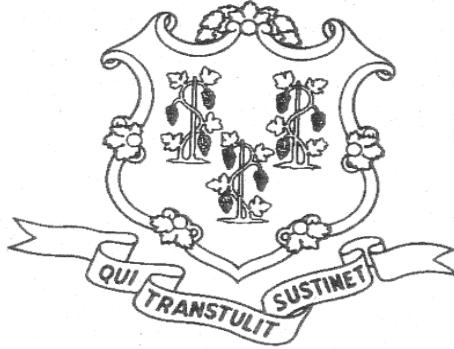


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2020

Name of Facility (as licensed) Pendleton Health and Rehabilitation	
Address (No. & Street, City, State, Zip Code) 44 Maritime Dr., Mystic, CT 06355	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020

License Numbers:	CCNH 2069-C	RHNS	(Specify)	Medicare Provider 07-5341
------------------	----------------	------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH 2069-C	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Pendleton Health and Rehabilitation [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, 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) Sue Peglow		Printed Name (Owner)	
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public			

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Pendleton Health and Rehabilitation	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 44 Maritime Dr., Mystic, CT 06355				
Report Prepared By Margaret Philen	Phone Number 832-467-6225	Date		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

	Phone No. of Facility 860-572-1700	Report for Year Ended 9/30/2020	Page 2
Name of Facility (as shown on license) Pendleton Health and Rehabilitation		Address (No. & Street, City, State, Zip) 44 Maritime Dr., Mystic, CT 06355	
License Numbers:	CCNH 2069-C	RHNS	(Specify)
Medicare Provider No. 07-5341			
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:		Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes	<input checked="" type="radio"/> No
		If "Yes," explain fully.	
Administrator Name of Administrator Sue Peglow			
		Nursing Home Administrator's License No.:	001290
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name		License No.:	

General Information and Questionnaire Partners/Members

General Information and Questionnaire

Corporate Owners

General Information and Questionnaire

Individual Proprietorship

General Information and Questionnaire

Related Parties*

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes <input checked="" type="radio"/> No <div style="float: right; margin-top: -20px;">If "Yes," provide the Name/Address and complete the information on Page 11 of the report.</div>				
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?				<input checked="" type="radio"/> Yes <input type="radio"/> No <div style="float: right; margin-top: -20px;">If "Yes," provide the following information:</div>				
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party	
		Yes	No	%**				Description of Goods/Services Provided
SSC Administrative Svc, LLC	8601 Dunwoody Place, Ste 775, Sandy Springs, GA 30350	<input type="radio"/>	<input checked="" type="radio"/>		Back Office Services	Page 16/C.1.m.12	261,278	261,278
SSC Consulting Svc, LLC	8601 Dunwoody Place, Ste 775, Sandy Springs, GA 30350	<input type="radio"/>	<input checked="" type="radio"/>		Consulting Services	Page 16/C.1.m.12	516,852	516,852
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020	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		License No.		Report for Year Ended			Page of
Pendleton Health and Rehabilitation		2069-C		9/30/2020			6 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					
Pitney Bowes	<input type="radio"/>	<input checked="" type="radio"/>	Postage Meter	01/30/06	Month to Month	1,357	1,357
Krystal Kleer	<input type="radio"/>	<input checked="" type="radio"/>	Water Cooler			239	239
Canon Financial Services	<input type="radio"/>	<input checked="" type="radio"/>	Copier	12/15/16	48 months	4,635	4,635
Quench	<input type="radio"/>	<input checked="" type="radio"/>	Water Cooler			479	479
Willimantic Waste Paper Co	<input type="radio"/>	<input checked="" type="radio"/>	Garbage Collection			58	58
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?				<input type="radio"/> Yes	<input checked="" type="radio"/> No	Total ***	6,768

* 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 Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020	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 2 3 4	Address (No. & Street, City, State, Zip Code)
---	---

Services Provided by This Firm (*describe fully*)

1	\$
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 Dechert LLP 2 Polsinelli 3 ProTitle USA 4 Stotler Hayes Group, LLC 5	Telephone Number 816-753-1000
--	----------------------------------

