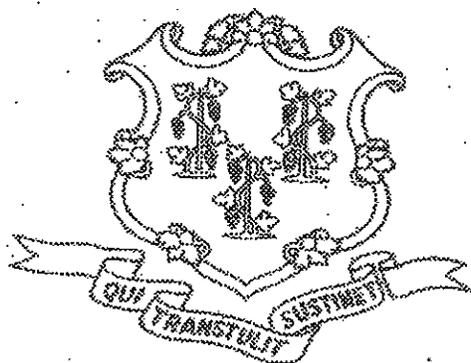


State of Connecticut



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Annual Report of Long-Term Care Facility Cost Year 2015

Name of Facility (as licensed) 1 Emerson Drive North Operations LLC, d/b/a Kimberly Hall North		<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;"> RECEIVED DEC 31 2015 DEPT. OF SOCIAL SERVICES OFFICE OF CON AND RATE SETTINGS </div>
Address (No. & Street, City, State, Zip Code) One Emerson Drive, Windsor, CT 06095		
Type of Facility		
<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)
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015	

License Numbers:	CCNH 2376	RHNS	(Specify)	Medicare Provider 07-5279
------------------	--------------	------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH 000010769	RHNS	ICF-IID
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For Department Use Only

Sequence Number Assigned	Signed and Notarized	Date Received	Sequence Number Assigned	Signed and Notarized	Date Received

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC,d/b/a Kimberl	2376	9/30/2015	1	37

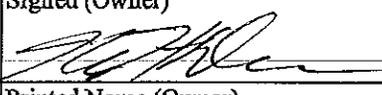
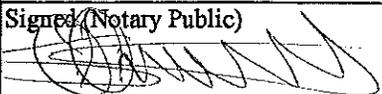
Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 North Operations LLC,d/b/a Kimberly Hall North [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
					11/13/2015
Printed Name (Administrator)			Printed Name (Owner)		
Thomas Russo			Keith Davis, V.P. of Reimb., Genesis Healthcare		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)		Comm. Expires
	PA	11/13/15			1 1
Address of Notary Public					

(Notary Seal)

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC,d/b/a Kimberl	2376	9/30/2015	1	37

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 North Operations LLC,d/b/a Kimberly Hall North [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)		Date	Signed (Owner)		Date
Printed Name (Administrator)			Printed Name (Owner)		
Thomas Russo			Keith Davis, V.P. of Reimb., Genesis Healthcare		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires	
				/ /	
Address of Notary Public					

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility 1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall North		Period Covered:	From 10/1/2014	To 9/30/2015
Address of Facility One Emerson Drive, Windsor, CT 06095				
Report Prepared By Thomas Farnan		Phone Number 978-247-5029	Date 12/20/2014	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$ 506,718	506,718		
2. Laundry wages paid	\$ 26,044	26,044		
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$ 4,486,824	4,486,824		
5. All other wages paid	\$ 722,502	722,502		
6. Total Wages Paid	\$ 5,742,087	5,742,087		
7. Total salaries paid	\$ 216,378	216,378		
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$ 5,958,465	5,958,465		

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 860-688-6443		Report for Year Ended 9/30/2015	Page 2	of 37
Name of Facility (as shown on license) 1 Emerson Drive North Operations LLC, d/b/a Kimberly Hall N		Address (No. & Street, City, State, Zip) One Emerson Drive, Windsor, CT 06095		
License Numbers:	CCNH 2376	RHNS (Specify)	Medicare Provider No. 07-5279	
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year?				
		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," explain fully.
Administrator				
Name of Administrator Thomas Russo		Nursing Home Administrator's License No.:	001789	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

General Information and Questionnaire
Corporate Owners

Name of Facility 1 Emerson Drive North Operations LLC,d/b/a	License No. 2376	Report for Year Ended 9/30/2015	Page 3A	of 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		
1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall North	101 East State Street, Kennett Square, PA 19348	PA		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
See Attached				
Names of Stockholders Owning at Least 10% of Shares				
See Attached				

