State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) St. Camillus Rehabilitation and Nursing Center		
Address (No. & Street, City, State, Zip Code) 494 Elm Street, Stamford, CT 06902		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2322-C			07-5320

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	20363		

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

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St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2017	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for St. Camillus Rehabilitation and Nursing Center [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, 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
			[signature]	11/6/2017
Printed Name (Administrator) Byron,Helen			Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare	
Subscribed and Sworn to before me: Gretchen A. Jeannette	State of PA	Date 11-6-17	Signed (Notary Public) Gretchen A. Jeannette	Comm. Expires 09/23/21
Address of Notary Public	101 E. State St. Kennett Square, PA 19348			

(Notary Seal)

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
Gretchen A. Jeannette, Notary Public
Kennett Square Boro, Chester County
My Commission Expires Sept. 23, 2021
MEMBER, PENNSYLVANIA ASSOCIATION OF NOTARIES

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility St. Camillus Rehabilitation and Nursing Center	Period Covered:		From 10/1/2016	To 9/30/2017
Address of Facility 494 Elm Street, Stamford, CT 06902				
Report Prepared By Thomas Farnan	Phone Number 978-247-5029		Date 12/20/2014	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$	282,230	282,230		
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$	3,212,870	3,212,870		
5. All other wages paid	$	615,784	615,784		
6. ***Total Wages Paid***	$	4,110,885	4,110,885		
7. Total salaries paid	$	267,281	267,281		
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	4,378,165	4,378,165		

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
203-325-0200	9/30/2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
St. Camillus Rehabilitation and Nursing Center	494 Elm Street, Stamford, CT 06902

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	2322-C			07-5320

Type of Facility (Check appropriate box(es))

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

Type of Ownership (Check appropriate box)

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

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

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

Administrator

Name of Administrator	Nursing Home Administrator's License No.:	
Byron,Helen		36.001605

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

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

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

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Cente	2322-C	9/30/2017	3A	37

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
St. Camillus Rehabilitation and Nursing Center	101 East State Street, Kennett Square, PA 19348	PA

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

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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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	⊙	○		Home Office	Pg 16/m12	429,402	429,402
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	⊙	○	63%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	442,294	442,294
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	○	⊙		Staffing Pool	Pg 10/A12	7,928	7,928
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	⊙	○	83%	Medical Director /NP	Pg 13/B8, Pg 10/A12	31,865	31,865
Career Staffing	101 East State Street, Kennett Square, PA 19348	⊙	○	60%	Outside Agency	Pg 13/B11 a,b,c		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	⊙	○	44%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	14,950	14,950
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Insurance	Pg 27/14	191,782	191,782
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Capital Interest	Page 17, page 26-12A	32,351	32,351
		○	○					

* Use additional sheets if necessary.

** Provide the percentage amount of revenue received from non-related parties.

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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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 (*See listing page 13*)
Maintenance and operation of plant	Square feet
Property costs (depreciation)	Square feet
Employee health and welfare	Gross salaries
Management services	Appropriate cost center involved
All other General Administrative expenses	Total of Direct and Allocated Costs

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						Total ***	

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

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

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

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

Independent Accounting Firm

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

Services Provided by This Firm (*describe fully*)

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

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

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 American Arbitration Association	972-702-8222
2 Treasurer State of Connecticut	203-323-2149
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1 13727 Noel Road St 700 Dallas, TX 75240
2 888 Washington Blvd P O Box 10152 Stamford, CT 06904
3
4
5

Services Provided by This Firm (*describe fully*)

1	for work regarding Union Grievance	$
2	Citation, Application fee of Conservator	$ 61
3		$
4		$
5		$
		Charge for Services Provided $ 61