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

1 1095 Avenue of the Americas, New York, NY 10036-6797
2 900 West 48th Place, Ste 900, Kansas City, MO 64112
3 P.O. Box 52328, Philadelphia, PA 19115
4 10517 Ocean Hwy, Unit 4-27, Pawleys Island, SC 29585
5

Services Provided by This Firm (*describe fully*)

1 Legal Svc related to COVID request with Landlord	\$ 6,318
2 Consultation for Paycheck Protection Program	\$ 463
3 Title Search	\$ 88
4 Consultation for resident assets and Mortgage recording	\$ 7,543
5	\$
	Charge for Services Provided
	\$ 14,413

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

Yes No

Schedule of Resident Statistics

Name of Facility Pendleton Health and Rehabilitation			License No. 2069-C			Report for Year Ended 9/30/2020				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					120	120						
A. On last day of PREVIOUS report period	120	120										
B. On last day of THIS report period	120	120							120	120		
2. Number of Residents					99	99						
A. As of midnight of PREVIOUS report period	99	99										
B. As of midnight of THIS report period	90	90							90	90		
3. Total Number of Days Care Provided During Period					5,389	5,389			1,794	1,794		
A. Medicare	7,183	7,183										
B. Medicaid (Conn.)	21,812	21,812			16,458	16,458			5,354	5,354		
C. Medicaid (other states)												
D. Private Pay	3,621	3,621			2,657	2,657			964	964		
E. State SSI for RCH												
F. Other (Specify) VA / Hospice	2,598	2,598			1,984	1,984			614	614		
G. Total Care Days During Period (3A thru F)	35,214	35,214			26,488	26,488			8,726	8,726		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	35,214	35,214			26,488	26,488			8,726	8,726		

Schedule of Resident Statistics (Cont'd)

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?

 Yes No

If "YES", provide the following information:

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

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

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

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

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

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	TOTAL	CCNH	RHNS	(Specify)
	14,433	14,433		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	24,036	24,036		
2. Restorative Treatments				
C. Other				
D. Total Physical Therapy Treatments	38,469	38,469		

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	2,214	2,214	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	2,047	2,047	
2. Restorative Treatments			
C. Other			
D. Total Speech Therapy Treatments	4,261	4,261	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	12,443	12,443	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	23,804	23,804	
2. Restorative Treatments			
C. Other			
D. Total Occupational Therapy Treatments	36,247	36,247	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2020		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)
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	141,065	2,144			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	368,375	17,154			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor					
c. Dietary Workers	281,579	19,295			
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers					
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	67,967	2,096			
b. Other Maintenance Workers	21,656	1,271			
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	210,174	4,192			
b. RN					
1. Direct Care	1,082,407	28,113			
2. Administrative**	240,652	5,959			
c. LPN					
1. Direct Care	1,105,863	35,593			
2. Administrative**					
d. Aides and Attendants	1,142,145	61,804			
e. Physical Therapists	458,840	11,736			
f. Speech Therapists	78,615	2,035			
g. Occupational Therapists	354,116	9,435			
h. Recreation Workers	142,019	5,827			
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	110,945	4,222			
n. Marketing					
o. Other (Specify)					
See Attached Schedule	100,501	3,496			
A-13. Total Salary Expenditures	5,906,922	214,372			

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

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

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

Schedule of Other Salaries and Wages (Page 10)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility Pendleton Health and Rehabilitation				License No. 2069-C		Report for Year Ended 9/30/2020			Page 11	of 37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
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.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Pendleton Health and Rehabilitation				2069-C		9/30/2020			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***										
Sue Peglow	141,065			Standard Package	Administrative Responsibilities for day to day operations	2,144	A.2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020		Page 13	of 37
Item	Total Cost and Hours				
	CCNH	Hours	RHNS	Hours	(Specify)
*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	4,800	Fee for svc			
3. Pharmacist	12,964	Fee for svc			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	43,596	696			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	54,000	240			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**	78,927	218			
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					
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	7,222	Fee for svc			
2. Administrative***	7,180	141			
b. LPN					
1. Direct Care					
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify)					
See Attached Schedule					
B-13 Total Fees Paid in Lieu of Salaries	208,689	1,295			

