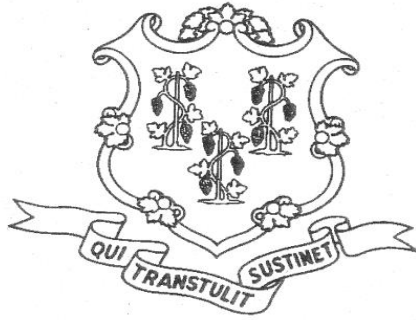


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2023

Name of Facility (as licensed) St. Camillus Stamford OPCO LLC	
Address (No. & Street, City, State, Zip Code) 494 Elm Street, Stamford, CT 06902	
Type of Facility Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <span style="margin-left: 150px;"><input type="checkbox"/> (Specify)</span> <span style="margin-left: 150px;"><input type="checkbox"/> (Specify)</span>	
Report for Year Beginning 10/1/2022	Report for Year Ending 9/30/2023

License Numbers:	CCNH / RHNS 2322-C	(Specify)	(Specify)	Medicare Provider 07-5320
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Medicaid Provider Numbers:	CCNH / RHNS 20363	(Specify)	(Specify)
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**General Information**

Name of Facility (as licensed) St. Camillus Stamford OPCO LLC	License No. 2322-C	Report for Year Ended 9/30/2023	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 St. Camillus Stamford OPCO LLC [facility name], for the cost report period beginning October 1, 2022 and ending September 30, 2023, 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) Reuven Fischer			Printed Name (Owner) Akiva Fried		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility St. Camillus Stamford OPCO LLC		Period Covered:	From 10/1/2022	To 9/30/2023
Address of Facility 494 Elm Street, Stamford, CT 06902				
Report Prepared By CJLC LLC		Phone Number 860-610-9009	Date 2/5/2024	
Item	Total	CCNH / RHNS	(Specify)	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. <b>Total Wages Paid</b>	\$			
7. Total salaries paid	\$			
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$			

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 203-325-0200		Report for Year Ended 9/30/2023	Page 2	of 37
Name of Facility (as shown on license) St. Camillus Stamford OPCO LLC		Address (No. & Street, City, State, Zip) 494 Elm Street, Stamford, CT 06902		
License Numbers:	CCNH / RHNS 2322-C	(Specify)	(Specify)	Medicare Provider No. 07-5320
Type of Facility (Check appropriate box(es)) Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home (CCNH) & RHNS Combined <input type="checkbox"/> (Specify) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box) <input type="checkbox"/> Proprietorship <input checked="" type="checkbox"/> LLC <input type="checkbox"/> Partnership <input type="checkbox"/> Profit Corp. <input type="checkbox"/> Non-Profit Corp. <input type="checkbox"/> Government <input type="checkbox"/> 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="checkbox"/> Yes <input checked="" type="checkbox"/> No                 If "Yes," explain fully.				
<b>Administrator</b>				
Name of Administrator Reuven Fischer		Nursing Home Administrator's License No.:	2076	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		









### General Information and Questionnaire Related Parties\*

Name of Facility St. Camillus Stamford OPCO LLC	License No. 2322-C	Report for Year Ended 9/30/2023	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?     Yes     No    If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Ark Healthcare Management LLC	494 Elm Street, Stamford, CT 06902	<input type="radio"/>	<input checked="" type="radio"/>		Management fees	16/m12	931,452	
St. Camillus Stamford Propco LLC	494 Elm Street, Stamford, CT 06902	<input type="radio"/>	<input checked="" type="radio"/>		Property rental	22/9	800,003	
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<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 St. Camillus Stamford OPCO LLC	License No. 2322-C	Report for Year Ended 9/30/2023	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**  
**Other Lines of Business**

Name of Facility St. Camillus Stamford OPCO LLC	License No. 2322-C	Report for Year Ended 9/30/2023	Page 6	of 37
Square footage of entire facility.		0		
<b>Outpatient Therapy</b>				
Does the Facility provide outpatient therapy services?		No		
<i>If yes, please complete the following:</i>				
Square footage of therapy space.				
<b>Meals on Wheels</b>				
Does the facility provide Meals on Wheels?		No		
<i>If yes, please complete the following:</i>				
Square footage of kitchen				
Number of meals served per week				
No	Are meals included in meals served on page 18 of the Annual Report?			
No	Are direct costs included in the Annual Report?			
<i>If yes, please state where costs are reported.</i>				
No	Are drivers for the program included in the facility's payroll?			
<i>If yes, please complete the following:</i>				
		Amount Reported		
		Annual Report page and line		
Please state the salary amounts of specific cooks and/or dietary aides				
Please state where the cooks and/or dietary aides are reported in the Annual Report				
<b>Apartments, Independent Living, Assisted Living</b>				
Does the facility have apartments, independent living, and/or assisted living?		No		
<i>If yes, please complete the following:</i>				
Square footage of apartments				
Square footage of independent living				
Square footage of assisted living				
Please identify the services provided:				

**General Information and Questionnaire**  
**Other Lines of Business (Continued)**

Name of Facility St. Camillus Stamford	License No. 2322-C	Report for Year Ended 9/30/2023	Page 7	of 37
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**Child Day Care**

