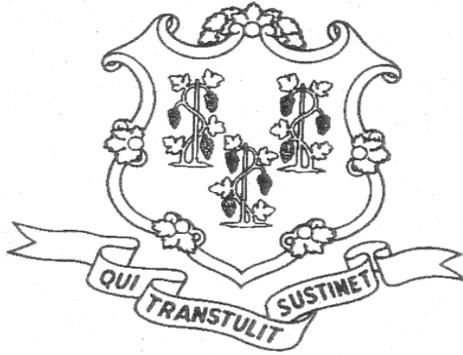


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as licensed) 1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center	
Address (No. & Street, City, State, Zip Code) One Emerson Drive, Windsor, CT 06095	
Type of Facility Chronic and Convalescent Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH) (RHNS)	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

License Numbers:	CCNH 2369	RHNS	(Specify)	Medicare Provider 07-5237
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Medicaid Provider Numbers:	CCNH 000010751	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 South Operations LLC, d/b/a Kimber	2369	9/30/2018	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for 1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, 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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center		Period Covered:	From 10/1/2017	To 9/30/2018
Address of Facility One Emerson Drive, Windsor, CT 06095				
Report Prepared By Thomas Farnan		Phone Number 978-247-5029	Date 12/21/2018	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$ 26,899	26,899		
4. Nursing wages paid	\$ 3,671,707	3,671,707		
5. All other wages paid	\$ 564,917	564,917		
6. Total Wages Paid	\$ 4,263,523	4,263,523		
7. Total salaries paid	\$ 249,004	249,004		
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$ 4,512,527	4,512,527		

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	Report for Year Ended	Page	of
860-688-6443	9/30/2018	2	37

Name of Facility (as shown on license)	Address (No. & Street, City, State, Zip)
1 Emerson Drive South Operations LLC, d/b/a Kimberly South	One Emerson Drive, Windsor, CT 06095

License Numbers:	CCNH 2369	RHNS (Specify)	Medicare Provider No. 07-5237
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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.
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Administrator		
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 South Operations LLC, d/b/	License No. 2369	Report for Year Ended 9/30/2018	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation 1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center	Business Address 101 East State Street, Kennett Square, PA 19348	State(s) in Which Incorporated 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 South Operations LLC, d/b/a Kimberly	License No. 2369	Report for Year Ended 9/30/2018	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 Healthcare	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Home Office	Pg 16/m12	421,446	421,446
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	63%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	993,346	993,346
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input type="radio"/>	<input checked="" type="radio"/>	50%	Staffing Pool	Pg 10/A12, p15-1	9,764	9,764
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	85%	Medical Director /NP	Pg 13/B8, Pg 10/A12	28,680	28,680
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	91%	Outside Agency	Pg 13/B11 pg 10-12, 15	5,089	5,089
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>	40%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E2	94,795	94,795
Genesis Healthcare	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	209,813	209,813
Genesis Healthcare	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Capital Interest	Page 17, page 26-12A	41,692	41,692

* Use additional sheets if necessary.

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

General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a	License No. 2369	Report for Year Ended 9/30/2018	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 South Operations LLC, d/b/a Kimberly So			License No. 2369		Report for Year Ended 9/30/2018		Page of 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						
	<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"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?								<input type="radio"/> Yes <input type="radio"/> No Total ***

* 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 South Operations	License No. 2369	Report for Year Ended 9/30/2018	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 Greater Windsor Probate Court 2 3 4 5	Telephone Number 860-644-2511
---	----------------------------------

Address (*No. & Street, City, State, Zip Code*)
 1 1540 Sullivan Ave South Windsor, CT 06074
 2
 3
 4
 5

Services Provided by This Firm (*describe fully*)

1 Probate Court Fees for conservatorship	\$
2	\$
3 Saving on R.E tax reduction based on the tax assessment	\$
4	\$
5	\$
	Charge for Services Provided
	\$

