State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2016

Name of Facility (as licensed) Glen Hill Care and Rehabilitation Center		
Address (No. & Street, City, State, Zip Code) 1 Glen Hill Road, Danbury, CT 06811		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016	

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2217-C			07-5031

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	7153		

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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Glen Hill Care and Rehabilitation Center	2217-C	9/30/2016	1	37

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 Glen Hill Care and Rehabilitation Center [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

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

(Notary Seal)

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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 Glen Hill Care and Rehabilitation Center	Period Covered:		From 10/1/2015	To 9/30/2016
Address of Facility 1 Glen Hill Road, Danbury, CT 06811				
Report Prepared By Thomas Farnan	Phone Number 978-247-5029		Date 12/21/2016	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$	360,966	360,966		
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$	3,231,979	3,231,979		
5. All other wages paid	$	511,741	511,741		
6. ***Total Wages Paid***	$	4,104,686	4,104,686		
7. Total salaries paid	$	269,103	269,103		
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	4,373,790	4,373,790		

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
203-744-2840	9/30/2016	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Glen Hill Care and Rehabilitation Center	1 Glen Hill Road, Danbury, CT 06811

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2217-C			07-5031

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.:	
Talamona,Marnie		1575

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
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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
Glen Hill Care and Rehabilitation Center	101 East State Street, Kennett Square, PA 19348	PA

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

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2016	3B	37

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	421,237	421,237
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	⊙	○	62%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	1,260,545	1,260,545
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	⊙	○	56%	Staffing Pool	Pg 10/A12	1,758	1,758
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	⊙	○	83%	Case Management	Pg 13/B8, Pg 10/A12	51,151	51,151
Career Staffing	101 East State Street, Kennett Square, PA 19348	⊙	○	80%	Staffing Pool	Pg 13/B11 a,b,c		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	⊙	○	51%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	13,830	13,830
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Insurance	Pg 27/14	156,916	156,916
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Capital Interest	Page 17, page 26-12A	39,167	39,167
		○	○					

* 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		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
						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

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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 GOLDMAN GRUDER & WOOD, LLC	(203) 899-8900
2 Schettino and Temchin Attorneys at Law	(860) 621-4352
3	
4	
5	

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

1 200 Connecticut Ave. Norwalk, CT 06854
2 18 Peck st, North Haven, CT 06473
3
4
5

Services Provided by This Firm (*describe fully*)

1	Draft applications for PJR, telephone conferences, property searches, correspondence with clients	$
2	Probate claim and court fees	$
3		$
4		$
5		$
		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 Fees pg. 15 1-e

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Schedule of Resident Statistics

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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	100	100			100	100			100	100		
B. On last day of THIS report period	100	100			100	100			100	100		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	88	88			88	88			88	88		
B. As of midnight of THIS report period	93	93			88	88			93	93		
3. Total Number of Days Care Provided During Period												
A. Medicare	8,723	8,723			6,688	6,688			2,035	2,035		
B. Medicaid (Conn.)	18,312	18,312			13,274	13,274			5,038	5,038		
C. Medicaid (other states)												
D. Private Pay	3,836	3,836			2,965	2,965			871	871		
E. State SSI for RCH												
F. Other (Specify)	2,240	2,240			1,634	1,634			606	606		
G. Total Care Days During Period (3A thru F)	33,111	33,111			24,561	24,561			8,550	8,550		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	14	14			2	2			12	12		
B. Other Bed Reserve Days	36	36			31	31			5	5		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	33,161	33,161			24,594	24,594			8,567	8,567		

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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	23	53		17				
Per Diem Rate								
a. One bed rm.				468.00				
b. Two bed rms.	663.50	206.22		444.47				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	2,560	2,560		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	343	343		
C. Other	30,812	30,812		
D. ***Total Physical Therapy Treatments***	33,715	33,715		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	232	232		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	6	6		
C. Other	1,615	1,615		
D. ***Total Speech Therapy Treatments***	1,853	1,853		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	963	963		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	266	266		
C. Other	28,244	28,244		
D. ***Total Occupational Therapy Treatments***	29,473	29,473		

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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)	145,381	2,091				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	175,075	7,675				
5. Dietary Service						
a. Head Dietitian	29,897	1,018				
b. Food Service Supervisor	58,444	2,221				
c. Dietary Workers	272,625	18,453				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	56,479	2,098				
b. Other Maintenance Workers	24,445	1,559				
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	123,723	2,107				
b. RN						
1. Direct Care	1,118,516	31,862				
2. Administrative**	39,802	1,022				
c. LPN						
1. Direct Care	726,355	26,625				
2. Administrative**						
d. Aides and Attendants	1,281,151	77,086				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	99,614	4,257				
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	156,129	5,914				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	66,156	3,789				
A-13. Total Salary Expenditures	4,373,790	187,776				