Does the Facility provide Child Day Care?  No

*If yes, please complete the following:*

	Square footage of child day care space.
	Average number of daily participants.
	Number of meals per day provided to child day care.
	Nature of services provided:

**Adult Day Care**

Does the Facility provide Adult Day Care?  No

*If yes, please complete the following:*

	Square footage of adult day care space.
	Please state where it is located in relation to the facility.
	Average number of daily participants.
	Number of meals per day provided to adult day care.
	Nature of services provided:

### Schedule of Resident Statistics

Name of Facility St. Camillus Stamford OPCO LLC			License No. 2322-C		Report for Year Ended 9/30/2023				Page 8	of 37		
	Total All Levels	Total CCNH / RHNS Level	Total (Specify)	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH / RHNS	(Specify)	(Specify)	Total	CCNH / RHNS	(Specify)	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	124	124			124	124						
B. On last day of THIS report period	124	124							124	124		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	96	96			96	96						
B. As of midnight of THIS report period	106	106							106	106		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,457	4,457			3,463	3,463			994	994		
B. Medicaid (Conn.)	30,480	30,480			22,069	22,069			8,411	8,411		
C. Medicaid (other states)												
D. Private Pay	2,248	2,248			1,872	1,872			376	376		
E. State SSI for RCH												
F. Other (Specify) Managed Care	1,691	1,691			1,469	1,469			222	222		
G. Total Care Days During Period (3A thru F)	38,876	38,876			28,873	28,873			10,003	10,003		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	815	815			635	635			180	180		
B. Other Bed Reserve Days	17	17			2	2			15	15		
5. <b>Total Resident Days (3G + 4A + 4B)</b>	39,708	39,708			29,510	29,510			10,198	10,198		

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

Name of Facility St. Camillus Stamford OPCO LLC	License No. 2322-C	Report for Year Ended 9/30/2023	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)	(Specify)	Lost			Gained			CCNH / RHNS	(Specify)	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH / RHNS	(Specify)	(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)	(Specify)
1st change			
2nd change			
3rd change			
4th change			

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH / RHNS	CCNH / RHNS	(Specify)	CCNH / RHNS	(Specify)	(Specify)	R.C.H.	ICF-MR
No. of Residents	13	88		5				
Per Diem Rate								
a. One bed rm.		#####		580.00				
b. Two bed rms.				525.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH / RHNS	(Specify)	Outpatient	(Specify)
A. Medicare - Part B	696	696			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	4,078	4,078			
<b>D. Total Physical Therapy Treatments</b>	<b>4,774</b>	<b>4,774</b>			
8. Total Number of Speech Therapy Treatments					
A. Medicare - Part B	204	204			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	880	880			
<b>D. Total Speech Therapy Treatments</b>	<b>1,084</b>	<b>1,084</b>			
9. Total Number of Occupational Therapy Treatments					
A. Medicare - Part B	1,191	1,191			
B. Medicaid (Exclusive of Part B)					
1. Maintenance Treatments					
2. Restorative Treatments					
C. Other	5,526	5,526			
<b>D. Total Occupational Therapy Treatments</b>	<b>6,717</b>	<b>6,717</b>			

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

CSP-10 Rev. 3/2023

**Report of Expenditures - Salaries & Wages**

Name of Facility		License No.		Report for Year Ended			Page		of	
St. Camillus Stamford OPCO LLC		2322-C		9/30/2023			10		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 / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours	
<b>A. Salaries and Wages*</b>										
1. Operators/Owners (Complete also Sec. I of Schedule A1)										
2. Administrator(s) (Complete also Sec. III of Schedule A1)	140,385		2,377							
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)										
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	357,351		14,105							
5. Dietary Service										
a. Head Dietitian										
b. Food Service Supervisor										
c. Dietary Workers	502,080		25,526							
6. Housekeeping Service										
a. Head Housekeeper										
b. Other Housekeeping Workers	460,151		24,611							
7. Repairs & Maintenance Services										
a. Engineer or Chief of Maintenance										
b. Other Maintenance Workers	36,636		2,028							
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	151,412		2,287							
b. RN										
1. Direct Care	132,948		2,134							
2. Administrative**	1,000,784		16,865							
c. LPN										
1. Direct Care	928,439		25,737							
2. Administrative**										
d. Aides and Attendants	1,530,520		69,519							
e. Physical Therapists										
f. Speech Therapists										
g. Occupational Therapists										
h. Recreation Workers	92,760		4,508							
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	132,159		3,564							
n. Marketing										
o. Other (Specify) See Attached Schedule	127,685		3,770							
<i>A-13. Total Salary Expenditures</i>	<i>5,593,310</i>		<i>197,031</i>							

\* 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 in the Adjustment column.

