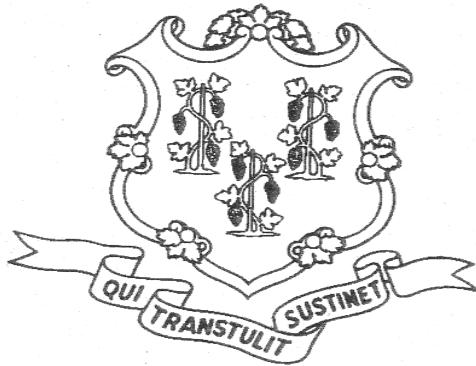


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2022

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)		Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS)		<input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2021		Report for Year Ending 9/30/2022			

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 9/30/2022	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, 2021 and ending September 30, 2022, 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**

<b>Data Required for Real Wage Adjustment</b>		Page 1A	of 37
Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center	Period Covered: From 10/1/2021 To 9/30/2022		
Address of Facility One Emerson Drive, Windsor, CT 06095			
Report Prepared By Rick Fink	Phone Number 410-494-7657	Date 12/28/2022	
Item	Total	CCNH	RHNS (Specify)
1. Dietary wages paid	\$		
2. Laundry wages paid	\$		
3. Housekeeping wages paid	\$ 37,461	37,461	
4. Nursing wages paid	\$ 4,896,621	4,896,621	
5. All other wages paid	\$ 706,047	706,047	
6. <b>Total Wages Paid</b>	\$ 5,640,129	5,640,129	
7. Total salaries paid	\$ 317,249	317,249	
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$ 5,957,378	5,957,378	

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility	Report for Year Ended	Page	of
860-688-6443	9/30/2022	2	37

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 type="checkbox"/> Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> 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/	License No. 2369	Report for Year Ended 9/30/2022	Page of 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	
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 Kir	License No. 2369	Report for Year Ended 9/30/2022	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 9/30/2022			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 type="radio"/>	<input checked="" type="radio"/>		Home Office	Pg 16/m12	530,581	530,581
Genesis ElderCare Rehabilitation Services GRS	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	74%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	602,766	602,766
		<input type="radio"/>	<input checked="" type="radio"/>				142	142
Genesis ElderCare Physician Services GPS_C	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	87%	Medical Director /NP	Pg 13/B8, Pg 10/A12		
Career Staffing Carstaff_C	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	86%	Nursing Agency/ Temporary Services	Pg 13/B11 pg 10-12, 1	84,808	83,697
Respiratory Health Services NCRHS C	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>	61%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	119,293	119,293
Insurance Program Insur_C	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	(68,121)	(68,121)
		<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 9/30/2022	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 9/30/2022	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

#### Legal Services Information

Name of Legal Firm or Independent Attorney 1 Dorsi & Dorsi Attorneys and Conselors at Law 2 3 4 5	Telephone Number 203-934-6651
--	----------------------------------

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

1 537 Washington Ave West Haven, CT 06516 2 3 4 5	
---	--

Services Provided by This Firm (*describe fully*)

1 Saving on R.E Taxes (R.E Tax Appeal and Settlement Fees)	\$
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided
	\$

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

Yes     No

## 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 9/30/2022				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					110	110						
A. On last day of PREVIOUS report period	110	110										
B. On last day of THIS report period	180	180							180	180		
2. Number of Residents					81	81						
A. As of midnight of PREVIOUS report period	81	81										
B. As of midnight of THIS report period	98	98							98	98		
3. Total Number of Days Care Provided During Period					2,758	2,758			700	700		
A. Medicare	3,458	3,458										
B. Medicaid (Conn.)	21,793	21,793			15,914	15,914			5,879	5,879		
C. Medicaid (other states)												
D. Private Pay	3,458	3,458			2,258	2,258			1,200	1,200		
E. State SSI for RCH												
F. Other (Specify)	5,029	5,029			3,922	3,922			1,107	1,107		
G. Total Care Days During Period (3A thru F)	33,738	33,738			24,852	24,852			8,886	8,886		
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	6	6			6	6						
<b>5. Total Resident Days (3G + 4A + 4B)</b>	<b>33,744</b>	<b>33,744</b>			<b>24,858</b>	<b>24,858</b>			<b>8,886</b>	<b>8,886</b>		

## 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 9/30/2022	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)
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	8	64		26				
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.								
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B		TOTAL	CCNH	RHNS	(Specify)
		728	728		
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments		1,035	1,035		
C. Other		11,409	11,409		
D. <b>Total Physical Therapy Treatments</b>		13,172	13,172		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B		140	140	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments		88	88	
C. Other		813	813	
D. <b>Total Speech Therapy Treatments</b>		1,041	1,041	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B		566	566	
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments		793	793	
C. Other		10,540	10,540	
D. <b>Total Occupational Therapy Treatments</b>		11,899	11,899	