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

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	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	124	124			124	124			124	124		
B. On last day of THIS report period	124	124			124	124			124	124		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	94	94			94	94			89	89		
B. As of midnight of THIS report period	93	93			89	89			93	93		
3. Total Number of Days Care Provided During Period												
A. Medicare	1,945	1,945			1,710	1,710			235	235		
B. Medicaid (Conn.)	29,391	29,391			21,756	21,756			7,635	7,635		
C. Medicaid (other states)												
D. Private Pay	1,550	1,550			1,228	1,228			322	322		
E. State SSI for RCH												
F. Other (Specify)	838	838			666	666			172	172		
G. Total Care Days During Period (3A thru F)	33,724	33,724			25,360	25,360			8,364	8,364		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	2	2							2	2		
B. Other Bed Reserve Days	2	2			2	2						
5. ***Total Resident Days*** **(3G + 4A + 4B)**	33,728	33,728			25,362	25,362			8,366	8,366		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-IID
No. of Residents	5	82		6				
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.	614.01	263.05		483.31				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	3,082	3,082		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	305	305		
C. Other	7,448	7,448		
D. ***Total Physical Therapy Treatments***	10,835	10,835		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	800	800		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	63	63		
C. Other	664	664		
D. ***Total Speech Therapy Treatments***	1,527	1,527		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,284	2,284		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	148	148		
C. Other	6,758	6,758		
D. ***Total Occupational Therapy Treatments***	9,190	9,190		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ 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)	128,601	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	213,690	11,038				
5. Dietary Service						
a. Head Dietitian	9,972	293				
b. Food Service Supervisor	32,475	1,248				
c. Dietary Workers	239,784	14,334				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	78,456	2,111				
b. Other Maintenance Workers	27,144	1,860				
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	138,680	2,556				
b. RN						
1. Direct Care	975,964	24,104				
2. Administrative**	6,962	190				
c. LPN						
1. Direct Care	832,372	27,762				
2. Administrative**						
d. Aides and Attendants	1,331,928	75,725				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	145,051	6,727				
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	151,442	5,206				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	65,644	3,136				
A-13. Total Salary Expenditures	4,378,165	178,375				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

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

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

Schedule of Other Salaries and Wages (Page 10)

		CCNH		RHNS		(Specify)	
Position		**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Ward Clerks	0	$ -	-			0	0
Coordinator-Staffing Centers	0	$ 17,219	931			0	0
Central Supply	0	$ 11,405	616			0	0
Medical Records	0	$ 37,020	1,589			0	0
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
-	-	-	-				
Total		$ 65,643.58	$ 3,135.99	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

		CCNH		RHNS		(Specify)	
Service		**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
1020620010	Consulting Fees	480.52	n/a			-	
3010620020	Purchased Services	980.00	n/a				
3155620020	Purchased Services	26.45	n/a				
3155620020	Purchased Services	1,284.00	n/a				
1020620010	Consulting Fees	(3.48)	n/a				
0	0	-	n/a				
0	0	-	n/a				
Total		$ 2,767.49	$ -	$ -	0	$ -	0

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2017	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)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2017	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* **										
Byron,Helen	128,601				Management of Center	2,086	2			
					Management of Center					
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2017	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						
2. Dentist	8,713	60				
3. Pharmacist	7,701	157				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	361,536	4,953				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	41,900	222				
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	62,334	799				
b. Other						
10. Occupational Therapist						
a. Resident Care	69,117	947				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	12,200	288				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	2,767					
B-13 Total Fees Paid in Lieu of Salaries	566,268	7,425				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2017	14	37

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

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

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2017	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	187,543	187,543		
2. Disability Insurance	$				
3. Unemployment Insurance	$	73,320	73,320		
4. Social Security (F.I.C.A.)	$	326,846	326,846		
5. Health Insurance	$	130,582	130,582		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	241,894	241,894		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	600,375	600,375		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and	$				
Profit Sharing Plans for Owners and					
Operators (Discriminatory)*					
c. Bad Debts*	$	311,477	311,477		
d. Accounting and Auditing	$				
e. Legal (*Services should be fully described on Page 7)*	$	61	61		
f. Insurance on Lives of Owners and	$				
Operators (*Specify*)*					
g. Office Supplies	$	14,815	14,815		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	17,209	17,209		
2. Cellular Phones	$	2,207	2,207		
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*)	$	1,192	1,192		
See Attached Schedule					
3. Resident Day User Fee	$	650,737	650,737		
Subtotal	$	2,558,258	2,558,258		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description		CCNH	RHNS	(Specify)
1020520020	Union Health & Welfare	$ 20,545	$ -	
3005520020	Union Health & Welfare	$ 10,073	$ -	
3030520020	Union Health & Welfare	$ 53,965	$ -	
3215520020	Union Health & Welfare	$ 190,206	$ -	
3225520020	Union Health & Welfare	$ 319,507	$ -	
5035520020	Union Health & Welfare	$ 6,079	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
Total		$ 600,375	$ -	$ -

