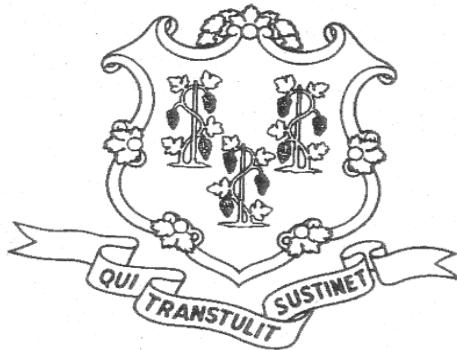


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) 1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center	
Address (No. & Street, City, State, Zip Code) One Emerson Drive, Windsor, CT 06095	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

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

General Information

Name of Facility (as licensed) 1 Emerson Drive South Operations LLC, d/b/a Kimber	License No. 2369	Report for Year Ended 9/30/2021	Page 1	of 37
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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, 2020 and ending September 30, 2021, 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) Diane Morris - VP Reimbursement	
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public			

(Notary Seal)

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

Data Required for Real Wage Adjustment				Page 1A	of 37
Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center	Period Covered:	From 10/1/2020	To 9/30/2021		
Address of Facility One Emerson Drive, Windsor, CT 06095					
Report Prepared By Rick Fink	Phone Number 410-494-7657	Date 12/28/2021			
Item	Total	CCNH	RHNS	(Specify)	
1. Dietary wages paid	\$				
2. Laundry wages paid	\$				
3. Housekeeping wages paid	\$	35,650	35,650		
4. Nursing wages paid	\$	3,398,330	3,398,330		
5. All other wages paid	\$	618,090	618,090		
6. Total Wages Paid	\$	4,052,070	4,052,070		
7. Total salaries paid	\$	262,813	262,813		
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$	4,314,883	4,314,883		

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 9/30/2021	Page 2
Name of Facility (as shown on license) 1 Emerson Drive South Operations LLC, d/b/a Kimberly South		Address (No. & Street, City, State, Zip) One Emerson Drive, Windsor, CT 06095	
License Numbers:	CCNH 2369	RHNS (Specify)	Medicare Provider No. 07-5237
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:		Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes <input checked="" type="radio"/> No	If "Yes," explain fully.
Administrator			
Name of Administrator 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 Partners/Members

General Information and Questionnaire
Corporate Owners

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a	License No. 2369	Report for Year Ended 9/30/2021	Page of 3A 37
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated	
1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center	101 East State Street, Kennett Square, PA 19348	PA	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
See Attached			
Names of Stockholders Owning at Least 10% of Shares			
See Attached			

General Information and Questionnaire

Individual Proprietorship

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kin	License No. 2369	Report for Year Ended 9/30/2021	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

General Information and Questionnaire

Related Parties*

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kimber		License No. 2369	Report for Year Ended 9/30/2021			Page 4	of 37	
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes	<input checked="" type="radio"/> No	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?				<input checked="" type="radio"/> Yes	<input type="radio"/> 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 Administrative Services LLC	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Home Office	Pg 16/m12	509,353	509,353
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	548,997	548,997
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input type="radio"/>	<input checked="" type="radio"/>		Staffing Pool	Pg 10/A12, p15-1		
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Medical Director /NP	Pg 13/B8, Pg 10/A12		
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Outside Agency	Pg 13/B11 pg 10-12, 1		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>		Respiratory Therapy	Pg 13/B12, Pg 20/C5E	112,833	112,833
Genesis Healthcare Ins Program	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	210,246	210,246
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a K	License No. 2369	Report for Year Ended 9/30/2021	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.

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

○ 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 9/30/2021	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 KPMG Peat Marwick 2 3 4	Address (No. & Street, City, State, Zip Code) 1600 Market Street, Philadelphia, PA 19103
---	---

Services Provided by This Firm (*describe fully*)

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

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

Yes No Included in Management Fee pg. 16 m-12

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1	
2	
3	
4	
5	

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

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
5	\$

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

Are These Charges Reflected in the Expenditure Portion of This Report? Legal Fees pg. 15 1-e

Schedule of Resident Statistics

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center			License No. 2369				Report for Year Ended 9/30/2021				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					180	180						
A. On last day of PREVIOUS report period	180	180										
B. On last day of THIS report period	180	180							180	180		
2. Number of Residents					78	78						
A. As of midnight of PREVIOUS report period	78	78										
B. As of midnight of THIS report period	81	81							81	81		
3. Total Number of Days Care Provided During Period					2,009	2,009			670	670		
A. Medicare	2,679	2,679										
B. Medicaid (Conn.)	21,289	21,289			15,853	15,853			5,436	5,436		
C. Medicaid (other states)												
D. Private Pay	1,615	1,615			1,129	1,129			486	486		
E. State SSI for RCH												
F. Other (Specify)	4,230	4,230			3,135	3,135			1,095	1,095		
G. Total Care Days During Period (3A thru F)	29,813	29,813			22,126	22,126			7,687	7,687		
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	12	12							12	12		
5. Total Resident Days (3G + 4A + 4B)	29,825	29,825			22,126	22,126			7,699	7,699		

Schedule of Resident Statistics (Cont'd)

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a	License No. 2369	Report for Year Ended 9/30/2021	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?