## Report of Expenditures - Salaries &amp; Wages

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kimberly Sou	License No. 2369	Report for Year Ended 9/30/2022	Page 10	of 37	
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes <input type="radio"/> No			
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	168,435	2,048			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	267,182	11,367			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor					
c. Dietary Workers					
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers	37,461	2,069			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	32,764	1,321			
b. Other Maintenance Workers	37,478	2,012			
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	148,814	2,007			
b. RN					
1. Direct Care	1,096,582	21,597			
2. Administrative**	198,488	4,710			
c. LPN					
1. Direct Care	1,407,523	31,319			
2. Administrative**					
d. Aides and Attendants	2,127,640	80,544			
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	148,514	5,579			
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	220,108	6,275			
n. Marketing					
o. Other (Specify)					
See Attached Schedule	66,388	3,109			
<i>A-13. Total Salary Expenditures</i>	5,957,378	173,955			

\* 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 9/30/2022			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)							
<b>Section I - Operators/Owners</b>										
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										

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

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

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) 1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center				License No. 2369	Report for Year Ended 9/30/2022			Page 12	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)							
<b>Section III - Administrators***</b>										
Thomas Russo - 10/1/2021 - present	168,435				Management of Center	2,048	2			
-										
-										
<b>Section IV - Assistant Administrators</b>										
-										
-										
-										
-										

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

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

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

**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	9/30/2022		13	37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary</b> (For all such services complete Schedule B1)					
1. Dietitian					
2. Dentist	12,399	85			
3. Pharmacist	18,268	373			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	305,415	4,184			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	42,672	226			
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	63,114	809			
b. Other					
10. Occupational Therapist					
a. Resident Care	272,761	3,736			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	(1,127)	(19)			
2. Administrative***					
b. LPN					
1. Direct Care	59,433	1,403			
2. Administrative***					
c. Aides	26,502	1,085			
d. Other					
12. Other (Specify)					
See Attached Schedule	142,814				
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	942,252	11,882			

\* 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	9/30/2022	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 154,264	154,264		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 33,409	33,409		
4. Social Security (F.I.C.A.)	\$ 440,388	440,388		
5. Health Insurance	\$ 359,236	359,236		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 200,125	200,125		
8. Uniform Allowance	\$			
9. Other (Specify) See Attached Schedule	\$ 33,135	33,135		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 151,783	151,783		
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	\$ 28,770	28,770		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 12,643	12,643		
2. Cellular Phones	\$ 2,570	2,570		
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	\$ 100	100		
3. Resident Day User Fee	\$ 560,226	560,226		
<b>Subtotal</b>	\$ 1,976,651	1,976,651		

\* 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)
3005520020	\$ 901	\$ -	\$ -
3040520020	\$ 375	\$ -	\$ -
3080520020	\$ 310	\$ -	\$ -
3210520020	\$ 1,757	\$ -	\$ -
3215520020	\$ 2,434	\$ -	\$ -
3225520020	\$ 21,104	\$ -	\$ -
5035520020	\$ 387	\$ -	\$ -
3005520050	\$ 471	\$ -	\$ -
3040520050	\$ 263	\$ -	\$ -
3080520050	\$ -	\$ -	\$ -
3080520050	\$ 3,991	\$ -	\$ -
3225520050	\$ 1,000	\$ -	\$ -
1020520060	\$ 143	\$ -	\$ -
<b>Total</b>	<b>\$ 33,135</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Taxes**

Description	CCNH	RHNS	(Specify)
Sales Tax	\$ 100	\$ -	\$ -
Sales Tax	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
<b>Total</b>	<b>\$ 100</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC, d/b/a Kimbe	2369	9/30/2022	16	37
Item	Total	CCNH	RHNS	(Specify)
<b><i>Subtotals Brought Forward:</i></b>	1,976,651	1,976,651		
l. Travel and Entertainment				
1. Resident Travel and Entertainment	\$			
2. Holiday Parties for Staff	\$	246	246	
3. Gifts to Staff and Residents	\$			
4. Employee Travel	\$	126	126	
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> )	\$			
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$			
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	14,398	14,398	
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	\$	1,185	1,185	
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	12,752	12,752	
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	535	535	
9. Subscriptions	\$			
10. Contributions*** See Attached Schedule	\$			
11. Services Provided by Contract ( <i>Specify and Complete     Schedule C-2, Page 21 for each firm or individual</i> )	\$	8,919	8,919	
12. Administrative Management Services**	\$	474,707	474,707	
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	103,992	103,992	
<b><i>C-14 Total Administrative &amp; General Expenditures</i></b>	<b>\$</b>	<b>2,593,510</b>	<b>2,593,510</b>	

\* 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	\$ -	\$ -	\$ -
<b>Total Other Travel and Entertainment</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Advertising**

Description	CCNH	RHNS	(Specify)
Advertising	\$ 7,913	\$ -	\$ -
Marketing Expense	\$ 4,951	\$ -	\$ -
Marketing Exp- Corporate Spend	\$ 1,511	\$ -	\$ -
Marketing Exp- Corporate Spend	\$ -	\$ -	\$ -
Marketing Expense	\$ 22	\$ -	\$ -
	\$ -	\$ -	\$ -
<b>Total Other Advertising</b>	<b>\$ 14,398</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Dues**