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH / RHNS			(Specify)			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
Admissions	\$ 127,685		3,770						
<b>Total</b>	\$ 127,685	\$ -	3,770	\$ -	\$ -	-	\$ -	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH / RHNS			(Specify)			(Specify)		
	\$	Adjustment	Hours	\$	Adjustment	Hours	\$	Adjustment	Hours
Outside Purchase Salaries	\$ 1,229		49						
<b>Total</b>	\$ 1,229	\$ -	49	\$ -	\$ -	-	\$ -	\$ -	-



**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	
St. Camillus Stamford OPCO LLC				2322-C	9/30/2023			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH / RHNS	(Specify)	(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>										
Sheila Finkelstein	7,365					680	A4			

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
St. Camillus Stamford OPCO LLC				2322-C	9/30/2023			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)	(Specify)							
<b>Section III - Administrators***</b>										
Reuven Fischer	140,385				Full administrative management of everyday functions of	2,377	A2			
<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
St. Camillus Stamford OPCO LLC	2322-C	9/30/2023						13	37
Total Cost and Hours									
Item	CCNH / RHNS	Adjustment	Hours	(Specify)	Adjustment	Hours	(Specify)	Adjustment	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>									
1. Dietitian	60,084		1,178						
2. Dentist									
3. Pharmacist									
4. Podiatrist									
5. Physical Therapy									
a. Resident Care	230,549		3,294						
b. Other									
6. Social Worker	6,484		282						
7. Recreation Worker									
8. Physicians									
a. Medical Director (entire facility)	48,000		48						
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	56,624		1,490						
b. Other									
10. Occupational Therapist									
a. Resident Care	329,514	(329,514)	6,461						
b. Other									
11. Nurses and aides and attendants									
a. RN									
1. Direct Care	570,413		5,233						
2. Administrative***	33,473		307						
b. LPN									
1. Direct Care	830,054		10,780						
2. Administrative***									
c. Aides	851,633		18,514						
d. Other									
12. Other (Specify)									
See Attached Schedule	1,229		49						
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>3,018,057</b>	<b>(329,514)</b>	<b>47,636</b>						

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

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

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

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

Name of Facility St. Camillus Stamford OPCO LLC		License No. 2322-C		Report for Year Ended 9/30/2023	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Nutrasource RD LLC, 10 Crawfords Corner, Holmdel NJ	Dietician	<input type="radio"/>	<input checked="" type="radio"/>			
Health Drive Dental, 100 Crossing Blvd, Framingham, MA	Dental Service	<input type="radio"/>	<input checked="" type="radio"/>			
CT Dental, 300 Church St, Wallingford, CT	Dental Service	<input type="radio"/>	<input checked="" type="radio"/>			
Preferred Therapy Solutions, PO Box 69363, Baltimore, Maryland	PT/ST/OT	<input type="radio"/>	<input checked="" type="radio"/>			
InHouse Care LLC, 276 Highland Ave, Waterbury, CT	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Hartford Healthcare, PO Box 412744, Boston, MA	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
Five Star Care, 410 Melville Ave, Lakewood, NJ	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Career Staff Unlimited, PO Box 301076, Dallas TX	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Empro Staffing, PO Box 190331, Brooklyn, MY	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			

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

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

Name of Facility	License No.	Report for Year Ended					Page	of
St. Camillus Stamford OPCO LLC	2322-C	9/30/2023					15	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
<b>I. Administrative and General</b>								
<b>a. Employee Health &amp; Welfare Benefits</b>								
1. Workmen's Compensation	\$ 129,967	129,967						
2. Disability Insurance	\$							
3. Unemployment Insurance	\$ 55,805	55,805						
4. Social Security (F.I.C.A.)	\$ 418,481	418,481						
5. Health Insurance	\$ 1,039,481	1,039,481						
6. Life Insurance (employees only) (not-owners and not-operators)	\$							
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 318,334	318,334						
8. Uniform Allowance	\$							
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 34,336	34,336						
<b>b. Personal Retirement Plans, Pensions, and        Profit Sharing Plans for Owners and        Operators (Discriminatory)*</b>	\$							
<b>c. Bad Debts*</b>	\$ 712,759	712,759	(712,759)					
<b>d. Accounting and Auditing</b>	\$ 42,592	42,592						
<b>e. Legal (<i>Services should be fully described on Page 15b</i>)</b>	\$ 132,127	132,127	(30,497)					
<b>f. Insurance on Lives of Owners and        Operators (<i>Specify</i>)*</b>	\$							
<b>g. Office Supplies</b>	\$ 20,325	20,325						
<b>h. Telephone and Cellular Phones</b>								
1. Telephone & Pagers	\$ 17,399	17,399						
2. Cellular Phones	\$ 2,810	2,810						
<b>i. Appraisal (<i>Specify purpose and        attach copy</i>)*</b>	\$							
<b>j. Corporation Business Taxes (<i>franchise tax</i>)</b>	\$ 72,000	72,000	(71,750)					
<b>k. Other Taxes (<i>Not related to property - See Page 22</i>)</b>								
1. Income*	\$							
2. Other ( <i>Specify</i> ) See Attached Schedule	\$							
3. Resident Day User Fee	\$ 692,294	692,294						
<b>Subtotal</b>	\$ 3,688,710	3,688,710	(815,006)					

\* Facility should self-disallow the expense in the Adjustment column.