General Information and Questionnaire Related Parties*

Name of Facility 1 Emerson Drive North Operations LLC, d/b/a Kimberl	License No. 2376	Report for Year Ended 9/30/2015	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 type="radio"/> Yes <input checked="" 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 Health Ventures	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Home Office	Pg 16/m12	584,341	584,341
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	63% PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	597,137	597,137
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	55% Staffing Pool	Pg 10/A12	15,581	15,581
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	85% Case Management	Pg 13/B8, Pg 10/A12	33,510	33,510
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Staffing Pool	Pg 13/B11 a,b,c		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>	43% Respiratory Therapy	Pg 13/B12, Pg 20/C5E	14,005	14,005
Liberty Health (Insurance)	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Insurance	Pg 27/14	190,713	190,713
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	Capital Interest	Page 17, page 26-12A	56,580	56,580

* 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 North Operations LLC,d/b/a K	License No. 2376	Report for Year Ended 9/30/2015	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
Accounting Basis

Name of Facility 1 Emerson Drive North Operations	License No. 2376	Report for Year Ended 9/30/2015	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:
 Accrual Cash Modified Cash

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

Independent Accounting Firm	
Name of Accounting Firm 1 Wells fargo institutional Retirement and Trust 2 3 4	Address (No. & Street, City, State, Zip Code) PO BOX 563957 Charlotte NC 28556

Services Provided by This Firm (describe fully)		
1 401K plan auditing for collective bargaining unit employees		\$ (65)
2		\$
3		\$
4		\$
		Charge for Services Provided
		\$ (65)

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 Bloom & Witkin 2 3 4 5	Telephone Number 617 456-0500

Address (No. & Street, City, State, Zip Code)	
1 470 Atlantic Ave - 3rd Fl Boston, MA 02210 2 3 4 5	

Services Provided by This Firm (describe fully)		
1 Saving the Real Estate Tax - R.E Tax Abatement		\$ 6,753
2		\$
3		\$
4		\$
5		\$
		Charge for Services Provided
		\$ 6,753

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

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended		Page	of											
		9/30/2015				8	37									
		Period 10/1 Thru 6/30						Period 7/1 Thru 9/30								
1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall North	2376	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Total	CCNH	RHNS	Total	CCNH	RHNS	Total	CCNH	RHNS	Total	
1. Certified Bed Capacity																
A. On last day of PREVIOUS report period		150	150			150	150			150	150		150	150		
B. On last day of THIS report period		150	150			150	150			150	150		150	150		
2. Number of Residents																
A. As of midnight of PREVIOUS report period		132	132			132	132			132	132		131	131		
B. As of midnight of THIS report period		133	133			133	133			133	133		133	133		
3. Total Number of Days Care Provided During Period																
A. Medicare		3,831	3,831			3,831	3,000			3,000	3,000		831	831		
B. Medicaid (Conn.)		37,519	37,519			37,519	28,463			28,463	28,463		9,056	9,056		
C. Medicaid (other states)																
D. Private Pay		6,247	6,247			6,247	4,595			4,595	4,595		1,652	1,652		
E. State SSI for RCH																
F. Other (Specify)		1,817	1,817			1,817	1,350			1,350	1,350		467	467		
G. Total Care Days During Period (3A thru F)		49,414	49,414			49,414	37,408			37,408	37,408		12,006	12,006		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds																
A. Medicaid Bed Reserve Days		3	3			3	3			3	3					
B. Other Bed Reserve Days		56	56			56	30			30	30		26	26		
5. Total Resident Days (3G + 4A + 4B)		49,473	49,473			49,473	37,441			37,441	37,441		12,032	12,032		

Schedule of Resident Statistics (Cont'd)

Name of Facility 1 Emerson Drive North Operations LLC,d/b/a			License No. 2376			Report for Year Ended 9/30/2015			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days								CCNH	RHNS	(Specify)			
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID				
No. of Residents	9		101		23								
Per Diem Rate													
a. One bed rm.					343.00								
b. Two bed rms.	450.46		199.39		337.50								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								5,826	5,826				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								104	104				
C. Other								9,771	9,771				
D. Total Physical Therapy Treatments								15,701	15,701				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								766	766				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								11	11				
C. Other								2,584	2,584				
D. Total Speech Therapy Treatments								3,361	3,361				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								5,068	5,068				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments								104	104				
C. Other								9,843	9,843				
D. Total Occupational Therapy Treatments								15,015	15,015				