Schedule of Other Taxes

Description		CCNH	RHNS	(Specify)
1020640110	Sales Tax	$ 691	$ -	0
1020640110	Sales Tax	$ 501	$ -	0
0	0	$ -	$ -	0
0	0	$ -		
Total		$ 1,192	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2017	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,558,258	2,558,258		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	250	250		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	1,202	1,202		
5. Education Expenses Related to Seminars and Conventions	$	50	50		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	10,883	10,883		
See Attached Schedule					
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	$	2,727	2,727		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	7,752	7,752		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	1,826	1,826		
10. Contributions***	$	1,570	1,570		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	3,044	3,044		
12. Administrative Management Services**	$	434,545	434,545		
13. Other (*Specify*)	$	16,811	16,811		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	3,038,918	3,038,918		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description		CCNH	RHNS	(Specify)
1020630020	Advertising	$ 259.17	0	0
1020630020	Advertising	$ 1,400.92	0	0
1020630330	Marketing Expense	$ 3,749.14	0	0
1020630330	Marketing Expense	$ (14.32)	0	0
3165630330	Marketing Expense	$ 474.10	0	0
1020630331	Marketing Exp- Corporate Spend	$ 12.72	0	0
1020630331	Marketing Exp- Corporate Spend	$ 456.91	0	0
1020630331	Marketing Exp- Corporate Spend	4,544.23	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
-	-	-	-	-
Total Other Advertising		$ 10,883	$ -	$ -

Schedule of Dues

Description		CCNH	RHNS	(Specify)
1020630310	Licenses and Certification fee	7751.83	0	0
0	0	0	0	0
0	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0

1020630310	0	0	0	0
1020630310	0	0	0	0
1020630310	0	0	0	0
			0	0
Total Dues		$ 7,752	$ -	$ -

Schedule of Contributions

Description		**CCNH**	**RHNS**	**(Specify)**
1020630135	Political Contributions	1569.69	0	0
0	0	0	0	0
0	0	0	0	0
Total Contributions		$ 1,570	$ -	$ -

Schedule of Other Administrative and General

Description		**CCNH**	**RHNS**	**(Specify)**
1020630060	Bank Service Charges	$ 2,943.81	0	0
1020630120	Collection Fees	$ 488.90	self-disallowed	0
1020630120	Collection Fees	$ 115.36	self-disallowed	0
1020630140	Education Expense	$ 335.62	0	0
1020630140	Education Expense	$ 18.10	0	0
1020630180	Employee Physicals	$ 6,861.66	0	0
1020630200	Employee Relations	$ 4,675.92	0	0
1020630380	Printing	$ 158.43	0	0
1020630610	Training Expense	$ 273.37	0	0
1020630610	Training Expense	$ 532.88	0	0
1020640090	Miscellaneous	$ (5,798.60)	0	0
1020640090	Miscellaneous	$ (1.32)	0	0
1020660080	Rental Expense	$ 3,952.42	0	0
1020660080	Rental Expense	$ 10.68	0	0
1020660990	Accrued Expense Estimation	$ (986.59)	self-disallowed	0
1020720070	State Tax Annual Report Filing	$ 320.00	0	0
5095720090	Landlord Operating Taxes	$ 2,400.00	0	0
1020630120	Collection Fees	$ 510.00	self-disallowed	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
Total Other Administrative and General		$ 16,811	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
St. Camillus Rehabilitation and Nursing C	2322-C	9/30/2017	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	429,402	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	32,351	Capital Interest	pg 26 12-A-1

