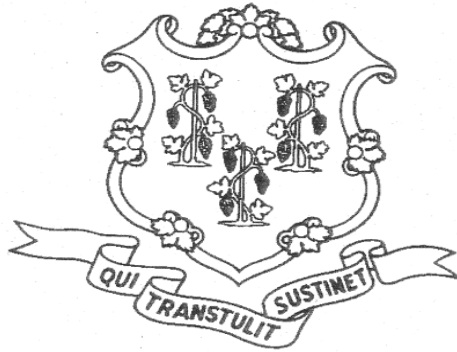


# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2016

Name of Facility (as licensed) St. Joseph's Manor Care and Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 6448 Main Street, Trumbull, CT 06611	
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 10/1/2015	Report for Year Ending 9/30/2016

License Numbers:	CCNH 2321-C	RHNS	(Specify)	Medicare Provider 07-5001
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Medicaid Provider Numbers:	CCNH 6841	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
St. Joseph's Manor Care and Rehabilitation Center	2321-C	9/30/2016	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 St. Joseph's Manor Care and Rehabilitation Center [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, 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)		
Gaudioso, Marian			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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility St. Joseph's Manor Care and Rehabilitation Center		Period Covered:	From 10/1/2015	To 9/30/2016
Address of Facility 6448 Main Street, Trumbull, CT 06611				
Report Prepared By Thomas Farnan		Phone Number 978-247-5029	Date 12/21/2016	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$ 1,359,917	1,264,723		95,194
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$ 9,681,293	9,597,528		83,765
5. All other wages paid	\$ 1,578,237	1,467,760		110,477
6. <b>Total Wages Paid</b>	\$ 12,619,447	12,330,011		289,436
7. Total salaries paid	\$ 524,559	513,869		10,690
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$ 13,144,006	12,843,881		300,125

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 203-268-6204	Report for Year Ended 9/30/2016	Page 2	of 37
Name of Facility (as shown on license) St. Joseph's Manor Care and Rehabilitation Center		Address (No. & Street, City, State, Zip ) 6448 Main Street, Trumbull, CT 06611		
License Numbers:	CCNH 2321-C	RHNS	(Specify)	Medicare Provider No. 07-5001
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.				
<b>Administrator</b>				
Name of Administrator Gaudioso, Marian		Nursing Home Administrator's License No.:	1650	
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 St. Joseph's Manor Care and Rehabilitation C	License No. 2321-C	Report for Year Ended 9/30/2016	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		
St. Joseph's Manor Care and Rehabilitation Center	101 East State Street, Kennett Square, PA 19348	PA		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
N/A				
Names of Stockholders Owning at Least 10% of Shares				
N/A				





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

**General Information and Questionnaire  
Related Parties\***

Name of Facility St. Joseph's Manor Care and Rehabilitation Center	License No. 2321-C	Report for Year Ended 9/30/2016	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	%**				
Genesis Health Ventures	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Home Office	Pg 16/m12	1,102,784	1,102,784
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	62%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	1,174,678	1,174,678
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	56%	Staffing Pool	Pg 10/A12	2,655	2,655
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	83%	Case Management	Pg 13/B8, Pg 10/A12	48,000	48,000
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	80%	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"/>	51%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	65,158	65,158
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	483,602	483,602
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	98,115	98,115
		<input type="radio"/>	<input 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. Joseph's Manor Care and Rehabilitation Cent	License No. 2321-C	Report for Year Ended 9/30/2016	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

### General Information and Questionnaire Leases (Excluding Real Property)

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

Name of Facility St. Joseph's Manor Care and Rehabilitation Center			License No. 2321-C	Report for Year Ended 9/30/2016			Page 6	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 type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input 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.

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

Name of Facility St. Joseph's Manor Care and Rehab	License No. 2321-C	Report for Year Ended 9/30/2016	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

- Accrual     Cash     Modified Cash

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

**Independent Accounting Firm**

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

Services Provided by This Firm (*describe fully*)

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

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

- Yes     No

**Legal Services Information**

Name of Legal Firm or Independent Attorney 1 GOLDMAN GRUDER & WOOD, LLC 2 Christopher Paoletti and Joan S. Mehlhorn State Marshal 3 STATE OF CT, PROBATE COURT 4 5	Telephone Number (203) 899-8900  (203) 452-5068
---	--