(Carry Subtotals forward to next page)

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

**Schedule of Other Employee Benefits**

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Union Training Fund	\$ 34,336					
<b>Total</b>	\$ 34,336	\$ -	\$ -	\$ -	\$ -	\$ -

**Schedule of Other Taxes**

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
<b>Total</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

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

Name of Facility St. Camillus Stamford OPCO LLC	License No. 2322-C	Report for Year Ended 9/30/2023	Page 15b	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	Address (No. & Street, City, State, Zip Code)
1 CJLC LLC	225 Pitkin Street East Hartford, CT 06108
2 A/R Solutions	
3 Pease Bell	
4 1099.com	

Services Provided by This Firm (*describe fully*)

1 Medicaid Cost Report and Accounting Services	\$ 8,354
2 Billing Support	\$ 10,888
3 Audit & Tax	\$ 23,333
4 1099s	\$ 17
	<b>Charge for Services Provided</b>
	\$ 42,592

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

- Yes     No    15/1d

**Legal Services Information**

Name of Legal Firm or Independent Attorney	Telephone Number
1 Ford & Harrison LLP	
2 Wiggin and Dana	
3 American Arbitration Association	
4 Murtha Cullina	
5 Sheppard Mullin	

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

1
2
3
4
5

Services Provided by This Firm (*describe fully*)

1 Employee Matters	\$ 92,003
2 Collection Matters	\$ 30,497
3 Employee Matters	\$ 2,275
4 Tax Matters	\$ 2,277
5 Employee Matters	\$ 5,076
	<b>Charge for Services Provided</b>
	\$ 132,128

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

- Yes     No    15/1e

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

Name of Facility	License No.	Report for Year Ended				Page	of
St. Camillus Stamford OPCO LLC	2322-C	9/30/2023				16	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
<b>Subtotals Brought Forward:</b>	3,688,710	3,688,710	(815,006)				
<b>l. Travel and Entertainment</b>							
1. Resident Travel and Entertainment \$							
2. Holiday Parties for Staff \$							
3. Gifts to Staff and Residents \$							
4. Employee Travel \$	14,322	14,322					
5. Education Expenses Related to Seminars and Conventions \$	3,415	3,415					
6. Automobile Expense ( <i>not purchase or depreciation</i> ) \$							
7. Other ( <i>Specify</i> ) \$							
See Attached Schedule							
<b>m. Other Administrative and General Expenses</b>							
1. Advertising Help Wanted ( <i>all such expenses</i> ) \$	2,594	2,594					
2. Advertising Telephone Directory ( <i>all such expenses</i> )*** \$							
3. Advertising Other ( <i>Specify</i> )*** \$	12,334	12,334	(12,334)				
See Attached Schedule							
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 \$	1,613	1,613					
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) \$	13,409	13,409					
See Attached Schedule							
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.*** \$							
9. Subscriptions \$							
10. Contributions*** \$	275	275	(275)				
See Attached Schedule							
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> ) \$							
12. Administrative Management Services** \$	931,452	931,452					
13. Other ( <i>Specify</i> ) \$	311,470	311,470	(263)				
See Attached Schedule							
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$ 4,979,594	4,979,594	(827,878)				

\* 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 in the Adjustment column.



Schedule of Other Travel and Entertainment

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Business Promotion	\$ 4,713	\$ (4,713)				
Marketing Events	\$ 7,621	\$ (7,621)				
<b>Total Other Advertising</b>	\$ 12,334	\$ (12,334)	\$ -	\$ -	\$ -	\$ -

Schedule of Dues

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
OnShift	\$ 4,806					
CAHCF	\$ 7,062					
AMEX	\$ 1,541					
<b>Total Dues</b>	\$ 13,409	\$ -	\$ -	\$ -	\$ -	\$ -

Schedule of Contributions

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Donations	\$ 275	\$ (275)				
<b>Total Contributions</b>	\$ 275	\$ (275)	\$ -	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Background Check	\$ 4,021					
Fees & Registration	\$ 8,978					
Licenses & Permits	\$ 1,240					
Computer Services	\$ 161,265					
Small Computer Equipment	\$ 1,629					
Payroll Services	\$ 33,364					
Late Fees	\$ 263	\$ (263)				
Bank Charges	\$ 9,417					
Miscellaneous Expense	\$ 91,293					
<b>Total Other Administrative and General</b>	\$ 311,470	\$ (263)	\$ -	\$ -	\$ -	\$ -

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

Name of Facility St. Camillus Stamford OPCO LLC	License No. 2322-C	Report for Year Ended 9/30/2023	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
ARK HealthCare Management	931,452	Management Services	16/m12