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

Schedule of Resident Statistics

Name of Facility		License No.			Report for Year Ended				Page		of	
1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center		2369			9/30/2018				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	180	180			180	180			180	180		
B. On last day of THIS report period	180	180			180	180			180	180		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	94	94			94	94			95	95		
B. As of midnight of THIS report period	95	95			95	95			95	95		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,490	5,490			4,463	4,463			1,027	1,027		
B. Medicaid (Conn.)	23,893	23,893			17,668	17,668			6,225	6,225		
C. Medicaid (other states)												
D. Private Pay	1,847	1,847			1,414	1,414			433	433		
E. State SSI for RCH												
F. Other (Specify)	3,993	3,993			3,006	3,006			987	987		
G. Total Care Days During Period (3A thru F)	35,223	35,223			26,551	26,551			8,672	8,672		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	2	2			1	1			1	1		
5. Total Resident Days (3G + 4A + 4B)	35,225	35,225			26,552	26,552			8,673	8,673		

Schedule of Resident Statistics (Cont'd)

Name of Facility 1 Emerson Drive South Operations LLC, d/b/			License No. 2369			Report for Year Ended 9/30/2018			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	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	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID				
No. of Residents	13		71		11								
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	557.85		209.32		390.71								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									2,063	2,063			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									994	994			
C. Other									20,385	20,385			
D. Total Physical Therapy Treatments									23,442	23,442			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									249	249			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									146	146			
C. Other									2,293	2,293			
D. Total Speech Therapy Treatments									2,688	2,688			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									1,172	1,172			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									778	778			
C. Other									20,254	20,254			
D. Total Occupational Therapy Treatments									22,204	22,204			

Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kimberly Sou	License No. 2369	Report for Year Ended 9/30/2018	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
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	136,295	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	199,800	8,947				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers						
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers	26,899	1,730				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	47,292	1,739				
b. Other Maintenance Workers	17,631	1,076				
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	112,709	2,064				
b. RN						
1. Direct Care	806,205	20,231				
2. Administrative**	161,204	4,024				
c. LPN						
1. Direct Care	1,141,969	37,848				
2. Administrative**						
d. Aides and Attendants	1,483,501	84,671				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	122,664	6,119				
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	177,530	6,082				
n. Marketing						
o. Other (Specify) See Attached Schedule	78,827	4,383				
<i>A-13. Total Salary Expenditures</i>	4,512,527	180,999				

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		(Specify)		
	\$	Hours	\$	Hours	\$	Hours	
Ward Clerks	0	0	0	0			
Central Supply	0	4,987.62	284				
Medical Records	0	38,178.65	2,271				
Nursing Unit Secretary	0	35,660.81	1,828				
	0	0	0	0			
	0	0	0	0			
	0	0	0	0			
	0	0	0	0			
	0	0	0	0			
	0	0	0	0			
	0	0	0	0			
	0	0	0	0			
	0	0	0	0			
	0	0	0	0			
	0	0	0	0			
	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		78827	4383	\$ -	-	\$ -	-
		0	0				

Schedule of Other Fees (Page 13)

Service		CCNH		RHNS		(Specify)	
		\$	Hours	\$	Hours	\$	Hours
1020620010	Consulting Fees	1,257.07	n/a				
3010620020	Purchased Services	160.00	n/a				
3015620020	Purchased Services	8,729.15	n/a				
3155620020	Purchased Services	57,071.34	n/a				
		0	-	n/a			
		0	-	n/a			
		0	-	-			
		0	-	n/a			
		0					
		0					
		0					
		0					
		0					
		0					
		0					
		0					
		0					
		0					
		0					
Total		67218	0	\$ -	-	\$ -	-

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

Name of Facility				License No.	Report for Year Ended			Page	of	
1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center				2369	9/30/2018			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
1 Emerson Drive South Operations LLC, d/b/a Kimberly South Cente				2369	9/30/2018			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***										
Thomas Russo	136,295				Management of Center	2,086	2			
					Management of Center		2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
1 Emerson Drive South Operations LLC, d/b/a Kim	2369	9/30/2018	13	37		
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	12,055	83				
3. Pharmacist	10,130	207				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	875,389	11,992				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	97,289	515				
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	51,201	656				
b. Other						
10. Occupational Therapist						
a. Resident Care	107,637	1,474				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	1,715	29				
2. Administrative***						
b. LPN						
1. Direct Care	3,710	88				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	67,218					
B-13 Total Fees Paid in Lieu of Salaries	1,226,343	15,043				

