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

DRAFT

St. Camillus Center

Facility: 318
Page: 22
Date: 01/06/2016

Page - Lic. Type - Rate Yr	Error Message
3-CCH	Physician Hourly Limit Cost Year Variable is 0, hourly limits cannot be checked
3-CCH	Dietician Hourly Limit Cost Year Variable is 0, hourly limits cannot be checked
4-CCH	Physician Hourly Limit Cost Year Variable is 0, hourly limits cannot be checked
4-CCH	Dietician Hourly Limit Cost Year Variable is 0, hourly limits cannot be checked
4-CCH	OT fees do not agree to OT fee adjustment
11-CCH	(2), Total Expenses does not foot
16-CCH	(7,016), Television Revenue is greater than reported on page 13
17	Administrator's salary needs to be entered
DRD	Bed Capacity not entered in the DRD
18	Annual Report Fair Rent (pg. 23, 24) Additions total (206,205) does not match Real Property Additions on pg. 18 of Rate Comp. (0)
RC-Nurs Fac-CCH	No Self Pay rates entered

State of Connecticut

15-22 K DC

Annual Report of Long-Term Care Facility

Cost Year 2015

Name of Facility (as licensed) St. Camillus Rehabilitation and Nursing Center	
Address (No. & Street, City, State, Zip Code) 494 Elm Street, Stamford, CT 06902	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2322-C			07-5320

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	20363		

For Department Use Only

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

State of Connecticut
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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	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 IMPRISIONMENT 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 St. Camillus Rehabilitation and Nursing 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) Anna Durkovic			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 / /
Address of Notary Public				

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
OLUSEGUN A. OMOLAJA, Notary Public
Upper Darby Twp., Delaware County
My Commission Expires May 28, 2017

(Notary Seal)

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General Information

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St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2015	1	37

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

(Notary Seal)

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

Data Required for Real Wage Adjustment				Page 1A	of 37
Name of Facility St. Camillus Rehabilitation and Nursing Center	Period Covered:			From 10/1/2014	To 9/30/2015
Address of Facility 494 Elm Street, Stamford, CT 06902					
Report Prepared By Thomas Farnan	Phone Number 978-247-5029			Date 12/20/2014	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$	477,111	477,111		
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$	3,983,316	3,983,316		
5. All other wages paid	$	653,680	653,680		
6. ***Total Wages Paid***	$	5,114,107	5,114,107		
7. Total salaries paid	$	255,600	255,600		
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	5,369,707	5,369,707		

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.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-325-0200	9/30/2015	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
St. Camillus Rehabilitation and Nursing Center	494 Elm Street, Stamford, CT 06902

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2322-C			07-5320

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ⊙ LLC ○ Partnership ○ Profit Corp. ○ Non-Profit Corp. ○ Government ○ 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? ○ Yes ⊙ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Anna Durkovic	1825

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2015	3	37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned
Harborside Health I Corporatio	101 Sun Ave. NE, Albuquerque, NM 87109		1
Harborside Healthcare Limited	101 Sun Ave. NE, Albuquerque, NM 87109		99

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Cente	2322-C	9/30/2015	3A	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
St. Camillus Rehabilitation and Nursing Center	101 East State Street, Kennett Square, PA 19348	PA

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
N/A			
Names of Stockholders Owning at Least 10% of Shares			
N/A			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2015	3B	37

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2015	4	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	%**				
Genesis Health Ventures	101 East State Street, Kennett Square, PA 19348	⊙	○		Home Office	Pg 16/m12	477,984	477,984
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	⊙	○	63%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	704,506	704,506
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	⊙	○	55%	Staffing Pool	Pg 10/A12	17,919	17,919
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	⊙	○	85%	Case Management	Pg 13/B8, Pg 10/A12	40,140	40,140
Career Staffing	101 East State Street, Kennett Square, PA 19348	⊙	○		Staffing Pool	Pg 13/B11 a,b,c	21,322	21,322
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	⊙	○	43%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	30,858	30,858
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Insurance	Pg 27/14	158,974	158,974
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Capital Interest	Page 17, page 26-12A	46,281	46,281
		○	○					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

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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
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2015	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					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
						Total ***	

Is a Mileage Log Book Maintained for All Leased Vehicles ? O Yes O No

* 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.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nu	2322-C	9/30/2015	7	37