 Yes No

If "YES", provide the following information:

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

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.

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	10	57		14				
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.	651.36	236.22		434.02				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		1,254	1,254		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments		1,199	1,199		
C. Other					
D. Total Physical Therapy Treatments		2,453	2,453		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		193	193	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments		61	61	
C. Other				
D. Total Speech Therapy Treatments		254	254	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		658	658	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments		591	591	
C. Other				
D. Total Occupational Therapy Treatments		1,249	1,249	

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 9/30/2021		Page 10	of 37
Are time records maintained by all individuals receiving compensation?			<input checked="" type="radio"/> Yes	<input type="radio"/> No	
Item	Total Cost and Hours				
	CCNH	Hours	RHNS	Hours	(Specify)
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	136,405	2,128			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	196,204	8,678			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor					
c. Dietary Workers					
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers	35,650	2,133			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	31,374	1,353			
b. Other Maintenance Workers	36,612	2,111			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers					
9. Barber and Beautician Services					
10. Protective Services					
11. Accounting Services					
a. Head Accountant					
b. Other Accountants					
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	126,408	2,134			
b. RN					
1. Direct Care	970,595	23,330			
2. Administrative**	166,300	3,802			
c. LPN					
1. Direct Care	865,813	27,172			
2. Administrative**					
d. Aides and Attendants	1,326,212	69,286			
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	144,747	5,870			
i. Physicians					
1. Medical Director					
2. Utilization Review					
3. Resident Care***					
j. Dentists					
k. Pharmacists					
l. Podiatrists					
m. Social Workers/Case Management	209,152	6,429			
n. Marketing					
o. Other (Specify) See Attached Schedule	69,410	3,511			
<i>A-13. Total Salary Expenditures</i>	4,314,883	157,937			

* 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)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center			License No. 2369		Report for Year Ended 9/30/2021			Page 11	of 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.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center				2369		9/30/2021			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 1/8/2019 - present	136,405				Management of Center	2,128	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	9/30/2021		13	37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)
*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	13,712	94			
3. Pharmacist	11,879	242			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	521,456	7,143			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	10,222	54			
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	25,256	324			
b. Other					
10. Occupational Therapist					
a. Resident Care	62,591	857			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care					
2. Administrative***					
b. LPN					
1. Direct Care	22,171	524			
2. Administrative***					
c. Aides	12,978	531			
d. Other					
12. Other (Specify)					
See Attached Schedule	224,857				
B-13 Total Fees Paid in Lieu of Salaries	905,122	9,770			

* 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*

* 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	9/30/2021	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 647,945	647,945		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 30,200	30,200		
4. Social Security (F.I.C.A.)	\$ 309,587	309,587		
5. Health Insurance	\$ 452,169	452,169		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 124,422	124,422		
8. Uniform Allowance	\$			
9. Other (Specify) See Attached Schedule	\$ 17,412	17,412		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 91,077	91,077		
d. Accounting and Auditing	\$			
e. Legal (Services should be fully described on Page 7)	\$ 36,408	36,408		
f. Insurance on Lives of Owners and Operators (Specify)*	\$			
g. Office Supplies	\$ 19,767	19,767		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 12,544	12,544		
2. Cellular Phones	\$ 3,142	3,142		
i. Appraisal (Specify purpose and attach copy)*	\$			
j. Corporation Business Taxes (franchise tax)	\$			
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$			
2. Other (Specify) See Attached Schedule	\$ 173	173		
3. Resident Day User Fee	\$ 515,501	515,501		
Subtotal	\$ 2,260,346	2,260,346		