Description	CCNH	RHNS	(Specify)
Licenses & Certifications	\$ 13,287	\$ -	\$ -
Dues to Chamber of Commerce	\$ (535)	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
<b>Total Dues</b>	<b>\$ 12,752</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Contributions**

Description	CCNH	RHNS	(Specify)
Contributions	\$ -	\$ -	\$ -
Political Contributions	\$ -	\$ -	\$ -
<b>Total Contributions</b>	<b>0</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Administrative and General**

Description	CCNH	RHNS	(Specify)
Bank Service Charges	\$ 12,368	\$ -	\$ -
Collection Fees	\$ 56,050	self-disallowed	\$ -
Education Expense	\$ -	\$ -	\$ -
Employee Physicals	\$ 14,060	\$ -	\$ -
Employee Relations	\$ 5,501	\$ -	\$ -
Printing	\$ 191	\$ -	\$ -
Training Expense	\$ 300	\$ -	\$ -
Fines & Penalties	\$ 3,179	self-disallowed	\$ -
Miscellaneous	\$ (232)	\$ -	\$ -
Rental Expense	\$ 4,428	\$ -	\$ -
Accrued Expense Estimation	\$ -	self-disallowed	\$ -
Landlord Operating Taxes	\$ -	\$ -	\$ -
State Tax Annual Report Filing	\$ 80	\$ -	\$ -
Recruiting Fees	\$ 7,170	\$ -	\$ -
Recruiting Fees	\$ -	\$ -	\$ -
Non-recurring Charges	\$ -	\$ -	\$ -
Uniforms	\$ -	\$ -	\$ -
Equipment Non-Capitalized	\$ 895	\$ -	\$ -
	0	\$ -	\$ -
	0	\$ -	\$ -
<b>Total Other Administrative and General</b>	<b>\$ 103,992</b>	<b>\$ -</b>	<b>\$ -</b>

State of Connecticut

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

CSP-17 Rev. 10/97

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

Name of Facility	License No.	Report for Year Ended	Page of
1 Emerson Drive South Operations LLC,	2369	9/30/2022	17   37
Genesis Administrative Services LLC, 101 East St., Kennett Square, PA 19348	530,581	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
	2369	9/30/2022		18   37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 193,309	193,309		
2. Non-Food Supplies	\$ 28,255	28,255		
3. Other (Specify) _____	\$ _____			
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 646,380	646,380		
c. Other (Specify) _____	\$ _____			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 867,944</b>	<b>867,944</b>		
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 9/30/2022	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. \$	4,871	4,871	
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. \$	7,949	7,949	
b. Purchased Services ( <i>by contract other than through Management Services</i> ) (Complete Schedule C-2 att. Page 21)	\$	188,768	188,768	
c. Other (Specify)	\$			
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	<b>201,588</b>	<b>201,588</b>	
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	9/30/2022		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 14,427	14,427		
1. Supplies - Cleaning ( <i>Mops, pails, brooms, etc.</i> )					
b. Purchased Services ( <i>by contract other than through Management Services</i> ) <i>(Complete Schedule C-2 att. Page 21)</i>	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 278,979	278,979		
C. Other ( <i>Specify</i> )	\$				
<b>4D. Total Housekeeping Expenditures (4a + b + c )</b>	\$	<b>293,406</b>	<b>293,406</b>		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from	\$	295,125	295,125		
b. Medicine Cabinet Drugs	\$	51,714	51,714		
c. Medical and Therapeutic Supplies	\$	214,130	214,130		
d. Ambulance/Limousine***	\$	2,495	2,495		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	6,934	6,934		
f. X-rays and Related Radiological Procedures***	\$	6,441	6,441		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h. Laboratory***	\$	45,497	45,497		
i. Recreation	\$	26,560	26,560		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other ( <i>Specify</i> )**** See Attached Schedule	\$	99,776	99,776		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>	\$	<b>748,671</b>	<b>748,671</b>		

\* 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)
Incontinency	\$ 49,057	\$ -	\$ -
Incontinency - Rebates	\$ (7,144)	\$ -	\$ -
Advertising-Help Wanted	\$ 11,428	\$ -	\$ -
Books, Dues & Subscriptions	\$ -	\$ -	\$ -
Education Expense	\$ 130	\$ -	\$ -
Supplies	\$ 3,393	\$ -	\$ -
Supplies	\$ 16,896	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -
Office Supplies	\$ -	\$ -	\$ -
Office Supplies	\$ -	\$ -	\$ -
Office Supplies	\$ -	\$ -	\$ -
Training Expense	\$ -	\$ -	\$ -
Rental Expense	\$ -	\$ -	\$ -
Rental Expense	\$ 25,025	\$ -	\$ -
Consolidated Billing	\$ 843	\$ -	\$ -
Tuition Reimbursement	\$ -	\$ -	\$ -
Tuition Reimbursement	\$ -	\$ -	\$ -
Tuition Reimbursement	\$ -	\$ -	\$ -
Employee Relations	\$ 149	\$ -	\$ -
Licenses & Certifications	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -
T&E-Lodging/Transportation	\$ -	\$ -	\$ -
	0	\$ -	\$ -
<b>Total Other Resident Care</b>	<b>\$ 99,776</b>	<b>\$ -</b>	<b>\$ -</b>

