558,029	
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 2,558,029	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 3,534,422	

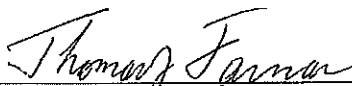
G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LL	2369	9/30/2015	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (Equity)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	700,338
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(1,760,457)
6. Gain or Loss for Period			\$	(969,571)
	10/1/2014	thru 9/30/2015		
7. Total Net Worth			\$	(2,029,690)
C. Total Reserves and Net Worth			\$	(2,029,690)
D. Total Liabilities, Reserves, and Net Worth			\$	1,504,732

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC,	2369	9/30/2015	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2014			\$	(1,060,119)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	12,332,434
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	13,302,005
D. Net Income or Deficit			\$	(969,571)
E. Balance			\$	(2,029,690)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period		09/30/15	\$	(2,029,690)

I. Preparer's/Reviewer's Certification

Name of Facility 1 Emerson Drive South Operations LLC,	License No. 2369	Report for Year Ended 9/30/2015	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
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 <i>Sr. Director of Reimbursement</i>	Date Signed <i>12/28/2015</i>		
Printed Name of Preparer Thomas Farnan Title -Sr. Director of Reimbursement				
Address Address 200 Brickstone Square, Andover, MA 01810		Phone Number 978-247-5029		