* 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**

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
1020520020 Union Health & Welfare	\$ 2	\$ -	\$ -
3005520020 Union Health & Welfare	\$ 789	\$ -	\$ -
3030520020 Union Health & Welfare	\$ (214)	\$ -	\$ -
3040520020 Union Health & Welfare	\$ 326	\$ -	\$ -
3080520020 Union Health & Welfare	\$ 208	\$ -	\$ -
3225520020 Union Health & Welfare	\$ 11,712	\$ -	\$ -
5035520020 Union Health & Welfare	\$ 349	\$ -	\$ -
3005520050 Employee Benefits-Other	\$ 308	\$ -	\$ -
3040520050 Employee Benefits-Other	\$ 240	\$ -	\$ -
3080520050 Employee Benefits-Other	\$ 3,202	\$ -	\$ -
	\$ 492	\$ -	\$ -
	\$ -	\$ -	\$ -
Total	\$ 17,412	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
1020640110 Sales Tax	\$ 173	\$ -	\$ -
1020640110 Sales Tax	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
Total	\$ 173	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2021		16	37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		2,260,346	2,260,346		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	178	178		
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	243	243		
5. Education Expenses Related to Seminars and Conventions	\$				
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>)	\$	117	117		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	22,829	22,829		
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	\$	943	943		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	13,540	13,540		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	535	535		
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$	1,280	1,280		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	8,508	8,508		
12. Administrative Management Services**	\$	394,545	394,545		
13. Other (<i>Specify</i>) See Attached Schedule	\$	42,706	42,706		
<i>C-14 Total Administrative & General Expenditures</i>	\$	2,745,770	2,745,770		

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

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

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
1020630020 Advertising	\$ 13,532	\$ -	\$ -
1020630330 Marketing Expense	\$ 7,432	\$ -	\$ -
1020630331 Marketing Exp- Corporate Spend	\$ 2,096	\$ -	\$ -
3165630330 Marketing Exp- Corporate Spend	\$ (231)	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
Total Other Advertising	\$ 22,829	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
1020630310 Licenses & Certifications	\$ 14,075	\$ -	\$ -
1020630310 Dues to Chamber of Commerce	\$ (535)	\$ -	\$ -
1020630310	\$ -	\$ -	\$ -
1020630310	\$ -	\$ -	\$ -
1020630310	\$ -	\$ -	\$ -
Total Dues	\$ 13,540	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
1020630130 Contributions	\$ -	\$ -	\$ -
1020630135 Political Contributions	\$ 1,280	\$ -	\$ -
Total Contributions	\$ 1,280	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
1020630060 Bank Service Charges	\$ 7,180	\$ -	\$ -
1020630120 Collection Fees	\$ 25,365	self-disallowed	\$ -
1020630140 Education Expense	\$ 22	\$ -	\$ -
1020630180 Employee Physicals	\$ 2,112	\$ -	\$ -
1020630200 Employee Relations	\$ 1,928	\$ -	\$ -
1020630380 Printing	\$ 746	\$ -	\$ -
1020630610 Training Expense	\$ 70	\$ -	\$ -
1020640080 Fines & Penalties	\$ -	self-disallowed	\$ -
1020640090 Miscellaneous	\$ 678	\$ -	\$ -
1020660080 Rental Expense	\$ 3,331	\$ -	\$ -
1020660990 Accrued Expense Estimation	\$ (126)	self-disallowed	\$ -
595720090 Landlord Operating Taxes	\$ -	\$ -	\$ -
1020720070 State Tax Annual Report Filing	\$ 80	\$ -	\$ -
3080630440 Recruiting Fees	\$ -	\$ -	\$ -
3080630441 Recruiting Fees	\$ -	\$ -	\$ -
7010800030 Non-recurring Charges	\$ -	\$ -	\$ -
1020630640 Uniforms	\$ -	\$ -	\$ -
1020640060 Equipment Non-Capitalized	\$ 1,321	\$ -	\$ -
	\$ -	\$ -	\$ -
Total Other Administrative and General	\$ 42,706	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility 1 Emerson Drive South Operations LLC,	License No. 2369	Report for Year Ended 9/30/2021	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 Administrative Services LLC, 101 East St., Kennett Square, PA 19348	509,353	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12