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

1 200 Connecticut Ave. Norwalk, CT 06854
2 3301 Maine St Bridgeport, CT 06606
3 Town Hall, 5866 Main St., Trumbull, CT 06611
4
5

Services Provided by This Firm (*describe fully*)

1 Applications and affidavits of debt, Probate Court conferences and correspondence, review title search	\$
2 State Marshall fee for Citation Appointment of Conservator	\$ 432
3 Hearing Fees & Notices, Conservatorship Fees	\$ 662
4	\$
5	\$
	Charge for Services Provided
	\$ 1,094

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 St. Joseph's Manor Care and Rehabilitation Center				License No. 2321-C		Report for Year Ended 9/30/2016				Page 8	of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	297	274		23	297	274		23	297	274		23
B. On last day of THIS report period	297	274		23	297	274		23	297	274		23
2. Number of Residents												
A. As of midnight of PREVIOUS report period	272	253		19	272	253		19	275	256		19
B. As of midnight of THIS report period	264	246		18	275	256		19	264	246		18
3. Total Number of Days Care Provided During Period												
A. Medicare	6,586	6,586			5,459	5,459			1,127	1,127		
B. Medicaid (Conn.)	76,936	76,936			57,231	57,231			19,705	19,705		
C. Medicaid (other states)												
D. Private Pay	5,459	5,459			3,744	3,744			1,715	1,715		
E. State SSI for RCH	6,486			6,486	4,827			4,827	1,659			1,659
F. Other (Specify)	3,765	3,765			3,009	3,009			756	756		
G. Total Care Days During Period (3A thru F)	99,232	92,746		6,486	74,270	69,443		4,827	24,962	23,303		1,659
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	88	7		81	85	6		79	3	1		2
B. Other Bed Reserve Days	57	57			44	44			13	13		
5. <b>Total Resident Days (3G + 4A + 4B)</b>	99,377	92,810		6,567	74,399	69,493		4,906	24,978	23,317		1,661

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

Name of Facility St. Joseph's Manor Care and Rehabilitation Center			License No. 2321-C			Report for Year Ended 9/30/2016			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <span style="float: right;"><input type="radio"/> Yes <input checked="" type="radio"/> No</span> 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	(Specify)	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID			
No. of Residents	7		216			23			18				
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	596.94		249.92			493.60			94.00				
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									4,043	4,043			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									1,715	1,715			
C. Other									20,353	20,353			
D. <b>Total Physical Therapy Treatments</b>									26,111	26,111			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									524	524			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									247	247			
C. Other									2,133	2,133			
D. <b>Total Speech Therapy Treatments</b>									2,904	2,904			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									5,809	5,809			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									1,763	1,763			
C. Other									23,308	23,308			
D. <b>Total Occupational Therapy Treatments</b>									30,880	30,880			

### Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
St. Joseph's Manor Care and Rehabilitation Center	2321-C	9/30/2016	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
<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)	136,338	1,945			10,262	146
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	5,682	215			428	16
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	469,721	21,298			35,355	1,603
5. Dietary Service						
a. Head Dietitian	123,516	4,180			9,297	315
b. Food Service Supervisor	190,877	8,649			14,367	651
c. Dietary Workers	950,330	66,000			71,530	4,968
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	127,612	3,792			9,605	285
b. Other Maintenance Workers	256,300	14,582			19,291	1,098
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	371,849	7,884				
b. RN						
1. Direct Care	1,639,204	46,312			700	20
2. Administrative**	145,304	3,670				
c. LPN						
1. Direct Care	3,221,544	108,237			20,475	640
2. Administrative**						
d. Aides and Attendants	4,312,147	241,964			41,565	2,295
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	310,187	17,249			23,347	1,298
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	303,942	12,337			22,877	929
n. Marketing						
o. Other (Specify) See Attached Schedule	279,329	14,727			21,025	1,108
<i>A-13. Total Salary Expenditures</i>	<b>12,843,881</b>	<b>573,041</b>			<b>300,125</b>	<b>15,372</b>

\* 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				License No.	Report for Year Ended				Page	of
St. Joseph's Manor Care and Rehabilitation Center				2321-C	9/30/2016				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)							
<b>Section I - Operators/Owners</b>										
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										

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

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

**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. Joseph's Manor Care and Rehabilitation Center				2321-C	9/30/2016			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)							
<b>Section III - Administrators***</b>										
Gaudioso, Marian	136,338		10,262		Management of Center	2,091	2			
<b>Section IV - Assistant Administrators</b>										
Bewry, Nickeisha	5,682		428		Assists in overseeing facility operations	231	3			

\*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.

