State of Connecticut

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Annual Report of Long-Term Care Facility
Cost Year 2015

RECEIVED
DEC 31 2015
DEPT OF SOCIAL SERVICES
OFFICE OF CON AND RATE SETTINGS

Name of Facility (as licensed) Governor's House Care and Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 36 Firetown Road, Simsbury, CT 06070	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2200-C			07-5338

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	20628		

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
Governor's House Care and Rehabilitation Center	2200-C	9/30/2015	1	37

Administrator's/Owner's Certification

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

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

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

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

Signed (Administrator)		Date	Signed (Owner)	Date
				11/18/2015
Printed Name (Administrator) Rachel DeMaida			Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare	
Subscribed and Sworn to before me:	State of PA	Date 11/13/15	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

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

(Notary Seal)

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Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Governor's House Care and Rehabilitation Center	Period Covered:		From 10/1/2014	To 9/30/2015
Address of Facility 36 Firetown Road, Simsbury, CT 06070				
Report Prepared By Thomas Farnan	Phone Number 978-247-5029		Date 12/21/2015	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$	322,942	322,942		
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$	2,462,625	2,462,625		
5. All other wages paid	$	372,899	372,899		
6. ***Total Wages Paid***	$	3,158,466	3,158,466		
7. Total salaries paid	$	194,695	194,695		
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	3,353,161	3,353,161		

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-658-1018	9/30/2015	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Governor's House Care and Rehabilitation Center	36 Firetown Road, Simsbury, CT 06070

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2200-C			07-5338

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

○ Proprietorship ⊙ LLC ○ Partnership ○ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ⊙ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Rachel DeMaida	001889

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Center	2200-C	9/30/2015	3	37

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

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

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Ce	2200-C	9/30/2015	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Governor's House Care and Rehabilitation Center	101 East State Street, Kennett Square, PA 19348	PA

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

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Center	2200-C	9/30/2015	3B	37

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

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Center	2200-C	9/30/2015	4	37

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties: Yes	No	%**	Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
Genesis Health Ventures	101 East State Street, Kennett Square, PA 19348	⊙	○		Home Office	Pg 16/m12	296,874	296,874
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	⊙	○	63%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	646,291	646,291
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	⊙	○	55%	Staffing Pool	Pg 10/A12	25,961	25,961
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	⊙	○	85%	Case Management	Pg 13/B8, Pg 10/A12	24,000	24,000
Career Staffing	101 East State Street, Kennett Square, PA 19348	⊙	○		Staffing Pool	Pg 13/B11 a,b,c	2,540	2,540
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	⊙	○	43%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	42,431	42,431
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Insurance	Pg 27/14	88,292	88,292
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Capital Interest	Page 17, page 26-12A	29,630	29,630
		○	○					

* Use additional sheets if necessary.
** Provide the percentage amount of revenue received from non-related parties.

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Cente	2200-C	9/30/2015	5	37

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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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					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						Total ***	

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

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabi	2200-C	9/30/2015	7	37

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

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

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

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

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 SCHETTINO AND TEMCHIN	(203) 239-6699
2 Goldman Gruder & Woods LLC	203-899-8900
3 RICHARD E OSTOP	
4 Treasurer State of Connecticut	
5	

Address (*No. & Street, City, State, Zip Code*)
1 18 Peck Street, North Haven, CT 06473
2 200 Connecticut Avenue Norwalk, CT 06854
3 P.O Box 42 Simbury CT 06070
4 Simbury CT 06070
5

Services Provided by This Firm (*describe fully*)

1	Review, Preparation and filing of Application for Conservator Appointment, Prep & filing of litigation	$
2	Review, Preparation and filing of Application for Conservator Appointment, Prep & filing of litigation	$
3	State Marshall Fee - Conservator	$
4	Probate Court Fees	$
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

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30 Total	CCNH	RHNS	(Specify)	Period 7/1 Thru 9/30 Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	73	73			73	73			73	73		
B. On last day of THIS report period	73	73			73	73			73	73		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	72	72			72	72			64	64		
B. As of midnight of THIS report period	61	61			64	64			61	61		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,668	4,668			3,727	3,727			941	941		
B. Medicaid (Conn.)	16,116	16,116			12,242	12,242			3,874	3,874		
C. Medicaid (other states)												
D. Private Pay	1,517	1,517			1,149	1,149			368	368		
E. State SSI for RCH												
F. Other (Specify)	1,628	1,628			1,129	1,129			499	499		
G. Total Care Days During Period (3A thru F)	23,929	23,929			18,247	18,247			5,682	5,682		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	18	18			18	18						
B. Other Bed Reserve Days	19	19			17	17			2	2		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	23,966	23,966			18,282	18,282			5,684	5,684		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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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
				Lost			Gained						
	CCNH (1)	RHNS (2)	(Specify) (3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID
No. of Residents	9	44		8				
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.	511.06	240.25		481.17				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	1,629	1,629		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	59	59		
2. Restorative Treatments	15,274	15,274		
C. Other	16,962	16,962		
D. ***Total Physical Therapy Treatments***				
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	133	133		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	5	5		
2. Restorative Treatments	1,271	1,271		
C. Other	1,409	1,409		
D. ***Total Speech Therapy Treatments***				
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,014	1,014		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	14	14		
2. Restorative Treatments	14,322	14,322		
C. Other	15,350	15,350		
D. ***Total Occupational Therapy Treatments***				