*** 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
		9/30/2021		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 143,714	143,714		
2. Non-Food Supplies	\$ 26,603	26,603		
3. Other (Specify) _____	\$ 193	193		
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 568,683	568,683		
c. Other (Specify) _____	\$			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 739,193	739,193		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kimberly	License No. 2369	Report for Year Ended 9/30/2021		Page of 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. \$	5,130	5,130	
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. \$	6,695	6,695	
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	146,164	146,164	
c. Other (Specify)	\$			
3D. Total Laundry Expenditures (3a + b + c)	\$	157,989	157,989	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended		Page	of
1 Emerson Drive South Operations LLC, d/b/a	2369	9/30/2021		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 23,333	23,333		
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 194,266	194,266		
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	217,599	217,599		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	219,501	219,501		
b. Medicine Cabinet Drugs	\$	21,536	21,536		
c. Medical and Therapeutic Supplies	\$	186,161	186,161		
d. Ambulance/Limousine***	\$	6,423	6,423		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	7,859	7,859		
f. X-rays and Related Radiological Procedures***	\$	9,650	9,650		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	49,474	49,474		
i. Recreation	\$	24,044	24,044		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	92,997	92,997		
5M. Total Resident Care Expenditures (5a - 5j)	\$	617,645	617,645		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
3060610160 Incontinency	\$ 40,228	\$ -	\$ -
3060610161 Incontinency - Rebates	\$ (8,203)	\$ -	\$ -
3080630030 Advertising-Help Wanted	\$ 4,562	\$ -	\$ -
3080630080 Books, Dues & Subscriptions	\$ -	\$ -	\$ -
3080630140 Education Expense	\$ 152	\$ -	\$ -
3120630530 Supplies	\$ 1,823	\$ -	\$ -
3155630530 Supplies	\$ 21,216	\$ -	\$ -
3170630530 Supplies	\$ -	\$ -	\$ -
3090630535 Office Supplies	\$ -	\$ -	\$ -
3120630535 Office Supplies	\$ -	\$ -	\$ -
3165630535 Office Supplies	\$ -	\$ -	\$ -
3080630610 Training Expense	\$ -	\$ -	\$ -
3120660080 Rental Expense	\$ 505	\$ -	\$ -
3155660080 Rental Expense	\$ 21,240	\$ -	\$ -
3010610300 Consolidated Billing	\$ 10,194	\$ -	\$ -
3080630630 Tuition Reimbursement	\$ -	\$ -	\$ -
3210630630 Tuition Reimbursement	\$ -	\$ -	\$ -
3225630630 Tuition Reimbursement	\$ -	\$ -	\$ -
3080630200 Employee Relations	\$ 307	\$ -	\$ -
3080630310 Licenses & Certifications	\$ 1,013	\$ -	\$ -
3165630530 Supplies	\$ (407)	\$ -	\$ -
3080630550 T&E-Lodging/Transportation	\$ 367	\$ -	\$ -
	\$ -	\$ -	\$ -
Total Other Resident Care	\$ 92,997	\$ -	\$ -

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

* 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 1 Emerson Drive South Operations LLC, d/b/a	License No. 2369	Report for Year Ended 9/30/2021			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	145,989	145,989			
b. Heat	\$	58,719	58,719			
c. Light & Power	\$	121,301	121,301			
d. Water	\$	127,646	127,646			
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)	\$	453,655	453,655			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$	809	809			
b. Building & Building Improvements	\$	3,235	3,235			
c. Non-Movable Equipment	\$	4,219	4,219			
d. Movable Equipment	\$	15,542	15,542			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	23,805	23,805			
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	\$	274,992	274,992			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	59,259	59,259			
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	358,056	358,056			

* 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 1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center				License No. 2369			Report for Year Ended 9/30/2021				Page 23	of 37	
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
A. Land Improvements											809		
1. Acquired prior to this report period				8,094		8,094	674	S/L	Various	809			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal											809		
B. Building and Building Improvements											3,235		
1. Acquired prior to this report period				32,435		32,435	2,827	S/L	Various	2,932			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)				3,636		3,636				303			
B-4. Subtotal											3,235		
C. Non-Movable Equipment											4,219		
1. Acquired prior to this report period				42,186		42,186	3,313	S/L	Various	4,219			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal											4,219		
	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					51,194		51,194	5,310	S/L	Various	7,930		
b. Disposals (attach schedule)					(2,712)		(2,712)						
c. Acquired during this report period (attach schedule)					86,801		86,801				7,611		
D-3. Subtotal													
E. Total Depreciation												15,542	23,805

Schedule of Land Improvements Acquired during this report period

*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:				
11/30/2020	8 - Sheridan Sconce LED Lights	\$ 1,388	10	\$ 116
11/30/2020	14 - 12" 16w 1 LED Wall Bracket Lights	\$ 2,248	10	\$ 187
Total additions for Building Improvement		\$ 3,636		\$ 303 *
Deletions:				
Total deletions for Building Improvement		\$ -		\$ - ***

