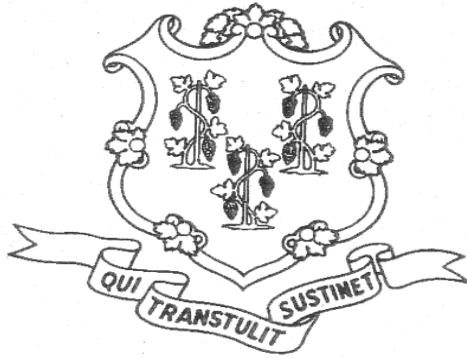


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2020

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 Rest Home with Nursing <input checked="" type="checkbox"/> Nursing Home only <input type="checkbox"/> Supervision only <input type="checkbox"/> (Specify) (CCNH) (RHNS)	
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020

License Numbers:	CCNH 2217-C	RHNS	(Specify)	Medicare Provider 07-5031
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Medicaid Provider Numbers:	CCNH 7153	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) Glen Hill Care and Rehabilitation Center	License No. 2217-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 Glen Hill Care and Rehabilitation Center [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) Merisa Kolenovic			Printed Name (Owner) Lashuan Bethea-VP-Legislative Affairs-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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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 Glen Hill Care and Rehabilitation Center	Period Covered:	From 10/1/2019	To 9/30/2020	
Address of Facility 1 Glen Hill Road, Danbury, CT 06811				
Report Prepared By Thomas Farnan	Phone Number 978-247-5029	Date 12/28/2020		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$ 3,601,699	3,601,699		
5. All other wages paid	\$ 629,996	629,996		
6. Total Wages Paid	\$ 4,231,695	4,231,695		
7. Total salaries paid	\$ 255,142	255,142		
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$ 4,486,836	4,486,836		

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

Phone No. of Facility 203-744-2840		Report for Year Ended 9/30/2020	Page 2	of 37
Name of Facility (as shown on license) Glen Hill Care and Rehabilitation Center		Address (No. & Street, City, State, Zip) 1 Glen Hill Road, Danbury, CT 06811		
License Numbers:	CCNH 2217-C	RHNS	(Specify)	Medicare Provider No. 07-5031
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust				
If this facility opened or closed during report year provide:		Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
Administrator				
Name of Administrator Merisa Kolenovic		Nursing Home Administrator's License No.:	2052	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		

**General Information and Questionnaire
 Corporate Owners**

Name of Facility Glen Hill Care and Rehabilitation Center	License No. 2217-C	Report for Year Ended 9/30/2020	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation Glen Hill Care and Rehabilitation Center	Business Address 101 East State Street, Kennett Square, PA 19348	State(s) in Which Incorporated PA		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
See Attached				
Names of Stockholders Owning at Least 10% of Shares				
See Attached				

**General Information and Questionnaire
Related Parties***

Name of Facility Glen Hill Care and Rehabilitation Center	License No. 2217-C	Report for Year Ended 9/30/2020	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility? Yes No If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Genesis Administrative Services LLC	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Home Office	Pg 16/m12	375,635	375,635
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	64%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	1,105,203	1,105,203
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	<input type="radio"/>	<input checked="" type="radio"/>	37%	Staffing Pool	Pg 10/A12, p15-1		
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	85%	Medical Director /NP	Pg 13/B8, Pg 10/A12	19,989	19,989
Career Staffing	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>	66%	Outside Agency	Pg 13/B11 pg 10-12, 15		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	<input checked="" type="radio"/>	<input type="radio"/>	50%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E2	13	13
Genesis Healthcare Ins Program	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	181,508	181,508
Genesis Administrative Services LLC	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Capital Interest	Page 17, page 26-12A		
		<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 Glen Hill Care and Rehabilitation Center	License No. 2217-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.

- In the preparation of this Report, were all costs allocated as required? Yes No If "No," explain fully why such allocation was not made.
- Explain the allocation of related company expenses and attach copy of appropriate supporting data.
- 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 Glen Hill Care and Rehabilitation Center			License No. 2217-C			Report for Year Ended 9/30/2020		Page 6	of 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed		
	Yes	No							
	<input type="radio"/>	<input 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"/>							
	<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 ***									

* 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 Glen Hill Care and Rehabilitation	License No. 2217-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 KPMG Peat Marwick 2 3 4	Address (No. & Street, City, State, Zip Code) 1600 Market Street, Philadelphia, PA 19103
---	---

Services Provided by This Firm (*describe fully*)

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

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No Included in Management Fee pg. 16 m-12

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Goldman Gruder & Woods LLC 2 Wiggan And Dana LLP 3 4 5	Telephone Number 203-899-8900 203-498-4400
--	--

Address (*No. & Street, City, State, Zip Code*)
 1 200 Connecticut Ave Norwalk, CT 06854
 2 One Century Tower, New Haven, CT 06508
 3
 4
 5

Services Provided by This Firm (*describe fully*)

