

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2016

Name of Facility (as licensed) 1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall North	
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 10/1/2015	Report for Year Ending 9/30/2016

License Numbers:	CCNH 2376	RHNS	(Specify)	Medicare Provider 07-5279
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Medicaid Provider Numbers:	CCNH 000010769	RHNS	ICF-IID
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**For Department Use Only**

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

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### General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC,d/b/a Kimber	2376	9/30/2016	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 North Operations LLC,d/b/a Kimberly Hall North [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, 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) Thomas Russo			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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility 1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall North		Period Covered:	From 10/1/2015	To 9/30/2016
Address of Facility One Emerson Drive, Windsor, CT 06095				
Report Prepared By Thomas Farnan		Phone Number 978-247-5029	Date 12/20/2014	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$ 514,103	514,103		
2. Laundry wages paid	\$ 24,373	24,373		
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$ 4,497,911	4,497,911		
5. All other wages paid	\$ 663,463	663,463		
6. <b>Total Wages Paid</b>	\$ 5,699,849	5,699,849		
7. Total salaries paid	\$ 209,379	209,379		
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$ 5,909,228	5,909,228		

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 9/30/2016	Page 2	of 37
Name of Facility (as shown on license) 1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall		Address (No. & Street, City, State, Zip ) One Emerson Drive, Windsor, CT 06095		
License Numbers:	CCNH 2376	RHNS (Specify)	Medicare Provider No. 07-5279	
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
<input type="radio"/> Yes <input checked="" type="radio"/> No         If "Yes," explain fully.				
<b>Administrator</b>				
Name of Administrator Thomas Russo		Nursing Home Administrator's License No.:	001789	
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 North Operations LLC,d/b/a	License No. 2376	Report for Year Ended 9/30/2016	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 North Operations LLC,d/b/a Kimberly Hall North	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 1 Emerson Drive North Operations LLC,d/b/a Kimberl	License No. 2376	Report for Year Ended 9/30/2016	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?     Yes     No    If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?     Yes     No    If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Genesis Health Ventures	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Home Office	Pg 16/m12	567,558	567,558
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	62%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	557,333	557,333
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	56%	Staffing Pool	Pg 10/A12	5,970	5,970
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	83%	Case Management	Pg 13/B8, Pg 10/A12	54,462	54,462
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	80%	Staffing Pool	Pg 13/B11 a,b,c		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>	51%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	5,179	5,179
Liberty Health (Insurance)	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	231,676	231,676
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Capital Interest	Page 17, page 26-12A	51,094	51,094
		<input type="radio"/>	<input type="radio"/>					

\* Use additional sheets if necessary.

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

**General Information and Questionnaire**  
**Basis for Allocation of Costs**

Name of Facility 1 Emerson Drive North Operations LLC,d/b/a K	License No. 2376	Report for Year Ended 9/30/2016	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

**General Information and Questionnaire  
Leases (Excluding Real Property)**

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

Name of Facility 1 Emerson Drive North Operations LLC,d/b/a Kimberly Ha			License No. 2376	Report for Year Ended 9/30/2016			Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input type="radio"/> No	<b>Total ***</b>

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

\*\* Attach copies of newly acquired leases.

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

**General Information and Questionnaire**  
**Accounting Basis**

Name of Facility 1 Emerson Drive North Operations	License No. 2376	Report for Year Ended 9/30/2016	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

Name of Accounting Firm 1 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	\$
2	\$
3	\$
4	\$
	Charge for Services Provided
	\$

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

- Yes     No

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 Bloom & Witkin 2 State of CT - Greater Windsor Probate District 3 Goldman Gruder & Woods LLC 4 5	Telephone Number 617 456-0500  203-899-8900
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Address (*No. & Street, City, State, Zip Code*)

1 470 Atlantic Ave - 3rd Fl Boston, MA 02210
2 1540 Sullivan Ave South Windsor, CT 06074-2788
3 200 Connecticut Norwalk, CT 06854
4
5

Services Provided by This Firm (*describe fully*)

1 Saving the Real Estate Tax - R.E Tax Abatement	\$	2,694
2 Probate Court and Marshall Fees for Conservatorship	\$	1,300
3 James Woods case-case closed- the center avoid a potential penalty from State Medicaid Dept.	\$	10,740
4	\$	
5	\$	
	Charge for Services Provided	
	\$	14,734