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

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

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

Report of Expenditures

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

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020	Page 15	of 37
Item		Total	CCNH	RHNS (Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 567,841	567,841		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 50,225	50,225		
4. Social Security (F.I.C.A.)	\$ 432,158	432,158		
5. Health Insurance	\$ 204,098	204,098		
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 1,917	1,917		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$ 10,251	10,251		
9. Other (Specify) See Attached Schedule	\$ 7,404	7,404		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 166,900	166,900		
d. Accounting and Auditing	\$			
e. Legal (Services should be fully described on Page 7)	\$ 14,413	14,413		
f. Insurance on Lives of Owners and Operators (Specify)*	\$			
g. Office Supplies	\$ 28,389	28,389		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 27,405	27,405		
2. Cellular Phones	\$ 1,406	1,406		
i. Appraisal (Specify purpose and attach copy)*	\$			
j. Corporation Business Taxes (franchise tax)	\$ 550	550		
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$			
2. Other (Specify) See Attached Schedule	\$ 56,561	56,561		
3. Resident Day User Fee	\$ 589,234	589,234		
Subtotal	\$ 2,158,752	2,158,752		

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Outsource Services - Activities	\$ 2,841		
Employee Medical Exp & Innoculations	\$ 3,984		
Employee Physical	\$ 579		
Total	\$ 7,404	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Sales Tax	\$ 56,561		
Total	\$ 56,561	\$ -	\$ -

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

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		2,158,752	2,158,752		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$	32,874	32,874		
4. Employee Travel	\$	850	850		
5. Education Expenses Related to Seminars and Conventions	\$	15,198	15,198		
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>)	\$	8,765	8,765		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	13,733	13,733		
4. Fund-Raising***	\$				
5. Medical Records	\$	2,285	2,285		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	16,209	16,209		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	10,718	10,718		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	1,147	1,147		
9. Subscriptions	\$	941	941		
10. Contributions*** See Attached Schedule	\$	235	235		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	72,837	72,837		
12. Administrative Management Services**	\$	679,527	679,527		
13. Other (<i>Specify</i>) See Attached Schedule	\$	890,776	890,776		
C-14 Total Administrative & General Expenditures	\$	3,904,847	3,904,847		

* 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)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Marketing Supplies	\$ 3,067		
Periodic Maintenance - Marketing	\$ 2,244		
Advertising	\$ 8,423		
Total Other Advertising	\$ 13,733	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Professional Dues - Physical Plant	\$ 939		
Professional Dues - Administrative	\$ 9,779		
Total Dues	\$ 10,718	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Donations/Contributions	\$ 235		

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Director & Trustee Fees	\$ 525		
Staff Meetings	\$ 48		
Employee Background Screening	\$ 6,924		
Licenses	\$ 4,247		
Penalties & Late Filings	\$ 21,831		
Bank Charges/Surety Bonds	\$ 5,272		
Lost Resident Prop/Memoriam Benevolence/Misc Exp	\$ 1,050		
Interest Expense	\$ 850,880		
Total Other Administrative and General	\$ 890,776	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020	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 #

*** 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 Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020		Page 18 of 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 3,186	3,186		
2. Non-Food Supplies	\$ 14,905	14,905		
3. Other (Specify) _____ Equipment Lease	\$ 2,620	2,620		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 372,626	372,626		
c. Other (Specify) _____	\$			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 393,337	393,337		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020		Page 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. \$	1,217	1,217	
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. \$	10,956	10,956	
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	234,111	234,111	
c. Other (Specify)	\$			
3D. Total Laundry Expenditures (3a + b + c)	\$	246,284	246,284	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 28,875	28,875		
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 255,115	255,115		
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	283,989	283,989		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Omnicare	\$	359,668	359,668		
b. Medicine Cabinet Drugs	\$	29,223	29,223		
c. Medical and Therapeutic Supplies	\$	165,257	165,257		
d. Ambulance/Limousine***	\$	20,796	20,796		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	37,348	37,348		
f. X-rays and Related Radiological Procedures***	\$	24,171	24,171		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	19,847	19,847		
i. Recreation	\$	3,884	3,884		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	249,749	249,749		
5M. Total Resident Care Expenditures (5a - 5j)	\$	909,943	909,943		