**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	License No.	Report for Year Ended 9/30/2022			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	181,370	181,370			
b. Heat	\$	91,186	91,186			
c. Light & Power	\$	126,288	126,288			
d. Water	\$	137,721	137,721			
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$					
f. Other ( <i>itemize</i> )	\$					
See Attached Schedule						
6g. <b>Total Maint. &amp; Operating Expense</b> (6a - 6f)	\$	536,564	536,564			
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$	809	809			
b. Building & Building Improvements	\$	13,627	13,627			
c. Non-Movable Equipment	\$	5,045	5,045			
d. Movable Equipment	\$	20,060	20,060			
*7e. <b>Total Depreciation Costs</b> (7a + b + c + d)	\$	39,542	39,542			
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other ( <i>Specify</i> )	\$					
*8e. <b>Total Amortization Costs</b> (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	313,675	313,675			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	84,860	84,860			
c. Personal property taxes	\$					
11. <b>Total Property Expenses</b> (7e + 8e + 9 + 10)	\$	438,077	438,077			

\* 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**

## Depreciation Schedule

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kimberly South Center				License No. 2369			Report for Year Ended 9/30/2022				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. <b>Land Improvements</b>													
1. Acquired prior to this report period				8,094		8,094	1,484	S/L	Various	809			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal											809		
B. <b>Building and Building Improvements</b>													
1. Acquired prior to this report period				36,071		36,071	6,062	S/L	Various	3,296			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)				162,517		162,517				10,331			
B-4. Subtotal											13,627		
C. <b>Non-Movable Equipment</b>													
1. Acquired prior to this report period				42,186		42,186	7,532	S/L	Various	4,218			
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)				12,403		12,403			827	827			
C-4. Subtotal											5,045		
D. <b>Movable Equipment</b>	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									
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					135,283		135,283	20,852	S/L	Various	19,746		
b. Disposals (attach schedule)													
Acquired during this report period (attach schedule):													
c. Administrative					16,743		16,743				314		
d. Standard Resident													
e. Specialized Resident													
Total Acquired during this report period					16,743		16,743				314		
D-3. Subtotal											20,060		
E. <b>Total Depreciation</b>											39,541		

**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
<b>Additions:</b>				
3/31/2022	New Fire Door & Associated Door Hardw	\$ 4,585	20	\$ 115
8/31/2022	Hollow Metal Door - Boiler Room	\$ 4,992	20	\$ 21
5/31/2022	Hot Water Storage Tank	\$ 116,788	5	\$ 7,786
5/31/2022	Additional work for hot water heater repla	\$ 2,000	5	\$ 133
5/31/2022	Hot Water Heater	\$ 34,152	5	\$ 2,277
<b>Total additions for Building Improvement:</b>		\$ 162,517		\$ 10,331
<b>Deletions:</b>				
<b>Total deletions for Building Improvement:</b>		\$ -		\$ -

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
1/31/2022	New 5 ton RTU unit for Dining Room	\$ 12,403	10	\$ 827
<b>Total additions for Non-Movable Equipment</b>		\$ 12,403		\$ 827
<b>Deletions:</b>				
<b>Total deletions for Non-Movable Equipment</b>		\$ -		\$ -

\*Ties to Page 23, Line C3

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

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

\*Ties to Page 23, Line D2c

\*\*Ties to Page 23, Line D2c

**Schedule of Leasehold Improvements Acquired during this report period**

\*Ties to Page 24, Line C3

\*\*Ties to Page 24, Line C2

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## Amortization Schedule\*

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kimberly Sou			License No. 2369		Report for Year Ended 9/30/2022			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 9/30/2022	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	110			
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	313,675
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 9/30/2022			Page of 26   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 00					
2. Second Mortgage	\$				
Name of Lender	Rate				
Address of Lender 00					
3. Third Mortgage	\$				
Name of Lender	Rate				
Address of Lender 00					
4. Fourth Mortgage	\$				
Name of Lender	Rate				
Address of Lender 00					
B. CHEFA Loan Information					
1. Original Loan Amount	\$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
12 B7. <b>Total Building Interest Expense (A1 - A4 + B5)</b>	\$				

(Carry Subtotals forward to next page )