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 1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall North			License No. 2376		Report for Year Ended 9/30/2016				Page 8	of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	150	150			150	150			150	150		
B. On last day of THIS report period	150	150			150	150			150	150		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	133	133			133	133			137	137		
B. As of midnight of THIS report period	135	135			137	137			135	135		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,568	2,568			2,040	2,040			528	528		
B. Medicaid (Conn.)	37,737	37,737			28,125	28,125			9,612	9,612		
C. Medicaid (other states)												
D. Private Pay	8,639	8,639			6,625	6,625			2,014	2,014		
E. State SSI for RCH												
F. Other (Specify)	994	994			834	834			160	160		
G. Total Care Days During Period (3A thru F)	49,938	49,938			37,624	37,624			12,314	12,314		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	1	1							1	1		
B. Other Bed Reserve Days	9	9			7	7			2	2		
5. <b>Total Resident Days (3G + 4A + 4B)</b>	49,948	49,948			37,631	37,631			12,317	12,317		

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

Name of Facility 1 Emerson Drive North Operations LLC,d/b/a			License No. 2376			Report for Year Ended 9/30/2016			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <span style="float: right;"><input type="radio"/> Yes <input checked="" type="radio"/> No</span>													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH	RHNS	(Specify)	
				(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	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID					
No. of Residents	7	100		28									
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	486.70	209.91		344.31									
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									4,316	4,316			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									381	381			
C. Other									7,880	7,880			
D. <b>Total Physical Therapy Treatments</b>									12,577	12,577			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									428	428			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									34	34			
C. Other									1,646	1,646			
D. <b>Total Speech Therapy Treatments</b>									2,108	2,108			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									3,719	3,719			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									382	382			
C. Other									9,015	9,015			
D. <b>Total Occupational Therapy Treatments</b>									13,116	13,116			

### Report of Expenditures - Salaries & Wages

Name of Facility 1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall N	License No. 2376	Report for Year Ended 9/30/2016	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	111,559	2,091				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	200,395	10,141				
5. Dietary Service						
a. Head Dietitian	29,669	871				
b. Food Service Supervisor	59,230	2,143				
c. Dietary Workers	425,205	28,383				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	44,066	1,705				
b. Other Maintenance Workers	46,168	2,213				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	24,373	1,424				
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	97,819	2,082				
b. RN						
1. Direct Care	1,192,543	30,092				
2. Administrative**	140,120	3,786				
c. LPN						
1. Direct Care	834,174	25,831				
2. Administrative**						
d. Aides and Attendants	2,250,705	127,512				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	172,909	10,751				
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	199,924	7,243				
n. Marketing						
o. Other (Specify) See Attached Schedule	80,369	4,475				
<i>A-13. Total Salary Expenditures</i>	5,909,228	260,744				

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

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

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





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

Name of Facility				License No.	Report for Year Ended				Page	of
1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall North				2376	9/30/2016				11	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section I - Operators/Owners</b>										
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
I Emerson Drive North Operations LLC,d/b/a Kimberly Hall North				2376	9/30/2016			12	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
<b>Section III - Administrators***</b>										
Thomas Russo	111,559				Management of Center	2,091	2			
<b>Section IV - Assistant Administrators</b>										

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

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

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

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

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended	Page	of		
1 Emerson Drive North Operations LLC,d/b/a Kimb	2376	9/30/2016	13	37		
<b>Total Cost and Hours</b>						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian	2,103	57				
2. Dentist	12,625	86				
3. Pharmacist	9,716	198				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	439,398	6,019				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	43,170	228				
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	52,113	668				
b. Other						
10. Occupational Therapist						
a. Resident Care	138,067	1,891				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	(19,319)	(456)				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	1,112					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>678,985</b>	<b>8,692</b>				

\* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

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

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



**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC,d/b/a Ki	2376	9/30/2016	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 243,572	243,572		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 78,847	78,847		
4. Social Security (F.I.C.A.)	\$ 432,180	432,180		
5. Health Insurance	\$ 607,478	607,478		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 290,644	290,644		
8. Uniform Allowance	\$			
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 36,972	36,972		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 49,227	49,227		
d. Accounting and Auditing	\$			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 14,734	14,734		
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 22,933	22,933		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 45,868	45,868		
2. Cellular Phones	\$ 26	26		
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	\$ (37)	(37)		
3. Resident Day User Fee	\$ 975,077	975,077		
<b>Subtotal</b>	\$ 2,797,521	2,797,521		