**\* 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
St. Camillus Stamford OPCO LLC		2322-C	9/30/2023				18	37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
2. Dietary								
a. In-House Preparation & Service								
1. Raw Food	\$ 316,298	316,298						
2. Non-Food Supplies	\$ 38,316	38,316						
3. Other (Specify) _____	\$							
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$							
c. Other (Specify) _____	\$							
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 354,614</b>	<b>354,614</b>						
2E. Dietary Questionnaire		Total	CCNH / RHNS		(Specify)	(Specify)		
F. Resident Meals:	Total no. of meals served per day:*	3	3					
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		License No.	Report for Year Ended				Page	of
St. Camillus Stamford OPCO LLC		2322-C	9/30/2023				19	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
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. \$							
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. \$							
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$							
c. Other (Specify) Laundry Supplies	\$	127,141	127,141					
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	\$	127,141	127,141					
<b>3E. Laundry Questionnaire</b>								
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
St. Camillus Stamford OPCO LLC		2322-C	9/30/2023				20	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
4.	Housekeeping	Sq. Ft. Serviced by Personnel						
a.	In-House Care	Amt.	\$ 46,026	46,026				
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.	\$ 39,177	39,177				
C.	Other ( <i>Specify</i> )	\$						
4D.	<b>Total Housekeeping Expenditures</b> (4a + b + c)	\$	85,203	85,203				
5.	Resident Care (Supplies)**							
a.	Prescription Drugs***							
1.	Own Pharmacy	\$						
2.	Purchased from	\$	229,459	229,459	(229,459)			
b.	Medicine Cabinet Drugs	\$						
c.	Medical and Therapeutic Supplies	\$						
d.	Ambulance/Limousine***	\$						
e.	Oxygen							
1.	For Emergency Use	\$						
2.	Other***	\$	21,025	21,025	(21,025)			
f.	X-rays and Related Radiological Procedures***	\$	2,593	2,593	(2,593)			
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$						
h.	Laboratory***	\$	35,541	35,541	(35,541)			
i.	Recreation	\$	4,546	4,546				
j.	Direct Management Services*	\$						
k.	Indirect Management Services*	\$						
l.	Cable TV	\$	8,177	8,177				
m.	Other (Specify)**** See Attached Schedule	\$	168,954	168,954	(8,405)			
n.	Physical Therapy Expense	\$						
o.	Speech Therapy Expense	\$						
5P.	<b>Total Resident Care Expenditures</b> (5a - 5o)	\$	470,295	470,295	(297,023)			

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

**Schedule of Other Resident Care**

<b>Description</b>	<b>CCNH / RHNS</b>	<b>Adjustment</b>	<b>(Specify)</b>	<b>Adjustment</b>	<b>(Specify)</b>	<b>Adjustment</b>
Outside Medical Billing	\$ 2,503					
Medicare A Transportation	\$ 8,405	\$ (8,405)				
Nursing Supplies Non-Billable	\$ 158,002					
Resident Specific Supplies	\$ 44					
<b>Total Other Resident Care</b>	<b>\$ 168,954</b>	<b>\$ (8,405)</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility St. Camillus Stamford OPCO LLC			License No. 2322-C		Report for Year Ended 9/30/2023				Page of 21   37	
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH / RHNS	(Specify)	(Specify)	Pg	Line
Coastal Mechanical		<input type="radio"/>	<input checked="" type="radio"/>		Maintenance Service	10,488			22	6f
Hartford Elevator LLC		<input type="radio"/>	<input checked="" type="radio"/>		Elevator Services	25,575			22	6f
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

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

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

Name of Facility St. Camillus Stamford OPCO LLC	License No. 2322-C	Report for Year Ended 9/30/2023					Page 22	of 37
Item	Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment	
6. Maintenance & Operation of Plant								
a. Repairs & Maintenance	\$ 41,427	41,427						
b. Heat	\$ 82,610	82,610						
c. Light & Power	\$ 181,772	181,772						
d. Water	\$ 58,210	58,210						
e. Equipment Lease (Provide detail on page 22b)	\$							
f. Other (itemize)	\$ 121,530	121,530	(3,616)					
See Attached Schedule								
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	\$ 485,549	485,549	(3,616)					
7. Depreciation (complete schedule page 23*)								
a. Land Improvements	\$							
b. Building & Building Improvements	\$ 11,911	11,911						
c. Non-Movable Equipment	\$							
d. Movable Equipment	\$ 22,858	22,858						
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	\$ 34,769	34,769						
8. Amortization (Complete att. Schedule Page 24*)								
a. Organization Expense	\$ 712	712						
b. Mortgage Expense	\$							
c. Leasehold Improvements	\$							
d. Other (Specify)	\$							
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	\$ 712	712						
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 800,003	800,003						
10. Property Taxes								
a. Real estate taxes paid by owner	\$ 70,417	70,417						
b. Real estate taxes paid by lessor	\$							
c. Personal property taxes	\$ 10,190	10,190						
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	\$ 916,090	916,090						

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



**Schedule of Other Repairs and Maintenance**

Description	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Equipment Rental	\$ 17,550					
Minor Equipment/Furniture	\$ 1,517					
Minor Maintenance Equipment	\$ 481					
Maintenance Service Contracts	\$ 57,162					
Contracted Maintenance Service	\$ 25,741					
Yard Maintenance	\$ 15,463					
Chow Expenses	\$ 3,616	\$ (3,616)				
<b>Total Other Repairs and Maintenance</b>	\$ 121,530	\$ (3,616)	\$ -	\$ -	\$ -	\$ -

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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 St. Camillus Stamford OPCO LLC			License No. 2322-C		Report for Year Ended 9/30/2023		Page 22b	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input checked="" type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
	<input type="radio"/>	<input checked="" type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes <input type="radio"/> No	<b>Total ***</b>

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

\*\* Attach copies of newly acquired leases.