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
1 Emerson Drive North Operations LLC,d/b/a Kimberly Hal	2376	9/30/2015	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	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	109,952	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	193,028	9,380				
5. Dietary Service						
a. Head Dietitian	29,287	875				
b. Food Service Supervisor	57,373	2,115				
c. Dietary Workers	420,058	28,774				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	43,281	1,742				
b. Other Maintenance Workers	46,193	2,265				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	26,044	1,572				
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	106,425	2,096				
b. RN						
1. Direct Care	1,209,732	31,646				
2. Administrative**	132,054	3,709				
c. LPN						
1. Direct Care	827,572	25,521				
2. Administrative**						
d. Aides and Attendants	2,236,371	133,204				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	183,527	11,587				
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	256,473	9,114				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	81,095	4,815				
<i>A-13. Total Salary Expenditures</i>	5,958,465	270,498				

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

Name of Facility (as licensed)		License No.		Report for Year Ended		Page	of		
1 Emerson Drive North Operations LLC, d/b/a Kimberly Hall North		2376		9/30/2015		12	37		
Name	Salary Paid		Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS (Specify)							
Section III - Administrators***									
Thomas Russo	109,952			Management of Center	2,086	2			
Section IV - Assistant Administrators									

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
1 Emerson Drive North Operations LLC,d/b/a Kimb	2376	9/30/2015	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian	976	26				
2. Dentist	16,723	115				
3. Pharmacist	11,027	225				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	511,629	7,009				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	33,510	177				
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	49,583	636				
b. Other						
10. Occupational Therapist						
a. Resident Care	122,556	1,679				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	32,439	766				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	1,627					
B-13 Total Fees Paid in Lieu of Salaries	780,069	10,632				

* 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.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC,d/b/a Kir	2376	9/30/2015	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 287,768	287,768		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 113,889	113,889		
4. Social Security (F.I.C.A.)	\$ 432,962	432,962		
5. Health Insurance	\$ 659,732	659,732		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 19,403	19,403		
8. Uniform Allowance	\$			
9. Other (<i>Specify</i>) See Attached Schedule	\$ 32,621	32,621		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 171,236	171,236		
d. Accounting and Auditing	\$ (65)	(65)		
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 6,753	6,753		
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$			
g. Office Supplies	\$ 12,946	12,946		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 38,733	38,733		
2. Cellular Phones	\$			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$			
j. Corporation Business Taxes (<i>franchise tax</i>)	\$			
k. Other Taxes (<i>Not related to property - See Page 22</i>)				
1. Income*	\$			
2. Other (<i>Specify</i>) See Attached Schedule	\$ 1,471	1,471		
3. Resident Day User Fee	\$ 925,533	925,533		
Subtotal	\$ 2,702,981	2,702,981		

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended		Page	of
1 Emerson Drive North Operations LLC,d/b/a Kimber	2376	9/30/2015		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	2,702,981	2,702,981			
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$ 338	338			
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 2,077	2,077			
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	\$ 7,995	7,995			
4. Fund-Raising***	\$				
5. Medical Records	\$ (0)	(0)			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$ 2,882	2,882			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 11,209	11,209			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$ 2,065	2,065			
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 3,192	3,192			
12. Administrative Management Services**	\$ 515,635	515,635			
13. Other (<i>Specify</i>) See Attached Schedule	\$ 31,592	31,592			
C-14 Total Administrative & General Expenditures	\$ 3,279,967	3,279,967			

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

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

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

Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
I Emerson Drive North Operations LLC,d	2376	9/30/2015	17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	584,341	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	56,580	Capital Interest	pg 26 12-A-1

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC,d/b/a Kimberly	2376	9/30/2015	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 229,790	229,790		
2. Non-Food Supplies	\$ 32,507	32,507		
3. Other (Specify) _____	\$ (1,348)	(1,348)		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 2,796	2,796		
c. Management Services**	\$			
d. Other (Specify) _____	\$			
2E. Total Dietary Expenditures (2a + b + c + d)	\$ 263,745	263,745		
2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*				
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No				
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.				
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.				
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility		License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC,d/b/a Kimberly		2376	9/30/2015	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. \$	6,140	6,140		
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. \$	9,500	9,500		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	210,537	210,537		
c. Management Services**	\$				
d. Other (Specify)	\$				
3E. Total Laundry Expenditures (3a + b + c + d)	\$	226,177	226,177		
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
I. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
J. Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
L. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				

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

All allocations should add to total recorded in 3E.