\* 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 North Operations LLC,d/b/a Kimberly Hall North  
9/30/2016

Attachment Page 15

**Schedule of Other Employee Benefits**

Description		CCNH	RHNS	(Specify)
3005520020	Union Health & Welfare	1,297.56	0	
3030520020	Union Health & Welfare	3,811.23	0	
3060520020	Union Health & Welfare	245.90	0	
3080520020	Union Health & Welfare	443.41	0	
3225520020	Union Health & Welfare	21,473.99	0	
5035520020	Union Health & Welfare	457.00	0	
3225520050	Employee Benefits-Other	9,243.07	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
0	0	-	0	
<b>Total</b>		<b>\$ 36,972</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Taxes**

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax	274.00	-	-
1020640110	Sales Tax	(311.00)	0	0
0	0	0	0	0
0	0	-		
<b>Total</b>		<b>\$ (37)</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility	License No.	Report for Year Ended		Page	of
1 Emerson Drive North Operations LLC,d/b/a Kimbe	2376	9/30/2016		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b><i>Subtotals Brought Forward:</i></b>	2,797,521	2,797,521			
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 146	146			
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 1,819	1,819			
5. Education Expenses Related to Seminars and Conventions	\$ 195	195			
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	\$ 8,488	8,488			
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	\$ 4,505	4,505			
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$ 9,064	9,064			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 190	190			
10. Contributions*** See Attached Schedule	\$ 1,741	1,741			
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$ 2,661	2,661			
12. Administrative Management Services**	\$ 542,994	542,994			
13. Other ( <i>Specify</i> ) See Attached Schedule	\$ 44,712	44,712			
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	\$ 3,414,034	3,414,034			

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

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

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







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

Name of Facility 1 Emerson Drive North Operations LLC, d	License No. 2376	Report for Year Ended 9/30/2016	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	567,558	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	51,094	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 North Operations LLC,d/b/a Kimberl	2376	9/30/2016	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 227,438	227,438		
2. Non-Food Supplies	\$ 33,126	33,126		
3. Other (Specify) _____	\$ (5,150)	(5,150)		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 2,618	2,618		
c. Management Services**	\$			
d. Other (Specify) _____	\$ 40	40		
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 258,072</b>	<b>258,072</b>		
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 North Operations LLC,d/b/a Kimberly	2376	9/30/2016	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. \$ 6,212	6,212		
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. \$ 8,759	8,759		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 234,924	234,924		
c. Management Services**	\$			
d. Other (Specify)	\$			
<b>3E. Total Laundry Expenditures (3a + b + c + d)</b>	<b>\$ 249,896</b>	<b>249,896</b>		
<b>3F. Laundry Questionnaire</b>				
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 North Operations LLC,d/b/a	2376	9/30/2016	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. \$	19,308	19,308		
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. \$	349,221	349,221		
c. Management Services*	\$				
d. Other ( <i>Specify</i> )	\$				
<b>4E. Total Housekeeping Expenditures (4a + b + c + d)</b>	\$	368,529	368,529		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	71,135	71,135		
b. Medicine Cabinet Drugs	\$	30,376	30,376		
c. Medical and Therapeutic Supplies	\$	88,862	88,862		
d. Ambulance/Limousine****	\$	4,030	4,030		
e. Oxygen					
1. For Emergency Use	\$				
2. Other****	\$	3,837	3,837		
f. X-rays and Related Radiological Procedures****	\$	5,378	5,378		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory****	\$	10,994	10,994		
i. Recreation	\$	40,359	40,359		
j. Other (Specify)**** See Attached Schedule	\$	75,910	75,910		
<b>5K. Total Resident Care Expenditures (5a - 5j)</b>	\$	330,881	330,881		