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

### Depreciation Schedule

Name of Facility St. Camillus Stamford OPCO LLC		License No. 2322-C		Report for Year Ended 9/30/2023			Page 23	of 37				
Property Item		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals			
<b>A. Land Improvements</b>												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal												
<b>B. Building and Building Improvements</b>												
1. Acquired prior to this report period		121,023		121,023	6,342	SL	10	10,081				
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)		35,720						1,830				
B-4. Subtotal									11,911			
<b>C. Non-Movable Equipment</b>												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
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								
<b>D. Movable Equipment</b>												
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					90,753		90,753	29,803	SL	Various	18,383	
b. Disposals (attach schedule)												
Acquired during this report period (attach schedule):												
c. Administrative					50,125						2,313	
d. Standard Resident					18,077						2,162	
e. Specialized Resident												
Total Acquired during this report period					68,202						4,475	
D-3. Subtotal												22,858
<b>E. Total Depreciation</b>												34,769

Schedule of Land Improvements Acquired during this report period

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

\*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>				
12/31/2022	HVAC	\$ 1,289	10	\$ 107
12/31/2022	Circuit Breaker	\$ 1,031	15	\$ 57
2/5/2023	Elevator	\$ 12,070	20	\$ 402
2/1/2023	HVAC	\$ 2,148	10	\$ 143
3/1/2023	Siding	\$ 4,800	10	\$ 280
3/31/2023	TCP	\$ 1,400	10	\$ 82
3/31/2023	FCFS	\$ 1,656	10	\$ 97
8/21/1903	FCFS	\$ 1,329	10	\$ 78
3/31/2023	Coastal Mechanical	\$ 3,867	10	\$ 226
3/31/2023	Building Improvements	\$ 6,130	10	\$ 358
<b>Total additions for Building Improvements</b>		\$ 35,720		\$ 1,830 *
<b>Deletions:</b>				
<b>Total deletions for Building Improvements</b>		\$ -		\$ - **

\*Ties to Page 23, Line B3

\*\*Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
<b>Total additions for Non-Movable Equipment</b>		\$ -		\$ - *
<b>Deletions:</b>				

<b>Total deletions for Non-Movable Equipment</b>		\$ -	\$ -

\*Ties to Page 23, Line C3  
 \*\*Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Pick One	Cost	Useful Life	Depreciation
		Movable Category			
<b>Additions:</b>					
10/13/2022	Sonicwall	Administrative	\$ 2,845	5	\$ 569
12/12/2022	Scale	Standard Resident	\$ 952	5	\$ 159
12/12/2022	Patient Lifts	Standard Resident	\$ 4,414	5	\$ 736
12/12/2022	Vital Sign Monitors & Stands	Standard Resident	\$ 5,303	5	\$ 884
3/31/2023	Fridge	Administrative	\$ 10,135	5	\$ 591
4/28/2023	Sentenia	Administrative	\$ 4,165	5	\$ 416
6/1/2023	Bed & Wheelchair	Standard Resident	\$ 1,987	5	\$ 132
6/26/2023	Elevator Improvements	Administrative	\$ 2,871	20	\$ 48
7/9/2023	14 AC Units	Administrative	\$ 4,452	5	\$ 223
7/9/2023	2 AC Units	Administrative	\$ 1,170	5	\$ 58
9/28/2023	5 AC Units	Administrative	\$ 2,745	5	\$ 46
9/28/2023	5 AC Units	Administrative	\$ 3,292	5	\$ 55
9/30/2023	Air Surveyers	Administrative	\$ 12,200	5	\$ 203
9/30/2023	Air Surveyers	Administrative	\$ 6,250	5	\$ 104
1/19/2023	Mattress	Standard Resident	\$ 1,467	7	\$ 157
8/1/2023	Mattress	Standard Resident	\$ 3,954	7	\$ 94
		PICK A CATEGORY			
<b>Total additions for Movable Equipment</b>			\$ 68,202		\$ 4,475
<b>Deletions:</b>					
<b>Total deletions for Movable Equipment</b>			\$ -		\$ -

\*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
<b>Additions:</b>				
<b>Total additions for Leasehold Improvement</b>		\$ -		\$ -
<b>Deletions:</b>				
<b>Total deletions for Leasehold Improvement</b>		\$ -		\$ -

\*Ties to Page 24, Line C3  
 \*\*Ties to Page 24, Line C2

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

**Amortization Schedule\***

Name of Facility St. Camillus Stamford OPCO LLC			License No. 2322-C		Report for Year Ended 9/30/2023			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							
<b>A. Organization Expense</b>									
1. Start Up Costs	10	2020	15	10,676	1,424			712	
2.									
3.									
A-4. Subtotal									712
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									712

\* 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 St. Camillus Stamford OPCO LLC	License No. 2322-C	Report for Year Ended 9/30/2023	Page 25	of 37	
<b>11. Property Questionnaire</b>					
<b>Part A</b>					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased					
2. Date Structure Completed					
3. If <b>NOT</b> Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity	124				
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
<b>Part B - Owner and Related Parties</b>		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 _____					
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	

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

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

Name of Facility		License No.	Report for Year Ended				Page	of
St. Camillus Stamford OPCO LLC		2322-C	9/30/2023				26	37
Item		Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
12. Interest								
A. Building, Land Improvement & Non-Movable Equipment								
1. First Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
2. Second Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
3. Third Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
4. Fourth Mortgage		\$						
Name of Lender		Rate						
Address of Lender								
B. CHEFA Loan Information								
1. Original Loan Amount		\$						
2. Loan Origination Date								
3. Interest Rate %								
4. Term								
5. CHEFA Interest Expense								
12 B7. <b>Total Building Interest Expense</b> (A1 - A4 + B5)		\$						