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/31/20	Rental for 12 Spot Cooling Units while ne	\$ 10,460	7	\$ 1,370
12/31/20	2 - Unimac Washers, Unimac Tumbler, 1	\$ 32,743	7	\$ 3,508
02/28/21	2 - Welch Allyn 4400 Spot Monitors & 2 -	\$ 4,758	7	\$ 397
10/31/20	Lounge Chair Grade E	\$ 2,712	10	\$ 249
10/31/20	2 - Kinsey Round End Tables	\$ 810	10	\$ 74
10/31/20	Sofa Grade Z Removable	\$ 2,300	10	\$ 211
11/30/20	10 - Double Stepped Cornice Board	\$ 4,029	10	\$ 336
03/31/21	1 - Six Pan Electric Steamer & Leg Kit for	\$ 5,764	10	\$ 288
05/31/21	Double Deck Gas Convection Oven & Sw	\$ 11,276	10	\$ 376
05/31/21	Single Quick Disconnect Kit	\$ 309	10	\$ 10
07/31/21	1 - 3 Gallon Double Coffee Urn	\$ 2,638	10	\$ 44
07/31/21	Panacea Lightweight Wheelchair	\$ 178	10	\$ 3
07/31/21	8 - Panacea Lightweight Wheelchairs	\$ 1,438	10	\$ 24
08/31/21	Panacea Heavy Duty Wheelchair	\$ 205	10	\$ 2
11/30/20	2 - Mobile 5 drawer tool carts	\$ 715	5	\$ 119
08/31/21	4 - Direct Supply Linen Carts	\$ 1,463	5	\$ 24
05/31/21	15 - Panacea Mattresses & 5 - Panacea M	\$ 4,461	3	\$ 496
12/31/20	(2) Genesis 76ix72i Stationary Safety Par-Direct Supply 28639725	\$ 542	5	\$ 81
Total additions for Movable Equipment		\$ 86,801		\$ 7,611 *
Deletions:				
9/30/2020	Reversal September 2020 DSSI Accrual	\$ (2,712)		
Total deletions for Movable Equipment		\$ (2,712)		\$ - **

*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 Improvemen		\$ -		\$ - *
Deletions:				
Total deletions for Leasehold Improvemen		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kimberly Sou			License No. 2369		Report for Year Ended 9/30/2021			Page 24	of 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 9/30/2021	Page 25	of 37
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11. Property Questionnaire

Part A

Is the property either owned by the Facility
or leased from a Related Party?

Yes

No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total			
1. Date Land Purchased	n/a			
2. Date Structure Completed	n/a			
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	n/a			
b. Building	n/a			

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
Next HC-JV	Facility Lease	2/1/2019 -1/31	15 years	274,992
587 Fifth Avenue New York, NY 10017				

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 1 Emerson Drive South Operations L	License No. 2369	Report for Year Ended 9/30/2021	Page 26	of 37
Item	Total	CCNH	RHNS	(Specify)
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
2. Second Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
3. Third Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
4. Fourth Mortgage	\$			
Name of Lender	Rate			
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount	\$			
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$			

(Carry Subtotals forward to next page)

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

Name of Facility 1 Emerson Drive South Operations	License No. 2369	Report for Year Ended 9/30/2021			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment			\$			
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)			\$			
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			\$			
12. D. Other Interest Expense (Specify)			\$			
13. Total All Interest Expense (12B7 + 12C3 + 12D)			\$			
14. Insurance						
a. Insurance on Property (buildings only)			\$ 6,307	6,307		
b. Insurance on Automobiles			\$			
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)			\$ 203,940	203,940		
2. Fire and Extended Coverage			\$			
3. Other (Specify)			\$			
14d. Total Insurance Expenditures (14a + b + c)			\$ 210,247	210,247		
15. Total All Expenditures (A-13 thru C-14)			\$ 10,720,158	10,720,158		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of
Item No.	Page No.	Line No.		CCNH	RHNS	28 37
			Item Description	Total Amount of Decrease		
<i>Page 10 - Salaries and Wages</i>						
1.			Outpatient Service Costs	\$		
2.			Salaries not related to Resident Care	\$		
3.			Occupational Therapy	\$		
4.			Other - See attached Schedule	\$ 16,236	16,236	
<i>Page 13 - Professional Fees</i>						
5.	13	B-8-c	Resident Care Physicians **	\$		
6.		B-10	Occupational Therapy	\$		
7.			Other - See attached Schedule	\$ 727,134	727,134	
<i>Pages 15 & 16 - Administrative and General</i>						
8.			Discriminatory Benefits	\$		
9.	15	1-c	Bad Debts	\$ 91,077	91,077	
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.	16	m-2 &	Unallowable Advertising *	\$ 22,829	22,829	
19.			Income Tax / Corporate Business Tax	\$		
20.			Fund Raising / Contributions	\$ 1,280	1,280	
21.			Unallowable Management Fees	\$ (114,808)	(114,808)	
22.			Barber and Beauty	\$		
23.			Other - See attached Schedule	\$ 468,654	468,654	
<i>Page 18 - Dietary Expenditures</i>						
24.			Meals to employees, guests and others who are not residents	\$		
<i>Page 19 - Laundry Expenditures</i>						
25.			Laundry services to employees, guests and others who are not residents	\$		
<i>Page 20 - Housekeeping Expenditures</i>						
26.			Housekeeping services to employees, guests and others who are not residents	\$		
Subtotal (Items 1 - 26)			\$ 1,212,403	1,212,403		