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

**B. Report of Expenditures - Professional Fees**

Name of Facility	License No.	Report for Year Ended	Page	of		
St. Joseph's Manor Care and Rehabilitation Center	2321-C	9/30/2016	13	37		
<b>Total Cost and Hours</b>						
Item	CCNH	Hours	RHNS	Hours	(Specify)	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	2,221	60				
2. Dentist	29,341					
3. Pharmacist	19,395	485				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	1,051,364	17,523				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	56,450	192				
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	72,906	1,376				
b. Other						
10. Occupational Therapist						
a. Resident Care	211,480	3,916				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	(57,736)	(1,273)				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	17,831					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>1,403,252</b>	<b>22,279</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 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
St. Joseph's Manor Care and Rehabilitation Center	2321-C	9/30/2016	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 695,573	681,662		13,911
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 172,882	169,424		3,458
4. Social Security (F.I.C.A.)	\$ 968,599	949,227		19,372
5. Health Insurance	\$ 1,107,921	1,085,763		22,158
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 740,164	725,361		14,803
8. Uniform Allowance	\$			
9. Other (Specify) See Attached Schedule	\$			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 396,461	368,709		27,752
d. Accounting and Auditing	\$			
e. Legal (Services should be fully described on Page 7)	\$ 1,094	1,017		77
f. Insurance on Lives of Owners and Operators (Specify)*	\$			
g. Office Supplies	\$ 56,084	52,158		3,926
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 52,041	48,398		3,643
2. Cellular Phones	\$ 2,363	2,198		165
i. Appraisal (Specify purpose and attach copy)*	\$			
j. Corporation Business Taxes (franchise tax)	\$			
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$			
2. Other (Specify) See Attached Schedule	\$ 2,106	1,959		147
3. Resident Day User Fee	\$ 1,345,687	1,345,687		
<b>Subtotal</b>	\$ 5,540,975	5,431,563		109,412

\* 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	
St. Joseph's Manor Care and Rehabilitation Center	2321-C	9/30/2016	16	37	
Item		Total	CCNH	RHNS	(Specify)
<b>Subtotals Brought Forward:</b>		5,540,975	5,431,563		109,412
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	251	233		18
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	5,973	5,555		418
5. Education Expenses Related to Seminars and Conventions	\$	142	132		10
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> )	\$	551	512		39
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )***	\$	15,989	14,870		1,119
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	\$	8,611	8,008		603
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> )	\$	24,156	22,465		1,691
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions***	\$	3,563	3,563		
See Attached Schedule					
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$	3,479	3,235		244
12. Administrative Management Services**	\$	1,219,033	1,133,701		85,332
13. Other ( <i>Specify</i> )	\$	77,759	72,316		5,443
See Attached Schedule					
<b>C-14 Total Administrative &amp; General Expenditures</b>	<b>\$</b>	<b>6,900,482</b>	<b>6,696,152</b>		<b>204,330</b>

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

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

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







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

Name of Facility St. Joseph's Manor Care and Rehabilitatio	License No. 2321-C	Report for Year Ended 9/30/2016	Page of 17   37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	1,102,784	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	98,115	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 St. Joseph's Manor Care and Rehabilitation Center		License No. 2321-C	Report for Year Ended 9/30/2016	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$	477,343	443,929		33,414
2. Non-Food Supplies	\$	62,633	58,249		4,384
3. Other (Specify) _____	\$	(29,697)	(27,618)		(2,079)
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Management Services**		\$			
d. Other (Specify) _____		\$	40	37	3
<b>2E. Total Dietary Expenditures (2a + b + c + d)</b>		\$	510,319	474,597	35,722
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
St. Joseph's Manor Care and Rehabilitation Center		2321-C	9/30/2016		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. \$	15,307	14,236		1,071
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. \$	13,709	12,749		960
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	659,590	613,419		46,171
c. Management Services**		\$				
d. Other (Specify)		\$				
<b>3E. Total Laundry Expenditures (3a + b + c + d)</b>		\$	<b>688,606</b>	<b>640,404</b>		<b>48,202</b>
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
St. Joseph's Manor Care and Rehabilitation Center		2321-C	9/30/2016		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.	\$	28,105	26,138		1,967
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.	\$	986,497	917,442		69,055
c. Management Services*		\$				
d. Other ( <i>Specify</i> )		\$				
<b>4E. Total Housekeeping Expenditures (4a + b + c + d)</b>		\$	1,014,602	943,580		71,022
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		\$				
2. Purchased from		\$	456,109	456,109		
b. Medicine Cabinet Drugs		\$	52,776	52,776		
c. Medical and Therapeutic Supplies		\$	399,194	399,194		
d. Ambulance/Limousine****		\$	18,409	18,409		
e. Oxygen						
1. For Emergency Use		\$				
2. Other****		\$	36,698	36,698		
f. X-rays and Related Radiological Procedures****		\$	24,502	24,502		
g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )		\$				
h. Laboratory****		\$	64,592	64,592		
i. Recreation		\$	42,864	39,864		3,000
j. Other ( <i>Specify</i> )**** See Attached Schedule		\$	214,179	199,186		14,993
<b>5K. Total Resident Care Expenditures (5a - 5j)</b>		\$	1,309,323	1,291,330		17,993