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

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

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

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Constable	203-323-2149
2 Treasurer State of Connecticut	203-323-2149
3 Morrow Morgan Smith Inc	860 678-1530
4 Russell Phillips & Associates LLC	585 223-1130
5	

Address (*No. & Street, City, State, Zip Code*)
1 888 Washington Blvd P O Box 10152 Stamford, CT 06904
2 888 Washington Blvd P O Box 10152 Stamford, CT 06904
3 11 Talcott Notch Rd 2FL Farmington, CT 06032
4 500 CrossKeys Office Park Fair Port, NY 14450
5

Services Provided by This Firm (*describe fully*)

1	Application for permanent conservatorship	$
2	Citation, Application fee of Conservator	$
3	Reducing the R.E tax-R.E tax Assessment Revaluation	$ 6,250
4	Annual Fee for the CT Region LT Care Mutual Aid Plan	$ 350
5		$
		Charge for Services Provided $ 6,600

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

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2015	8	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	124	124			124	124			124	124		
B. On last day of THIS report period	124	124			124	124			124	124		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	104	104			104	104			107	107		
B. As of midnight of THIS report period	100	100			107	107			100	100		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,348	4,348			3,344	3,344			1,004	1,004		
B. Medicaid (Conn.)	31,716	31,716			24,143	24,143			7,573	7,573		
C. Medicaid (other states)												
D. Private Pay	1,978	1,978			1,618	1,618			360	360		
E. State SSI for RCH												
F. Other (Specify)	1,996	1,996			1,582	1,582			414	414		
G. Total Care Days During Period (3A thru F)	40,038	40,038			30,687	30,687			9,351	9,351		
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	9	9			9	9						
5. ***Total Resident Days*** **(3G + 4A + 4B)**	40,047	40,047			30,696	30,696			9,351	9,351		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Cent	2322-C	9/30/2015	9	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						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID
No. of Residents	9	80		11				
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.	594.66	254.78		490.19				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,306	3,306		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	781	781		
C. Other	15,809	15,809		
D. ***Total Physical Therapy Treatments***	19,896	19,896		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	504	504		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	89	89		
C. Other	1,527	1,527		
D. ***Total Speech Therapy Treatments***	2,120	2,120		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,874	1,874		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	475	475		
C. Other	12,367	12,367		
D. ***Total Occupational Therapy Treatments***	14,716	14,716		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2015	10	37

Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

Item	Total Cost and Hours					
	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)	138,239	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	227,236	11,067				
5. Dietary Service						
a. Head Dietitian	26,644	840				
b. Food Service Supervisor	66,371	2,332				
c. Dietary Workers	384,096	22,502				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	76,683	2,118				
b. Other Maintenance Workers	42,732	2,958				
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	117,361	2,013				
b. RN						
1. Direct Care	1,293,460	31,699				
2. Administrative**	28,554	752				
c. LPN						
1. Direct Care	963,021	30,176				
2. Administrative**						
d. Aides and Attendants	1,630,554	95,269				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	149,003	7,212				
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	158,026	5,539				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	67,727	3,411				
A-13. Total Salary Expenditures	5,369,707	219,974				

* 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 $	CCNH Hours	RHNS $	RHNS Hours	(Specify) $	(Specify) Hours
Ward Clerks	0	$ -	-			0	0
Coordinator-Staffing Centers	0	$ 1,365	64			0	0
Central Supply	0	$ -	-			0	0
Medical Records	0	$ 66,362	3,347			0	0
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
Total		$ 67,727.28	$ 3,411.01	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

Service		CCNH $	CCNH Hours	RHNS $	RHNS Hours	(Specify) $	(Specify) Hours
1020620010	Consulting Fees	148.85	n/a			-	
1020620010	Consulting Fees	409.70	n/a				
1020620010	Consulting Fees	(7.21)	n/a				
3010620020	Purchased Services	54,773.17	n/a				
3010620020	Purchased Services	(54,333.00)	n/a				
3155620020	Purchased Services	8.71	n/a				
3155620020	Purchased Services	1,749.16	n/a			-	
Total		$ 2,749.38	$ -	$ -	0	$ -	0

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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
St. Camillus Rehabilitation and Nursing Center	2322-C	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.

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	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* **										
Anna Durkovic	138,239				Management of Center	2,086	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.