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Center	2200-C	9/30/2015	10	37

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

Item	Total Cost and Hours					
	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	94,811	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	137,884	6,503				
5. Dietary Service						
a. Head Dietitian	11,513	421				
b. Food Service Supervisor	52,179	2,105				
c. Dietary Workers	259,250	15,377				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	57,019	2,161				
b. Other Maintenance Workers	9,970	713				
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	99,884	2,170				
b. RN						
1. Direct Care	707,876	18,905				
2. Administrative**	22,702	570				
c. LPN						
1. Direct Care	610,820	20,338				
2. Administrative**						
d. Aides and Attendants	1,065,062	64,242				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	69,188	3,853				
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	98,839	3,929				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	56,164	3,394				
A-13. Total Salary Expenditures	3,353,161	146,768				

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

Schedule of Other Salaries and Wages (Page 10)

Position		CCNH $	CCNH Hours	RHNS $	RHNS Hours	(Specify) $	(Specify) Hours
Ward Clerks	0	$ -	-	$ -	-	$ -	-
Coordinator-Staffing Cen	0	$ 39,634.88	2,225.35	$ -	-	$ -	-
Central Supply	0	$ 447.36	27.31	$ -	-	$ -	-
Medical Records	0	$ 16,081.40	1,141.83	$ -	-	$ -	-
0	0	$ -	-	$ -	-	$ -	-
0	0	$ -	-	$ -	-	$ -	-
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		$ 56,163.64	$ 3,394.49	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

Service		CCNH $	CCNH Hours	RHNS $	RHNS Hours	(Specify) $	(Specify) Hours
1020620010	Consulting Fees	$ 148.85	n/a			$ -	
1020620010	Consulting Fees	$ 409.70	n/a			$ -	
1020620010	Consulting Fees	$ (7.21)	n/a			$ -	
3010620020	Purchased Services	$ 10,675.70	n/a			$ -	
3010620020	Purchased Services	$ (10,556.00)	n/a			$ -	
3015620020	Purchased Services	$ 14,694.00	n/a			$ -	
3155620020	Purchased Services	$ (118.22)	n/a			$ -	
3155620020	Purchased Services	$ 3,556.84	n/a			$ -	
0	0	$ -	-			$ -	
Total		$ 18,803.66	$ -	$ -	-	$ -	-

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Center	2200-C	9/30/2015	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Rachel DeMaida	94,811				Management of Center	2,086	2			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Center	2200-C	9/30/2015	13	37

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
***B. Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	842	23				
2. Dentist	8,709	60				
3. Pharmacist	6,091	124				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	574,594	7,871				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	24,000	127				
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	18,357	235				
b. Other						
10. Occupational Therapist						
a. Resident Care	56,460	773				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	1,812	30				
2. Administrative***						
b. LPN						
1. Direct Care	28,442	672				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	18,804					
B-13 Total Fees Paid in Lieu of Salaries	738,110	9,915				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Center	2200-C	9/30/2015	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Genesis Eldercare Hospitality Services, 101 East State Street, Kennett Square, PA 19348	Dietary Services	⊙	○	Common Ownership
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	⊙	○	Common Ownership
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	⊙	○	Common Ownership
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	⊙	○	Common Ownership
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	⊙	○	Common Ownership
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
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		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Center	2200-C	9/30/2015	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	200,514	200,514		
2. Disability Insurance	$				
3. Unemployment Insurance	$	76,491	76,491		
4. Social Security (F.I.C.A.)	$	244,237	244,237		
5. Health Insurance	$	257,213	257,213		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$				
8. Uniform Allowance	$				
9. Other (*Specify*) See Attached Schedule	$	17,854	17,854		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	174,287	174,287		
d. Accounting and Auditing	$				
e. Legal (*Services should be fully described on Page 7*)	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	14,832	14,832		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	32,869	32,869		
2. Cellular Phones	$				
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	$	1,818	1,818		
3. Resident Day User Fee	$	390,300	390,300		
Subtotal	$	1,410,416	1,410,416		

* 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

Governor's House Care and Rehabilitation Center
9/30/2015

Schedule of Other Employee Benefits

Description		CCNH	RHNS	(Specify)
1020520020	Union Health & Welfare	$ 6,562	$ -	
3005520020	Union Health & Welfare	$ 307	$ -	
3080520020	Union Health & Welfare	$ 493	$ -	
3215520020	Union Health & Welfare	$ 5,149	$ -	
3225520020	Union Health & Welfare	$ 9,458	$ -	
5035520020	Union Health & Welfare	$ 78	$ -	
1020520050	Employee Benefits-Other	$ (6,562)	$ -	
3030520020	Union Health & Welfare	$ 2,368	$ -	
5035520020	Union Health & Welfare	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
Total		$ 17,854	$ -	$ -