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

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

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

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

Name of Facility		License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC, d/b/a Kimberly		2369	9/30/2018	14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
		<input checked="" type="radio"/>	<input type="radio"/>		
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership	
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		
		<input type="radio"/>	<input type="radio"/>		

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
1 Emerson Drive South Operations LLC, d/b/a K	2369	9/30/2018		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 208,304	208,304			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 57,834	57,834			
4. Social Security (F.I.C.A.)	\$ 333,251	333,251			
5. Health Insurance	\$ 383,229	383,229			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 139,920	139,920			
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 17,890	17,890			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 322,589	322,589			
d. Accounting and Auditing	\$				
e. Legal (<i>Services should be fully described on Page 7</i>)	\$				
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 22,858	22,858			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 13,060	13,060			
2. Cellular Phones	\$ 1,011	1,011			
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	\$ 644	644			
3. Resident Day User Fee	\$ 563,041	563,041			
Subtotal	\$ 2,063,631	2,063,631			

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

(Carry Subtotals forward to next page)

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

1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center
9/30/2018

Attachment Page 15

Schedule of Other Employee Benefits

Description		CCNH	RHNS	(Specify)
3005520020	Union Health & Welfar	\$ 678	\$ -	
3030520020	Union Health & Welfar	\$ -	\$ -	
3040520020	Union Health & Welfar	\$ 263	\$ -	
3080520020	Union Health & Welfar	\$ 366	\$ -	
3225520020	Union Health & Welfar	\$ 13,989	\$ -	
5035520020	Union Health & Welfar	\$ 142	\$ -	
3040520050	Employee Benefits-Oth	\$ 252	\$ -	
3225520050	Employee Benefits-Oth	\$ 2,155	\$ -	
3080520060	Benefit Allocations	\$ 45	\$ -	
	0	0	\$ -	
	0	0	\$ -	
Total		\$ 17,890	\$ -	\$ -

0

Schedule of Other Taxes

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax	\$ 644		
1020640110	Sales Tax	\$ -		
	0	0	\$ -	
	0	0	\$ -	
Total		\$ 644	\$ -	\$ -

0

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

Name of Facility	License No.	Report for Year Ended		Page	of
1 Emerson Drive South Operations LLC, d/b/a Kimbe	2369	9/30/2018		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	2,063,631	2,063,631			
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 125	125			
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 298	298			
5. Education Expenses Related to Seminars and Conventions	\$ 655	655			
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	\$ 15,169	15,169			
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 2,175	2,175			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 12,842	12,842			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$ 761	761			
10. Contributions*** See Attached Schedule	\$ 2,360	2,360			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 4,612	4,612			
12. Administrative Management Services**	\$ 421,274	421,274			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 48,319	48,319			
C-14 Total Administrative & General Expenditures	\$ 2,572,221	2,572,221			

* 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 South Operations LLC,	License No. 2369	Report for Year Ended 9/30/2018	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 Healthcare , 101 East St., Kennett Square, PA 19348	421,446	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Healthcare , 101 East St., Kennett Square, PA 19348	41,692	Capital Interest	pg 26 12-A-1

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC, d/b/a Kimber	2369	9/30/2018	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 162,113	162,113		
2. Non-Food Supplies	\$ 28,026	28,026		
3. Other (Specify) _____ Contra Meal Expense	\$ (323)	(323)		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 568,482	568,482		
c. Other (Specify) _____ Books, Dues & Subscriptions	\$			
2D. Total Dietary Expenditures (2a + b + c)	\$ 758,298	758,298		
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 1 Emerson Drive South Operations LLC, d/b/a Kimberly		License No. 2369	Report for Year Ended 9/30/2018	Page 19	of 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*		Lbs.			
1.	Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	4,960	4,960	
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. \$	6,201	6,201	
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	151,033	151,033	
c. Other (Specify)		\$			
3D. Total Laundry Expenditures (3a + b + c)		\$	162,194	162,194	
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H. Did you receive revenue from employees?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K. Did you receive revenue from these people?		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L. Where is the revenue received reported in the Cost Report?		(Page/Line Item)			

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3E.