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B. Report of Expenditures - Professional Fees

Name of Facility St. Camillus Rehabilitation and Nursing Center	License No. 2322-C		Report for Year Ended 9/30/2015		Page 13	of 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	1,088	29				
2. Dentist	13,605	93				
3. Pharmacist	10,518	215				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	621,344	8,512				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	40,140	212				
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	43,065	552				
b. Other						
10. Occupational Therapist						
a. Resident Care	72,941	999				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	65,030	1,536				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	2,749					
B-13 Total Fees Paid in Lieu of Salaries	870,481	12,148				

* 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.

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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
St. Camillus Rehabilitation and Nursing Center	2322-C	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	⊙	○	Common Ownership
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	⊙	○	Common Ownership
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	⊙	○	Common Ownership
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	⊙	○	Common Ownership
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	⊙	○	Common Ownership
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
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		○	○	
		○	○	
		○	○	
		○	○	

* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2015	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	329,031	329,031		
2. Disability Insurance	$				
3. Unemployment Insurance	$	104,216	104,216		
4. Social Security (F.I.C.A.)	$	397,670	397,670		
5. Health Insurance	$	125,218	125,218		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$				
8. Uniform Allowance	$				
9. Other (*Specify*) See Attached Schedule	$	705,780	705,780		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	172,760	172,760		
d. Accounting and Auditing	$				
e. Legal (*Services should be fully described on Page 7*)	$	6,600	6,600		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	24,781	24,781		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	26,075	26,075		
2. Cellular Phones	$	2,446	2,446		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22*)					
1. Income*	$				
2. Other (*Specify*) See Attached Schedule	$	3,793	3,793		
3. Resident Day User Fee	$	715,227	715,227		
Subtotal	$	2,613,597	2,613,597		

* 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

St. Camillus Rehabilitation and Nursing Center
9/30/2015

Schedule of Other Employee Benefits

Description		CCNH	RHNS	(Specify)
1020520020	Union Health & Welfar	$ 15,684	$ -	
3005520020	Union Health & Welfar	$ 11,638	$ -	
3030520020	Union Health & Welfar	$ 87,524	$ -	
3215520020	Union Health & Welfar	$ 210,432	$ -	
3225520020	Union Health & Welfar	$ 372,372	$ -	
5035520020	Union Health & Welfar	$ 8,131	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
Total		$ 705,780	$ -	$ -

Schedule of Other Taxes

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax	$ 3,793	$ -	0
1020640110	Sales Tax	$ -	$ -	0
0	0	$ -	$ -	0
0	0	$ -		
Total		$ 3,793	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2015	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,613,597	2,613,597		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	250	250		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	2,608	2,608		
5. Education Expenses Related to Seminars and Conventions	$				
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	69	69		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	8,305	8,305		
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	$	4,248	4,248		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	9,595	9,595		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	2,380	2,380		
10. Contributions*** See Attached Schedule	$	1,715	1,715		
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	2,598	2,598		
12. Administrative Management Services**	$	568,927	568,927		
13. Other (*Specify*) See Attached Schedule	$	54,628	54,628		
C-14 Total Administrative & General Expenditures	$	3,268,920	3,268,920		

* 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
Total Other Travel and Entertainment		$ -	$ -	$ -

Schedule of Other Advertising

Description		CCNH	RHNS	(Specify)
1020630020	Advertising	$ 591.70	0	0
1020630020	Advertising	$ 384.88	0	0
1020630020	Advertising	$ 1,015.57	0	0
1020630330	Marketing Expense	$ 1,002.52	0	0
1020630330	Marketing Expense	$ 25.57	0	0
1020630331	Marketing Exp- Corporate Spend	$ 754.01	0	0
1020630331	Marketing Exp- Corporate Spend	$ 4,530.31	0	0
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
Total Other Advertising		$ 8,305	$ -	$ -

Schedule of Dues

Description		CCNH	RHNS	(Specify)
1020630310	Licenses and Certification fee	9595	0	0
0	0	0	0	0
0	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
1020630310	0	0	0	0
1020630310	0	0	0	0
			0	0
Total Dues		$ 9,595	$ -	$ -

Schedule of Contributions

Description		**CCNH**	**RHNS**	**(Specify)**
1020630135	Political Contributions	1715	0	0
0	0	0	0	0
0	0	0	0	0
Total Contributions		$ 1,715	$ -	$ -