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

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

**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 North Operations LLC,d/b/a K		2376	9/30/2015		20	37
Item		Total	CCNH	RHNS	(Specify)	
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	25,287	25,287			
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. \$	315,478	315,478			
c. Management Services*		\$				
d. Other (<i>Specify</i>)		\$				
4E. Total Housekeeping Expenditures (4a + b + c + d)		\$ 340,765	340,765			
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		\$				
2. Purchased from		\$ 97,139	97,139			
b. Medicine Cabinet Drugs		\$ 16,546	16,546			
c. Medical and Therapeutic Supplies		\$ 116,049	116,049			
d. Ambulance/Limousine***		\$ 1,290	1,290			
e. Oxygen						
1. For Emergency Use		\$				
2. Other***		\$ 4,432	4,432			
f. X-rays and Related Radiological Procedures***		\$ 8,306	8,306			
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)		\$				
h. Laboratory****		\$ 12,158	12,158			
i. Recreation		\$ 42,408	42,408			
j. Other (Specify)**** See Attached Schedule		\$ 84,640	84,640			
5K. Total Resident Care Expenditures (5a - 5j)		\$ 382,968	382,968			

* 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.

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

Name of Facility	License No.	Report for Year Ended			Page	of
I Emerson Drive North Operations LLC,d/b/a	2376	9/30/2015			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 91,223	91,223				
b. Heat	\$ 26,382	26,382				
c. Light & Power	\$ 268,047	268,047				
d. Water	\$ 48,285	48,285				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 433,936	433,936				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 10	10				
b. Building & Building Improvements	\$ 1,149,959	1,149,959				
c. Non-Movable Equipment	\$ 1,560	1,560				
d. Movable Equipment	\$ 64,455	64,455				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 1,215,985	1,215,985				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,564,221	1,564,221				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 118,608	118,608				
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 2,898,814	2,898,814				

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

Depreciation Schedule

Name of Facility 1 Emerson Drive North Operations LLC, d/b/a Kimberly Hall North		License No. 2376		Report for Year Ended 9/30/2015				Page 23	of 37
Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
A. Land Improvements									
1. Acquired prior to this report period	96		96	21	S/L	Various	10		
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
A-4. Subtotal								10	
B. Building and Building Improvements									
1. Acquired prior to this report period	10,455,644		10,455,644	3,080,314	S/L	Various	1,149,686		
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	16,331		16,331				274		
B-4. Subtotal								1,149,959	
C. Non-Movable Equipment									
1. Acquired prior to this report period	9,630		9,630	2,158	S/L	Various	1,166		
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)	8,016		8,016				394		
C-4. Subtotal								1,560	
D. Movable Equipment									
1. Motor Vehicles (Specify name, model and year of each vehicle)									
a.					S/L	Various			
b.									
c.									
d.									
2. Movable Equipment									
a. Acquired prior to this report period	492,543		492,543	174,650	S/L	Various	63,940		
b. Disposals (attach schedule)									
c. Acquired during this report period (attach schedule)	10,766		10,766				515		
D-3. Subtotal								64,455	
E. Total Depreciation								1,215,985	

Additions:				
12/31/2014	Sales and Use Tax 12/2014	202.00	7.00	21.64
3/31/2015	2 Spot Vital Signs Monitor, NIBP	4,658.09	7.00	332.72
4/30/2015	Backflow preventor for dishwasher	800.82	10.00	33.37
6/30/2015	Hotel Cuber	5,104.80	10.00	127.62
Total additions for Movable Equipment		\$ 10,766		\$ 515
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ -

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility 1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall		License No. 2376		Report for Year Ended 9/30/2015		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	License No.	Report for Year Ended	Page	of	
1 Emerson Drive North Operations LLC	2376	9/30/2015	25	37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*			<input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," complete Part B. If "No," complete Part C.		
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description		Total			
1. Date Land Purchased					
2. Date Structure Completed					
3. IF NOT Original Owner, Date of Purchase					
4. Date of Initial Licensure					
5. Total Licensed Bed Capacity		150			
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)					
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of					
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	
Healthcare REIT, Inc	Building and Equipment	04/01/11	20	1,564,221	
Address: One Seagate Suite 1500					
Toledo, OH 43603-1475					

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
1 Emerson Drive North Operations LL		2376	9/30/2015		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$ 56,580	56,580		
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$ 56,580	56,580		