* 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	\$ 16,236	\$ -	\$ -
Total Other Salaries Adjustment			\$ 16,236	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	\$ 122,645	\$ -	\$ -
13	5	Rehabilitation Services	\$ 398,812	\$ -	\$ -
13	9	Speech Therapist	\$ 25,256	\$ -	\$ -
13	10	Occupational Therapist	\$ 62,591	\$ -	\$ -
13	12	Other	\$ 850	\$ -	\$ -
13	12	Other	\$ 3,080	\$ -	\$ -
13	12	Respiratory Purchased Services	\$ 113,901	\$ -	\$ -
Total Other Fees Adjustments			\$ 727,134	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	\$ 25,365	\$ -	\$ -
16	m-13	Estimated Accrual	\$ (126)	\$ -	\$ -
16	m-13	Non-recurring Charges	\$ -	\$ -	\$ -
16	m-13	Dues to Chamber of Commerce	\$ 535	\$ -	\$ -
16	m-13	Penalty	\$ -	\$ -	\$ -
16	m-12		0	\$ -	\$ -
15	1-a-1	adj workers comp	\$ 349,452	\$ -	\$ -
13	B12	Adj to the SNAP Strike Cost (disallowabe)	\$ 93,429	\$ -	\$ -
0	0		0	\$ -	\$ -
Total Other A&G Adjustments			\$ 468,654	\$ -	\$ -

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	9/30/2021		29 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 1,212,403	1,212,403		
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs	\$ 219,501	219,501		
28.	20	5-d	Ambulance/Limousine	\$ 6,423	6,423		
29.	20	5-f	X-rays, etc	\$ 9,650	9,650		
30.	20	5-h	Laboratory	\$ 49,474	49,474		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 7,859	7,859		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 52,649	52,649		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation				
			See Attached Schedule	\$ (36,760)	(36,760)		
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	\$ 17,283	17,283		
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 161,791	161,791		
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)				\$ 1,700,273	1,700,273		

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	\$ 10,194	\$ -	\$ -
20	5-j	Respiratory Supplies	\$ 21,216	\$ -	\$ -
20	5-j	Respiratory Rental	\$ 21,240	\$ -	\$ -
0	0-Jan		0	\$ -	\$ -
0	0-Jan		0	\$ -	\$ -
0	0-Jan		0	\$ -	\$ -
Total Other Ancillary Costs			\$ 52,649	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Page 22	7a	Land Imp	\$ (0)	\$ -	\$ -
Page 22	7b	Bldg Imp	\$ (5,984)	\$ -	\$ -
Page 22	7c	Non Movable Equip	\$ (519)	\$ -	\$ -
Page 22	7d	Movable Equip	\$ (30,257)	\$ -	\$ -
0	0-Jan		0	\$ -	\$ -
Total Excess Movable Equipment Depreciation			\$ (36,760)	\$ -	\$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 30	of 37
		Item	Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 8,625,125	8,625,125				
b. Medicaid Room and Board Contractual Allowance **	\$ (3,715,462)	(3,715,462)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,193,663	1,193,663				
b. Medicare Room and Board Contractual Allowance **	\$ (37,541)	(37,541)				
4. a. Private-Pay Residents and Other	\$ 2,597,247	2,597,247				
b. Private-Pay Room and Board Contractual Allowance **	\$ (728,571)	(728,571)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 98,597	98,597				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (3,101)	(3,101)				
c. Prescription Drugs - Non-Medicare	\$ 138,936	138,936				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (40,364)	(40,364)				
2. a. Medical Supplies - Medicare	\$ 345	345				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (11)	(11)				
c. Medical Supplies - Non-Medicare	\$ 31	31				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (13)	(13)				
3. a. Physical Therapy - Medicare	\$ 244,972	244,972				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (7,704)	(7,704)				
c. Physical Therapy - Non-Medicare	\$ 417,665	417,665				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (127,729)	(127,729)				
4. a. Speech Therapy - Medicare	\$ 69,659	69,659				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (2,191)	(2,191)				
c. Speech Therapy - Non-Medicare	\$ 89,925	89,925				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (27,561)	(27,561)				
5. a. Occupational Therapy - Medicare	\$ 197,830	197,830				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (6,222)	(6,222)				
c. Occupational Therapy - Non-Medicare	\$ 341,693	341,693				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (102,225)	(102,225)				
6. a. Other (<i>Specify</i>) - Medicare	\$ 74,765	74,765				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 181,460	181,460				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 9,473,217	9,473,217				
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>)	\$ 2,863	2,863				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$ 2,334	2,334				
8. Other (<i>Specify</i>)	\$ 804,885	804,885				
V. Total Other Revenue (1 thru 8)	\$ 810,081	810,081				
VI. Total All Revenue (III +V)	\$ 10,283,299	10,283,299				