Schedule of Other Administrative and General

Description		**CCNH**	**RHNS**	**(Specify)**
1020630060	Bank Service Charges	$ 8,179.65	0	0
1020630120	Collection Fees	$ 18,693.04	self-disallowed	0
1020630120	Collection Fees	$ 22.97	self-disallowed	0
1020630120	Collection Fees	$ 66.38	self-disallowed	0
1020630120	Collection Fees	$ 440.00	self-disallowed	0
1020630140	Education Expense	$ 31.67	0	0
1020630140	Education Expense	$ 38.89	0	0
1020630180	Employee Physicals	$ 14,402.50	0	0
1020630200	Employee Relations	$ 2,202.25	0	0
1020630200	Employee Relations	$ 212.09	0	0
1020630380	Printing	$ 1,063.42	0	0
1020630380	Printing	$ 154.48	0	0
1020630610	Training Expense	$ 648.70	0	0
1020630610	Training Expense	$ 84.03	0	0
1020630610	Training Expense	$ 652.20	0	0
1020640090	Miscellaneous	$ 200.55	0	0
1020640090	Miscellaneous	$ 4.87	0	0
1020660080	Rental Expense	$ 3,790.66	0	0
1020660990	Accrued Expense Estimation	$ 188.77	self-disallowed	0
5095720020	Cap Stk/Franchise Tax	$ 1,150.92	0	0
5095720090	Landlord Operating Taxes	$ 2,400.00	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
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 Administrative and General		$ 54,628	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility St. Camillus Rehabilitation and Nursing C	License No. 2322-C	Report for Year Ended 9/30/2015	Page 17 of 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	477,984	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	46,281	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.**

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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
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2015	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	195,330	195,330		
2. Non-Food Supplies	$	22,787	22,787		
3. Other (*Specify*)_____	$	(1,081)	(1,081)		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	2	2		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	217,038	217,038		

		Total	CCNH	RHNS	(Specify)
2F.	Dietary Questionnaire				
G.	Resident Meals: Total no. of meals served per day:*				

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ 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.

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CSP-19 Rev. 9/2002

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

Name of Facility St. Camillus Rehabilitation and Nursing Center	License No. 2322-C	Report for Year Ended 9/30/2015		Page 19 | of 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.*** — Lbs.				
Amt. $	3,800	3,800		
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. $	6,635	6,635		
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)* — $	293,134	293,134		
c. Management Services** — $				
d. Other (*Specify*) — $				
3E. ***Total Laundry Expenditures*** (3a + b + c + d) — $	303,569	303,569		

3F.	Laundry Questionnaire			
G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
H.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ 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.

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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
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2015	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	19,701	19,701		
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel					
(*Complete Schedule C-2 att. Page 21*)	Amt.	$	440,368	440,368		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	460,069	460,069		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	151,308	151,308		
b. Medicine Cabinet Drugs		$	12,070	12,070		
c. Medical and Therapeutic Supplies		$	120,780	120,780		
d. Ambulance/Limousine***		$	8,843	8,843		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	17,956	17,956		
f. X-rays and Related Radiological Procedures***		$	15,442	15,442		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	20,407	20,407		
i. Recreation		$	13,980	13,980		
j. Other (Specify)**** See Attached Schedule		$	82,198	82,198		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	442,983	442,983		

* 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	$ 60,881	0	0
3060610161	Incontinency - Rebates	$ (3,882)	0	0
3080630030	Advertising-Help Wan	$ 1,385	0	0
3080630030	Advertising-Help Wan	$ 907	0	0
3080630080	Books, Dues & Subscr	$ 120	0	0
3080630140	Education Expense	$ 2,391	0	0
3080630140	Education Expense	$ 151	0	0
3080630140	Education Expense	$ 590	0	0
3120630530	Supplies	$ 1,848	0	0
3155630530	Supplies	$ 3,499	0	0
3155630530	Supplies	$ 4,226	0	0
3090630535	Office Supplies	$ 83	0	0
3120630535	Office Supplies	$ (0)	0	0
3080630550	T&E-Lodging/Transpo	$ 86	0	0
3120660080	Rental Expense	$ 440	0	0
3155660080	Rental Expense	$ (47)	0	0
3155660080	Rental Expense	$ 7,817	0	0
3010610300	Consolidated Billing	$ 1,702	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
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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		$ 82,198	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2015	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	⊙	○	Vendor Contracted	Laundry Purchased Services	293,134			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	⊙	○	Vendor Contracted	Housekeeping Purchased Services	440,368			20	4b
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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).