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
1 Emerson Drive North Operations		2376		9/30/2015		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				56,580	56,580		
12. C. Movable Equipment							
1. Automotive Equipment \$							
A. Item		Rate	Amount				
Lender							
Address of Lender							
2. Other (Specify) \$							
A. Item		Rate	Amount				
Lender							
Address of Lender							
B. Item		Rate	Amount				
Lender							
Address of Lender							
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) \$							
12. D. Other Interest Expense (Specify) \$							
13. Total All Interest Expense (12B7 + 12C3 + 12D) \$				56,580	56,580		
14. Insurance							
a. Insurance on Property (buildings only) \$				10,232	10,232		
b. Insurance on Automobiles \$							
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)			\$	180,481	180,481		
2. Fire and Extended Coverage			\$				
3. Other (Specify)			\$				
14d. Total Insurance Expenditures (14a + b + c) \$				190,713	190,713		
15. Total All Expenditures (A-13 thru C-14) \$				14,812,199	14,812,199		

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall N				2376	9/30/2015	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 11,065	11,065		
Page 13 - Professional Fees							
5.	13	B-8-c	Resident Care Physicians **	\$			
6.		B-10	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 684,616	684,616		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 171,236	171,236		
10.			Accounting & Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m-2 &	Unallowable Advertising *	\$ 7,995	7,995		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 2,065	2,065		
21.			Unallowable Management Fees	\$ 572,215	572,215		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 9,758	9,758		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents	\$			
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 1,458,950	1,458,950		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
10	2	Administrator's salary disallowed	0	11065	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
Total Other Salaries Adjustment			\$ 11,065	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	105403.7	0
13	5	Rehabilitation Services	3195620020	406224.81	0
13	9	Speech Therapist	3170620020	49582.5	0
13	10	Occupational Therapist	3105620020	122556.13	0
13	12	Other	3010620020	248.32	0
13	12	Other	3015620020	-395.7	0
13	12	Respiratory Purchased Servies	3155620020	996.71	0
				0	0
				0	0
				0	0
				0	0
Total Other Fees Adjustments			\$ 684,616	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Collection Fees	1020630120	7760.55	0
16	m13	Estimated Accrual	1020660990	907.21	0
16	m8a	Chamber of Commerce License Fee		0	0
16	m13	Non-recurring charges	7010800030	0	0
16	m-13	Penalty and Fines	1020640080	1090	0
16	1m8	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
0	0	0	0	0	0
Total Other A&G Adjustments			\$ 9,758	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall				2376	9/30/2015	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,458,950	1,458,950		
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs	\$ 97,139	97,139		
28.	20	5-d	Ambulance/Limousine	\$ 1,290	1,290		
29.	20	5-f	X-rays, etc	\$ 8,306	8,306		
30.	20	5-h	Laboratory	\$ 12,158	12,158		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 4,432	4,432		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 31,030	31,030		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$ (196,152)	(196,152)		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51. Total Amount of Decrease (Items 1 - 50)				\$ 1,417,153	1,417,153		

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

1 Emerson Drive North Operations LLC,d/b/a Kimberly Hall North
9/30/2015

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	207	0	0
20	5-j	Respiratory Supplies	7,797	0	0
20	3-j	Respiratory Rental	1,279	0	0
20	5-j	Cable TV	21,747	0	allow \$3600
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
Total Other Ancillary Costs			\$ 31,030	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14 c1	General Liability Insurance Adjust	(196,152)	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
0	0-Jan		0	0	0
Total Other Adjustments			\$ (196,152)	\$ -	\$ -