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
II-6-a	Medicare-X-Ray	\$ 3,784	\$ -	\$ -
II-6-a	Medicare-Laboratory	\$ 20,238	\$ -	\$ -
II-6-a	Medicare-Respiratory Therapy & Supplies	\$ 35,213	\$ -	\$ -
II-6-a	Medicare-Nursing Treatment Supplies	\$ -	\$ -	\$ -
II-6-a	Medicare-Audiology	\$ -	\$ -	\$ -
II-6-a	Medicare-Incontinency	\$ -	\$ -	\$ -
II-6-a	Medicare-Oxygen & Supplies	\$ -	\$ -	\$ -
II-6-a	Medicare-Physician Visit	\$ -	\$ -	\$ -
II-6-a	Medicare-Ambulance	\$ 10,997	\$ -	\$ -
II-6-a	Medicare-Flu Shot	\$ 6,961	\$ -	\$ -
II-6-a	Medicare-Contractual-X-Ray	\$ (119)	\$ -	\$ -
II-6-a	Medicare-Contractual-Laboratory	\$ (636)	\$ -	\$ -
II-6-a	Medicare Contractual-Respiratory Therapy & Supplies	\$ (1,107)	\$ -	\$ -
II-6-a	Medicare Contractual-Nursing Treatment Supplies	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual-Audiology	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual-Incontinency	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual-Oxygen & Supplies	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual-Physician Visit	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual-Ambulance	\$ (346)	\$ -	\$ -
II-6-a	Medicare Contractual-Flu Shot	\$ (219)	\$ -	\$ -
<hr/>				
Total Other Resident Revenue - Medicare				
		\$ 74,765	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
II-6-b	Medicaid-X-Ray	\$ 281	\$ -	\$ -
II-6-b	Medicaid-Laboratory	\$ 1,306	\$ -	\$ -
II-6-b	Medicaid-Respiratory Therapy & Supplies	\$ 45,752	\$ -	\$ -
II-6-b	Medicaid-Nursing Treatment Supplies	\$ -	\$ -	\$ -
II-6-b	Medicaid-Audiology	\$ -	\$ -	\$ -
II-6-b	Medicaid-Incontinency	\$ -	\$ -	\$ -
II-6-b	Medicaid-Oxygen & Supplies	\$ -	\$ -	\$ -
II-6-b	Medicaid-Physician Visit	\$ -	\$ -	\$ -
II-6-b	Medicaid-Ambulance	\$ -	\$ -	\$ -
II-6-b	Medicaid-Flu Shot	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid-X-Ray	\$ (121)	\$ -	\$ -
II-6-b	Contractuals-Medicaid-Laboratory	\$ (563)	\$ -	\$ -
II-6-b	Contractuals-Medicaid-Respiratory Therapy & Supplies	\$ (19,099)	\$ -	\$ -
II-6-b	Contractuals-Medicaid-Nursing Treatment Supplies	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid-Audiology	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid-Incontinency	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid-Oxygen & Supplies	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid-Physician Visit	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid-Ambulance	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid-Flu Shot	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid-X-Ray	\$ 3,065	\$ -	\$ -
II-6-b	Non-Medicaid-Laboratory	\$ 12,694	\$ -	\$ -
II-6-b	Non-Medicaid-Respiratory Therapy & Supplies	\$ 53,563	\$ -	\$ -
II-6-b	Non-Medicaid-Nursing Treatment Supplies	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid-Audiology	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid-Incontinency	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid-Oxygen & Supplies	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid-Physician Visit	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid-Ambulance	\$ 5,111	\$ -	\$ -
II-6-b	Non-Medicaid-Flu Shot	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid-Capitation Contracts	\$ 140,322	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid-X-Ray	\$ (860)	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid-Laboratory	\$ (3,561)	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid-Respiratory Therapy & Supplies	\$ (15,025)	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid-Nursing Treatment Supplies	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid-Audiology	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid-Incontinency	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid-Oxygen & Supplies	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid-Physician Visit	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid-Ambulance	\$ (1,434)	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid-Flu Shot	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid-Capitation Contracts	\$ (39,363)	\$ -	\$ -
<hr/>				
Total Other Resident Revenue				
		\$ 181,460	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
IV-5	Interest On Overdue Accounts	430055	\$ 2,863	\$ -	\$ -
Total Interest Income		\$ 2,863	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
IV-8	Elim Basic Healthcare Revenue	\$ 132,553	\$ -	\$ -
IV-8	Fed Stim - Phase II	\$ 4,760	\$ -	\$ -
IV-8	Federal Stimulus 4	\$ 284,622	\$ -	\$ -
IV-8	Federal Stimulus 4 - Part 2	\$ -	\$ -	\$ -
IV-8	State COVID Support - Other	\$ 210,363	\$ -	\$ -
IV-8	Misc Income	\$ 6,230	\$ -	\$ -
IV-8	Telehealth Facility Fee	\$ 9,679	\$ -	\$ -
IV-8	Rental Income	\$ 154,272	\$ -	\$ -
IV-8	Antibody Infusion Therapy	\$ 2,405	\$ -	\$ -
<hr/>				
Total Other Revenue				
		\$ 804,885	\$ -	\$ -