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CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2015	22	37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	226,385	226,385		
b. Heat	$	76,342	76,342		
c. Light & Power	$	159,324	159,324		
d. Water	$	55,772	55,772		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	517,823	517,823		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	421	421		
b. Building & Building Improvements	$	14,121	14,121		
c. Non-Movable Equipment	$	19,031	19,031		
d. Movable Equipment	$	17,233	17,233		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	50,806	50,806		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$	87,878	87,878		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	139,273	139,273		
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	277,957	277,957		

* 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)
Total Other Repairs and Maintenance	$ -	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	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
A. **Land Improvements**								
1. Acquired prior to this report period	4,215		4,215	403	S/L	Various	421	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								421
B. **Building and Building Improvements**								
1. Acquired prior to this report period	154,426		154,426	17,101	S/L	Various	11,342	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	131,861		131,861				2,780	
B-4. Subtotal								14,121
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	138,370		138,370	28,186	S/L	Various	15,375	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	74,344		74,344				3,656	
C-4. Subtotal								19,031

	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.									S/L	Various		
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					122,843		122,843	35,908	S/L	Various	16,628	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					9,885		9,885				605	
D-3. Subtotal												17,233
E. *Total Depreciation*												50,806

St. Camillus Rehabilitation and Nursing Center
9/30/2015

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Land Improvements		0		0	*
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:					
1/31/2015	Emergency E Stop button on generato	1,305.08	20.00	43.50	
3/31/2015	75 ft sewage drain line	10,100.00	20.00	252.50	
4/30/2015	Replacement DVR on Security Syster	2,057.86	20.00	42.87	
5/31/2015	Zone valve for hot water line	1,875.00	20.00	31.25	
6/30/2015	Property Management Time Allocatio	603.41	20.00	7.54	
6/30/2015	Supply/install zone expander and smo	8,506.94	20.00	106.34	
12/31/2014	Upgrade to elevator system	28,865.52	15.00	1,443.28	
5/31/2015	Deposit on elevator upgrade	28,865.52	15.00	641.46	
6/30/2015	Passenger elevator upgrade	1,799.44	15.00	29.99	
6/30/2015	Service elevator upgrade	2,858.16	15.00	47.64	
7/31/2015	Zone valve for hot water line	1,875.00	20.00	15.63	
7/31/2015	2 Gould sewage pumps	11,289.27	20.00	94.08	
7/31/2015	Solid State Starter	2,858.16	20.00	23.82	
9/30/2015	Egress mag locks	27,126.69	20.00	-	
9/30/2015	Balance on zone valve replacement	1,875.00	20.00	-	
Total additions for Building Improvements		$ 131,861		$ 2,780	*
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:					
12/31/2014	Hot water storage tank	30,495.00	10.00	2,287.13	
4/30/2015	Hot water storage tank	31,275.00	10.00	1,303.13	
7/31/2015	Compressor in kitchen A/C unit	3,951.59	10.00	65.86	
9/30/2015	1st install on McQuay chiller	8,622.00	10.00	-	
Total additions for Non-Movable Equipment		$ 74,344		$ 3,656	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line C3**

****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
1/31/2015	5 TV's for facility patient rooms	1,116.62	7.00	106.34
1/31/2015	Sales and Use Tax Jan 2015	5.00	7.00	0.48
12/31/2014	(3) 1.6 cu ft medical grade refrigerato	1,572.43	10.00	117.93
1/31/2015	Enclosed Wood Frame Cork Board	331.23	10.00	22.08
3/31/2015	SS Manual Heavy Duty Can Opener	467.92	10.00	23.40
4/30/2015	5 Wheelchairs w/footrests 3 overbed t	890.09	10.00	37.09
4/30/2015	2 PANACEA HEAVY DUTY WIDE	543.98	10.00	22.67
4/30/2015	TREX2 18 X 16 FULL ARMS BLAC	264.66	10.00	11.03
4/30/2015	18 in Viper wheelchair w/arm attachi	680.33	10.00	28.35
5/31/2015	CONVEYOR TOASTER 800 SLICE	1,001.50	10.00	33.38
6/30/2015	9000XT SUPER HEMI 16X16	531.95	10.00	13.30
4/30/2015	Tilt Truck, 5/8 Cubic Yard, 30	533.87	5.00	44.49
1/31/2015	Replacement Pump for Panacea A	382.62	3.00	85.03
11/30/2014	Mobil Iron licenses deployed 11/2014	15.90	3.00	4.42