* 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)
Non Chargeable Supplies	\$ 135,099		
Incontinent Care Supplies	\$ 43,425		
Personal Protection Equip	\$ 38,764		
Pandemic Testing	\$ 5,364		
Lease Equipment	\$ 15,428		
Minor Equipment Purchase	\$ 11,668		
Total Other Resident Care	\$ 249,749	\$ -	\$ -

Report of Expenditures

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

* List all contracted services over \$10,000. Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020			Page 22 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 182,283	182,283			
b. Heat	\$ 85,692	85,692			
c. Light & Power	\$ 150,732	150,732			
d. Water	\$ 72,614	72,614			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 6,768	6,768			
f. Other (<i>itemize</i>)	\$ 111,065	111,065			
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 609,153	609,153			
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements	\$				
b. Building & Building Improvements	\$ 533,756	533,756			
c. Non-Movable Equipment	\$				
d. Movable Equipment	\$ 19,434	19,434			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 553,190	553,190			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$				
d. Other (<i>Specify</i>)	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$				
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$ 218,363	218,363			
c. Personal property taxes	\$ 5,329	5,329			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 776,882	776,882			

* 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)
Supplies - Physical Plant	\$ 6,685		
Infectious Waste Disposal	\$ 2,853		
Garbage Service	\$ 22,140		
Contract Svcs - Periodic Maintenance	\$ 41,569		
Lease Expense - Physical Plant	\$ 559		
Offsite Storage Lease	\$ 9,245		
Minor Equipment Purchase - Physical Plant	\$ 12,494		
TV Cable/Dish	\$ 12,268		
Network - WAN	\$ 3,252		
Total Other Repairs and Maintenance	\$ 111,065	\$ -	\$ -

Depreciation Schedule

Schedule of Land Improvements Acquired during this report period

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
See separate additions file		\$ 177,068		\$ 12,493
Total additions for Building Improvement		\$ 177,068		\$ 12,493
Deletions:				
		\$ (10,908)		
Total deletions for Building Improvement		\$ (10,908)		\$ -

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
See separate additions file		\$ 38,787		\$ 1,340
Total additions for Movable Equipment		\$ 38,787		\$ 1,340 *
Deletions:				
		\$ (15,678)		
Total deletions for Movable Equipment		\$ (15,678)		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
See separate additions file				
Total additions for Leasehold Improvements		\$ -		\$ - *
Deletions:				
Total deletions for Leasehold Improvements		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Pendleton Health and Rehabilitation			License No. 2069-C		Report for Year Ended 9/30/2020			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020	Page 25	of 37
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11. Property Questionnaire

Part A

Is the property either owned by the Facility
or leased from a Related Party?*

Yes

No

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

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

Description	Total			
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	120			
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

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 9/30/2020			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage	\$					
Name of Lender	Rate					
Address of Lender						
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)	\$					

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended 9/30/2020			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
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)		\$				
14. Insurance						
a. Insurance on Property (buildings only)		\$ 39,785	39,785			
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$				
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$ 56,652	56,652			
Gen&Prof Liability Ins and Crime/Kidnap						
14d. Total Insurance Expenditures (14a + b + c)		\$ 96,437	96,437			
15. Total All Expenditures (A-13 thru C-14)		\$ 13,336,483	13,336,483			

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Pendleton Health and Rehabilitation			2069-C	9/30/2020		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.	10	A.12.	Occupational Therapy	\$ 354,116	354,116		
4.			Other - See attached Schedule	\$ 64,241	64,241		
			Page 13 - Professional Fees				
5.	13	B.8.c	Resident Care Physicians **	\$ 78,927	78,927		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
			Pages 15 & 16 - Administrative and General				
8.			Discriminatory Benefits	\$			
9.	15	C.1.c	Bad Debts	\$ 166,900	166,900		
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	C.1.m	Unallowable Advertising *	\$ 13,733	13,733		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$ 679,527	679,527		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ (689,668)	(689,668)		
			Page 18 - Dietary Expenditures				
24.			Meals to employees, guests and others who are not residents	\$ (6,854)	(6,854)		
			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)			\$ 660,922	660,922			