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

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

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

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



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

Name of Facility			License No.		Report for Year Ended			Page of		
1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall North			2376		9/30/2016			21	37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	<input checked="" type="radio"/>	<input type="radio"/>	Vendor Contracted	Laundry Purchased Services	234,924			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input checked="" type="radio"/>	<input type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	349,221			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"/>							
		<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 North Operations LLC,d/b/a	2376	9/30/2016			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 92,761	92,761				
b. Heat	\$ 25,033	25,033				
c. Light & Power	\$ 239,844	239,844				
d. Water	\$ 60,426	60,426				
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$					
f. Other ( <i>itemize</i> )	\$					
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$ 418,064	418,064				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 10	10				
b. Building & Building Improvements	\$ 1,150,652	1,150,652				
c. Non-Movable Equipment	\$ 1,982	1,982				
d. Movable Equipment	\$ 63,629	63,629				
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$ 1,216,272	1,216,272				
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other ( <i>Specify</i> )	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,625,548	1,625,548				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 103,746	103,746				
c. Personal property taxes	\$					
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$ 2,945,566	2,945,566				

\* 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 1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall North		License No. 2376			Report for Year Ended 9/30/2016			Page 23	of 37			
Property Item		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
<b>A. Land Improvements</b>												
1. Acquired prior to this report period		96		96	30	S/L	Various	10				
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal									10			
<b>B. Building and Building Improvements</b>												
1. Acquired prior to this report period		10,471,975		10,471,975	4,230,274	S/L	Various	1,150,502				
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)		8,732		8,732				150				
B-4. Subtotal									1,150,652			
<b>C. Non-Movable Equipment</b>												
1. Acquired prior to this report period		17,645		17,645	3,718	S/L	Various	1,965				
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)		2,084		2,084				17				
C-4. Subtotal									1,982			
	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
<b>D. Movable Equipment</b>												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.								S/L	Various			
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					503,309		503,309	239,106	S/L	Various	62,922	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					7,640		7,640				707	
D-3. Subtotal												63,629
<b>E. Total Depreciation</b>												1,216,273



<b>Total additions for Building Improvements:</b>		\$ 8,732		\$ 150
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ -

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

**Schedule of Non-Movable Equipment Acquired during this report period**

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
8/31/2016	2 ton condenser for A/C unit	2,084.46	10.00	17.37
<b>Total additions for Non-Movable Equipment</b>		\$ 2,084		\$ 17
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ -

\*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
<b>Additions:</b>				
11/30/2015	GE Zoneline PTAC	2,684.10	7.00	319.54
2/29/2016	Rice Lake Fold-Up Portable Wheelchair Scale	1,919.15	7.00	159.93
5/31/2016	Invacare Perfecto2 V 5-Liter Oxygen Concentrator	1,942.93	7.00	92.52
11/30/2015	4.5 QT MIXER	348.09	10.00	29.01
12/31/2015	Medical grade refrigerator	527.54	10.00	39.57
<b>Total additions for Movable Equipment</b>		\$ 7,640		\$ 707
<b>Deletions:</b>				



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

**Amortization Schedule\***

Name of Facility			License No.		Report for Year Ended			Page	of
1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall			2376		9/30/2016			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

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

Name of Facility 1 Emerson Drive North Operations LI	License No. 2376	Report for Year Ended 9/30/2016	Page 25	of 37
11. Property Questionnaire				
<b>Part A</b>				
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description		Total		
1. Date Land Purchased				
2. Date Structure Completed				
3. If <b>NOT</b> Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity		150		
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				
<b>Part B - Owner and Related Parties</b>		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 _____				
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
Well Tower / Healthcare REIT, Inc	Building and Equipment	04/01/11	20	1,625,548
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 North Operations LI		2376	9/30/2016		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$ 51,094	51,094		
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. <b>Total Building Interest Expense</b> (A1 - A4 + B5)			\$ 51,094	51,094		

(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 North Operations		2376		9/30/2016		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				51,094	51,094		
12. C. Movable Equipment							
1. Automotive Equipment				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify)				\$			
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$			
12. D. Other Interest Expense (Specify)				\$			
13. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$ 51,094	51,094		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 11,070	11,070		
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$ 220,606	220,606		
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$ 231,676	231,676		
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$ 14,856,024	14,856,024		

**D. Adjustments to Statement of Expenditures**

Name of Facility				License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall N				2376	9/30/2016	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 11,001	11,001		
<b>Page 13 - Professional Fees</b>							
5.	13	B-8-c	Resident Care Physicians **	\$			
6.		B-10	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 629,879	629,879		
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 49,227	49,227		
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 *	\$ 8,488	8,488		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 1,741	1,741		
21.			Unallowable Management Fees	\$ 594,088	594,088		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 216,212	216,212		
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 1,510,637	1,510,637		