1/31/2015	1 HP LaserJet PRO 400	223.68	3.00	49.71	
8/31/2015	Direct Choice Overbed Table	441.43	10.00	3.68	
8/31/2015	Epoch Office Chair, Mid-Back	201.66	10.00	1.68	
9/30/2015	18 in Viper wheelchair	680.33	10.00	-	
Total additions for Movable Equipment		$ 9,885		$ 605	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report period

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

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2015	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	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
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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursin	2322-C	9/30/2015	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ 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	124
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
SABRA, 101 Sun Ave. NE, Albuquerque, NM 87109	Facility Lease	11/15/10 - 6/30	127 months	87,878

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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursin	2322-C	9/30/2015	26	37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	46,281	46,281		
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)	$	46,281	46,281		

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page of
St. Camillus Rehabilitation and Nur	2322-C	9/30/2015	27 | 37

Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				46,281	46,281		
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)			$	46,281	46,281		
14. Insurance							
a. Insurance on Property (buildings only)			$	9,861	9,861		
b. Insurance on Automobiles			$				
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*)			$	149,114	149,114		
2. Fire and Extended Coverage			$				
3. Other (*Specify*)			$				
14d. ***Total Insurance Expenditures (14a + b + c)***			$	158,975	158,975		
15. ***Total All Expenditures (A-13 thru C-14)***			$	11,933,801	11,933,801		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
St. Camillus Rehabilitation and Nursing Center	2322-C	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 $	46,216	46,216		
Page 13 - Professional Fees							
5.	13	B-8-c	Resident Care Physicians ** $				
6.		B-10	Occupational Therapy $				
7.			Other - See attached Schedule $	739,548	739,548		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1-c	Bad Debts $	172,760	172,760		
10.			Accounting & Legal $				
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.	16	m-2 &	Unallowable Advertising * $	8,305	8,305		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $	1,715	1,715		
21.			Unallowable Management Fees $	615,208	615,208		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	19,411	19,411		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	1,603,163	1,603,163		

* 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	$ 46,216	0	0
0	0	0	0	0	0	0
0	0	0	0	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				$ 46,216	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	$ 125,507	$ -	$ -
13	5	Rehabilitation Services	3195620020	$ 495,837	$ -	$ -
13	9	Speech Therapist	3170620020	$ 43,065	$ -	$ -
13	10	Occupational Therapist	3105620020	$ 72,941	$ -	$ -
13	12	Other	3010620020	$ 440	$ -	$ -
13	12	Other	3015620020	$ -	$ -	$ -
13	12	Respiratory Purchased Servies	3155620020	$ 1,758	$ -	$ -
Total Other Fees Adjustments				$ 739,548	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
0	0	0	0	$ -	0	0
16	m-13	Collection Fees	1020630120	$ 19,222	0	0
16	m-13	Estimated Accrual	1020660990	$ 189	0	0
16	m-13	Non-recurring Charges	7010800030	$ -	0	0
16	m-13	Dues to Chamber of Commerce	0	$ -	0	0
16	m-13	Penalty and Fines	1020640080	$ -	0	0
16	m-12	Management Fee disallowed	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				$ 19,411	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2015	29	37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	1,603,163	1,603,163		
Page 20 - Resident Care Supplies***								
27.	20	5-a-2	Prescription Drugs	$	151,308	151,308		
28.	20	5-d	Ambulance/Limousine	$	8,843	8,843		
29.	20	5-f	X-rays, etc	$	15,442	15,442		
30.	20	5-h	Laboratory	$	20,407	20,407		
31.			Medical Supplies	$				
32.	20	5-e-2	Oxygen (non emergency)	$	17,956	17,956		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	19,234	19,234		
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	$	63,665	63,665		
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)***			$	1,900,018	1,900,018		

*** 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.

Attachment Page 29

St. Camillus Rehabilitation and Nursing Center
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Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	$ 1,702	3010610300	$ -
20	5-j	RHS Intercompany Supplies	$ 7,725	3155630530	$ -
20	5-j	RHS Intercompany Rental	$ 7,770	3155660080	$ -
20	5-i	Cable TV	$ 2,037	3005660130	allow $3600
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
Total Other Ancillary Costs			$ 19,234	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14 c1	General liability Insurance Adjust	63665.3497	-	-
0	0	0	-	-	-
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 Adjustments			$ 63,665	$ -	$ -