Schedule of Other Taxes

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax	$ 1,818	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
Total		$ 1,818	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Center	2200-C	9/30/2015	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,410,416	1,410,416		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	151	151		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	3,204	3,204		
5. Education Expenses Related to Seminars and Conventions	$				
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)*** See Attached Schedule	$	11,427	11,427		
4. Fund-Raising***	$				
5. Medical Records	$	0	0		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	212	212		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	5,687	5,687		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	690	690		
9. Subscriptions	$	299	299		
10. Contributions*** See Attached Schedule	$	(321)	(321)		
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual*)	$	4,600	4,600		
12. Administrative Management Services**	$	349,601	349,601		
13. Other (*Specify*) See Attached Schedule	$	214,347	214,347		
C-14 Total Administrative & General Expenditures	$	2,000,314	2,000,314		

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

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

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

Schedule of Other Travel and Entertainment

Description		CCNH	RHNS	(Specify)
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
Total Other Travel and Entertainment		$ -	$ -	$ -

Schedule of Other Advertising

Description		CCNH	RHNS	(Specify)
1020630020	Advertising	$ 632	$ -	$ -
1020630020	Advertising	$ 385	$ -	$ -
1020630020	Advertising	$ 1,016	$ -	$ -
1020630330	Marketing Expense	$ 4,480	$ -	$ -
1020630330	Marketing Expense	$ 26	$ -	$ -
3080630330	Marketing Expense	$ 58	$ -	$ -
1020630331	Marketing Exp- Corporate Spend	$ 301	$ -	$ -
1020630331	Marketing Exp- Corporate Spend	$ 4,530	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
Total Other Advertising		$ 11,427	$ -	$ -

Schedule of Dues

Description		CCNH	RHNS	(Specify)
1020630310	Licenses and Certification	$ 5,687	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -

0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
Total Dues		$ 5,687	$ -	$ -

Schedule of Contributions

Description		CCNH	RHNS	(Specify)
1020630135	Political Contributions	$ (321)	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
Total Contributions		$ (321)	$ -	$ -

Schedule of Other Administrative and General

Description		CCNH	RHNS	(Specify)
1020630060	Bank Service Charges	$ 2,858	$ -	$ -
1020630120	Collection Fees	$ 228	self-disallowed	$ -
1020630120	Collection Fees	$ 23	self-disallowed	$ -
1020630120	Collection Fees	$ 66	self-disallowed	$ -
1020630120	Collection Fees	$ 515	self-disallowed	$ -
1020630140	Education Expense	$ 206	$ -	$ -
1020630140	Education Expense	$ 39	$ -	$ -
1020630180	Employee Physicals	$ 11,694	$ -	$ -
1020630200	Employee Relations	$ 5,710	$ -	$ -
1020630200	Employee Relations	$ 212	$ -	$ -
1020630380	Printing	$ 21	$ -	$ -
1020630380	Printing	$ 154	$ -	$ -
1020630610	Training Expense	$ 458	$ -	$ -
1020630610	Training Expense	$ 84	$ -	$ -
1020630610	Training Expense	$ 652	$ -	$ -
1020630640	Uniforms	$ 203	$ -	$ -
1020640090	Miscellaneous	$ 350	$ -	$ -
1020640090	Miscellaneous	$ (2)	$ -	$ -
1020660080	Rental Expense	$ 3,301	$ -	$ -
1020660990	Accrued Expense Estimation	$ 30	self-disallowed	$ -
5095720020	Cap Stk/Franchise Tax	$ 1,151	$ -	$ -
5095720090	Landlord Operating Taxes	$ 2,400	$ -	$ -
7010800030	Non-recurring Charges	$ 183,994	self-disallowed	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
Total Other Administrative and General		$ 214,347	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Governor's House Care and Rehabilitation	License No. 2200-C	Report for Year Ended 9/30/2015	Page 17 of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	296,874	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	29,630	Capital Interest	pg 26 12-A-1

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Center	2200-C	9/30/2015	18	37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	123,730	123,730		
2. Non-Food Supplies	$	12,228	12,228		
3. Other (*Specify*)_____	$	(5,736)	(5,736)		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	130,223	130,223		

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

H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

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

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CSP-19 Rev. 9/2002

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

Name of Facility Governor's House Care and Rehabilitation Center	License No. 2200-C	Report for Year Ended 9/30/2015		Page 19 of 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.*** — Lbs.				
Amt. $	3,644	3,644		
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. $	-816	-816		
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)* — $	119,113	119,113		
c. Management Services** — $				
d. Other (*Specify*) — $				
3E. ***Total Laundry Expenditures*** (3a + b + c + d) — $	121,941	121,941		

3F. Laundry Questionnaire			
G. Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
H. Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I. Where is the revenue received reported in the Cost Report?			(Page/Line Item)
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K. Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
L. Where is the revenue received reported in the Cost Report?			(Page/Line Item)

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Cente	2200-C	9/30/2015	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	13,988	13,988		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	178,519	178,519		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	192,507	192,507		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	209,751	209,751		
b. Medicine Cabinet Drugs		$	12,968	12,968		
c. Medical and Therapeutic Supplies		$	88,700	88,700		
d. Ambulance/Limousine***		$	7,511	7,511		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	26,116	26,116		
f. X-rays and Related Radiological Procedures***		$	17,181	17,181		
g. ~~Dental (*Not dentists who should be included under salaries or fees*)~~		$				
h. Laboratory***		$	19,315	19,315		
i. Recreation		$	28,434	28,434		
j. Other (Specify)**** See Attached Schedule		$	47,885	47,885		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	457,862	457,862		

* 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.