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

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

Name of Facility	License No.	Report for Year Ended	Page of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2017	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	154,079	154,079		
2. Non-Food Supplies	$	20,157	20,157		
3. Other (*Specify*)_____	$	(2,633)	(2,633)		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	210,532	210,532		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	382,135	382,135		

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

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

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

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CSP-19 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2017	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	4,990	4,990		
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. $	9,197	9,197		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	273,798	273,798		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	287,986	287,986		

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

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

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

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

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CSP-20 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2017	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	8,075	8,075		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	410,898	410,898		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	418,973	418,973		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	92,055	92,055		
b. Medicine Cabinet Drugs		$	25,287	25,287		
c. Medical and Therapeutic Supplies		$	103,434	103,434		
d. Ambulance/Limousine***		$	10,732	10,732		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	9,235	9,235		
f. X-rays and Related Radiological Procedures***		$	4,344	4,344		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	16,048	16,048		
i. Recreation		$	13,085	13,085		
j. Other (Specify)**** See Attached Schedule		$	55,780	55,780		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	330,000	330,000		

* 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	$ 40,815	0	0
3080630030	Advertising-Help Wan	$ 204	0	0
3080630030	Advertising-Help Wan	$ 754	0	0
3080630140	Education Expense	$ 285	0	0
3080630140	Education Expense	$ 676	0	0
3080630310	Licenses & Certificati	$ 305	0	0
3120630530	Supplies	$ 2,396	0	0
3155630530	Supplies	$ 1,224	0	0
3155630530	Supplies	$ 1,779	0	0
3010630535	Office Supplies	$ 0	0	0
3090630535	Office Supplies	$ 244	0	0
3120630535	Office Supplies	$ 731	0	0
3165630535	Office Supplies	$ 95	0	0
3120660080	Rental Expense	$ 170	0	0
3155660080	Rental Expense	$ 41	0	0
3155660080	Rental Expense	$ 3,065	0	0
3010610300	Consolidated Billing	$ 2,998	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	0	0
0	0	$ -	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 Resident Care		$ 55,780	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2017	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Laundry Purchased Services	273,798			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Housekeeping Purchased Services	410,898			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Dietary Purchased Servies	205,664			18	2b
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

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

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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. Camillus Rehabilitation and Nursing Cente	2322-C	9/30/2017			22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	222,456	222,456		
b. Heat	$	54,764	54,764		
c. Light & Power	$	156,298	156,298		
d. Water	$	58,105	58,105		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	491,625	491,625		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	421	421		
b. Building & Building Improvements	$	28,955	28,955		
c. Non-Movable Equipment	$	24,925	24,925		
d. Movable Equipment	$	17,377	17,377		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	71,679	71,679		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$	159,741	159,741		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	139,410	139,410		
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	370,830	370,830		

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

Schedule of Other Repairs and Maintenance

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

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2017	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period	4,215		4,215	1,246	S/L	Various	421	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								421
B. **Building and Building Improvements**								
1. Acquired prior to this report period	402,447		402,447	57,497	S/L	Various	28,955	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								28,955
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	232,203		232,203	71,342	S/L	Various	24,686	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	9,985		9,985				239	
C-4. Subtotal								24,925

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.									S/L	Various		
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					157,403		157,403	68,873	S/L	Various	15,257	
b. Disposals (attach schedule)					(16)		(16)					
c. Acquired during this report period (attach schedule)					18,548		18,548				2,120	
D-3. Subtotal												17,377
E. ***Total Depreciation***												71,679

St. Camillus Rehabilitation and Nursing Center
9/30/2017

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation				
Additions:								
Total additions for Land Improvements		0		0	*	0		0
Deletions:								
Total deletions for Land Improvements		$ -		$ -	**	0		0