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
1 Emerson Drive South Operations LLC, d/b/a		2369	9/30/2018		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. \$	16,423	16,423		
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. \$	208,876	208,876		
c.	Other (<i>Specify</i>) T&E-Mileage/Parking/Tolls		\$			
4D	Total Housekeeping Expenditures (4a + b + c)		\$ 225,299	225,299		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from Neighborcare	\$	366,781	366,781		
b.	Medicine Cabinet Drugs	\$	20,148	20,148		
c.	Medical and Therapeutic Supplies	\$	135,315	135,315		
d.	Ambulance/Limousine***	\$	23,489	23,489		
e.	Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	21,005	21,005		
f.	X-rays and Related Radiological Procedures***	\$	14,000	14,000		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	37,706	37,706		
i.	Recreation	\$	31,666	31,666		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** Total Resident Care Expenditures	\$	97,225	97,225		
5M.	Total Resident Care Expenditures (5a - 5j)		\$ 747,335	747,335		

* 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 1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center			License No. 2369		Report for Year Ended 9/30/2018			Page of 21 37		
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Laundry Purchased Services	151,033			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	208,876			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Dietary Purchased Services	568,482			18	2b
		<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 South Operations LLC, d/b/a	2369	9/30/2018			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 128,693	128,693				
b. Heat	\$ 62,318	62,318				
c. Light & Power	\$ 130,109	130,109				
d. Water	\$ 90,915	90,915				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 412,034	412,034				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$ 2,496	2,496				
c. Non-Movable Equipment	\$ 450	450				
d. Movable Equipment	\$ 53,299	53,299				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 56,246	56,246				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 292,244	292,244				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 141,810	141,810				
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 490,300	490,300				

* 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	\$ -	\$ -	\$ -

Depreciation Schedule

Name of Facility				License No.			Report for Year Ended			Page	of		
1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center				2369			9/30/2018			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				1,900		1,900	1,029	S/L	Various				
2. Disposals (attach schedule)				(1,900)		(1,900)	(1,029)						
3. Acquired during this report period (attach schedule)													
A-4. Subtotal													
B. Building and Building Improvements													
1. Acquired prior to this report period				3,937,907		3,937,907	2,913,367	S/L	Various	0			
2. Disposals (attach schedule)				(3,937,907)		(3,937,907)	(2,913,367)						
3. Acquired during this report period (attach schedule)				69,338		69,338				2,496			
B-4. Subtotal											2,496		
C. Non-Movable Equipment													
1. Acquired prior to this report period				40,761		40,761	9,147	S/L	Various	0			
2. Disposals (attach schedule)				(40,761)		(40,761)	(9,147)						
3. Acquired during this report period (attach schedule)				5,191		5,191				450			
C-4. Subtotal											450		
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year								
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period						448,328		448,328	250,570	S/L	Various	52,313	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						13,891		13,891				987	
D-3. Subtotal													53,299
E. Total Depreciation													56,246

1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center
9/30/2018

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:				
10/1/2017	Various Deletions (see the attached)	(1,900.00)		(1,029.17)
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
Total deletions for Land Improvements		\$ (1,900)		\$ (1,029) **