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Schedule of Other Resident Care

Description		CCNH	RHNS	(Specify)
3060610160	Incontinency	$ 25,368.95	$ -	$ -
3060610161	Incontinency - Rebates	$ (1,518.51)	$ -	$ -
3080630030	Advertising-Help Wan	$ 1,385.44	$ -	$ -
3080630030	Advertising-Help Wan	$ 978.54	$ -	$ -
3080630080	Books, Dues & Subscr	$ 120.00	$ -	$ -
3080630140	Education Expense	$ 866.85	$ -	$ -
3080630140	Education Expense	$ 151.08	$ -	$ -
3080630140	Education Expense	$ 590.37	$ -	$ -
3080630200	Employee Relations	$ 540.72	$ -	$ -
3120630530	Supplies	$ 612.42	$ -	$ -
3155630530	Supplies	$ 965.53	$ -	$ -
3155630530	Supplies	$ 6,907.50	$ -	$ -
3165630530	Supplies	$ 9.72	$ -	$ -
3090630535	Office Supplies	$ 1,313.21	$ -	$ -
3155660080	Rental Expense	$ (103.99)	$ -	$ -
3155660080	Rental Expense	$ 5,306.32	$ -	$ -
3010610300	Consolidated Billing	$ 4,397.78	$ -	$ -
3010610300	Consolidated Billing	$ (6.70)	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
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0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
Total Other Resident Care		$ 47,885	$ -	$ -

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CSP-21 Rev. 10/2001

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

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Center	2200-C	9/30/2015	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Laundry Purchased Services	119,113			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Housekeeping Purchased Services	178,519			20	4b
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* List all contracted services over $10,000. Use additional sheets if necessary.
** Refer to Page 4 for definition of related.
*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended			Page of
Governor's House Care and Rehabilitation Cen	2200-C	9/30/2015			22 | 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	197,584	197,584		
b. Heat	$	42,742	42,742		
c. Light & Power	$	135,815	135,815		
d. Water	$	37,601	37,601		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*) See Attached Schedule	$				
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	413,741	413,741		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	(3,429)	(3,429)		
c. Non-Movable Equipment	$	9,661	9,661		
d. Movable Equipment	$	14,917	14,917		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	21,148	21,148		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$	947,006	947,006		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	182,875	182,875		
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,151,029	1,151,029		

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

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Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Total Other Repairs and Maintenance	$ -	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Center	2200-C	9/30/2015	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**					S/L	Various		
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**	152,133		152,133	4,372	S/L	Various	0	
1. Acquired prior to this report period	(152,133)		(152,133)				(4,372)	
2. Disposals (attach schedule)	64,172		64,172				943	
3. Acquired during this report period (attach schedule)								(3,429)
B-4. Subtotal								
C. **Non-Movable Equipment**	84,087		84,087	14,989	S/L	Various	9,165	
1. Acquired prior to this report period								
2. Disposals (attach schedule)	7,445		7,445				496	
3. Acquired during this report period (attach schedule)								9,661
C-4. Subtotal								

	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)									S/L	Various		
a.												
b.												
c.												
d.												
2. Movable Equipment					78,700		78,700	29,472	S/L	Various	12,508	
a. Acquired prior to this report period												
b. Disposals (attach schedule)					41,406		41,406				2,409	
c. Acquired during this report period (attach schedule)												14,917
D-3. Subtotal												21,149
E. ***Total Depreciation***												

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Schedule of Land Improvements Acquired during this report period

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

***Ties to Page 23, Line A3**

****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
4/30/2015	2 Daikin water source heat pumps	$ 3,934.95	20	$ 81.98	
5/31/2015	Jeron Provider 680	$ 31,209.47	20	$ 520.16	
5/31/2015	Awing w/stationary pipe frame	$ 3,703.95	10	$ 123.47	
7/31/2015	Labor and material Fire door magnets	$ 7,433.87	20	$ 61.95	
7/31/2015	Weathermaster awning	$ 4,553.95	10	$ 75.90	
7/31/2015	Delayed egress maglock	$ 1,750.52	10	$ 29.18	
8/31/2015	Water source heat pump	$ 4,892.10	20	$ 20.38	
8/31/2015	Water source heat pump	$ 6,274.65	20	$ 26.14	
8/31/2015	Upper and lower cabinets and counter	$ 418.98	10	$ 3.49	
Total additions for Building Improvements		$ 64,172		$ 943	*
Deletions:					
10/31/2013	Repairs to nurse call system	(3,463.02)	20.00	(158.72)	
11/30/2013	Fire alarm	(11,750.60)	20.00	(489.61)	