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

Name of Facility	License No.	Report for Year Ended 9/30/2022			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						
00						
2. Other (Specify)			\$			
A. Item	Rate	Amount				
Lender						
Address of Lender						
00						
B. Item	Rate	Amount				
Lender						
Address of Lender						
00						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)			\$			
12. D. Other Interest Expense (Specify)			\$			
13. <b>Total All Interest Expense</b> (12B7 + 12C3 + 12D)			\$			
14. Insurance						
a. Insurance on Property (buildings only)			\$ 14,011	14,011		
b. Insurance on Automobiles			\$			
c. Insurance other than Property (as specified above)						
1. Umbrella ( <i>Blanket Coverage</i> )			\$ (82,132)	(82,132)		
2. Fire and Extended Coverage			\$			
3. Other (Specify)			\$			
14d. <b>Total Insurance Expenditures</b> (14a + b + c)			\$ (68,121)	(68,121)		
15. <b>Total All Expenditures</b> (A-13 thru C-14)			\$ 12,511,268	12,511,268		

## **D. Adjustments to Statement of Expenditures**

Name of Facility 1 Emerson Drive South Operations LLC, d/b/a Kimberly South			License No. 2369	Report for Year Ended 9/30/2022		Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b><i>Page 10 - Salaries and Wages</i></b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 45,791	45,791		
<b><i>Page 13 - Professional Fees</i></b>							
5.	13	B-8-c	Resident Care Physicians **	\$			
6.		B-10	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 764,477	764,477		
<b><i>Pages 15 &amp; 16 - Administrative and General</i></b>							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 151,783	151,783		
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 *	\$ 14,398	14,398		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$ (55,874)	(55,874)		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 17,402	17,402		
<b><i>Page 18 - Dietary Expenditures</i></b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b><i>Page 19 - Laundry Expenditures</i></b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b><i>Page 20 - Housekeeping Expenditures</i></b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ 937,977	\$ 937,977			

\* 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	\$ 45,791	\$ -	\$ -
0	0		0	\$ -	\$ -
0	0		0	\$ -	\$ -
0	0		0	\$ -	\$ -
0	0		0	\$ -	\$ -
0	0		0	\$ -	\$ -
0	0		0	\$ -	\$ -
<b>Total Other Salaries Adjustment</b>			<b>\$ 45,791</b>	<b>\$ -</b>	<b>\$ -</b>

---

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	\$ 82,101	\$ -	\$ -
13	5	Rehabilitation Services	\$ 223,314	\$ -	\$ -
13	9	Speech Therapist	\$ 63,114	\$ -	\$ -
13	10	Occupational Therapist	\$ 272,761	\$ -	\$ -
13	12	Other	\$ 252	\$ -	\$ -
13	12	Other	\$ 4,051	\$ -	\$ -
13	12	Respiratory Purchased Servies	\$ 117,773	\$ -	\$ -
13	11a	Nursing Agency Purchased -RN	\$ 44	\$ -	\$ -
13	11b	Nursing Agency Purchased -LPN	\$ 738	\$ -	\$ -
13	11c	Nursing Agency Purchased -Certified Nursing Aides	\$ 329	\$ -	\$ -
<b>Total Other Fees Adjustments</b>			<b>\$ 764,477</b>	<b>\$ -</b>	<b>\$ -</b>

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**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	\$ 56,050	\$ -	\$ -
16	m-13	Estimated Accrual	\$ -	\$ -	\$ -
16	m-13	Non-recurring Charges	\$ -	\$ -	\$ -
16	m-13	Dues to Chamber of Commerce	\$ 535	\$ -	\$ -
16	m-13	Penalty	\$ 3,179	\$ -	\$ -
16	m-12		0	\$ -	\$ -
15	1-a-1	adj workers comp	\$ (42,362)	\$ -	\$ -
13	B12	Adj to the SNAP Strike Cost (disallowabe)	\$ -	\$ -	\$ -
0	0		0	\$ -	\$ -
0	0		0	\$ -	\$ -
0	0		0	\$ -	\$ -
0	0		0	\$ -	\$ -
<b>Total Other A&amp;G Adjustments</b>			<b>\$ 17,402</b>	<b>\$ -</b>	<b>\$ -</b>

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**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 So			2369	9/30/2022		29   37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 937,977	937,977		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5-a-2	Prescription Drugs	\$ 295,125	295,125		
28.	20	5-d	Ambulance/Limousine	\$ 2,495	2,495		
29.	20	5-f	X-rays, etc	\$ 6,441	6,441		
30.	20	5-h	Laboratory	\$ 45,497	45,497		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 6,934	6,934		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 42,764	42,764		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ (25,155)	(25,155)		
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$ 17,874	17,874		
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ (174,520)	(174,520)		
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 1,155,433	1,155,433		

\*\*\* 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	\$ 843	\$ -	\$ -
20	5-j	Respiratory Supplies	\$ 16,896	\$ -	\$ -
20	5-j	Respiratory Rental	\$ 25,025	\$ -	\$ -
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	\$ -	\$ -
<b>Total Other Ancillary Costs</b>			<b>\$ 42,764</b>	<b>\$ -</b>	<b>\$ -</b>