G. Balance Sheet

Name of Facility 1 Emerson Drive South Operations LLC	License No. 2369	Report for Year Ended 9/30/2021	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$ 4,834	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,083,615	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$ (40,313)	
4. Inventories			\$ 53,891	
5. Prepaid Expenses			\$ 58,328	
a. Prepaid Expenses				
b. Prepaid Property Tax	48,395			
c. Prepaid Personal Property Tax	9,933			
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$ 1,160,355	
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost 8,094	Accum. Depreciation 1,484	\$ 6,610	
3. Buildings	*Historical Cost 36,071	Accum. Depreciation 6,062	\$ 30,009	
4. Leasehold Improvements	*Historical Cost	Accum. Depreciation Net	\$	
5. Non-Movable Equipment	*Historical Cost 42,186	Accum. Depreciation 7,532	\$ 34,654	
6. Movable Equipment	*Historical Cost 135,283	Accum. Depreciation 20,852	\$ 114,431	
7. Motor Vehicles	*Historical Cost	Accum. Depreciation Net	\$	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$ 185,704	

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			\$ -

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
1 Emerson Drive South Operations LLC	2369	9/30/2021	32 37
Account			Amount
Total Brought Forward:			\$ 1,346,059
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>)			\$ (2,648,160)
I/C Due to/Due From Owned	(2,648,160)		
I/C Due to/Due From Multicare			
See Schedule			
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$ (2,648,160)
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ (1,302,102)

* 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 South Operations LLC, d/b/a	License No. 2369	Report for Year Ended 9/30/2021	Page 33	of 37
Account				Amount
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable				\$ 532,235
2. Notes Payable (<i>itemize</i>)				\$
See Schedule				
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$
Name of Lender		Purpose	Amount	Date Due
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$ 195,966
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$
6. Accrued Payroll Taxes Payable				\$ 1,282
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>)				\$ #VALUE!
See Schedule				#VALUE!
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ #VALUE!

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

G. Balance Sheet (cont'd)

Name of Facility 1 Emerson Drive South Operations LLC, d/b	License No. 2369	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
Total Brought Forward:			#VALUE!	
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>)				\$ (135)
LT Debt-Financing Obligation				
Escheatable Funds				(135)
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ (135)
C. Total All Liabilities (Lines A-13 + B-5)				\$ #VALUE!

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

Name of Facility 1 Emerson Drive South Operations LLC	License No. 2369	Report for Year Ended 9/30/2021	Page 35	of 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			\$	(3,145,007)
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	\$ (436,858)
7. Total Net Worth			\$	(2,881,527)
C. Total Reserves and Net Worth			\$	(2,881,527)
D. Total Liabilities, Reserves, and Net Worth			\$	#VALUE!

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC,	2369	9/30/2021	36	37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2020				\$ (2,444,669)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 10,283,300
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 10,720,158
D. Net Income or Deficit				\$ (436,858)
E. Balance				\$ (2,881,527)
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 (No., City, State, Zip)	Title	Amount		
2. Other Withdrawings (<i>Specify</i>)				\$
Purpose	Amount			
3. Total Deductions				\$
H. Balance at End of Period				\$ (2,881,527)

I. Preparer's/Reviewer's Certification

Name of Facility 1 Emerson Drive South Operations LLC,	License No. 2369	Report for Year Ended 9/30/2021	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

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
Rick Fink		
Address		Phone Number
200 Brickstone Square, Andover, MA 01810		410-494-7657
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number
Rick Fink		410-494-7657
Contact Email Address		
Rick.Fink@genesishcc.com		