11/30/2013	Mannington plank flooring	(11,887.80)	10.00	(990.66)	
11/30/2013	Water source heat pump	(5,316.44)	20.00	(221.52)	
11/30/2013	3 McQuay water source heat pumps	(5,450.00)	20.00	(227.09)	
12/31/2013	KABA Heavy Duty Lock set	(405.87)	20.00	(15.22)	
12/31/2013	KABA Heavy Duty Lock set	(1,217.62)	20.00	(45.66)	
1/31/2014	3 McQuay heat pumps	(5,796.08)	20.00	(193.20)	
1/31/2014	120 gal hot water stotage tank	(18,239.53)	20.00	(607.99)	
1/31/2014	Closet exhaust fan	(4,200.83)	20.00	(140.03)	
1/31/2014	2 McQuary consoles WSHP	(6,912.75)	20.00	(230.43)	
3/31/2014	Rebuilt pump on generator	(21,150.15)	20.00	(528.75)	
3/31/2014	Transmitter and System Tester	(666.16)	15.00	(22.21)	
4/30/2014	fire alarm system	(2,954.67)	20.00	(61.56)	
7/31/2014	Final install payment Healthcare Cor	(21,107.28)	20.00	(175.90)	
7/31/2014	Natural Gas Water Heater	(10,507.38)	20.00	(87.56)	
7/31/2014	1st install payment Healthcare Comm	(21,107.28)	20.00	(175.90)	
Total deletions for Building Improvements		$ (152,133)		$ (4,372)	**

***Ties to Page 23, Line B3**

****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
1/31/2015	Water source heat pump	$ 7,444.50	10	$ 496.30	
Total additions for Non-Movable Equipment		$ 7,445		$ 496	*
Deletions:					
Total deletions for Non-Movable Equipment		$ -		$ -	**

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

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

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
2/28/2015	Water source heat pump	6,646.88	7.00	553.91
2/28/2015	Water source heat pump	4,307.18	7.00	358.93
3/31/2015	15 Continu us 26i Long Term Care	4,948.75	7.00	353.48
4/30/2015	Reliant 450 Series Floor Lift	1,325.10	7.00	78.88
4/30/2015	Digital Lift Scale, 600 lb. Capacity	739.35	7.00	44.01
4/30/2015	Reliant 350 Series Sit-to-Stand	2,384.35	7.00	141.93

5/31/2015	Invacare Perfecto2 V 5-Liter Oxygen (	3,865.65	7.00	184.08	
12/31/2014	(2) 1.6 cu medical grade refrigerators	1,055.08	10.00	79.13	
2/28/2015	3 Tracer EX2 wheelchairs	476.94	10.00	27.82	
4/30/2015	2 GEN ONLY 80i UCXT Beds and ra	7,828.32	10.00	326.18	
5/31/2015	5 GEN ONLY 80i UCXT BED and	7,828.32	10.00	260.94	
Total additions for Movable Equipment		$ 41,406		$ 2,409	*
Deletions:					
Total deletions for Movable Equipment		$ -		$ -	**

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

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

Schedule of Leasehold Improvements Acquired during this report period

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

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Center	2200-C	9/30/2015	24	37

Item	Date of Acquisition: Month	Date of Acquisition: Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									

* Straight-line method must be used.

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.

B. Life of mortgage; OR

C. Remaining Life of Lease; OR

D. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitat	2200-C	9/30/2015	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ◉ No

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	73
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

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

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

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
SABRA, 101 Sun Ave. NE, Albuquerque, NM 87107	Facility Lease	11/15/10 - 6/30	87	947,006

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

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

Name of Facility	License No.	Report for Year Ended			Page of
Governor's House Care and Rehabilita	2200-C	9/30/2015			26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	29,630	29,630		
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)	$	29,630	29,630		

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page of
Governor's House Care and Rehabil	2200-C	9/30/2015	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	29,630	29,630		
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) $	29,630	29,630		
14. Insurance				
a. Insurance on Property (buildings only) $	4,724	4,724		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	83,568	83,568		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	88,292	88,292		
15. ***Total All Expenditures (A-13 thru C-14)*** $	8,676,809	8,676,809		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Governor's House Care and Rehabilitation Center	2200-C	9/30/2015	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $	20,106	20,106		
Page 13 - Professional Fees							
5.	13	B-8-c	Resident Care Physicians ** $				
6.		B-10	Occupational Therapy $				
7.			Other - See attached Schedule $	667,663	667,663		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1-c	Bad Debts $	174,287	174,287		
10.			Accounting & Legal $				
11.			Telephone $				
12.			Cellular Telephone $				
13.			Life insurance premiums on the life of Owners, Partners, Operators $				
14.			Gifts, flowers and coffee shops $				
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.			Automobile Expense (e.g. personal use) $				
18.	16	m-2 &	Unallowable Advertising * $	11,427	11,427		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $	(321)	(321)		
21.			Unallowable Management Fees $	379,231	379,231		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	185,547	185,547		
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) $	1,437,939	1,437,939		

(Carry Subtotal forward to next page)

* All except "Help Wanted".