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

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

Schedule of Building Improvements Acquired during this report period

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

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

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

Schedule of Non-Movable Equipment Acquired during this report perio

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation				
Additions:								
6/30/2017	2nd install for compressor on McQua	5,030.36	7.00	179.66				
8/31/2017	Compressor on McQuay Chiller	4,955.00	7.00	58.99				
				-				
Total additions for Non-Movable Equipmen		$ 9,985		$ 239	*	$ -		$ -
Deletions:								
Total deletions for Non-Movable Equipmen		$ -		$ -	**	$ -		$ -

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

Schedule of Movable Equipment Acquired during this report perio

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation				
Additions:								
1/31/2017	OCCASIONAL CHAIR	9,706.14	7.00	924.39				
5/31/2017	4 Qt. Food Processor	2,031.22	7.00	96.72				
10/31/2016	2 MATTRESS,GENESIS VISCO SE	627.47	3.00	191.73				
11/30/2016	2 MATTRESS,GENESIS VISCO SE	627.47	3.00	174.30				
12/31/2016	2 MATTRESS,GENESIS VISCO SE	627.47	3.00	156.87				
1/31/2017	2 MATTRESS,GENESIS VISCO SE	627.47	3.00	139.44				
2/28/2017	2 MATTRESS,GENESIS VISCO SE	627.47	3.00	122.01				
3/31/2017	2 MATTRESS,GENESIS VISCO SE	627.47	3.00	104.58				
4/30/2017	2 MATTRESS,GENESIS VISCO SE	627.47	3.00	87.15				
9/30/2017	3 MATTRESS,GENESIS VISCO SE	941.20	3.00	-				
4/30/2017	1 Cisco Catalyst 2960X	1,477.03	5.00	123.09				
Total additions for Movable Equipmen		$ 18,548		$ 2,120	*	$ -		$ -
Deletions:								
10/1/2016	Asset # 008847 Deleted Mobile Iron I	$ (16)						
Total deletions for Movable Equipmen		$ (16)		$ -	**	$ -		$ -

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report perio

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				

Total additions for Leasehold Improvemen		$ -		$ -	*	$ -		$ -
Deletions:								
Total deletions for Leasehold Improvemen		$ -		$ -	**	$ -		$ -

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2017	24	37

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

* Straight-line method must be used.

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.
B. Life of mortgage; OR
C. Remaining Life of Lease; OR
D. Actual Life if owned by Related Party.

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursin	2322-C	9/30/2017	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	124
6. Square Footage	
7. Acquisition Cost	
a. Land	
b. Building	

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

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

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
SABRA, 101 Sun Ave. NE, Albuquerque, NM 87109	Facility Lease	11/15/10 - 6/30	127 months	159,741

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

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

Name of Facility	License No.	Report for Year Ended	Page of
St. Camillus Rehabilitation and Nursi	2322-C	9/30/2017	26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	32,351	32,351		
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)	$	32,351	32,351		

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
St. Camillus Rehabilitation and Nur	2322-C	9/30/2017	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:	32,351	32,351		
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) $	32,351	32,351		
14. Insurance				
a. Insurance on Property (buildings only) $	8,521	8,521		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	183,261	183,261		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	191,782	191,782		
15. ***Total All Expenditures (A-13 thru C-14)*** $	10,489,033	10,489,033		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
St. Camillus Rehabilitation and Nursing Center	2322-C	9/30/2017	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 $	33,064	33,064		
Page 13 - Professional Fees							
5.	13	B-8-c	Resident Care Physicians ** $				
6.		B-10	Occupational Therapy $				
7.			Other - See attached Schedule $	495,278	495,278		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1-c	Bad Debts $	311,477	311,477		
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 * $	10,883	10,883		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $	1,570	1,570		
21.			Unallowable Management Fees $	466,896	466,896		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	(166,320)	(166,320)		
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) $	1,152,847	1,152,847		