\* 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	11001.24523	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
<b>Total Other Salaries Adjustment</b>			\$ 11,001	\$ -	\$ -

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	124174.98	0
13	5	Rehabilitation Services	3195620020	315223.09	0
13	9	Speech Therapist	3170620020	52113.09	0
13	10	Occupational Therapist	3105620020	138066.69	0
13	12	Other	3010620020	260	0
13	12	Other	3015620020	-26.6	0
13	12	Respiratory Purchased Servies	3155620020	68.09	0
				0	0
				0	0
				0	0
				0	0
				0	0
<b>Total Other Fees Adjustments</b>			\$ 629,879	\$ -	\$ -

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Collection Fees	1020630120	19912.73	0
16	m13	Estimated Accrual	1020660990	-1059.79	0
16	m8a	Chamber of Commerce License Fee	0	0	0
16	m13	Non-recurring charges	7010800030	0	0
16	m-13	Penalty and Fines	1020640080	0	0
16	1m8	0	0	0	0
15	1-a-1	adj workers comp	0	197359	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
<b>Total Other A&amp;G Adjustments</b>			\$ 216,212	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall			2376	9/30/2016	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,510,637	1,510,637		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5-a-2	Prescription Drugs	\$ 71,135	71,135		
28.	20	5-d	Ambulance/Limousine	\$ 4,030	4,030		
29.	20	5-f	X-rays, etc	\$ 5,378	5,378		
30.	20	5-h	Laboratory	\$ 10,994	10,994		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 3,837	3,837		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 26,449	26,449		
<b>Page 22 - Maintenance and Property</b>							
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	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
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	\$ (98,236)	(98,236)		
<b>Not For Profit Providers Only</b>							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51. <b>Total Amount of Decrease (Items 1 - 50)</b>				\$ 1,534,224	1,534,224		

\*\*\* 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 North Operations LLC,d/b/a Kimberly Hall North  
9/30/2016

#### Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	937	0	0
20	5-j	Respiratory Supplies	3,132	0	0
20	5-j	Respiratory Rental	1,095	0	0
20	5-i	Cable TV	21,286	0	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
<b>Total Other Ancillary Costs</b>			\$ 26,449	\$ -	\$ -

#### 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
<b>Total Excess Movable Equipment Depreciation</b>			\$ -	\$ -	\$ -

#### 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
<b>Total Other Property Adjustments</b>			\$ -	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14 c1	General liability Insurance Adjust	(98,236)	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
<b>Total Other Adjustments</b>			\$ (98,236)	\$ -	\$ -

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
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended		Page	of
1 Emerson Drive North Operations LLC,d/ 2376		9/30/2016		30	37
Item	Total	CCNH	RHNS	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 12,404,923	12,404,923			
b. Medicaid Room and Board Contractual Allowance **	\$ (4,593,731)	(4,593,731)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents( <i>all inclusive</i> )	\$ 881,010	881,010			
b. Medicare Room and Board Contractual Allowance **	\$ (207,427)	(207,427)			
4. a. Private-Pay Residents and Other	\$ 3,455,535	3,455,535			
b. Private-Pay Room and Board Contractual Allowance **	\$ (361,341)	(361,341)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 50,622	50,622			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (11,918)	(11,918)			
c. Prescription Drugs - Non-Medicare	\$ 25,287	25,287			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (3,080)	(3,080)			
2. a. Medical Supplies - Medicare	\$ 13	13			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (3)	(3)			
c. Medical Supplies - Non-Medicare	\$ 55	55			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (20)	(20)			
3. a. Physical Therapy - Medicare	\$ 413,354	413,354			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (97,321)	(97,321)			
c. Physical Therapy - Non-Medicare	\$ 216,968	216,968			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (27,515)	(27,515)			
4. a. Speech Therapy - Medicare	\$ 152,979	152,979			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (36,018)	(36,018)			
c. Speech Therapy - Non-Medicare	\$ 103,539	103,539			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (11,900)	(11,900)			
5. a. Occupational Therapy - Medicare	\$ 450,729	450,729			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (106,121)	(106,121)			
c. Occupational Therapy - Non-Medicare	\$ 277,880	277,880			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (34,334)	(34,334)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 8,707	8,707			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 221,802	221,802			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 13,172,674	13,172,674			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$ 58	58			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 35,651	35,651			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 35,709	35,709			
<b>VI. Total All Revenue</b> (III + V)	\$ 13,208,383	13,208,383			