* 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	A.12.o	Respiratory Therapist	\$ 64,241		
Total Other Salaries Adjustment			\$ 64,241	\$ -	\$ -

Schedule of Fees Adjustments

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	C.1.m.12	Adjust to Home Office CR Admin	\$ (261,278)		
16	C.1.m.12	Adjust to Home Office CR Consulting	\$ (516,852)		
15	C.1.a.5	Remove Self-Insured Health Ins. GL Exp	\$ 262,103		
15	C.1.a.5	Include Self Insured Health Ins. Paid Claims	\$ (202,274)		
16	C.1.j.	Franchise Taxes in Excess of \$250	\$ 300		
16	C.1.m.8a.	Civic Dues	\$ 1,147		
16	C.1.m.10	Donations/Contributions	\$ 235		
16	C.1.m.13	Memoriam/Benevolence	\$ 81		
16	C.1.m.13	Lost Resident Property	\$ 794		
16	C.1.m.13	Penalties and Late Filings	\$ 21,831		
16	C.1.m.13	Interest Income	\$ 493		
16	C.1.m.13	Interest Expense	\$ 3,226		
16	C.1.m.13	Director and Trustee Fees	\$ 525		
Total Other A&G Adjustments			\$ (689,668)	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended		Page of	
Pendleton Health and Rehabilitation			2069-C	9/30/2020		29 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 660,922	660,922		
Page 20 - Resident Care Supplies***							
27.	20	C.5.a	Prescription Drugs	\$ 359,668	359,668		
28.	20	C.5.d	Ambulance/Limousine	\$ 20,796	20,796		
29.	20	C.5.f	X-rays, etc	\$ 24,171	24,171		
30.	20	C.5.h	Laboratory	\$ 19,847	19,847		
31.	20		Medical Supplies	\$			
32.	20	C.5.e	Oxygen (non emergency)	\$ 37,348	37,348		
33.	20	C.5.c	Occupational Therapy	\$ 1,374	1,374		
34.			Other - See Attached Schedule	\$ 148,570	148,570		
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.	22	C.9	Rental of Building Space or Rooms	\$ 375	375		
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$ (80,252)	(80,252)		
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 1,192,819	1,192,819		