* 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	0
Coordinator-Staffing Centers	-	$ 14,759	822			0	0
Central Supply	-	$ 14,828	860			0	0
Medical Records	-	$ 36,569	2,108			0	0
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
Total		$ 66,155.78	3,789	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

		CCNH		RHNS		(Specify)	
Service		**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
1020620010	Consulting Fees	498.91	n/a			-	
3010620020	Purchased Services	9,753.82	n/a				
3010620020	Purchased Services	40.00	n/a				
3155620020	Purchased Services	896.64	n/a				
3155620020	Purchased Services	566.48	n/a				
1020620010	Consulting Fees	14.00	n/a				
0	0	-	-				
0	0	-	-				
0	0	-	-				
0	0	-	-				
Total		$ 11,770	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
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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
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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* **										
Marnie Tetreault	145,381				Management of Center	2,091	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.

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	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	847	23				
2. Dentist	15,790	108				
3. Pharmacist	8,973	183				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	1,180,918	16,177				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	40,140	212				
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	24,067	309				
b. Other						
10. Occupational Therapist						
a. Resident Care	36,285	497				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	1,526	23				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	11,770					
B-13 Total Fees Paid in Lieu of Salaries	1,320,314	17,533				

* 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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2016	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
Genesis Eldercare Hospitality Services, 101 East State Street, Kennett Square, PA 19348	Dietary Services	⊙	○	Common Ownership
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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2016	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	214,710	214,710		
2. Disability Insurance	$				
3. Unemployment Insurance	$	43,558	43,558		
4. Social Security (F.I.C.A.)	$	318,515	318,515		
5. Health Insurance	$	380,534	380,534		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	28,579	28,579		
d. Accounting and Auditing	$				
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	26,441	26,441		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	21,543	21,543		
2. Cellular Phones	$	2,695	2,695		
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*)	$	845	845		
See Attached Schedule					
3. Resident Day User Fee	$	478,289	478,289		
Subtotal	$	1,515,708	1,515,708		

* 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)
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
Total		$ -	$ -	$ -

Schedule of Other Taxes

Description		CCNH	RHNS	(Specify)
1020640110	Sales & Use Tax Exp	$ 845	$ -	0
1020640110	Sales Tax	$ -	$ -	0
1020640110	Sales Tax	$ -	$ -	0
0	0	$ -		
Total		$ 845	$ -	$ -

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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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2016	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,515,708	1,515,708		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	203	203		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	1,347	1,347		
5. Education Expenses Related to Seminars and Conventions	$	3,223	3,223		
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*)***	$	10,573	10,573		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	1,968	1,968		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	16,788	16,788		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	686	686		
10. Contributions***	$	1,167	1,167		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	4,031	4,031		
12. Administrative Management Services**	$	520,753	520,753		
13. Other (*Specify*)	$	25,055	25,055		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,101,501	2,101,501		

* 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	$ 149	$ -	0
1020630020	Advertising	$ 1,156	$ -	0
1020630330	Marketing Expense	$ 5,427	$ -	0
1020630330	Marketing Expense	$ 13	$ -	0
1020630331	Marketing Exp- Corpor	$ 446	$ -	0
1020630331	Marketing Exp- Corpor	$ 3,382	$ -	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 Advertising		$ 10,573	$ -	$ -

Schedule of Dues

Description		CCNH	RHNS	(Specify)
1020630310	Licenses & Certificatio	$ 16,788	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0

0	0	$ -	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0
Total Dues		$ 16,788	$ -	$ -

Schedule of Contributions

Description		**CCNH**	**RHNS**	**(Specify)**
1020630130	Contributions	$ 1,167	$ -	$ -
1020630135	Political Contributions	$ -	$ -	$ -
0	0	$ -	$ -	$ -
Total Contributions		$ 1,167	$ -	$ -