\* 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	4,369.31	-	0
II-6-a	Medicare Part A	Laboratory	3,449.31	-	0
II-6-a	Medicare Part A	Respiratory Therapy & Supplies	-	-	0
II-6-a	Medicare Part A	Nursing Treatment Supplies	-	-	0
II-6-a	Medicare Part A	Audiology	-	-	0
II-6-a	Medicare Part A	Incontinency	-	-	0
II-6-a	Medicare Part A	Oxygen & Supplies	-	-	0
II-6-a	Medicare Part A	Physician Visit	-	-	0
II-6-a	Medicare Part A	Ambulance	-	-	0
II-6-a	Medicare Part A	Flu Shot	3,570.00	-	0
II-6-a	Contractuals-Medicare	X-Ray	(1,028.72)	-	0
II-6-a	Contractuals-Medicare	Laboratory	(812.11)	-	0
II-6-a	Contractuals-Medicare	Respiratory Therapy & Supplies	-	-	0
II-6-a	Contractuals-Medicare	Nursing Treatment Supplies	-	-	0
II-6-a	Contractuals-Medicare	Audiology	-	-	0
II-6-a	Contractuals-Medicare	Incontinency	-	-	0
II-6-a	Contractuals-Medicare	Oxygen & Supplies	-	-	0
II-6-a	Contractuals-Medicare	Physician Visit	-	-	0
II-6-a	Contractuals-Medicare	Ambulance	-	-	0
II-6-a	Contractuals-Medicare	Flu Shot	(840.53)	-	0
<b>Total Other Resident Revenue - Medicare</b>			\$ 8,707	\$ -	\$ -

**Schedule of Other Non-Medicare Resident Revenue**

**Related Exp**

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	84.00	-	0
II-6-b	Medicaid	Laboratory	120.39	-	0
II-6-b	Medicaid	Respiratory Therapy & Supplies	55.24	-	0
II-6-b	Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Medicaid	Audiology	-	-	0
II-6-b	Medicaid	Incontinency	-	-	0
II-6-b	Medicaid	Oxygen & Supplies	85.50	-	0
II-6-b	Medicaid	Physician Visit	-	-	0
II-6-b	Medicaid	Ambulance	-	-	0
II-6-b	Medicaid	Flu Shot	-	-	0
II-6-b	Contractuals Medicaid	X-Ray	(31.11)	-	0
II-6-b	Contractuals Medicaid	Laboratory	(44.58)	-	0
II-6-b	Contractuals Medicaid	Respiratory Therapy & Supplies	(20.46)	-	0
II-6-b	Contractuals Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Contractuals Medicaid	Audiology	-	-	0
II-6-b	Contractuals Medicaid	Incontinency	-	-	0
II-6-b	Contractuals Medicaid	Oxygen & Supplies	(31.66)	-	0
II-6-b	Contractuals Medicaid	Physician Visit	-	-	0
II-6-b	Contractuals Medicaid	Ambulance	-	-	0
II-6-b	Contractuals Medicaid	Flu Shot	-	-	0
II-6-b	Private and Other	X-Ray	1,735.00	-	0
II-6-b	Private and Other	Laboratory	1,148.99	-	0



II-6-b	Private and Other	Respiratory Therapy & Supplies	(55.24)	-	0
II-6-b	Private and Other	Nursing Treatment Supplies	-	-	0
II-6-b	Private and Other	Audiology	-	-	0
II-6-b	Private and Other	Incontinency	-	-	0
II-6-b	Private and Other	Oxygen & Supplies	(85.50)	-	0
II-6-b	Private and Other	Physician Visit	-	-	0
II-6-b	Private and Other	Ambulance	-	-	0
II-6-b	Private and Other	Flu Shot	-	-	0
II-6-b	Private and Other	Capitation Contracts	244,718.50	-	0
II-6-b	Contractuals-Non-Medicaid	X-Ray	(181.43)	-	0
II-6-b	Contractuals-Non-Medicaid	Laboratory	(120.15)	-	0
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplies	5.78	-	0
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Contractuals-Non-Medicaid	Audiology	-	-	0
II-6-b	Contractuals-Non-Medicaid	Incontinency	-	-	0
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplies	8.94	-	0
II-6-b	Contractuals-Non-Medicaid	Physician Visit	-	-	0
II-6-b	Contractuals-Non-Medicaid	Ambulance	-	-	0
II-6-b	Contractuals-Non-Medicaid	Capitation Contracts	(25,589.94)	-	0
<b>Total Other Resident Revenue</b>			<b>\$ 221,802</b>	<b>\$ -</b>	<b>\$ -</b>