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing	2322-C	9/30/2015	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	14,548,361	14,548,361		
b. Medicaid Room and Board Contractual Allowance **	$	(6,573,814)	(6,573,814)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,022,376	2,022,376		
b. Medicare Room and Board Contractual Allowance **	$	(506,675)	(506,675)		
4. a. Private-Pay Residents and Other	$	1,939,942	1,939,942		
b. Private-Pay Room and Board Contractual Allowance **	$	(461,923)	(461,923)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	99,305	99,305		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(24,879)	(24,879)		
c. Prescription Drugs - Non-Medicare	$	78,718	78,718		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(21,236)	(21,236)		
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$	117	117		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(53)	(53)		
3. a. Physical Therapy - Medicare	$	781,446	781,446		
b. Physical Therapy - Medicare Contractual Allowance **	$	(195,779)	(195,779)		
c. Physical Therapy - Non-Medicare	$	259,412	259,412		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(69,200)	(69,200)		
4. a. Speech Therapy - Medicare	$	136,099	136,099		
b. Speech Therapy - Medicare Contractual Allowance **	$	(34,097)	(34,097)		
c. Speech Therapy - Non-Medicare	$	81,381	81,381		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(20,221)	(20,221)		
5. a. Occupational Therapy - Medicare	$	617,685	617,685		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(154,751)	(154,751)		
c. Occupational Therapy - Non-Medicare	$	203,324	203,324		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(52,964)	(52,964)		
6. a. Other *(Specify)* - Medicare	$	33,026	33,026		
b. Other *(Specify)* - Non-Medicare	$	85,839	85,839		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	12,771,439	12,771,439		
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	$	7,016	7,016		
5. Interest Income *(Specify)*	$	17	17		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	1,937	1,937		
V. Total Other Revenue (1 thru 8)	$	8,970	8,970		
VI. Total All Revenue (III +V)	$	12,780,409	12,780,409		

* *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	X-Ray	13,459.73	-	0
II-6-a	Medicare	Radiology Service	-	-	0
II-6-a	Medicare	Outpatient Therapy Program	-	-	0
II-6-a	Medicare	Laboratory	22,526.55	-	0
II-6-a	Medicare	Respiratory Therapy & Supplie	2,779.80	-	0
II-6-a	Medicare	Nursing Treatment Supplies	-	-	0
II-6-a	Medicare	Audiology	-	-	0
II-6-a	Medicare	Incontinency	-	-	0
II-6-a	Medicare	Oxygen & Supplies	-	-	0
II-6-a	Medicare	Physician Visit	-	-	0
II-6-a	Medicare	Ambulance	-	-	0
II-6-a	Medicare	Flu Shot	5,300.00	-	0
II-6-a	Medicare	Capitation Contracts	-	-	0
II-6-a	Medicare Contractual	X-Ray	(3,372.12)	-	0
II-6-a	Medicare Contractual	Radiology Service	-	-	0
II-6-a	Medicare Contractual	Outpatient Therapy Program	-	-	0
II-6-a	Medicare Contractual	Laboratory	(5,643.68)	-	0
II-6-a	Medicare Contractual	Respiratory Therapy & Supplie	(696.44)	-	0
II-6-a	Medicare Contractual	Nursing Treatment Supplies	-	-	0
II-6-a	Medicare Contractual	Audiology	-	-	0
II-6-a	Medicare Contractual	Incontinency	-	-	0
II-6-a	Medicare Contractual	Oxygen & Supplies	-	-	0
II-6-a	Medicare Contractual	Physician Visit	-	-	0
II-6-a	Medicare Contractual	Ambulance	-	-	0
II-6-a	Medicare Contractual	Flu Shot	(1,327.83)	-	0
II-6-a	Medicare Contractual	Capitation Contracts	-	-	0
Total Other Resident Revenue - Medicare			$ 33,026	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	II-6-b	Medicaid	169.28	-	-
II-6-b	II-6-b	Medicaid	-	-	-
II-6-b	II-6-b	Medicaid	-	-	-
II-6-b	II-6-b	Medicaid	474.25	-	-
II-6-b	II-6-b	Medicaid	1,245.39	-	-
II-6-b	II-6-b	Medicaid	-	-	-
II-6-b	II-6-b	Medicaid	-	-	-
II-6-b	II-6-b	Medicaid	-	-	-
II-6-b	II-6-b	Medicaid	-	-	-
II-6-b	II-6-b	Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Medicaid	(76.49)	-	-
II-6-b	II-6-b	Contractuals-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Medicaid	(214.29)	-	-
II-6-b	II-6-b	Contractuals-Medicaid	(562.74)	-	-
II-6-b	II-6-b	Contractuals-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Medicaid	-	-	-