Schedule of Other Administrative and General

Description		**CCNH**	**RHNS**	**(Specify)**
1020630060	Bank Service Charges	7,396.23	-	-
1020630120	Collection Fees	85.30	self-disallowed	-
1020630140	Education Expense	73.80	-	-
1020630140	Education Expense	3.44	-	-
1020630180	Employee Physicals	3,952.63	-	-
1020630200	Employee Relations	2,462.02	-	-
1020630380	Printing	1,294.89	-	-
1020630380	Printing	146.16	-	-
3080630441	Foreign Recruitment C	1,035.00	-	-
3080630441	Foreign Recruitment C	6,136.00	-	-
1020630610	Training Expense	138.38	-	-
1020630610	Training Expense	710.16	-	-
1020630640	Uniforms	362.32	-	-
1020640090	Miscellaneous	(0.32)	-	-
1020660990	Accrued Expense Estin	(1,958.18)	self-disallowed	-
5095720020	Cap Stk/Franchise Tax	287.94	-	-
1020720070	State Tax Annual Repo	138.75	-	-
5095720090	Landlord Operating Ta	2,400.00	-	-
1020630120	Collection Fees	390.00	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
0	0	-	-	-
Total Other Administrative and General		$ 25,055	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Glen Hill Care and Rehabilitation Center	License No. 2217-C	Report for Year Ended 9/30/2016	Page of 17 | 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	421,237	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	39,167	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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CSP-18 Rev. 9/2002

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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2016	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	147,629	147,629		
2. Non-Food Supplies	$	22,629	22,629		
3. Other (*Specify*)_____	$	(2,940)	(2,940)		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	2,708	2,708		
c. Management Services**	$				
d. Other (*Specify*)_____	$	40	40		
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	170,067	170,067		

		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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2016	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	4,104	4,104		
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. $	3,721	3,721		
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	92,073	92,073		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	99,898	99,898		

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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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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2016	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	13,737	13,737		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	137,436	137,436		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	151,173	151,173		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	264,138	264,138		
b. Medicine Cabinet Drugs		$	19,843	19,843		
c. Medical and Therapeutic Supplies		$	80,705	80,705		
d. Ambulance/Limousine***		$				
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	8,185	8,185		
f. X-rays and Related Radiological Procedures***		$	19,621	19,621		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	27,352	27,352		
i. Recreation		$	32,071	32,071		
j. Other (Specify)**** See Attached Schedule		$	65,796	65,796		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	517,711	517,711		

* 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	$ 42,982.56	$ -	$ -
3060610161	Incontinency - Rebate	$ (749.01)	$ -	$ -
3080630030	Advertising-Help Wan	$ 494.46	$ -	$ -
3080630030	Advertising-Help Wan	$ 281.10	$ -	$ -
3080630080	Books, Dues & Subsc	$ 525.85	$ -	$ -
3080630140	Education Expense	$ 385.35	$ -	$ -
3080630140	Education Expense	$ 1,067.07	$ -	$ -
3120630530	Supplies	$ 1,056.10	$ -	$ -
3155630530	Supplies	$ 4,707.60	$ -	$ -
3155630530	Supplies	$ 2,619.86	$ -	$ -
3165630530	Supplies	$ 37.23	$ -	$ -
3170630530	Supplies	$ 63.25	$ -	$ -
3120660080	Rental Expense	$ 333.80	$ -	$ -
3155660080	Rental Expense	$ (83.87)	$ -	$ -
3155660080	Rental Expense	$ 3,060.00	$ -	$ -
3010610300	Consolidated Billing	$ 9,015.14	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
Total Other Resident Care		$ 65,796	$ -	$ -

0

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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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2016	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	92,073			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	⊙	○	Vendor Contracted	Housekeeping Purchased Services	137,436			20	4b
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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
Glen Hill Care and Rehabilitation Cente	2217-C	9/30/2016	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	123,097	123,097		
b. Heat	$	87,466	87,466		
c. Light & Power	$	107,594	107,594		
d. Water	$	46,704	46,704		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	364,861	364,861		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	468	468		
b. Building & Building Improvements	$	15,898	15,898		
c. Non-Movable Equipment	$	14,307	14,307		
d. Movable Equipment	$	16,104	16,104		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	46,777	46,777		
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	$	1,533,673	1,533,673		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	121,395	121,395		
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,701,845	1,701,845		

* 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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2016	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	5,976		5,976	924	S/L	Various	468	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								468
B. **Building and Building Improvements**								
1. Acquired prior to this report period	194,159		194,159	31,423	S/L	Various	15,254	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	25,640		25,640				644	
B-4. Subtotal								15,898
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	130,874		130,874	39,289	S/L	Various	14,307	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								14,307

	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					112,438		112,438	53,209	S/L	Various	15,287	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					12,896		12,896				816	
D-3. Subtotal												16,104
E. ***Total Depreciation***												46,777

Glen Hill Care and Rehabilitation Center
9/30/2016

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
Deletions:				
Total deletions for Land Improvements		$ -		$ -