**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	\$ (520)	\$ -	\$ -
Page 22	7d	Movable Equip	\$ (18,651)	\$ -	\$ -
0	0-Jan		0	\$ -	\$ -
0	0-Jan		0	\$ -	\$ -
0	0-Jan		0	\$ -	\$ -
0	0-Jan		0	\$ -	\$ -
0	0-Jan		0	\$ -	\$ -
<b>Total Excess Movable Equipment Depreciation</b>			<b>\$ (25,155)</b>	<b>\$ -</b>	<b>\$ -</b>

**Schedule of Other Property Adjustments**

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

Schedule of Other - Indirect Adjustments

Attachment Page 29

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-i	Cable TV - Allowable \$3,600 Account#3005660130	\$ 17,874	\$ -	\$ -
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	\$ -	\$ -
<b>Total Other Adjustments</b>			<b>\$ 17,874</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14c1	General liability Insurance Adjust	\$ (174,520)	\$ -	\$ -
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	\$ -	\$ -
<b>Total Other Adjustments</b>			<b>\$ (174,520)</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Adjustments</b>			<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

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

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended 9/30/2022			Page of 30   37
Item		Total	CCNH	RHNS	(Specify)
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 9,238,776	9,238,776			
b. Medicaid Room and Board Contractual Allowance **	\$ (3,941,042)	(3,941,042)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,608,387	1,608,387			
b. Medicare Room and Board Contractual Allowance **	\$ 97,637	97,637			
4. a. Private-Pay Residents and Other	\$ 3,912,691	3,912,691			
b. Private-Pay Room and Board Contractual Allowance **	\$ (1,024,281)	(1,024,281)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 121,147	121,147			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ 7,354	7,354			
c. Prescription Drugs - Non-Medicare	\$ 239,883	239,883			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (64,959)	(64,959)			
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$ 97	97			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (26)	(26)			
3. a. Physical Therapy - Medicare	\$ 217,900	217,900			
b. Physical Therapy - Medicare Contractual Allowance **	\$ 13,228	13,228			
c. Physical Therapy - Non-Medicare	\$ 439,108	439,108			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (123,358)	(123,358)			
4. a. Speech Therapy - Medicare	\$ 38,385	38,385			
b. Speech Therapy - Medicare Contractual Allowance **	\$ 2,330	2,330			
c. Speech Therapy - Non-Medicare	\$ 88,746	88,746			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (26,344)	(26,344)			
5. a. Occupational Therapy - Medicare	\$ 231,985	231,985			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ 14,083	14,083			
c. Occupational Therapy - Non-Medicare	\$ 375,137	375,137			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (104,396)	(104,396)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 63,518	63,518			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 165,590	165,590			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 11,591,576	11,591,576			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$ 1,319	1,319			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$ 5,647	5,647			
8. Other ( <i>Specify</i> )	\$ 495,257	495,257			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 502,223	502,223			
<b>VI. Total All Revenue</b> (III +V)	\$ 12,093,799	12,093,799			

\* 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)
I-6-a	Medicare - X-Ray	\$ 2,235	\$ -	\$ -
I-6-a	Medicare - Laboratory	\$ 17,656	\$ -	\$ -
I-6-a	Medicare - Respiratory Therapy & Supplies	\$ 27,101	\$ -	\$ -
I-6-a	Medicare - Nursing Treatment Supplies	\$ -	\$ -	\$ -
I-6-a	Medicare - Audiology	\$ -	\$ -	\$ -
I-6-a	Medicare - Incontinency	\$ -	\$ -	\$ -
I-6-a	Medicare - Oxygen & Supplies	\$ -	\$ -	\$ -
I-6-a	Medicare - Physician Visit	\$ -	\$ -	\$ -
I-6-a	Medicare - Ambulance	\$ -	\$ -	\$ -
I-6-a	Medicare - Flu Shot	\$ 12,602	\$ -	\$ -
I-6-a	Medicare Contractual - X-Ray	\$ 153	\$ -	\$ -
I-6-a	Medicare Contractual - Laboratory	\$ 1,072	\$ -	\$ -
I-6-a	Medicare Contractual - Respiratory Therapy & Supplies	\$ 1,645	\$ -	\$ -
I-6-a	Medicare Contractual - Nursing Treatment Supplies	\$ -	\$ -	\$ -
I-6-a	Medicare Contractual - Audiology	\$ -	\$ -	\$ -
I-6-a	Medicare Contractual - Incontinency	\$ -	\$ -	\$ -
I-6-a	Medicare Contractual - Oxygen & Supplies	\$ -	\$ -	\$ -
I-6-a	Medicare Contractual - Physician Visit	\$ -	\$ -	\$ -
I-6-a	Medicare Contractual - Ambulance	\$ -	\$ -	\$ -
I-6-a	Medicare Contractual - Flu Shot	\$ 765	\$ -	\$ -
0		\$ -	\$ -	\$ -
<b>Total Other Resident Revenue - Medicare</b>		<b>\$ 63,518</b>	<b>\$ -</b>	<b>\$ -</b>