** 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	$ 20,106.00	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
Total Other Salaries Adjustment				$ 20,106	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	$ 70,323.32	$ -	$ -
13	5	Rehabilitation Services	3195620020	$ 504,270.90	$ -	$ -
13	9	Speech Therapist	3170620020	$ 18,357.13	$ -	$ -
13	10	Occupational Therapist	3105620020	$ 56,459.52	$ -	$ -
13	12	Other	3010620020	$ 119.70	$ -	$ -
13	12	Other	3015620020	$ 14,694.00	$ -	$ -
13	12	Respiratory Purchased Servies	3155620020	$ 3,438.62	$ -	$ -
Total Other Fees Adjustments				$ 667,663	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	0	$ 831.95	$ -	$ -
16	m-8a	Chamber of Commerce	0	$ 690.00	$ -	$ -
16	m-13	Estimated Accrual	0	$ 30.34	$ -	$ -
16	m-13	Penalty	0	$ -	$ -	$ -
16	m-13	Non-recurring Charges	0	$ 183,994.44	$ -	$ -
16	m-12	Management Fee disallowed	CBO service Fee	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
Total Other A&G Adjustments				$ 185,547	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	1,437,939	1,437,939		
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs $	209,751	209,751		
28.	20	5-d	Ambulance/Limousine $	7,511	7,511		
29.	20	5-f	X-rays, etc $	17,181	17,181		
30.	20	5-h	Laboratory $	19,315	19,315		
31.			Medical Supplies $				
32.	20	5-e-2	Oxygen (non emergency) $	26,116	26,116		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	36,174	36,174		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule $				
36.			Depreciation on Unallowable Motor Vehicles $				
37.			Unallowable Property and Real Estate Taxes $				
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.			Property Insurance $				
Other - Miscellaneous							
42.			Research or Experimental Activities $				
43.			Radio and Television Revenue $				
44.			Vending Machine Revenue $				
45.			Purchase Discounts and Allowances $				
46.			Duplications of functions or services $				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest $				
48.			Interest Income on Accounts Rec $				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule $	11,227	11,227		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule $				
51.			***Total Amount of Decrease (Items 1 - 50)*** $	1,765,214	1,765,214		

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

Attachment Page 29

Governor's House Care and Rehabilitation Center
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Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	$ 4,391.08	$ -	$ -
20	5-j	Respiratory Supplies	$ 7,873.03	$ -	$ -
20	5-j	Respiratory Rental	$ 5,202.33	$ -	$ -
20	5-i	Cable TV	$ 18,707.53	$ -	allow $3600
0	0-Jan		0 $ -	$ -	$ -
0	0-Jan		0 $ -	$ -	$ -
0	0-Jan		0 $ -	$ -	$ -
0	0-Jan		0 $ -	$ -	$ -
0	0-Jan		0 $ -	$ -	$ -
0	0-Jan		0 $ -	$ -	$ -
Total Other Ancillary Costs			$ 36,174	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other Adjustments

Page Ref	Line Ref	Description		CCNH	RHNS	(Specify)
27	14 c1	General liability Insurance Adjust		$ 11,226.94	$ -	$ -
0	0-Jan		0	$ -	$ -	$ -
0	0-Jan		0	$ -	$ -	$ -
0	0-Jan		0	$ -	$ -	$ -
0	0-Jan		0	$ -	$ -	$ -
0	0-Jan		0	$ -	$ -	$ -
0	0-Jan		0	$ -	$ -	$ -
0	0-Jan		0	$ -	$ -	$ -
0	0-Jan		0	$ -	$ -	$ -
0	0-Jan		0	$ -	$ -	$ -
Total Other Adjustments				$ 11,227	$ -	$ -

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitatio	2200-C	9/30/2015	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	7,679,504	7,679,504		
b. Medicaid Room and Board Contractual Allowance **	$	(3,826,044)	(3,826,044)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	2,271,757	2,271,757		
b. Medicare Room and Board Contractual Allowance **	$	(833,973)	(833,973)		
4. a. Private-Pay Residents and Other	$	1,608,541	1,608,541		
b. Private-Pay Room and Board Contractual Allowance **	$	(442,286)	(442,286)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	170,660	170,660		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(62,650)	(62,650)		
c. Prescription Drugs - Non-Medicare	$	61,799	61,799		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(18,589)	(18,589)		
2. a. Medical Supplies - Medicare	$	389	389		
b. Medical Supplies - Medicare Contractual Allowance **	$	(143)	(143)		
c. Medical Supplies - Non-Medicare	$	189	189		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(63)	(63)		
3. a. Physical Therapy - Medicare	$	691,364	691,364		
b. Physical Therapy - Medicare Contractual Allowance **	$	(253,803)	(253,803)		
c. Physical Therapy - Non-Medicare	$	191,347	191,347		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(53,841)	(53,841)		
4. a. Speech Therapy - Medicare	$	106,180	106,180		
b. Speech Therapy - Medicare Contractual Allowance **	$	(38,979)	(38,979)		
c. Speech Therapy - Non-Medicare	$	27,297	27,297		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(7,643)	(7,643)		
5. a. Occupational Therapy - Medicare	$	659,804	659,804		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(242,217)	(242,217)		
c. Occupational Therapy - Non-Medicare	$	196,135	196,135		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(54,550)	(54,550)		
6. a. Other *(Specify)* - Medicare	$	10,213	10,213		
b. Other *(Specify)* - Non-Medicare	$	6,984	6,984		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	7,847,383	7,847,383		
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	$	2,088	2,088		
5. Interest Income *(Specify)*	$	78	78		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$	6,256	6,256		
8. Other (*Specify*)	$	749	749		
V. Total Other Revenue (1 thru 8)	$	9,172	9,172		
VI. Total All Revenue (III +V)	$	7,856,554	7,856,554		