(Carry Subtotals forward to next page)



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

Name of Facility		License No.		Report for Year Ended				Page	of	
St. Camillus Stamford OPCO LLC		2322-C		9/30/2023				27	37	
Item				Total	CCNH / RHNS	Adjustment	(Specify)	Adjustment	(Specify)	Adjustment
Subtotals Brought Forward:										
12. C. Movable Equipment										
1. Automotive Equipment				\$						
A. Item		Rate	Amount							
Lender										
Address of Lender										
2. Other (Specify)				\$						
A. Item		Rate	Amount							
Lender										
Address of Lender										
B. Item		Rate	Amount							
Lender										
Address of Lender										
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)				\$						
12. D. Other Interest Expense (Specify)				\$	864	864				
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	864	864				
14. Insurance										
a. Insurance on Property (buildings only)				\$	133,837	133,837				
b. Insurance on Automobiles				\$						
c. Insurance other than Property (as specified above)										
1. Umbrella (Blanket Coverage)				\$						
2. Fire and Extended Coverage				\$						
3. Other (Specify)				\$						
14d. Total Insurance Expenditures (14a + b + c)				\$	133,837	133,837				
15. Total All Expenditures (A-13 thru C-14)				\$	16,164,555	16,164,555	(1,458,031)			

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended		Page	of
St. Camillus Stamford OPCO LLC	2322-C	9/30/2023		30	37
Item	Total	CCNH / RHNS	(Specify)	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 17,099,872	17,099,872			
b. Medicaid Room and Board Contractual Allowance **	\$				
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 2,377,669	2,377,669			
b. Medicare Room and Board Contractual Allowance **	\$ (54,611)	(54,611)			
4. a. Private-Pay Residents and Other	\$ 1,099,479	1,099,479			
b. Private-Pay Room and Board Contractual Allowance **	\$ (6,001,851)	(6,001,851)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 91,972	91,972			
b. Prescription Drugs - Medicare Contractual Allowance **	\$				
c. Prescription Drugs - Non-Medicare	\$ 65,211	65,211			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$				
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 123,678	123,678			
b. Physical Therapy - Medicare Contractual Allowance **	\$				
c. Physical Therapy - Non-Medicare	\$ 88,016	88,016			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$				
4. a. Speech Therapy - Medicare	\$ 76,485	76,485			
b. Speech Therapy - Medicare Contractual Allowance **	\$				
c. Speech Therapy - Non-Medicare	\$ 27,644	27,644			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$				
5. a. Occupational Therapy - Medicare	\$ 333,031	333,031			
b. Occupational Therapy - Medicare Contractual Allowance **	\$				
c. Occupational Therapy - Non-Medicare	\$ 118,698	118,698			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$				
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 404,950	404,950			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ (39,574)	(39,574)			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 15,810,669	15,810,669			
<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> )	\$ 945	945			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other ( <i>Specify</i> )	\$ 2,535,292	2,535,292			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 2,536,237	2,536,237			
<b>VI. Total All Revenue</b> (III +V)	\$ 18,346,906	18,346,906			

\* 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)	(Specify)
30/II6a	Lab - Med A	\$ 1,237		
30/II6a	C/A Medicare Room & Board	\$ 1,082,810		
30/II6a	C/A Medicare A - Therapy	\$ (412,010)		
30/II6a	C/A Medicare B - Therapy	\$ (46,760)		
30/II6a	C/A Managed Care - Therapy	\$ (220,327)		
<b>Total Other Resident Revenue - Medicare</b>		\$ 404,950	\$ -	\$ -

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

**Related Exp**

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
30/II6b	Lab Medicaid	\$ 236		
30/II6b	Lab - Managed Care	\$ 1,042		
30/II6b	Radiology - Med A	\$ 172		
30/II6b	Radiology - Medicaid	\$ 463		
30/II6b	Radiology - Managed Care	\$ 308		
30/II6b	Med Supplies - Other	\$ 71		
30/II6b	Flu Vaccine Revenue	\$ 9,729		
30/II6b	Other Vaccine Revenue	\$ 1,280		
30/II6b	C/A Managed Care - Ancillaries	\$ (40,250)		
30/II6b	C/A Hospice Room & Board	\$ (12,625)		
<b>Total Other Resident Revenue</b>		\$ (39,574)	\$ -	\$ -

**Interest Income**

Page Ref	Account	Account Balance	CCNH / RHNS	(Specify)	(Specify)
30/IV5	Interest Income		\$ 945		
<b>Total Interest Income</b>			\$ 945	\$ -	\$ -

**Schedule of Other Revenue**

Page Ref	Description	CCNH / RHNS	(Specify)	(Specify)
30/IV8	Miscellaneous Income	\$ 1,275,999		
30/IV8	Non-Patient Food	\$ (5)		
30/IV8	Other Income	\$ 181,223		
30/IV8	PPP Loan Forgiveness	\$ 1,078,075		
<b>Total Other Revenue</b>		\$ 2,535,292	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Stamford OPCO LLC	2322-C	9/30/2023	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	1,077,457
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	3,366,395
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	27,300
a. _____				
b. _____				
c. _____				
d. See Schedule		27,300		
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)			\$	4,471,152
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost <u>156,744</u>		\$	138,490
	Accum. Depreciation <u>18,254</u>	Net		
4. Leasehold Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>158,954</u>		\$	106,293
	Accum. Depreciation <u>52,661</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	27,396
_____				
See Schedule		27,396		
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	272,179