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

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

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

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

**Schedule of Other Resident Care**

Description		CCNH	RHNS	(Specify)
3060610160	Incontinency	136,922.04	-	10,305.96
3060610161	Incontinency - Rebate	(1,693.75)	-	(127.49)
3080630030	Advertising-Help War	573.31	-	43.15
3080630030	Advertising-Help War	261.42	-	19.68
3080630140	Education Expense	3,156.07	-	237.55
3080630140	Education Expense	992.38	-	74.69
3080630310	Licenses & Certificati	222.27	-	16.73
3165630340	Meetings & Seminars	63.94	-	4.81
3120630530	Supplies	12,163.72	-	915.55
3155630530	Supplies	4,083.29	-	307.34
3155630530	Supplies	5,404.35	-	406.78
3165630530	Supplies	5.56	-	0.42
3170630530	Supplies	52.17	-	3.93
3090630550	T&E-Lodging/Transp	145.39	-	10.94
3120660080	Rental Expense	310.43	-	23.37
3155660080	Rental Expense	80.99	-	6.10
3155660080	Rental Expense	18,167.55	-	1,367.45
3010610300	Consolidated Billing	18,275.11	-	1,375.55
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	0.00	0.00	0.00
0	0	0.00	0.00	0.00
0	0	0.00	0.00	0.00
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
<b>Total Other Resident Care</b>		\$ 199,186	\$ -	\$ 14,993
		0		0

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

Name of Facility St. Joseph's Manor Care and Rehabilitation Center			License No. 2321-C		Report for Year Ended 9/30/2016			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)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	<input checked="" type="radio"/>	<input type="radio"/>	Vendor Contracted	Laundry Purchased Services	659,590			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input checked="" type="radio"/>	<input type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	986,497			20	4b
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input 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).

## Annual Report of Long-Term Care Facility

CSP-22 Rev. 6/95

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

Name of Facility	License No.	Report for Year Ended			Page	of
St. Joseph's Manor Care and Rehabilitation Ce	2321-C	9/30/2016			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 382,181	355,428		26,753		
b. Heat	\$ 335,811	312,304		23,507		
c. Light & Power	\$ 359,645	334,470		25,175		
d. Water	\$ 402,310	374,148		28,162		
e. Equipment Lease ( <i>Provide detail on page 6</i> )	\$					
f. Other ( <i>itemize</i> )	\$					
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	\$ 1,479,947	1,376,350		103,597		
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 522	485		37		
b. Building & Building Improvements	\$ 45,292	42,122		3,170		
c. Non-Movable Equipment	\$ 28,972	26,944		2,028		
d. Movable Equipment	\$ 46,191	42,958		3,233		
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	\$ 120,977	112,509		8,468		
8. Amortization ( <i>Complete att. Schedule Page 24*</i> )						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other ( <i>Specify</i> )	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 2,297,278	2,136,469		160,809		
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 241,824	224,896		16,928		
c. Personal property taxes	\$					
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	\$ 2,660,079	2,473,874		186,205		