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

### Related Exp

Page	Ref	Description	CCNH	RHNS	(Specify)
I	I-6-b	Medicaid- X-Ray	314.52	-	-
I	I-6-b	Medicaid- Laboratory	1,545.10	-	-
I	I-6-b	Medicaid- Respiratory Therapy & Supplies	66,750.57	-	-
I	I-6-b	Medicaid- Nursing Treatment Supplies	-	-	-
I	I-6-b	Medicaid- Audiology	-	-	-
I	I-6-b	Medicaid- Incontinency	-	-	-
I	I-6-b	Medicaid- Oxygen & Supplies	-	-	-
I	I-6-b	Medicaid- Physician Visit	-	-	-
I	I-6-b	Medicaid- Ambulance	-	-	-
I	I-6-b	Medicaid- Flu Shot	-	-	-
I	I-6-b	Contractuals-Medicaid- X-Ray	(134.17)	-	-
I	I-6-b	Contractuals-Medicaid- Laboratory	(659.10)	-	-
I	I-6-b	Contractuals-Medicaid- Respiratory Therapy & Supplies	(24,208.44)	-	-
I	I-6-b	Contractuals-Medicaid- Nursing Treatment Supplies	-	-	-
I	I-6-b	Contractuals-Medicaid- Audiology	-	-	-
I	I-6-b	Contractuals-Medicaid- Incontinency	-	-	-
I	I-6-b	Contractuals-Medicaid- Oxygen & Supplies	-	-	-
I	I-6-b	Contractuals-Medicaid- Physician Visit	-	-	-
I	I-6-b	Contractuals-Medicaid- Ambulance	-	-	-
I	I-6-b	Contractuals-Medicaid- Flu Shot	-	-	-
I	I-6-b	Non-Medicaid- X-Ray	3,601.60	-	-
I	I-6-b	Non-Medicaid- Laboratory	5,830.11	-	-
I	I-6-b	Non-Medicaid- Respiratory Therapy & Supplies	44,711.43	-	-
I	I-6-b	Non-Medicaid- Nursing Treatment Supplies	-	-	-
I	I-6-b	Non-Medicaid- Audiology	-	-	-
I	I-6-b	Non-Medicaid- Incontinency	-	-	-
I	I-6-b	Non-Medicaid- Oxygen & Supplies	-	-	-
I	I-6-b	Non-Medicaid- Physician Visit	-	-	-
I	I-6-b	Non-Medicaid- Ambulance	-	-	-
I	I-6-b	Non-Medicaid- Flu Shot	-	-	-
I	I-6-b	Non-Medicaid- Capitation Contracts	124,641.00	-	-
I	I-6-b	Contractuals-Non-Medicaid- X-Ray	(942.84)	-	-
I	I-6-b	Contractuals-Non-Medicaid- Laboratory	(1,526.23)	-	-
I	I-6-b	Contractuals-Non-Medicaid- Respiratory Therapy & Supplies	(11,704.75)	-	-
I	I-6-b	Contractuals-Non-Medicaid- Nursing Treatment Supplies	-	-	-
I	I-6-b	Contractuals-Non-Medicaid- Audiology	-	-	-
I	I-6-b	Contractuals-Non-Medicaid- Incontinency	-	-	-
I	I-6-b	Contractuals-Non-Medicaid- Oxygen & Supplies	-	-	-
I	I-6-b	Contractuals-Non-Medicaid- Physician Visit	-	-	-
I	I-6-b	Contractuals-Non-Medicaid- Ambulance	-	-	-
I	I-6-b	Contractuals-Non-Medicaid- Flu Shot	-	-	-
I	I-6-b	Contractuals-Non-Medicaid- Capitation Contracts	(32,629.05)	-	-
I	I-6-b	0	-	-	-
<b>Total Other Resident Revenue</b>			<b>\$ 165,590</b>	<b>\$ -</b>	<b>\$ -</b>

### Interest Income

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
IV-5	Interest On Overdue Accounts-	\$ 1,319	\$ -	\$ -	-
0		\$ -	\$ -	\$ -	-
0		\$ -	\$ -	\$ -	-
	<b>Total Interest Income</b>	<b>\$ 1,319</b>			

S. A. J. H. 1993-B

**G. Balance Sheet**

Name of Facility 1 Emerson Drive South Operations LLC	License No. 2369	Report for Year Ended 9/30/2022	Page 31	of 37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$ 2,920	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,479,987	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$ 22,443	
4. Inventories			\$ 58,484	
5. Prepaid Expenses			\$ 66,376	
a. Prepaid Expenses		7,182		
b. Prepaid Property Tax		48,395		
c. Prepaid Personal Property Tax		10,799		
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$ 1,630,210	
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	8,094	\$ 5,801	
	Accum. Depreciation	2,293	Net	
3. Buildings	*Historical Cost	198,588	\$ 178,899	
	Accum. Depreciation	19,689	Net	
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	54,589	\$ 42,012	
	Accum. Depreciation	12,577	Net	
6. Movable Equipment	*Historical Cost	152,026	\$ 111,114	
	Accum. Depreciation	40,912	Net	
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$ 337,826	