***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:				
11/30/2015	2 Pushbutton Combination Door Lo	1,029.45	20.00	42.89
11/30/2015	Pushbutton Combination Door Lock	521.10	20.00	21.71
1/31/2016	Upgrade circulator	2,372.14	20.00	79.07
2/29/2016	6 eyewash stations	2,263.47	20.00	66.02
3/31/2016	Upgrade ciculator	2,061.86	20.00	51.55
3/31/2016	Electric heater for sprinkler pipes	1,185.21	20.00	29.63
2/29/2016	Upgrade boiler burner motor	1,156.29	15.00	44.97
3/31/2016	Wall coverings	1,722.87	10.00	86.14
7/31/2016	19 resident flooring bathrooms	13,327.78	10.00	222.13
Total additions for Building Improvements		$ 25,640		$ 644
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 period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Non-Movable Equipment		$ -		$ -
Deletions:				
Total deletions for Non-Movable Equipment		$ -		$ -

***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:				
7/31/2016	Frigidaire 10,000 BTU 115 Volt Casement Window Air Conditioner	1,160.73	7.00	27.64
2/29/2016	4 PANACEA STANDARD WHEELCHAIR	533.92	10.00	31.15
3/31/2016	Blixer, 7 qt Triple Phase, 4-Prong Plug, Two-speed	3,198.40	10.00	159.92
4/30/2016	OmniCycle Elite Rehab System	6,487.36	10.00	270.31
10/31/2015	3 MATTRESS, GENESIS VISCO	1,012.41	3.00	309.35
2/29/2016	office desk	122.28	10.00	7.13
8/31/2016	1 HP LaserJet PRO M426FDN	381.10	3.00	10.59
Total additions for Movable Equipment		$ 12,896		$ 816
Deletions:				
Total deletions for Movable Equipment		$ -		$ -

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

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

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation

Additions:				
Total additions for Leasehold Improvement		$ -		$ -
Deletions:				
Total deletions for Leasehold Improvement		$ -		$ -

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

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

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2016	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
Glen Hill Care and Rehabilitation Cer	2217-C	9/30/2016	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	100
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 87107	Facility Lease	11/15/10 - 6/30	127 months	1,533,673

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
Glen Hill Care and Rehabilitation Cer	2217-C	9/30/2016	26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$	39,167	39,167		
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)	$	39,167	39,167		

(*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
Glen Hill Care and Rehabilitation	2217-C	9/30/2016	27 | 37

Item				Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				39,167	39,167		
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)			$	39,167	39,167		
14. Insurance							
a. Insurance on Property (buildings only)			$	4,885	4,885		
b. Insurance on Automobiles			$				
c. Insurance other than Property (as specified above)							
1. Umbrella (*Blanket Coverage*)			$	152,031	152,031		
2. Fire and Extended Coverage			$				
3. Other (*Specify*)			$				
14d. ***Total Insurance Expenditures (14a + b + c)***			$	156,916	156,916		
15. ***Total All Expenditures (A-13 thru C-14)***			$	10,997,242	10,997,242		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2016	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 $	59,903	59,903		
Page 13 - Professional Fees							
5.	13	B-8-c	Resident Care Physicians ** $				
6.		B-10	Occupational Therapy $				
7.			Other - See attached Schedule $	1,252,527	1,252,527		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1-c	Bad Debts $	28,579	28,579		
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 * $	10,573	10,573		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $	1,167	1,167		
21.			Unallowable Management Fees $	559,920	559,920		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	66,221	66,221		
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) $	1,978,889	1,978,889		

* 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	$ 59,903	0	0
10	A-12d	unallowed C.N.A no license period sa	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				$ 59,903	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	$ 85,440	0	0
13	5	Rehabilitation Services	3195620020	$ 1,095,477	0	0
13	9	Speech Therapist	3170620020	$ 24,067	0	0
13	10	Occupational Therapist	3105620020	$ 36,285	0	0
13	12	Other	3010620020	$ 9,794	0	0
13	12	Other	3015620020	$ -	0	0
13	12	Respiratory Purchased Servies	3155620020	$ 1,463	0	0
					0	0
					0	0
					0	0
					0	0
					0	0
Total Other Fees Adjustments				$ 1,252,527	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	1020630120	$ 475	$ -	$ -
16	m-8a	Chamber of Commerce	1020630310	$ -	$ -	$ -
16	m-13	Estimated Accrual	1020660990	$ (1,958)	$ -	$ -
16	m-13	Fines	1020640080	$ -	$ -	$ -
16	m-13	Non-recurring Charges	7010800030	$ -	$ -	$ -
16	m-12	Management Fee disallowed	CBO service Fee	$ -	$ -	$ -
15	1-a-1	adj workers comp	0	$ 67,704	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
Total Other A&G Adjustments				$ 66,221	$ -	$ -