\* 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 St. Joseph's Manor Care and Rehabilitation Center			License No. 2321-C			Report for Year Ended 9/30/2016			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			6,132		6,132	971	S/L	Various	522												
2. Disposals (attach schedule)																					
3. Acquired during this report period (attach schedule)																					
A-4. Subtotal										522											
<b>B. Building and Building Improvements</b>																					
1. Acquired prior to this report period			523,626			111,924			43,573												
2. Disposals (attach schedule)																					
3. Acquired during this report period (attach schedule)			79,231		79,231				1,719												
B-4. Subtotal										45,292											
<b>C. Non-Movable Equipment</b>																					
1. Acquired prior to this report period			262,632		262,632	75,823	S/L	Various	28,460												
2. Disposals (attach schedule)																					
3. Acquired during this report period (attach schedule)			14,998		14,998				512												
C-4. Subtotal										28,972											
		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	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>D. Movable Equipment</b>																					
1. Motor Vehicles (Specify name, model and year of each vehicle)																					
a. Motor Vehicles (attach schedule)							8,930		8,930	6,325	S/L	Various	2,233								
b. Disposals (attach schedule)																					
c. Acquired during this report period (attach schedule)																					
d.																					
2. Movable Equipment																					
a. Acquired prior to this report period							311,705		311,705	110,414	S/L	Various	42,542								
b. Disposals (attach schedule)																					
c. Acquired during this report period (attach schedule)							20,573		20,573				1,416								
D-3. Subtotal																					46,191
<b>E. Total Depreciation</b>																					120,977





<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			License No.		Report for Year Ended			Page	of
St. Joseph's Manor Care and Rehabilitation Center			2321-C		9/30/2016			24	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.									
2.									
3.									
A-4. Subtotal									
<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>									

\* 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. Joseph's Manor Care and Rehabil	License No. 2321-C	Report for Year Ended 9/30/2016		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		297			
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
SABRA, 101 Sun Ave. NE, Albuquerque, NM 87109		Facility Lease	11/15/10 - 6/30	127 months	2,136,469

**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. Joseph's Manor Care and Rehabil		2321-C	9/30/2016			26	37
Item		Total	CCNH	RHNS	(Specify)		
12. Interest							
A. Building, Land Improvement & Non-Movable Equipment							
1. First Mortgage		\$ 98,115	91,247		6,868		
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)		\$ 98,115	91,247		6,868		

(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. Joseph's Manor Care and Rehabil		2321-C		9/30/2016		27	37
Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				98,115	91,247		6,868
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. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$ 98,115	91,247		6,868
14. Insurance							
a. Insurance on Property (buildings only)				\$ 30,852	28,692		2,160
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)			\$ 452,749	421,057			31,692
2. Fire and Extended Coverage			\$				
3. Other (Specify)			\$				
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$ 483,601	449,749		33,852
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$ 29,692,332	28,684,417		1,007,915

### D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended	Page	of	
St. Joseph's Manor Care and Rehabilitation Center			2321-C	9/30/2016	28	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 99,264	99,264		
<b>Page 13 - Professional Fees</b>							
5.	13	8-c	Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 1,273,432	1,273,432		
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 396,461	368,709		27,752
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 *	\$ 15,989	14,870		1,119
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 3,563	3,563		
21.			Unallowable Management Fees	\$ 1,317,148	1,224,948		92,200
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 392,583	392,583		
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 3,498,441	3,377,370		121,071

\* 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	\$ 11,911	0	0
10	a12o	0	0	\$ -	0	0
10	a12o	Day Treatment Wages	0	\$ 87,353	0	0
0	0	0	0	\$ -	0	0
0	0	0	0	\$ -	0	0
0	0	0	0	\$ -	0	0
<b>Total Other Salaries Adjustment</b>				\$ 99,264	\$ -	\$ -

**Schedule of Fees Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)	
13	5	Rehabilitation Services	3120620020	\$ 153,006	0	0
13	5	Rehabilitation Services	3195620020	\$ 818,708	0	0
13	9	Speech Therapist	3170620020	\$ 72,906	0	0
13	10	Occupational Therapist	3105620020	\$ 211,480	0	0
13	12	Other	3010620020	\$ 1,445	0	0
13	12	Other	3015620020	\$ 8,844	0	0
13	12	Respiratory Purchased Servies	3155620020	\$ 7,043	0	0
					0	0
					0	0
					0	0
					0	0
					0	0
<b>Total Other Fees Adjustments</b>				\$ 1,273,432	\$ -	\$ -
				\$ -		