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility 1 Emerson Drive North Operations LLC, 2376		License No. 2376		Report for Year Ended 9/30/2015		Page 30	of 37
Item				Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue							
1.	a.	Medicaid Residents (<i>CT only</i>)	\$	12,209,729	12,209,729		
	b.	Medicaid Room and Board Contractual Allowance **	\$	(4,839,357)	(4,839,357)		
2.	a.	Medicaid (<i>All other states</i>)	\$				
	b.	Other States Room and Board Contractual Allowance **	\$				
3.	a.	Medicare Residents (<i>all inclusive</i>)	\$	1,290,822	1,290,822		
	b.	Medicare Room and Board Contractual Allowance **	\$	(288,865)	(288,865)		
4.	a.	Private-Pay Residents and Other	\$	2,870,526	2,870,526		
	b.	Private-Pay Room and Board Contractual Allowance **	\$	(507,160)	(507,160)		
II. Other Resident Revenue							
1.	a.	Prescription Drugs - Medicare	\$	67,526	67,526		
	b.	Prescription Drugs - Medicare Contractual Allowance **	\$	(15,111)	(15,111)		
	c.	Prescription Drugs - Non-Medicare	\$	41,449	41,449		
	d.	Prescription Drugs - Non-Medicare Contractual Allowance **	\$	(8,354)	(8,354)		
2.	a.	Medical Supplies - Medicare	\$	59	59		
	b.	Medical Supplies - Medicare Contractual Allowance **	\$	(13)	(13)		
	c.	Medical Supplies - Non-Medicare	\$	176	176		
	d.	Medical Supplies - Non-Medicare Contractual Allowance **	\$	(17)	(17)		
3.	a.	Physical Therapy - Medicare	\$	434,345	434,345		
	b.	Physical Therapy - Medicare Contractual Allowance **	\$	(97,199)	(97,199)		
	c.	Physical Therapy - Non-Medicare	\$	264,250	264,250		
	d.	Physical Therapy - Non-Medicare Contractual Allowance **	\$	(50,251)	(50,251)		
4.	a.	Speech Therapy - Medicare	\$	187,854	187,854		
	b.	Speech Therapy - Medicare Contractual Allowance **	\$	(42,039)	(42,039)		
	c.	Speech Therapy - Non-Medicare	\$	94,110	94,110		
	d.	Speech Therapy - Non-Medicare Contractual Allowance **	\$	(18,455)	(18,455)		
5.	a.	Occupational Therapy - Medicare	\$	525,139	525,139		
	b.	Occupational Therapy - Medicare Contractual Allowance **	\$	(117,518)	(117,518)		
	c.	Occupational Therapy - Non-Medicare	\$	292,102	292,102		
	d.	Occupational Therapy - Non-Medicare Contractual Allowance **	\$	(57,585)	(57,585)		
6.	a.	Other (<i>Specify</i>) - Medicare	\$	9,652	9,652		
	b.	Other (<i>Specify</i>) - Non-Medicare	\$	217,637	217,637		
III. Total Resident Revenue (Section I. thru Section II.)				\$	12,463,452	12,463,452	
IV. Other Revenue *							
1.	Meals sold to guests, employees & others			\$			
2.	Rental of rooms to non-residents			\$			
3.	Telephone			\$			
4.	Rental of Television and Cable Services			\$	564	564	
5.	Interest Income (<i>Specify</i>)			\$	94	94	
6.	Private Duty Nurses' Fees			\$			
7.	Barber, Coffee, Beauty and Gift shops			\$			
8.	Other (<i>Specify</i>)			\$	27,302	27,302	
V. Total Other Revenue (1 thru 8)				\$	27,961	27,961	
VI. Total All Revenue (III +V)				\$	12,491,413	12,491,413	

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-a	Medicare Part A	X-Ray	395.00	-	0
II-6-a	Medicare Part A	Laboratory	5,637.96	-	0
II-6-a	Medicare Part A	Respiratory Therapy & Supplie	1,132.70	-	0
II-6-a	Medicare Part A	Nursing Treatment Supplies	-	-	0
II-6-a	Medicare Part A	Audiology	-	-	0
II-6-a	Medicare Part A	Incontinency	-	-	0
II-6-a	Medicare Part A	Oxygen & Supplies	792.30	-	0
II-6-a	Medicare Part A	Physician Visit	-	-	0
II-6-a	Medicare Part A	Ambulance	-	-	0
II-6-a	Medicare Part A	Flu Shot	4,476.31	-	0
II-6-a	Contractuals-Medicare	X-Ray	(88.39)	-	0
II-6-a	Contractuals-Medicare	Laboratory	(1,261.68)	-	0
II-6-a	Contractuals-Medicare	Respiratory Therapy & Supplie	(253.48)	-	0
II-6-a	Contractuals-Medicare	Nursing Treatment Supplies	-	-	0
II-6-a	Contractuals-Medicare	Audiology	-	-	0
II-6-a	Contractuals-Medicare	Incontinency	-	-	0
II-6-a	Contractuals-Medicare	Oxygen & Supplies	(177.30)	-	0
II-6-a	Contractuals-Medicare	Physician Visit	-	-	0
II-6-a	Contractuals-Medicare	Ambulance	-	-	0
II-6-a	Contractuals-Medicare	Flu Shot	(1,001.73)	-	0
Total Other Resident Revenue - Medicare			\$ 9,652	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	-	-	0
II-6-b	Medicaid	Laboratory	737.20	-	0
II-6-b	Medicaid	Respiratory Therapy & Supplie	10,221.62	-	0
II-6-b	Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Medicaid	Audiology	-	-	0
II-6-b	Medicaid	Incontinency	-	-	0
II-6-b	Medicaid	Oxygen & Supplies	3,032.40	-	0
II-6-b	Medicaid	Physician Visit	-	-	0
II-6-b	Medicaid	Ambulance	-	-	0
II-6-b	Medicaid	Flu Shot	-	-	0
II-6-b	Contractuals Medicaid	X-Ray	-	-	0
II-6-b	Contractuals Medicaid	Laboratory	(292.19)	-	0
II-6-b	Contractuals Medicaid	Respiratory Therapy & Supplie	(4,051.36)	-	0
II-6-b	Contractuals Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Contractuals Medicaid	Audiology	-	-	0
II-6-b	Contractuals Medicaid	Incontinency	-	-	0
II-6-b	Contractuals Medicaid	Oxygen & Supplies	(1,201.90)	-	0
II-6-b	Contractuals Medicaid	Physician Visit	-	-	0
II-6-b	Contractuals Medicaid	Ambulance	-	-	0
II-6-b	Contractuals Medicaid	Flu Shot	-	-	0
II-6-b	Private and Other	X-Ray	210.66	-	0