*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:				
11/30/2017	Vinyl plank in common areas	16,974.76	10	1,414.56
12/31/2017	(2) 120 volt 20 amp circuits and dupl	1,347.15	20	50.52
2/28/2018	3" drain line from 2nd to 1st floor	4,775.12	20	139.27
5/31/2018	Vinyl Flooring	12,722.13	10	424.07
6/30/2018	Install New Vinyl Flooring	15,858.39	10	396.46
6/30/2018	Install 6ft of New Drain Pipe	2,300.00	20	28.75
6/30/2018	New Magnet Holders Connected to F	2,462.00	20	30.78
8/31/2018	New Mounted LED Lights	2,826.20	20	11.78
9/30/2018	Elevator Tank Heater	2,127.00	15	-
9/30/2018	2 Elevator Doors & Hardware	7,945.41	20	-
		-	-	-
		-	-	-
		-	-	-
		-	-	-
		-	-	-
		-	-	-
		-	-	-
Total additions for Building Improvements		\$ 69,338		\$ 2,496 *
Deletions:				
10/1/2017	Various Deletions (see the attached)	(3,937,907.33)		(2,913,366.74)

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

Amortization Schedule*

Name of Facility			License No.		Report for Year Ended			Page	of
1 Emerson Drive South Operations LLC, d/b/a Kimberly Sou			2369		9/30/2018			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.

B. Life of mortgage; OR

C. Remaining Life of Lease; OR

D. Actual Life if owned by Related Party.

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

Name of Facility 1 Emerson Drive South Operations LL	License No. 2369	Report for Year Ended 9/30/2018	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased					
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	180				
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	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	
Well Tower / Healthcare REIT, Inc	Building and Equipment	04/01/11	20	292,244	
Address: One Seagate Suite 1500					
Toledo, OH 43603-1475					

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
1 Emerson Drive South Operations L		2369	9/30/2018		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$ 41,692	41,692		
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)			\$ 41,692	41,692		

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
1 Emerson Drive South Operations		2369		9/30/2018		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				41,692	41,692		
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)				\$ 41,692	41,692		
14. Insurance							
a. Insurance on Property (buildings only)				\$ 2,211	2,211		
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$ 207,603	207,603		
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$ 209,813	209,813		
15. Total All Expenditures (A-13 thru C-14)				\$ 11,358,056	11,358,056		

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC, d/b/a Kimberly South				2369	9/30/2018	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	\$ 23,350	23,350		
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 1,100,187	1,100,187		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.			Bad Debts	\$ 322,589	322,589		
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.			Unallowable Advertising *	\$ 15,169	15,169		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 2,360	2,360		
21.			Unallowable Management Fees	\$ (172)	(172)		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 67,004	67,004		
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)				\$ 1,530,488	1,530,488		

* 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	23350.02412	0
0	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			\$ 23,350	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	144920.14	0
13	5	Rehabilitation Services	3195620020	730468.61	0
13	9	Speech Therapist	3170620020	51200.79	0
13	10	Occupational Therapist	3105620020	107637.39	0
13	12	Other	3010620020	160	0
13	12	Other	3015620020	8729.15	0
13	12	Respiratory Purchased Servies	3155620020	57071.34	0
0	0		0	0	0
0	0		0	0	0
0	0		0	0	0
0	0		0	0	0
Total Other Fees Adjustments			\$ 1,100,187	\$ -	\$ -
			\$ -		

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Collection Fees	1020630120	26307.38	0
16	m13	Estimated Accrual	1020660990	-60.75	0
16	m8a	Chamber of Commerce	License Fee	0	0
16	m13	Non-recurring charges	7010800030	0	0
16	m-12		0	0	0
16	m-13	Penalty and Fines	1020640080	0	0
15	1-a-1	adj workers comp	0	-96018.18611	0
0	0-Jan		0	0	0
0	0		0	0	0
22	6.a	9.9% disallowed Dialysis	Repairs and Maint.	40792.99965	0
20	4c	9.9% disallowed Dialysis	Housekeeping	22305.54786	0
0	0	9.9% disallowed Dialysis	Capital	39902.91051	0
0	0	9.9% disallowed Dialysis	Fair Rent	33774.52925	0
Total Other A&G Adjustments			\$ 67,004	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended	Page	of	
1 Emerson Drive South Operations LLC, d/b/a Kimberly Sou			2369	9/30/2018	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,530,488	1,530,488		
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs	\$ 366,781	366,781		
28.			Ambulance/Limousine	\$ 23,489	23,489		
29.			X-rays, etc	\$ 14,000	14,000		
30.			Laboratory	\$ 37,706	37,706		
31.			Medical Supplies	\$			
32.			Oxygen (non emergency)	\$ 21,005	21,005		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 44,961	44,961		
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.			Other - Indirect	\$ 22,430	22,430		
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ (51,420)	(51,420)		
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 2,009,440	2,009,440		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center
9/30/2018