\* 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	
31	A5	Prepaid Insurance	\$ 5,617
31	A5	Prepaid Other	\$ 18,889
31	A5	Prepaid Taxes	\$ 2,794
<b>Total Prepaid Expenses</b>			\$ 27,300

Schedule of Other Current Assets (Itemize) 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	
31	B9	Work in Process	\$ 40,310
31	B9	Book vs Cost	\$ (12,914)
<b>Total Other Other Fixed Assets (Itemize)</b>			\$ 27,396

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	Allowance for Bad Debts	\$ (314,489)
<b>Total Other Assets</b>			\$ (314,489)

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	Due From Medicare	\$ (31,620)
33	A12	Due From Stamford	\$ (53,076)
33	A12	Due From Simsbury	\$ (135,061)
33	A12	Due From ABH OpCo	\$ (10,229)
33	A12	Due From Pharmacy	\$ (6,250)
33	A12	Due From Previous Owner	\$ 80,249
33	A12	Due From Branford OpCo	\$ (11,025)
33	A12	American Express	\$ 9,032
33	A12	Patient Refund	\$ (26,449)
33	A12	Accrued Expenses & Other	\$ 24,327
33	A12	Accrued Property Taxes	\$ 17,554
33	A12	Accrued Nursing Home Fee	\$ 57,469
33	A12	EIDL	\$ 500,000
33	A12	Due To Stamford PropCo	\$ (309,969)
33	A12	Due To Ark Management	\$ (4,569)
33	A12	Due To Simsbury	\$ 123,385
33	A12	Due To Previous Owner	\$ (50,483)
33	A12	Credit Card Suspense	\$ (32,580)
<b>Total Other Current Liabilities (Itemize)</b>			\$ 140,705

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
St. Camillus Stamford OPCO LLC	2322-C	9/30/2023	32	37
<b>Account</b>			<b>Amount</b>	
Total Brought Forward:			\$	4,743,331
<b>C. Leasehold or like property recorded for Equity Purposes.</b>				
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>			\$	
<b>D. Investment and Other Assets</b>				
1. Deferred Deposits			\$	32,155
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	10,676		
	Accum. Depreciation	2,135	Net	\$ 8,540
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> )			\$	(314,489)
_____				
See Schedule				(314,489)
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	(273,794)
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	4,469,537

\* 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 St. Camillus Stamford OPCO LLC		License No. 2322-C	Report for Year Ended 9/30/2023	Page 33	of 37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	1,614,542
2. Notes Payable ( <i>itemize</i> )				\$	
_____					
_____					
See Schedule					
3. Loans Payable for Equipment ( <i>Current portion</i> ) ( <i>itemize</i> )				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll ( <i>Exclusive of Owners and/or Stockholders only</i> )				\$	(46,746)
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	33,494
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> )				\$	140,705
_____					
_____					
_____					
See Schedule				140,705	
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>				\$	<b>1,741,995</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 St. Camillus Stamford OPCO LLC	License No. 2322-C	Report for Year Ended 9/30/2023		Page 34	of 37
Account				Amount	
Total Brought Forward:				1,741,995	
<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> )				\$	
See Schedule					
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 1,741,995	



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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Stamford OPCO LLC	2322-C	9/30/2023	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	497,692
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	47,499
6. Gain or Loss for Period			\$	2,182,351
	10/1/2022	thru	9/30/2023	
7. Total Net Worth			\$	2,727,542
<b>C. Total Reserves and Net Worth</b>			\$	2,727,542
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	4,469,537

### H. Changes in Total Net Worth

Name of Facility St. Camillus Stamford OPCO LLC	License No. 2322-C	Report for Year Ended 9/30/2023	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2022			\$	3,921,652
B. Total Revenue ( <i>From Statement of Revenue Page 30</i> )			\$	18,346,906
C. Total Expenditures ( <i>From Statement of Expenditures Page 27</i> )			\$	16,164,555
D. Net Income or Deficit			\$	2,182,351
E. Balance			\$	6,104,003
F. Additions				
1. Additional Capital Contributed ( <i>itemize</i> )				
2. Other ( <i>itemize</i> )				
F-3. Total Additions				
G. Deductions				
1. Drawings of Owners/Operators/Partners ( <i>Specify</i> )			\$	
Name and Address ( <i>No., City, State, Zip</i> )		Title	Amount	
2. Other Withdrawings ( <i>Specify</i> )			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$	6,104,003
				09/30/23

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

Name of Facility St. Camillus Stamford OPCO LLC	License No. 2322-C	Report for Year Ended 9/30/2023	Page 37	of 37
<i>Check appropriate category</i>				
Chronic and Convalescent Nursing <input checked="" type="checkbox"/> Home (CCNH) & RHNS Combined	<input type="checkbox"/> (Specify)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
CJLC LLC				
Address Address		Phone Number		
225 Pitkin St., East Hartford, CT 06108		860-610-9009		
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number		
CJLC		860-610-9009		
Contact Email Address				
annualreports@cjlc.com				