II-6-b	Private and Other	Laboratory	3,080.96	-	0
II-6-b	Private and Other	Respiratory Therapy & Supplie	(269.43)	-	0
II-6-b	Private and Other	Nursing Treatment Supplies	-	-	0
II-6-b	Private and Other	Audiology	-	-	0
II-6-b	Private and Other	Incontinency	-	-	0
II-6-b	Private and Other	Oxygen & Supplies	467.40	-	0
II-6-b	Private and Other	Physician Visit	-	-	0
II-6-b	Private and Other	Ambulance	-	-	0
II-6-b	Private and Other	Flu Shot	-	-	0
II-6-b	Private and Other	Capitation Contracts	250,593.00	-	0
II-6-b	Contractuals-Non-Medicaid	X-Ray	(37.22)	-	0
II-6-b	Contractuals-Non-Medicaid	Laboratory	(544.34)	-	0
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplie	47.60	-	0
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment Supplies	-	-	0
II-6-b	Contractuals-Non-Medicaid	Audiology	-	-	0
II-6-b	Contractuals-Non-Medicaid	Incontinency	-	-	0
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplies	(82.58)	-	0
II-6-b	Contractuals-Non-Medicaid	Physician Visit	-	-	0
II-6-b	Contractuals-Non-Medicaid	Ambulance	-	-	0
II-6-b	Contractuals-Non-Medicaid	Capitation Contracts	(41,274.38)	-	0
Total Other Resident Revenue			\$ 217,637	\$ -	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Inc	0	0	0	0
IV-5	Interest On Overdue Accounts	0000100250	94.27	0	0
Total Interest Income			\$ 94	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
IV-8	Donation	0	600.00	0
IV-8	CCATT Holdings-Tower lease	0	26,007.00	0
IV-8	hairdresser	0	695.45	0
Total Other Revenue			\$ 27,302	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC	2376	9/30/2015	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	13,411
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,186,143
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	2,239
4. Inventories			\$	61,649
5. Prepaid Expenses			\$	75,551
a. Prepaid Expenses				
b. Prepaid Property Tax	63,546			
c. Prepaid Personal Property Tax				
d. Prepaid Personal Property Tax	12,005			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,338,993
B. Fixed Assets				
1. Land			\$	940,000
2. Land Improvements	*Historical Cost	96	\$	66
	Accum. Depreciation	30		Net
3. Buildings	*Historical Cost	10,471,975	\$	6,241,701
	Accum. Depreciation	4,230,274		Net
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation			Net
5. Non-Movable Equipment	*Historical Cost	17,645	\$	13,927
	Accum. Depreciation	3,718		Net
6. Movable Equipment	*Historical Cost	503,309	\$	264,203
	Accum. Depreciation	239,106		Net
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation			Net
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	
PPE CIP				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	7,459,897