* 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	$ 33,064	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
Total Other Salaries Adjustment				$ 33,064	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	$ 96,168	$ -	$ -
13	5	Rehabilitation Services	3195620020	$ 265,367	$ -	$ -
13	9	Speech Therapist	3170620020	$ 62,334	$ -	$ -
13	10	Occupational Therapist	3105620020	$ 69,117	$ -	$ -
13	12	Other	3010620020	$ 980	$ -	$ -
13	12	Other	3015620020	$ -	$ -	$ -
13	12	Respiratory Purchased Servies	3155620020	$ 1,310	$ -	$ -
Total Other Fees Adjustments				$ 495,278	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
0	0	0	0	$ -	0	0
16	m-13	Collection Fees	1020630120	$ 1,114	0	0
16	m-13	Estimated Accrual	1020660990	$ (987)	0	0
16	m-13	Non-recurring Charges	7010800030	$ -	0	0
16	m-13	Dues to Chamber of Commerce	0	$ -	0	0
16	m-13	Penalty and Fines	1020640080	$ -	0	0
16	m-12	Management Fee disallowed	0	$ -	0	0
15	1-a-1	adj workers comp	0	$ (166,448)	0	0
0	0	0	0	$ -	0	0
0	0	0	0	$ -	0	0
Total Other A&G Adjustments				$ (166,320)	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
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Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	1,152,847	1,152,847		
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs $	92,055	92,055		
28.	20	5-d	Ambulance/Limousine $	10,732	10,732		
29.	20	5-f	X-rays, etc $	4,344	4,344		
30.	20	5-h	Laboratory $	16,048	16,048		
31.			Medical Supplies $				
32.	20	5-e-2	Oxygen (non emergency) $	9,235	9,235		
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $	12,719	12,719		
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 $	116,995	116,995		
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)*** $	1,414,975	1,414,975		

*** 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.

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Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	$ 2,998	3010610300	$ -
20	5-j	RHS Intercompany Supplies	$ 3,003	3155630530	$ -
20	5-j	RHS Intercompany Rental	$ 3,106	3155660080	$ -
20	5-i	Cable TV	$ 3,612	3005660130	allow $3600
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
Total Other Ancillary Costs			$ 12,719	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14 c1	General liability Insurance Adjust	116,994.64	-	-
27	14c1	General liability Insurance Adjust	0	-	-
0	0-Jan	0	-	-	-
0	0-Jan	0	-	-	-
0	0-Jan	0	-	-	-
0	0-Jan	0	-	-	-
0	0-Jan	0	-	-	-
0	0-Jan	0	-	-	-
0	0-Jan	0	-	-	-
0	0-Jan	0	-	-	-
Total Other Adjustments			$ 116,995	$ -	$ -

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing C	2322-C	9/30/2017	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	13,771,848	13,771,848		
b. Medicaid Room and Board Contractual Allowance **	$	(6,205,411)	(6,205,411)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	983,666	983,666		
b. Medicare Room and Board Contractual Allowance **	$	(253,999)	(253,999)		
4. a. Private-Pay Residents and Other	$	1,329,726	1,329,726		
b. Private-Pay Room and Board Contractual Allowance **	$	(302,452)	(302,452)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	68,073	68,073		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(17,578)	(17,578)		
c. Prescription Drugs - Non-Medicare	$	36,259	36,259		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(9,672)	(9,672)		
2. a. Medical Supplies - Medicare	$	184	184		
b. Medical Supplies - Medicare Contractual Allowance **	$	(47)	(47)		
c. Medical Supplies - Non-Medicare	$	130	130		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(59)	(59)		
3. a. Physical Therapy - Medicare	$	404,788	404,788		
b. Physical Therapy - Medicare Contractual Allowance **	$	(104,523)	(104,523)		
c. Physical Therapy - Non-Medicare	$	166,663	166,663		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(42,925)	(42,925)		
4. a. Speech Therapy - Medicare	$	132,924	132,924		
b. Speech Therapy - Medicare Contractual Allowance **	$	(34,323)	(34,323)		
c. Speech Therapy - Non-Medicare	$	54,971	54,971		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(14,687)	(14,687)		
5. a. Occupational Therapy - Medicare	$	371,989	371,989		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(96,054)	(96,054)		
c. Occupational Therapy - Non-Medicare	$	145,353	145,353		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(36,620)	(36,620)		
6. a. Other *(Specify)* - Medicare	$	19,043	19,043		
b. Other *(Specify)* - Non-Medicare	$	122,986	122,986		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	10,490,253	10,490,253		
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	$				
5. Interest Income *(Specify)*	$	(339)	(339)		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	4,250	4,250		
V. Total Other Revenue (1 thru 8)	$	3,911	3,911		
VI. Total All Revenue (III +V)	$	10,494,164	10,494,164		