* *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	-	-	0
II-6-a	Medicare Part A	Radiology Service	-	-	0
II-6-a	Medicare Part A	Outpatient Therapy Program	-	-	0
II-6-a	Medicare Part A	Laboratory	12,299.94	-	0
II-6-a	Medicare Part A	Respiratory Therapy & Supplie	1,307.50	-	0
II-6-a	Medicare Part A	Nursing Treatment Supplies	-	-	0
II-6-a	Medicare Part A	Audiology	-	-	0
II-6-a	Medicare Part A	Incontinency	-	-	0
II-6-a	Medicare Part A	Oxygen & Supplies	-	-	0
II-6-a	Medicare Part A	Physician Visit	-	-	0
II-6-a	Medicare Part A	Ambulance	-	-	0
II-6-a	Medicare Part A	Flu Shot	2,530.00	-	0
II-6-a	Contractuals-Medicare	X-Ray	-	-	0
II-6-a	Contractuals-Medicare	Radiology Service	-	-	0
II-6-a	Contractuals-Medicare	Outpatient Therapy Program	-	-	0
II-6-a	Contractuals-Medicare	Laboratory	(4,515.37)	-	0
II-6-a	Contractuals-Medicare	Respiratory Therapy & Supplie	(479.99)	-	0
II-6-a	Contractuals-Medicare	Nursing Treatment Supplies	-	-	0
II-6-a	Contractuals-Medicare	Audiology	-	-	0
II-6-a	Contractuals-Medicare	Incontinency	-	-	0
II-6-a	Contractuals-Medicare	Oxygen & Supplies	-	-	0
II-6-a	Contractuals-Medicare	Physician Visit	-	-	0
II-6-a	Contractuals-Medicare	Ambulance	-	-	0
II-6-a	Contractuals-Medicare	Flu Shot	(928.78)	-	0
Total Other Resident Revenue - Medicare			$ 10,213	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
Related Ex	0	0	-	-	-
Page Ref	Payor	Description	CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	-	-	-
II-6-b	Medicaid	Radiology Service	-	-	-
II-6-b	Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Medicaid	Laboratory	923.60	-	-
II-6-b	Medicaid	Respiratory Therapy & Supplie	7,060.84	-	-
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	-	-	-
II-6-b	Contractuals Medicaid	Radiology Service	-	-	-
II-6-b	Contractuals Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Contractuals Medicaid	Laboratory	(460.15)	-	-
II-6-b	Contractuals Medicaid	Respiratory Therapy & Supplie	(3,517.82)	-	-
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	Private and Other	X-Ray	-	-	-
II-6-b	Private and Other	Radiology Service	-	-	-
II-6-b	Private and Other	Outpatient Therapy Program	-	-	-
II-6-b	Private and Other	Laboratory	3,499.65	-	-
II-6-b	Private and Other	Respiratory Therapy & Supplie	607.71	-	-
II-6-b	Private and Other	Nursing Treatment Supplies	-	-	-
II-6-b	Private and Other	Audiology	-	-	-
II-6-b	Private and Other	Incontinency	-	-	-
II-6-b	Private and Other	Oxygen & Supplies	-	-	-
II-6-b	Private and Other	Physician Visit	-	-	-
II-6-b	Private and Other	Ambulance	-	-	-
II-6-b	Private and Other	Flu Shot	-	-	-
II-6-b	Private and Other	Capitation Contracts	-	-	-
II-6-b	Contractuals-Non-Medicaid	X-Ray	-	-	-
II-6-b	Contractuals-Non-Medicaid	Radiology Service	-	-	-
II-6-b	Contractuals-Non-Medicaid	Outpatient Therapy Program	-	-	-
II-6-b	Contractuals-Non-Medicaid	Laboratory	(962.27)	-	-
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplie	(167.10)	-	-
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	-	-	-
Total Other Resident Revenue			$ 6,984	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 30 line 1	430055	Interest On Overdue Accounts	$ 78.15	$ -	$ -
Total Interest Income			$ 78	$ -	$ -