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC		2376	9/30/2015	32	37
Account				Amount	
Total Brought Forward:				\$	8,798,890
C. Leasehold or like property recorded for Equity Purposes.					
1. Land					
\$					
2. Land Improvements					
		*Historical Cost	_____		
		Accum. Depreciation	_____	Net	\$
3. Buildings					
		*Historical Cost	_____		
		Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment					
		*Historical Cost	_____		
		Accum. Depreciation	_____	Net	\$
5. Movable Equipment					
		*Historical Cost	_____		
		Accum. Depreciation	_____	Net	\$
6. Motor Vehicles					
		*Historical Cost	_____		
		Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable					
\$					
C-8 Total Leasehold or Like Properties (C1 thru 7)					
\$					
D. Investment and Other Assets					
1. Deferred Deposits					
\$					
2. Escrow Deposits					
\$					
3. Organization Expense					
		*Historical Cost	_____		
		Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)					
\$					
5. Investments Related to Resident Care (<i>itemize</i>)					
\$					
6. Loans to Owners or Related Parties (<i>itemize</i>)					
\$					
Name and Address		Amount		Loan Date	
7. Other Assets (<i>itemize</i>)					
		I/C Due to/Due From Owned		(5,047,682)	\$
		I/C Due to/Due From Multicare			
D-8. Total Investments and Other Assets (Lines D1 thru 7)					
\$ (5,047,682)					
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)					
\$ 3,751,208					

* 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 North Operations LLC,d/b/a	2376	9/30/2015	33	37	
Account			Amount		
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable			\$	306,311	
2. Notes Payable (<i>itemize</i>)			\$		
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)			\$		
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll(<i>Exclusive of Owners and/or Stockholders only</i>)			\$	253,190	
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$		
6. Accrued Payroll Taxes Payable			\$	90	
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>)			\$	557,322	
Accr Exp Other	16,604	A/R Credit Gross Up Lia	219,280		
Accr Exp Water and Sewer	7,016	Deferred Revenue	80,074		
Accr Exp Gas	2,293	Accrued Provider/Bed Te	226,512		
Accr Exp Electricity	7,530	Accr Exp Suspense	(1,987)		
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	1,116,913	

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

(*Carry Total forward to next page*)

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC,d/b		2376	9/30/2015	34	37
Account				Amount	
Total Brought Forward:				1,116,913	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>temize</i>)					
\$					
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties (<i>temize</i>)				\$	
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities (<i>temize</i>)				\$	
LT Debt-Financing Obligation		11,702,224	11,702,224		
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 11,702,224	
C. Total All Liabilities (Lines A-13 + B-5)				\$ 12,819,137	

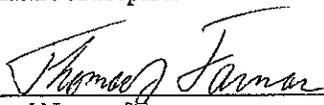
G. Balance Sheet (cont'd)
Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LL	2376	9/30/2015	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (equity)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	(1,929,122)
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(4,818,050)
6. Gain or Loss for Period			\$	(2,320,755)
	10/1/2014	thru	9/30/2015	
7. Total Net Worth			\$	(9,067,927)
C. Total Reserves and Net Worth			\$	(9,067,927)
D. Total Liabilities, Reserves, and Net Worth			\$	3,751,210

H. Changes in Total Net Worth

Name of Facility		License No.	Report for Year Ended	Page	of
1 Emerson Drive North Operations LLC, c		2376	9/30/2015	36	37
Account				Amount	
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			\$	(6,747,170)
B.	Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	12,491,442
C.	Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	14,812,199
D.	Net Income or Deficit			\$	(2,320,757)
E.	Balance			\$	(9,067,927)
F.	Additions				
	1. Additional Capital Contributed <i>(itemize)</i>				
	2. Other <i>(itemize)</i>				
F-3.	Total Additions			\$	
G.	Deductions				
	1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
	Name and Address <i>(No., City, State, Zip)</i>	Title	Amount		
	2. Other Withdrawings <i>(Specify)</i>			\$	
	Purpose	Amount			
	3. Total Deductions			\$	
H.	Balance at End of Period		09/30/15	\$	(9,067,927)

I. Preparer's/Reviewer's Certification

Name of Facility 1 Emerson Drive North Operations	License No. 2376	Report for Year Ended 9/30/2015	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer 	Title <i>Sr. Director of Reimbursement</i>	Date Signed <i>12/28/2015</i>		
Printed Name of Preparer Thomas Farnan - Director of Reimbursement Title -Sr. Director of Reimbursement				
Address Address 200 Brickstone Square, Andover, MA 01810			Phone Number 978-247-5029	