* *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	X-Ray	8,254.57	-	0
II-6-a	Medicare	Radiology Service	-	-	0
II-6-a	Medicare	Outpatient Therapy Program	-	-	0
II-6-a	Medicare	Laboratory	12,559.60	-	0
II-6-a	Medicare	Respiratory Therapy & Supplie	-	-	0
II-6-a	Medicare	Nursing Treatment Supplies	-	-	0
II-6-a	Medicare	Audiology	-	-	0
II-6-a	Medicare	Incontinency	-	-	0
II-6-a	Medicare	Oxygen & Supplies	-	-	0
II-6-a	Medicare	Physician Visit	-	-	0
II-6-a	Medicare	Ambulance	-	-	0
II-6-a	Medicare	Flu Shot	4,858.00	-	0
II-6-a	Medicare	Capitation Contracts	-	-	0
II-6-a	Medicare Contractual	X-Ray	(2,131.47)	-	0
II-6-a	Medicare Contractual	Radiology Service	-	-	0
II-6-a	Medicare Contractual	Outpatient Therapy Program	-	-	0
II-6-a	Medicare Contractual	Laboratory	(3,243.10)	-	0
II-6-a	Medicare Contractual	Respiratory Therapy & Supplie	-	-	0
II-6-a	Medicare Contractual	Nursing Treatment Supplies	-	-	0
II-6-a	Medicare Contractual	Audiology	-	-	0
II-6-a	Medicare Contractual	Incontinency	-	-	0
II-6-a	Medicare Contractual	Oxygen & Supplies	-	-	0
II-6-a	Medicare Contractual	Physician Visit	-	-	0
II-6-a	Medicare Contractual	Ambulance	-	-	0
II-6-a	Medicare Contractual	Flu Shot	(1,254.42)	-	0
II-6-a	Medicare Contractual	Capitation Contracts	-	-	0
Total Other Resident Revenue - Medicare			$ 19,043	$ -	$ -
			$ 0		

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	II-6-b	Medicaid	-	-	-
II-6-b	II-6-b	Medicaid	-	-	-
II-6-b	II-6-b	Medicaid	-	-	-
II-6-b	II-6-b	Medicaid	462.88	-	-
II-6-b	II-6-b	Medicaid	(6.20)	-	-
II-6-b	II-6-b	Medicaid	-	-	-
II-6-b	II-6-b	Medicaid	-	-	-
II-6-b	II-6-b	Medicaid	-	-	-
II-6-b	II-6-b	Medicaid	-	-	-
II-6-b	II-6-b	Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Medicaid	(208.57)	-	-
II-6-b	II-6-b	Contractuals-Medicaid	2.79	-	-
II-6-b	II-6-b	Contractuals-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	1,716.82	-	-
II-6-b	II-6-b	Non-Medicaid	-	-	-

II-6-b	II-6-b	Non-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	259.68	-	-
II-6-b	II-6-b	Non-Medicaid	6.20	-	-
II-6-b	II-6-b	Non-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	-	-	-
II-6-b	II-6-b	Non-Medicaid	1,824.00	-	-
II-6-b	II-6-b	Non-Medicaid	155,064.00	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	(390.50)	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	(59.07)	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	(1.41)	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	(414.88)	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	(35,269.99)	-	-
II-6-b	II-6-b	Contractuals-Non-Medicaid	-	-	-
0	0	0	-	-	-
II-6-b	0	0	-	-	-
Total Other Resident Revenue			$ 122,986	$ -	$ -
			$ (0)		