\* 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

<b>Total Prepaid Expenses</b>		\$ -

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

Page Ref Line Ref Description

<b>Total Other Current Assets (Itemize)</b>		\$ -

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

Page Ref Line Ref Description

<b>Total Other Other Fixed Assets (Itemize)</b>		\$ -

## Schedule of Other Assets Page 32 Line D7

Page Ref Line Ref Description

32	D7	ROU Bldg Asset-Oper Lease	
32	D7	AccumAmort-ROU Bldg OprLease	
<b>Total Other Assets</b>			\$ -

## Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref Line Ref Description

<b>Total Notes Payable</b>		\$ -

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

Page Ref Line Ref Description

33	A12	Accr Exp Other	\$ 35,773
33	A12	Accr Exp Water and Sewer	\$ 14,186
33	A12	Accr Exp Gas	\$ (9,152)
33	A12	Accr Exp Electricity	\$ 3,583
33	A12	Accr Exp Nursing Purchased Ser	\$ 441
33	A12	Deferred Revenue	\$ 16,959
33	A12	A/R Credit Gross Up Liability	\$ 78,638
33	A12	Accrued Provider/Bed Tax	\$ 155,107
33	A12	Accr Sales and Use Tax - FY18	\$ 280
33	A12	CP-Self Insurance WC Reserve	\$ 198,454
33	A12	CP-Self Insurance GPL Reserve	\$ 938,598
<b>Total Other Current Liabilities (Itemize)</b>			\$ 1,432,867

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

Page Ref Line Ref Description

<b>Total Other Current Liabilities (Itemize)</b>		\$ -

**G. Balance Sheet (cont'd)**

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive South Operations LLC	2369	9/30/2022	32	37
Account				Amount
	Total Brought Forward:			\$ 1,968,036
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				\$
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>				\$
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> )				\$ (299,656)
I/C Due to/Due From Owned		(299,656)		
I/C Due to/Due From Multicare				
See Schedule				
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>				\$ (299,656)
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>				\$ 1,668,380

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

**G. Balance Sheet (cont'd)**

Name of Facility	License No.	Report for Year Ended	Page of								
1 Emerson Drive South Operations LLC, d/b/a	2369	9/30/2022	33   37								
Account			Amount								
<b>Liabilities</b>											
A. Current Liabilities											
1. Trade Accounts Payable			\$ 773,806								
2. Notes Payable ( <i>itemize</i> )			\$								
See Schedule											
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )			\$								
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;">Name of Lender</th> <th style="text-align: left;">Purpose</th> <th style="text-align: left;">Amount</th> <th style="text-align: left;">Date Due</th> </tr> </thead> <tbody> <tr><td> </td><td> </td><td> </td><td> </td></tr> </tbody> </table>				Name of Lender	Purpose	Amount	Date Due				
Name of Lender	Purpose	Amount	Date Due								
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )			\$ 165,223								
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$								
6. Accrued Payroll Taxes Payable			\$ 477								
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> )			\$ 1,432,867								
See Schedule			1,432,867								
<b>A-13. Total Current Liabilities</b> (Lines A1 thru 12)			<b>\$ 2,372,373</b>								

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

(Carry Total forward to next page)

**G. Balance Sheet (cont'd)**

Name of Facility 1 Emerson Drive South Operations LLC, d/b	License No. 2369	Report for Year Ended 9/30/2022	Page 34	of 37
Account			Amount	
Total Brought Forward:			2,372,373	
<b>Liabilities (cont'd)</b>				
B. Long-Term Liabilities				
1. Loans Payable-Equipment ( <i>itemize</i> )				\$
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable				\$
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ 2,595,005
LT Debt-Financing Obligation	2,588,500			
Escheatable Funds	6,505			
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 2,595,005
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 4,967,378

## 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 9/30/2022	Page 35	of 37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	700,338
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(3,581,865)
6. Gain or Loss for Period	10/1/2021	thru	9/30/2022	\$ (417,470)
7. Total Net Worth			\$	(3,298,997)
<b>C. Total Reserves and Net Worth</b>				\$ (3,298,997)
<b>D. Total Liabilities, Reserves, and Net Worth</b>				\$ 1,668,381

## H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
1 Emerson Drive South Operations LLC	2369	9/30/2022	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2021				\$ (2,881,527)		
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )				\$ 12,093,799		
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )				\$ 12,511,269		
D. Net Income or Deficit				\$ (417,470)		
E. Balance				\$ (3,298,997)		
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. <b>Balance at End of Period</b>				\$ (3,298,997)		

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

Name of Facility 1 Emerson Drive South Operations LLC,	License No. 2369	Report for Year Ended 9/30/2022	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 Address 200 Brickstone Square, Andover, MA 01810		Phone Number 410-494-7657
Contacted Person Regarding Additional Information Needed Regarding This Report Rick Fink		Phone Number 410-494-7657
Contact Email Address Rick.Fink@genesishcc.com		