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20.00	5-j	Consolidated Billing	5,191.67	3010610300	-
20.00	5-j	Respiratory Supplies	21,259.13	3155630530	-
20.00	5-j	Respiratory Rental	18,509.88	3155660080	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
Total Other Ancillary Costs			44,960.68	-	-

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27.00	14c1	General liability Insurance Adjust	(51,419.89)	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
Total Other Adjustments			(51,419.89)	-	-

Schedule of Unallowable Building Interest

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

Schedule of Other - Miscellaneous - Indirect

Page Ref	Line Ref	Description	CCNH	RHNS	i
20.00	5-i	Cable TV	22,429.73	3005660130	allow \$3600
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
-	-	-	-	-	-
Total Other - Miscell			22,429.73	-	-

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
1 Emerson Drive South Operations LLC, c2369		9/30/2018			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 9,013,816	9,013,816				
b. Medicaid Room and Board Contractual Allowance **	\$ (4,126,448)	(4,126,448)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 2,379,282	2,379,282				
b. Medicare Room and Board Contractual Allowance **	\$ (631,627)	(631,627)				
4. a. Private-Pay Residents and Other	\$ 2,477,214	2,477,214				
b. Private-Pay Room and Board Contractual Allowance **	\$ (797,624)	(797,624)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 223,846	223,846				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (59,424)	(59,424)				
c. Prescription Drugs - Non-Medicare	\$ 167,280	167,280				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (55,764)	(55,764)				
2. a. Medical Supplies - Medicare	\$ 496	496				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (132)	(132)				
c. Medical Supplies - Non-Medicare	\$ 220	220				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (95)	(95)				
3. a. Physical Therapy - Medicare	\$ 755,564	755,564				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (200,579)	(200,579)				
c. Physical Therapy - Non-Medicare	\$ 494,461	494,461				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (167,473)	(167,473)				
4. a. Speech Therapy - Medicare	\$ 214,274	214,274				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (56,883)	(56,883)				
c. Speech Therapy - Non-Medicare	\$ 119,238	119,238				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (40,897)	(40,897)				
5. a. Occupational Therapy - Medicare	\$ 726,862	726,862				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (192,960)	(192,960)				
c. Occupational Therapy - Non-Medicare	\$ 495,450	495,450				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (166,491)	(166,491)				
6. a. Other (<i>Specify</i>) - Medicare	\$ 58,560	58,560				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 126,077	126,077				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 10,756,243	10,756,243				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$ 203	203				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$ 9,665	9,665				
8. Other (<i>Specify</i>)	\$ 141,713	141,713				
V. Total Other Revenue (1 thru 8)	\$ 151,581	151,581				
VI. Total All Revenue (III +V)	\$ 10,907,824	10,907,824				

* 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	10,133.99	0	0
II-6-a	Medicare Part A	Laboratory	17,056.34	0	0
II-6-a	Medicare Part A	Respiratory Therapy & Supplie	45,632.98	0	0
II-6-a	Medicare Part A	Nursing Treatment Supplies	-	0	0
II-6-a	Medicare Part A	Audiology	-	0	0
II-6-a	Medicare Part A	Incontinency	-	0	0
II-6-a	Medicare Part A	Oxygen & Supplies	-	0	0
II-6-a	Medicare Part A	Physician Visit	-	0	0
II-6-a	Medicare Part A	Ambulance	-	0	0
II-6-a	Medicare Part A	Flu Shot	6,901.26	0	0
II-6-a	Contractuals-Medicare	X-Ray	(2,690.26)	0	0
II-6-a	Contractuals-Medicare	Laboratory	(4,527.94)	0	0
0	Contractuals-Medicare	Respiratory Therapy & Supplie	(12,114.16)	0	0
0	Contractuals-Medicare	Nursing Treatment Supplies	-	0	0
0	Contractuals-Medicare	Audiology	-	0	0
0	Contractuals-Medicare	Incontinency	-	0	0
0	Contractuals-Medicare	Oxygen & Supplies	-	0	0
0	Contractuals-Medicare	Physician Visit	-	0	0
0	Contractuals-Medicare	Ambulance	-	0	0
0	Contractuals-Medicare	Flu Shot	(1,832.07)	0	0
Total Other Resident Revenue - Medicare			\$ 58,560	\$ -	\$ -
			\$ 0		