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
IV-5	Interest On Overdue Accou	0	(339)	-	-
0	0	0	-	-	-
0	0	0	-	-	-
Total Interest Income			$ (339)	$ -	$ -

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
IV-8	Medical Records - P Ziegle	0	183.65	-	-
IV-8	Education Expense	0	3,331.62	-	-
IV-8	Donation	0	600.00	-	-
IV-8	automated services	0	133.92	-	-
IV-8	0	0	-	-	-
IV-8	0	0	-	-	-
IV-8	0	0	-		
IV-8	0	0	-		
0	0	0	-		
Total Other Revenue			$ 4,249	$ -	$ -
			$ (1)		

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing	2322-C	9/30/2017	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 19,656
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,360,696
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (38,271)
4 Inventories				$ 41,092
5. Prepaid Expenses				$ 34,951
a. Prepaid Expenses		(9,029)		
b. Prepaid Property Tax		33,399		
c. Prepaid Personal Property Tax				
d. Prepaid Personal Property Tax		10,581		
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,418,123
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	4,215		$ 2,548
	Accum. Depreciation	1,667	Net	
3. Buildings	*Historical Cost	402,447		$ 315,995
	Accum. Depreciation	86,452	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	242,188		$ 145,921
	Accum. Depreciation	96,267	Net	
6. Movable Equipment	*Historical Cost	175,935		$ 89,685
	Accum. Depreciation	86,250	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 554,149

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

(*Carry Total forward to next page*)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing	2322-C	9/30/2017	32	37

Account				Amount
			Total Brought Forward:	$ 1,972,272
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 (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 1,035,678
I/C Due to/Due From Owned		1,035,678		
I/C Due to/Due From Multicare				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 1,035,678
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 3,007,950

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Cente	2322-C	9/30/2017	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 473,354
2. Notes Payable (*itemize*)					$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender	Purpose	Amount	Date Due		
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 151,296
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 1,006
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 320,450
Accrued Provider/Bed Tax	166,605	Deferred Revenue	15,877		
A/R Credit Gross Up Liability	93,210	Accr Gross Rec Tax-FY1	16,641		
Accr Exp Water and Sewer	1,717	Accr Exp Other	21,278		
Accr Exp Gas and Electricity	5,122	Accr Sales and Use Tax -			
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 946,106

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing Cen	2322-C	9/30/2017	34	37

Account	Amount
Total Brought Forward:	946,106
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ (170,045)
LT Debt-Financing Obligation	(170,045)	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ (170,045)
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 776,061

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

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing	2322-C	9/30/2017	35	37

Account					Amount	
A.	**Reserves**					
	1. Reserve for value of leased land				$	
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized				$	
	3. Reserve for depreciation value of leased personal property (*Equity)*				$	
	4. Reserve for leasehold real properties on which fair rental value is based				$	
	5. Reserve for funds set aside as donor restricted				$	
	6. Total Reserves				$	
B.	**Net Worth**					
	1. Owner's Capital				$	
	2. Capital Stock				$	
	3. Paid-in Surplus				$	
	4. Treasury Stock				$	
	5. Cumulated Earnings				$	2,226,759
	6. Gain or Loss for Period	10/1/2016	thru	9/30/2017	$	5,131
	7. Total Net Worth				$	2,231,890
C.	***Total Reserves and Net Worth***				$	2,231,890
D.	***Total Liabilities, Reserves, and Net Worth***				$	3,007,951

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing (	2322-C	9/30/2017	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2016			$ 2,226,760
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 10,494,164
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 10,489,034
D.	Net Income or Deficit			$ 5,130
E.	Balance			$ 2,231,890
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose	Amount		
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/17			$ 2,231,890

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
St. Camillus Rehabilitation and Nursing	2322-C	9/30/2017	37	37

Check appropriate category

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

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Thomas Farnan	Sr. Director of Reimbursement	12/19/2017

Printed Name of Preparer

Thomas Farnan Title -Sr. Director of Reimbursement

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