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	C.5.c	Ancillary COGS P.E.N Therapy	\$ 5,810		
20	C.5.c	Respiratory Therapy	\$ 7,527		
20	C.5.c	Ancillary COGS IV Therapy	\$ 20,350		
20	C.5.c	Ancillary COGS Equipment Rental	\$ 27,019		
20	C.5.c	Oxygen Concentrators	\$ 23,293		
20	C.5.c	Adjust Medical Supplies to Proper Cost-to-Charge Ratio	\$ 64,571		
Total Other Ancillary Costs			\$ 148,570	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020			Page 30	of 37
Item		Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)		\$ 17,053,445	17,053,445			
b. Medicaid Room and Board Contractual Allowance **		\$ (11,669,901)	(11,669,901)			
2. a. Medicaid (<i>All other states</i>)		\$				
b. Other States Room and Board Contractual Allowance **		\$				
3. a. Medicare Residents (<i>all inclusive</i>)		\$ 6,806,696	6,806,696			
b. Medicare Room and Board Contractual Allowance **		\$ (4,488,808)	(4,488,808)			
4. a. Private-Pay Residents and Other		\$ 6,307,598	6,307,598			
b. Private-Pay Room and Board Contractual Allowance **		\$ (2,984,441)	(2,984,441)			
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare		\$ 311,773	311,773			
b. Prescription Drugs - Medicare Contractual Allowance **		\$ (310,161)	(310,161)			
c. Prescription Drugs - Non-Medicare		\$ 224,901	224,901			
d. Prescription Drugs - Non-Medicare Contractual Allowance **		\$ (176,909)	(176,909)			
2. a. Medical Supplies - Medicare		\$				
b. Medical Supplies - Medicare Contractual Allowance **		\$				
c. Medical Supplies - Non-Medicare		\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **		\$				
3. a. Physical Therapy - Medicare		\$ 1,415,706	1,415,706			
b. Physical Therapy - Medicare Contractual Allowance **		\$ (705,748)	(705,748)			
c. Physical Therapy - Non-Medicare		\$ 236,116	236,116			
d. Physical Therapy - Non-Medicare Contractual Allowance **		\$ (192,409)	(192,409)			
4. a. Speech Therapy - Medicare		\$ 434,393	434,393			
b. Speech Therapy - Medicare Contractual Allowance **		\$ (158,598)	(158,598)			
c. Speech Therapy - Non-Medicare		\$ 45,453	45,453			
d. Speech Therapy - Non-Medicare Contractual Allowance **		\$ (42,018)	(42,018)			
5. a. Occupational Therapy - Medicare		\$ 1,409,045	1,409,045			
b. Occupational Therapy - Medicare Contractual Allowance **		\$ (754,870)	(754,870)			
c. Occupational Therapy - Non-Medicare		\$ 229,401	229,401			
d. Occupational Therapy - Non-Medicare Contractual Allowance **		\$ (205,438)	(205,438)			
6. a. Other (<i>Specify</i>) - Medicare		\$ 804,762	804,762			
b. Other (<i>Specify</i>) - Non-Medicare		\$ 540	540			
III. Total Resident Revenue (Section I. thru Section II.)		\$ 13,590,531	13,590,531			
IV. Other Revenue*						
1. Meals sold to guests, employees & others		\$ (6,854)	(6,854)			
2. Rental of rooms to non-residents		\$				
3. Telephone		\$				
4. Rental of Television and Cable Services		\$				
5. Interest Income (<i>Specify</i>)		\$ 493	493			
6. Private Duty Nurses' Fees		\$				
7. Barber, Coffee, Beauty and Gift shops		\$				
8. Other (<i>Specify</i>)		\$ 375	375			
V. Total Other Revenue (1 thru 8)		\$ (5,986)	(5,986)			
VI. Total All Revenue (III +V)		\$ 13,584,545	13,584,545			

* 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)
30 II.6.a	Medicare Oxygen	\$ 4,687		
	Medicare IV Therapy	\$ 14,078		
	Medicare Laboratory	\$ 4,312		
	Medicare X-Ray	\$ 6,486		
	Medicare Ancillary General	\$ 804,938		
	Medicare Contra Adjustment	\$ (29,739)		
	Total Other Resident Revenue - Medicare	\$ 804,762	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
30 II.6.b	HMO/MGD IV Therapy	\$ 7,497		
	HMO/MGD and VA Laboratory	\$ 1,157		
	HMO/MGD and VA X-Ray	\$ 2,258		
	Other Resident Revenue Contra Adjustment	\$ (10,371)		
	Total Other Resident Revenue	\$ 540	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30. IV.5	Interest Income - Administrative	\$ 493			
	Total Interest Income	\$ 493	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV.8	General Rental Receipt	\$ 375		
	Total Other Revenue	\$ 375	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2020	31	37
Account				Amount
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)				\$ 3,045
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				\$ 1,007,455
3. Other Accounts Receivable (Excluding Owners or Related Parties)				\$
4 Inventories				\$
5. Prepaid Expenses				\$ 2,454
a. Prepaid Insurance				1,125
b. Prepaid License				59
c. Prepaid Dues & Subscriptions				932
d. See Schedule				337
6. Interest Receivable				\$
7. Medicare Final Settlement Receivable				\$
8. Other Current Assets (<i>itemize</i>)				\$
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)				\$ 1,012,953
B. Fixed Assets				\$
1. Land				\$
2. Land Improvements				\$
*Historical Cost _____				
Accum. Depreciation _____				Net
3. Buildings				\$ 11,038,968
*Historical Cost _____				7,533,137
Accum. Depreciation _____				Net
4. Leasehold Improvements				\$
*Historical Cost _____				
Accum. Depreciation _____				Net
5. Non-Movable Equipment				\$
*Historical Cost _____				
Accum. Depreciation _____				Net
6. Movable Equipment				\$ 709,523
*Historical Cost _____				100,065
Accum. Depreciation _____				Net
7. Motor Vehicles				\$
*Historical Cost _____				
Accum. Depreciation _____				Net
8. Minor Equipment-Not Depreciable				\$
9. Other Fixed Assets (<i>itemize</i>)				\$ 5,585
Asset Clearing Acct				5,585
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)				\$ 7,638,788