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	-	0	0
II-6-b	Medicaid	Laboratory	1,060.32	0	0
II-6-b	Medicaid	Respiratory Therapy & Supplie	12,347.84	0	0
II-6-b	Medicaid	Nursing Treatment Supplies	-	0	0
II-6-b	Medicaid	Audiology	-	0	0
II-6-b	Medicaid	Incontinency	-	0	0
II-6-b	Medicaid	Oxygen & Supplies	-	0	0
II-6-b	Medicaid	Physician Visit	-	0	0
II-6-b	Medicaid	Ambulance	-	0	0
II-6-b	Medicaid	Flu Shot	-	0	0
II-6-b	Contractuals Medicaid	X-Ray	-	0	0
II-6-b	Contractuals Medicaid	Laboratory	(485.41)	0	0
II-6-b	Contractuals Medicaid	Respiratory Therapy & Supplie	(5,652.74)	0	0
II-6-b	Contractuals Medicaid	Nursing Treatment Supplies	-	0	0
II-6-b	Contractuals Medicaid	Audiology	-	0	0
II-6-b	Contractuals Medicaid	Incontinency	-	0	0
II-6-b	Contractuals Medicaid	Oxygen & Supplies	-	0	0
II-6-b	Contractuals Medicaid	Physician Visit	-	0	0
II-6-b	Contractuals Medicaid	Ambulance	-	0	0
II-6-b	Contractuals Medicaid	Flu Shot	-	0	0

II-6-b	Private and Other	X-Ray	5,536.87	0	0
II-6-b	Private and Other	Laboratory	10,807.59	0	0
II-6-b	Private and Other	Respiratory Therapy & Supplie	35,813.46	0	0
II-6-b	Private and Other	Nursing Treatment Supplies	-	0	0
II-6-b	Private and Other	Audiology	-	0	0
II-6-b	Private and Other	Incontinency	-	0	0
II-6-b	Private and Other	Oxygen & Supplies	-	0	0
II-6-b	Private and Other	Physician Visit	-	0	0
II-6-b	Private and Other	Ambulance	-	0	0
II-6-b	Private and Other	Flu Shot	-	0	0
II-6-b	Private and Other	Capitation Contracts	123,070.00	0	0
II-6-b	Contractuals-Non-Medicaid	X-Ray	(1,782.79)	0	0
II-6-b	Contractuals-Non-Medicaid	Laboratory	(3,479.87)	0	0
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplie	(11,531.37)	0	0
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment Supplies	-	0	0
II-6-b	Contractuals-Non-Medicaid	Audiology	-	0	0
II-6-b	Contractuals-Non-Medicaid	Incontinency	-	0	0
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplies	-	0	0
II-6-b	Contractuals-Non-Medicaid	Physician Visit	-	0	0
II-6-b	Contractuals-Non-Medicaid	Ambulance	-	0	0
II-6-b	Contractuals-Non-Medicaid	Flu Shot	-	0	0
II-6-b	Contractuals-Non-Medicaid	Capitation Contracts	(39,626.60)	0	0
Total Other Resident Revenue			\$ 126,077	\$ -	\$ -
			\$ 0		

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
IV-5	Interest On Overdue Account	0000100250	202.82	0	0
0	0	0	-	0	0
0	0	0	-	0	0
Total Interest Income			\$ 203	\$ -	\$ -
			\$ (0)		