II-6-b	II-6-b	Non-Medicaid	4,508.01	-	-
II-6-b	II-6-b	Non-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	134.64	-	-
II-6-b	II-6-b	Non-Medicaid	918.19	-	-
II-6-b	II-6-b	Non-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	105,746.00	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	(1,073.41)	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	(32.06)	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	(218.63)	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	(25,179.34)	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
0	0	0	-	-	-
II-6-b	0	0	-	-	-
Total Other Resident Revenue			$ 85,839	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
IV-5	Interest On Overdue Accoun	0	17	-	-
0	0	0	-	-	-
0	0	0	-	-	-
Total Interest Income			$ 17	$ -	$ -

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
IV-8	Medical Record	0	378.30	-	-
IV-8	DONATION	0	1,498.65	-	-
IV-8	Craftwood Lumber v Interlir	0	60.54	-	-
IV-8	0	0	-	-	-
IV-8	0	0	-	-	-
IV-8	0	0	-	-	-
Total Other Revenue			$ 1,937	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing	2322-C	9/30/2015	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 5,213
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,161,482
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 13,889
4 Inventories				$ 55,267
5. Prepaid Expenses				$ 25,616
a. Prepaid Expenses		(8,033)		
b. Prepaid Property Tax		30,707		
c. Prepaid Personal Property Tax				
d. Prepaid Personal Property Tax		2,942		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,261,467
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	4,215		$ 3,391
	Accum. Depreciation	824	Net	
3. Buildings	*Historical Cost	286,287		$ 255,064
	Accum. Depreciation	31,223	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	212,714		$ 165,497
	Accum. Depreciation	47,217	Net	
6. Movable Equipment	*Historical Cost	132,728		$ 79,587
	Accum. Depreciation	53,141	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 503,539

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing	2322-C	9/30/2015	32	37

	Account			Amount
			Total Brought Forward:	$ 1,765,006
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 (*itemize*)			$
	6. Loans to Owners or Related Parties (*itemize*)			$
	Name and Address	Amount	Loan Date	
	7. Other Assets (*itemize*)			$ 1,156,022
	I/C Due to/Due From Owned		1,156,022	
	I/C Due to/Due From Multicare			
D-8.	***Total Investments and Other Assets*** (Lines D1 thru 7)			$ 1,156,022
D-9.	***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$ 2,921,028

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Cente	2322-C	9/30/2015	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 438,439
2. Notes Payable (*itemize*)					$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll(*Exclusive of Owners and/or Stockholders only*)					$ 241,220
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ (9)
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 488,005
Accrued Provider/Bed Tax	166,794	Accr Exp Electricity	13,391		
A/R Credit Gross Up Liability	89,871	Deferred Revenue	1,401		
Accr Exp Water and Sewer	4,050	Accr Exp Other	196,196		
Accr Exp Gas	4,662	Accr Sales and Use Tax -	11,640		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 1,167,655

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Cer	2322-C	9/30/2015	34	37

Account	Amount
Total Brought Forward:	1,167,655
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$ 17,070
LT Debt-Financing Obligation 17,070	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 17,070
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 1,184,725

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing	2322-C	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		$
4. Treasury Stock		$
5. Cumulated Earnings		$ 889,695
6. Gain or Loss for Period	10/1/2014 thru 9/30/2015	$ 846,608
7. Total Net Worth		$ 1,736,303
C. ***Total Reserves and Net Worth***		$ 1,736,303
D. ***Total Liabilities, Reserves, and Net Worth***		$ 2,921,028

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing C	2322-C	9/30/2015	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			$ 889,694
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 12,780,409
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 11,933,800
D.	Net Income or Deficit			$ 846,609
E.	Balance			$ 1,736,303
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings (*Specify*)			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period***	09/30/15		$ 1,736,303

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing	2322-C	9/30/2015	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

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.

Signature of Preparer	Title	Date Signed
Thomas Farnan	Sr. Director of Reimbursement	12/28/2015

Printed Name of Preparer

Thomas Farnan Title -Sr. Director of Reimbursement

Addres Address	Phone Number
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