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

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

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

Page Ref	Line Ref	Description	
Total Other Other Fixed Assets (Itemize)			\$ -

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

Page Ref	Line Ref	Description	
33	G.A.12	Accrued Insurance - PLGL Post Petition claims	\$ 178,495
		Accrued Insurance - Self Funded Health Insurance Accrual	\$ 72,021
		Accrued Taxes - Property Taxes	\$ 240,974
		Accrued Taxes - Other Taxes	\$ 145,732
		Accrued Other	\$ 141
		Accrued Other - CMP	\$ 6,633
		Accrued Interest	\$ 81,717
		Sr. Debt/Term Loan	\$ 1,264,900
		CLO - Current	\$ 109,853
		Total Other Current Liabilities (Itemize)	\$ 2,100,467

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2020	32	37
Account			Amount	
			Total Brought Forward:	\$ 8,651,741
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)				\$ 10,509
Refundable Deposits	10,509			
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)				\$ 10,509
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)				\$ 8,662,251

* 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 Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020	Page 33	of 37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$	445,824
2. Notes Payable (<i>itemize</i>)			\$	
See Schedule				
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)			\$	360,542
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$	173,782
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable (<i>Current Portion</i>)			\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)			\$	
11. Accrued Income Taxes*			\$	412
12. Other Current Liabilities (<i>itemize</i>)			\$	3,291,290
Utility Accrual - Electric	5,086	AP - Unclaimed Patient](34,942)	
Utility Accrual - Water	31,194	AP - Medicare Accelerat	1,082,042	
AP Other	662	AP - Medicaid Accelerat	99,000	
AP - Agency Payable	7,780	See Schedule	2,100,467	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	4,271,851

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020	Page 34	of 37
Account			Amount	
Total Brought Forward:			4,271,851	
Liabilities (cont'd)				
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>)			\$	(9,549,569)
Name and Address of Lender	Amount	Loan Date		
Intercompany Revolver	(9,549,569)			
4. Other Long-Term Liabilities (<i>itemize</i>)			\$	10,245,662
L/T Benefits PLGL Post Petition Claims	387,637			
L/T Benefits Workers Comp Post Petition Claims	260,374			
Capital Lease Obligation	9,933,978			
See Schedule	(336,327)			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	696,093
C. Total All Liabilities (Lines A-13 + B-5)			\$	4,967,944

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

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020	Page 35	of 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 (<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. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	3,446,245
6. Gain or Loss for Period	10/1/2019	thru	9/30/2020	\$ 248,062
7. Total Net Worth			\$	3,694,307
C. Total Reserves and Net Worth			\$	3,694,307
D. Total Liabilities, Reserves, and Net Worth			\$	8,662,251

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Pendleton Health and Rehabilitation	2069-C	9/30/2020	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2019				\$		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$		
D. Net Income or Deficit				\$		
E. Balance				\$		
F. Additions						
1. Additional Capital Contributed (<i>itemize</i>)						
2. Other (<i>itemize</i>)						
F-3. Total Additions				\$		
G. Deductions						
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)				\$		
Name and Address (No., City, State, Zip)		Title	Amount			
2. Other Withdrawings (<i>Specify</i>)				\$		
Purpose		Amount				
3. Total Deductions				\$		
H. Balance at End of Period				\$		

I. Preparer's/Reviewer's Certification

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2020	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
Margaret Philen		
Address		Phone Number
5300 W. Sam Houston Pkwy N, Houston TX 77041		832-467-6225
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number
Margaret Philen		832-467-6225
Contact Email Address		
MLPhilen@Savasc.com		