**Schedule of Other A&G Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)	
16	m-8a	1020630310	Chamber of Commerce	\$ -	0	0
16	m-13	1020630120	Collection Fees	\$ 1,843	0	0
16	m-13	1020660990	Estimated Accrual	\$ 1,962	0	0
16	m-13	7010800030	Non-recurring charges	\$ -	0	0
16	m-13	1020640080	Penalty	\$ 15,410	0	0
0	0	0	0	\$ -	0	0
15	1a3	Adult Care SUTA	Adult Care; SUTA, FU	\$ 2,326	0	0
15	1a4	Adult Care; FICA	Adult Care; FICA	\$ 13,033	0	0
15	1-a-1	adj workers comp	0	358,008	0	0
0	0	0	0	0	0	0
<b>Total Other A&amp;G Adjustments</b>				\$ 392,583	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
St. Joseph's Manor Care and Rehabilitation Center				2321-C	9/30/2016	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 3,498,441	3,377,370		121,071
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5-a-2	Prescription Drugs	\$ 456,109	456,109		
28.	20	5-d	Ambulance/Limousine	\$ 18,409	18,409		
29.	20	5-f	X-rays, etc	\$ 24,502	24,502		
30.	20	5-h	Laboratory	\$ 64,592	64,592		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 36,698	36,698		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 69,548	69,548		
<b>Page 22 - Maintenance and Property</b>							
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	\$ 38,356	38,356		
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
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	\$ 389,650	389,650		
<b>Not For Profit Providers Only</b>							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	<b>Total Amount of Decrease (Items 1 - 50)</b>			\$ 4,596,305	4,475,233		121,071

\*\*\* 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.

St. Joseph's Manor Care and Rehabilitation Center  
9/30/2016

**Schedule of Other Ancillary Costs**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	\$ 19,651	\$ -	\$ -
20	5-j	Respiratory Supplies	\$ 10,202	\$ -	\$ -
20	5-j	Respiratory Rental	\$ 19,622	\$ -	\$ -
20	5-i	Cable TV	\$ 20,074	allow \$3600	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
<b>Total Other Ancillary Costs</b>			\$ 69,548	\$ -	\$ -
			\$ -		

**Schedule of Excess Movable Equipment Depreciation**

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

**Schedule of Other Property Adjustments**

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
22	6b	Adult day care -heat	4,519	-	-
22	6c	Adult day care -electricity	4,839	-	-
22	6d	Adult day care -water	5,413	-	-
22	6a	Tersian Towers Misc Revenue - Maint Dept	9,974	-	-
22	6b	Tersian Towers Misc Revenue- Electricity revenue	13,610	-	-
0	0-Jan		0 -	-	-
0	0-Jan		0 -	-	-
0	0-Jan		0 -	-	-
<b>Total Other Property Adjustments</b>			\$ 38,356	\$ -	\$ -
			\$ -		

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14 c1	General liability Insurance Adjust	\$ 389,650	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
<b>Total Other Adjustments</b>			\$ 389,650	\$ -	\$ -
			\$ -		

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Unallowable Building Interest</b>			\$ -	\$ -	\$ -

**F. Statement of Revenue**

Name of Facility	License No.	Report for Year Ended			Page	of
St. Joseph's Manor Care and Rehabilitation	2321-C	9/30/2016			30	37
Item	Total	CCNH	RHNS	(Specify)		
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>						
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 38,706,460	37,158,202		1,548,258		
b. Medicaid Room and Board Contractual Allowance **	\$ (18,851,124)	(18,097,079)		(754,045)		
2. a. Medicaid ( <i>All other states</i> )	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents( <i>all inclusive</i> )	\$ 3,314,231	3,314,231				
b. Medicare Room and Board Contractual Allowance **	\$ (943,015)	(943,015)				
4. a. Private-Pay Residents and Other	\$ 4,667,610	4,667,610				
b. Private-Pay Room and Board Contractual Allowance **	\$ (1,057,642)	(1,057,642)				
<b>II. Other Resident Revenue</b>						
1. a. Prescription Drugs - Medicare	\$ 298,223	298,223				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (84,855)	(84,855)				
c. Prescription Drugs - Non-Medicare	\$ 208,588	193,987		14,601		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (53,664)	(49,908)		(3,756)		
2. a. Medical Supplies - Medicare	\$ 52	52				
b. Medical Supplies - Medicare Contractual Allowance **	\$ (15)	(15)				
c. Medical Supplies - Non-Medicare	\$ 241	224		17		
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (98)	(91)		(7)		
3. a. Physical Therapy - Medicare	\$ 936,865	936,865				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (266,571)	(266,571)				
c. Physical Therapy - Non-Medicare	\$ 446,817	415,540		31,277		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (124,404)	(115,696)		(8,708)		
4. a. Speech Therapy - Medicare	\$ 221,247	221,247				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (62,953)	(62,953)				
c. Speech Therapy - Non-Medicare	\$ 144,212	134,117		10,095		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (39,904)	(37,111)		(2,793)		
5. a. Occupational Therapy - Medicare	\$ 1,172,034	1,172,034				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (333,485)	(333,485)				
c. Occupational Therapy - Non-Medicare	\$ 558,524	519,427		39,097		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (151,915)	(141,281)		(10,634)		
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 50,784	47,229		3,555		
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 312,667	290,780		21,887		
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 29,068,910	28,180,067		888,844		
<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	\$ (132)	(123)		(9)		
5. Interest Income ( <i>Specify</i> )	\$ 558	558				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$ 8,898	8,275		623		
8. Other ( <i>Specify</i> )	\$ 168,718	168,718				
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 178,042	177,428		614		
<b>VI. Total All Revenue</b> (III + V)	\$ 29,246,952	28,357,495		889,458		