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
			-	-	-
Pg 30 line 1	Donation	430060	225.02	-	-
Pg 30 line 1	JNF Enterprises LLC	0	15.00	-	-
Pg 30 line 1	Medical Record	0	509.38	-	-
Total Other Revenue			$ 749	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitati	2200-C	9/30/2015	31	37

Account			Amount
Assets			
A. Current Assets			
1. Cash (*on hand and in banks*)			$ 3,930
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			$ 837,255
3. Other Accounts Receivable (Excluding Owners or Related Parties)			$ 919
4 Inventories			$ 45,831
5. Prepaid Expenses			$ 74,062
a. Prepaid Expenses		26,371	
b. Prepaid Personal Property Tax			
c. Prepaid Personal Property Tax		2,937	
d. Interest Receivable			
6. Interest Receivable			$
7. Medicare Final Settlement Receivable			$
8. Other Current Assets (*itemize*)			$
Total Current Assets (Lines A1 thru 8)			
A-9. ***Total Current Assets*** (Lines A1 thru 8)			$ 961,997
B. Fixed Assets			
1. Land			$
2. Land Improvements	*Historical Cost		$
	Accum. Depreciation	Net	
3. Buildings	*Historical Cost	64,172	$ 63,229
	Accum. Depreciation	943 Net	
4. Leasehold Improvements	*Historical Cost		$
	Accum. Depreciation	Net	
5. Non-Movable Equipment	*Historical Cost	91,531	$ 66,881
	Accum. Depreciation	24,650 Net	
6. Movable Equipment	*Historical Cost	120,106	$ 75,717
	Accum. Depreciation	44,389 Net	
7. Motor Vehicles	*Historical Cost		$
	Accum. Depreciation	Net	
8. Minor Equipment-Not Depreciable			$
9. Other Fixed Assets (*itemize*)			$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)			$ 205,827

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitatic	2200-C	9/30/2015	32	37

Account			Amount
		Total Brought Forward:	$ 1,167,824
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 (*temize*)			$
6. Loans to Owners or Related Parties (*temize*)			$
Name and Address	Amount	Loan Date	
7. Other Assets (*itemize*)			$ (2,609,719)
I/C Due to/Due From Owned	(2,609,719)		
I/C Due to/Due From Multicare			
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$ (2,609,719)
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$ (1,441,895)

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation Cent	2200-C	9/30/2015	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 232,341
2. Notes Payable (*itemize*)					$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll(*Exclusive of Owners and/or Stockholders only*)					$ 235,169
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 400
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 286,881
Accrued Provider/Bed Tax	94,905	Accr Exp Electricity	8,899		
A/R Credit Gross Up Liability	104,856	Deferred Revenue	14,341		
Accr Exp Water and Sewer and GAS	5,769	Accr Exp Other	48,365		
Accr Exp Suspense	(1,894)	Accr Gross Rec Tax	11,640		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 754,791

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation C	2200-C	9/30/2015	34	37

Account	Amount
Total Brought Forward:	754,791
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$ 245,933
LT Debt-Financing Obligation 245,933	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$ 245,933
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 1,000,724

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

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitat	2200-C	9/30/2015	35	37

Account	Amount
A. **Reserves**	
1. Reserve for value of leased land	$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
3. Reserve for depreciation value of leased personal property *(equity)*	$
4. Reserve for leasehold real properties on which fair rental value is based	$
5. Reserve for funds set aside as donor restricted	$
6. Total Reserves	$
B. **Net Worth**	
1. Owner's Capital	$
2. Capital Stock	$
3. Paid-in Surplus	$
4. Treasury Stock	$
5. Cumulated Earnings	$ (1,622,361)
6. Gain or Loss for Period 10/1/2014 thru 9/30/2015	$ (820,257)
7. Total Net Worth	$ (2,442,618)
C. ***Total Reserves and Net Worth***	$ (2,442,618)
D. ***Total Liabilities, Reserves, and Net Worth***	$ (1,441,894)

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation	2200-C	9/30/2015	36	37

Account		Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014	$ (1,622,362)
B.	Total Revenue (*From Statement of Revenue Page 30*)	$ 7,856,553
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$ 8,676,809
D.	Net Income or Deficit	$ (820,256)
E.	Balance	$ (2,442,618)
F.	Additions	
	1. Additional Capital Contributed (*itemize*)	
	2. Other (*itemize*)	
F-3.	Total Additions	$
G.	Deductions	
	1. Drawings of Owners/Operators/Partners (*Specify*)	$

Name and Address (*No., City, State, Zip*)	Title	Amount

	2. Other Withdrawings (*Specify*)	$

Purpose	Amount

	3. Total Deductions	$
H.	***Balance at End of Period*** 09/30/15	$ (2,442,618)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Governor's House Care and Rehabilitation	2200-C	9/30/2015	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

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

Printed Name of Preparer

Thomas Farnan -Sr. Director of Reimbursement

Addres Address	Phone Number
200 Brickstone Square, Andover, MA 01810	978-247-5029