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)	
IV-8	Rehab Screen Insurance Pa	430060	\$140.00	0	0
0	Rehab Screen-Med B	0	\$40.00	0	0
0	Peachtree Interface	0	141,180.00	0	0
0	reclass: Transportation 610	0	339.00	0	0
0	Account balance adj 08/12	0	13.85	0	0
0	0	0	-	0	0
0	0	0	-	0	0
0	0	0	-	0	0
0	0	0	-	0	0
0	0	0	-	0	0
0	0	0	-	0	0
IV-8	0	0	-	0	0
Total Other Revenue			\$ 141,713	\$ -	\$ -
			\$ (0)		

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC	2369	9/30/2018	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	5,137
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,514,096
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	19,575
4. Inventories			\$	33,263
5. Prepaid Expenses			\$	108,543
a. Prepaid Expenses				
b. Prepaid Property Tax	92,405			
c. Prepaid Personal Property Tax				
d. Prepaid Personal Property Tax	16,138			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

A-9. Total Current Assets (Lines A1 thru 8)			\$	1,680,613
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost <u>69,338</u>		\$	66,842
	Accum. Depreciation <u>2,496</u>	Net		
4. Leasehold Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
5. Non-Movable Equipment	*Historical Cost <u>5,191</u>		\$	4,741
	Accum. Depreciation <u>450</u>	Net		
6. Movable Equipment	*Historical Cost <u>462,220</u>		\$	158,350
	Accum. Depreciation <u>303,870</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
PPE CIP				

B-10. Total Fixed Assets (Lines B1 thru 9)			\$	229,933

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC	2369	9/30/2018	32	37
Account			Amount	
Total Brought Forward:			\$	1,910,546
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
5. Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	(3,267,974)
	I/C Due to/Due From Owned	(3,267,974)		
	I/C Due to/Due From Multicare			
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	(3,267,974)
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	(1,357,428)

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC, d/b/a	2369	9/30/2018	33	37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	505,662
2. Notes Payable (<i>itemize</i>)			\$	

3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)			\$	129,088
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	972
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable (<i>Current Portion</i>)			\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)			\$	
11. Accrued Income Taxes*			\$	
12. Other Current Liabilities (<i>itemize</i>)			\$	298,196
Accr Exp Other	11,364	Accr Exp Water and Sew	8,982	
A/R Credit Gross Up Liability	117,155	Deferred Revenue	1,804	
Accr Exp Gas	4,329	Accrued Provider/Bed Tax	144,643	
Accr Exp Electricity	9,919	Accr Exp Suspense		
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	933,918

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC, d/		2369	9/30/2018	34	37
Account				Amount	
Total Brought Forward:				933,918	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					
\$					
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)				\$	
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 3,731,532	
LT Debt-Financing Obligation		3,731,022			
Escheatable Funds		510			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 3,731,532	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 4,665,450	

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

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LI	2369	9/30/2018	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	700,338
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(6,272,984)
6. Gain or Loss for Period	10/1/2017	thru 9/30/2018	\$	(450,230)
7. Total Net Worth			\$	(6,022,876)
C. Total Reserves and Net Worth			\$	(6,022,876)
D. Total Liabilities, Reserves, and Net Worth			\$	(1,357,426)

H. Changes in Total Net Worth

Name of Facility 1 Emerson Drive South Operations LLC	License No. 2369	Report for Year Ended 9/30/2018	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2017			\$	(5,572,644)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	10,907,824
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	11,358,056
D. Net Income or Deficit			\$	(450,232)
E. Balance			\$	(6,022,876)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period			\$	(6,022,876)

I. Preparer's/Reviewer's Certification

Name of Facility 1 Emerson Drive South Operations LLC,	License No. 2369	Report for Year Ended 9/30/2018	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
Thomas Farnan Title -Sr. Director of Reimbursement				
Address Address			Phone Number	
200 Brickstone Square, Andover, MA 01810			978-247-5029	