**Interest Income**

**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Interest Inc		0	-	0	0
IV-5	Interest On Overdue Accounts	0000100250	58.13	0	0
<b>Total Interest Income</b>			<b>\$ 58</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Revenue**

Page Ref	Description	CCNH	RHNS	(Specify)
IV-8	Settlement Check - Pines v Pharm	0	7,200.00	0
IV-8	CCATT Holdings-Tower lease	0	26,659.03	0
IV-8	hairdresser	0	1,321.25	0
IV-8	Medical Record	0	145.20	0
0	Surgi Care Inc.	0	325.53	0
0		0	-	0
0		0	-	0
<b>Total Other Revenue</b>			<b>\$ 35,651</b>	<b>\$ -</b>

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC	2376	9/30/2016	31	37
Account			Amount	
<b>Assets</b>				
<b>A. Current Assets</b>				
1. Cash ( <i>on hand and in banks</i> )			\$	6,175
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,048,213
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	36,344
4. Inventories			\$	60,563
5. Prepaid Expenses			\$	83,445
a. Prepaid Expenses	4,630			
b. Prepaid Property Tax	67,230			
c. Prepaid Personal Property Tax				
d. Prepaid Personal Property Tax	11,585			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
_____				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	1,234,740
<b>B. Fixed Assets</b>				
1. Land			\$	940,000
2. Land Improvements	*Historical Cost	96	\$	56
	Accum. Depreciation	40		
		Net		
3. Buildings	*Historical Cost	10,480,707	\$	5,099,781
	Accum. Depreciation	5,380,926		
		Net		
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation			
		Net		
5. Non-Movable Equipment	*Historical Cost	19,730	\$	14,030
	Accum. Depreciation	5,700		
		Net		
6. Movable Equipment	*Historical Cost	510,948	\$	208,213
	Accum. Depreciation	302,735		
		Net		
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation			
		Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
PPE CIP				
_____				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	6,262,080

\* 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 North Operations LLC	2376	9/30/2016	32	37
<b>Account</b>			<b>Amount</b>	
Total Brought Forward:			\$	7,496,820
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
3. Buildings		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
4. Non-Movable Equipment		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
5. Movable Equipment		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
6. Motor Vehicles		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense		*Historical Cost _____ Accum. Depreciation _____ Net	\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address		Amount	Loan Date	
7. Other Assets ( <i>itemize</i> )			\$	(4,670,890)
I/C Due to/Due From Owned		(4,670,890)		
I/C Due to/Due From Multicare				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	(4,670,890)
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	2,825,930

\* 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 1 Emerson Drive North Operations LLC,d/b	License No. 2376	Report for Year Ended 9/30/2016	Page 34	of 37
Account				Amount
Total Brought Forward:				1,595,077
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				
Name of Lender	Purpose	Amount	Date Due	\$
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$
Name and Address of Lender	Amount	Loan Date	\$	
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$
LT Debt-Financing Obligation		11,933,407	11,933,407	
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 11,933,407
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 13,528,484

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

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LL	2376	9/30/2016	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	(1,929,122)
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(7,125,789)
6. Gain or Loss for Period				
	10/1/2015	thru 9/30/2016	\$	(1,647,643)
7. Total Net Worth			\$	(10,702,554)
<b>C. Total Reserves and Net Worth</b>			\$	(10,702,554)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	2,825,930

### H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC	2376	9/30/2016	36	37
<b>Account</b>			<b>Amount</b>	
A. Balance at End of Prior Period as shown on Report of 09/30/2015			\$	(9,054,911)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	13,208,383
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	14,856,026
D. Net Income or Deficit			\$	(1,647,643)
E. Balance			\$	(10,702,554)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>		09/30/16	\$	(10,702,554)

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

Name of Facility 1 Emerson Drive North Operations	License No. 2376	Report for Year Ended 9/30/2016	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
Thomas Farnan - Director of Reimbursement    Title -Sr. Director of Reimbursement				
Address Address			Phone Number	
200 Brickstone Square, Andover, MA 01810			978-247-5029	