\* 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.







### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
St. Joseph's Manor Care and Rehabilitation	2321-C	9/30/2016	31	37
Account			Amount	
<b>Assets</b>				
<b>A. Current Assets</b>				
1. Cash ( <i>on hand and in banks</i> )			\$	14,581
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,400,153
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(8,327)
4. Inventories			\$	111,533
5. Prepaid Expenses			\$	8,688
a. Prepaid Expenses				
b. Prepaid Property Tax	2,657			
c. Prepaid Escrow Real Estate				
d. Prepaid Personal Property Tax	6,031			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
_____				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	2,526,628
<b>B. Fixed Assets</b>				
1. Land			\$	
2. Land Improvements	*Historical Cost	6,132		
	Accum. Depreciation	1,493		
	Net		\$	4,639
3. Buildings	*Historical Cost	602,858		
	Accum. Depreciation	157,216		
	Net		\$	445,642
4. Leasehold Improvements	*Historical Cost			
	Accum. Depreciation			
	Net		\$	
5. Non-Movable Equipment	*Historical Cost	277,631		
	Accum. Depreciation	104,795		
	Net		\$	172,836
6. Movable Equipment	*Historical Cost	332,278		
	Accum. Depreciation	154,372		
	Net		\$	177,906
7. Motor Vehicles	*Historical Cost	8,930		
	Accum. Depreciation	8,558		
	Net		\$	372
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
PPE CIP				
_____				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	801,395

\* 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
St. Joseph's Manor Care and Rehabilitati	2321-C	9/30/2016	32	37
Account			Amount	
Total Brought Forward:			\$	3,328,023
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 <b>Total Leasehold or Like Properties</b> (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> )			\$	1,749,718
O L/T A Suspense				
I/C Due to/Due From Owned			24,589,652	
I/C Due to/Due From Multicare			(22,839,934)	
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	1,749,718
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	5,077,742

\* 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. Joseph's Manor Care and Rehabilitation C		License No. 2321-C	Report for Year Ended 9/30/2016	Page 34	of 37
Account				Amount	
Total Brought Forward:				3,627,619	
<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> )				\$ 437,984	
LT Debt-Financing Obligation		437,984			
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 437,984	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 4,065,603	

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Joseph's Manor Care and Rehabilitation	2321-C	9/30/2016	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			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	1,457,516
6. Gain or Loss for Period			\$	(445,381)
	10/1/2015	thru 9/30/2016		
7. Total Net Worth			\$	1,012,135
<b>C. Total Reserves and Net Worth</b>			\$	1,012,135
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	5,077,738

### H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
St. Joseph's Manor Care and Rehabilitati	2321-C	9/30/2016	36	37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2015			\$	1,457,514
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	29,246,952
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	29,692,331
D. Net Income or Deficit			\$	(445,379)
E. Balance			\$	1,012,135
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><i>Balance at End of Period</i></b>			\$	1,012,135

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

Name of Facility St. Joseph's Manor Care and Rehabilitation	License No. 2321-C	Report for Year Ended 9/30/2016	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)		
<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				
Thomas Farnan Title -Sr. Director of Reimbursement				
Address Address			Phone Number	
200 Brickstone Square, Andover, MA 01810			978-247-5029	