1 Property Ownership search	\$
2 Deseased record services	\$
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

Schedule of Resident Statistics

Name of Facility Glen Hill Care and Rehabilitation Center			License No. 2217-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												
A. On last day of PREVIOUS report period	100	100			100	100						
B. On last day of THIS report period	100	100							100	100		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	94	94			94	94						
B. As of midnight of THIS report period	85	85							85	85		
3. Total Number of Days Care Provided During Period												
A. Medicare	6,972	6,972			5,313	5,313			1,659	1,659		
B. Medicaid (Conn.)	18,306	18,306			13,878	13,878			4,428	4,428		
C. Medicaid (other states)												
D. Private Pay	2,255	2,255			1,847	1,847			408	408		
E. State SSI for RCH												
F. Other (Specify)	2,954	2,954			2,256	2,256			698	698		
G. Total Care Days During Period (3A thru F)	30,487	30,487			23,294	23,294			7,193	7,193		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	8	8			8	8						
B. Other Bed Reserve Days	13	13			10	10			3	3		
5. Total Resident Days (3G + 4A + 4B)	30,508	30,508			23,312	23,312			7,196	7,196		

Schedule of Resident Statistics (Cont'd)

Name of Facility Glen Hill Care and Rehabilitation Center			License No. 2217-C			Report for Year Ended 9/30/2020			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	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	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	17		53		15								
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	669.19		221.57		498.53								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									1,743	1,743			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									113	113			
C. Other									16,249	16,249			
D. Total Physical Therapy Treatments									18,105	18,105			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									371	371			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									14	14			
C. Other									2,497	2,497			
D. Total Speech Therapy Treatments									2,882	2,882			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									1,891	1,891			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									102	102			
C. Other									16,900	16,900			
D. Total Occupational Therapy Treatments									18,893	18,893			

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Glen Hill Care and Rehabilitation Center	2217-C	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)	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)	137,772	2,112				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	249,986	9,029				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers						
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	73,038	2,075				
b. Other Maintenance Workers	23,580	1,516				
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	117,370	2,113				
b. RN						
1. Direct Care	1,111,558	26,827				
2. Administrative**	198,048	4,357				
c. LPN						
1. Direct Care	896,480	29,415				
2. Administrative**						
d. Aides and Attendants	1,313,699	68,664				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	106,193	4,156				
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	177,199	6,023				
n. Marketing						
o. Other (Specify) See Attached Schedule	81,914	4,056				
<i>A-13. Total Salary Expenditures</i>	4,486,836	160,343				

* 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)

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Ward Clerks	\$ -	-	\$ -	-	\$ -	-
Central Supply	\$ 3,710	206	\$ -	-	\$ -	-
Medical Records	\$ 45,431	2,123	\$ -	-	\$ -	-
Coordinator-Staffing Centers	\$ 32,774	1,727	\$ -	-	\$ -	-
Total	\$ 81,914	4,056	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Consulting Fees	\$ 5,658	n/a	\$ -	-	\$ -	-
Purchased Services	\$ 172	n/a	\$ -	-	\$ -	-
Purchased Services	\$ -	n/a	\$ -	-	\$ -	-
Purchased Services	\$ -	n/a	\$ -	-	\$ -	-
	0	\$ -	n/a	\$ -	-	\$ -
	0	\$ -	n/a	\$ -	-	\$ -
Total	\$ 5,830	-	\$ -	-	\$ -	-

**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	
Glen Hill Care and Rehabilitation Center				2217-C	9/30/2020			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

**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	
Glen Hill Care and Rehabilitation Center				2217-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***										
Merisa Kolenovic	131,296				Management of Center	2,000	2			
Rodriguez, Heather R - 10/1/2019-10/16/2019	6,476				Management of Center	112	2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2020	13	37		
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	10,860	74				
3. Pharmacist	12,543	256				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	966,685	13,242				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	46,505	246				
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	59,338	761				
b. Other						
10. Occupational Therapist						
a. Resident Care	81,924	1,122				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	31,320	522				
2. Administrative***						
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify)						
See Attached Schedule	5,830					
B-13 Total Fees Paid in Lieu of Salaries	1,215,005	16,224				

* 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*

Name of Facility		License No.	Report for Year Ended		Page	of
Glen Hill Care and Rehabilitation Center		2217-C	9/30/2020		14	37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
		<input type="radio"/>	<input checked="" type="radio"/>			
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	<input checked="" type="radio"/>	<input type="radio"/>	Common Ownership		
		<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"/>			
		<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"/>			
		<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.
 ** Refer to Page 4 for definition of related.

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	9/30/2020		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 240,378	240,378			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 39,194	39,194			
4. Social Security (F.I.C.A.)	\$ 324,785	324,785			
5. Health Insurance	\$ 322,483	322,483			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$				
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 4,405	4,405			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 123,313	123,313			
d. Accounting and Auditing	\$				
e. Legal (<i>Services should be fully described on Page 7</i>)	\$				
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 20,216	20,216			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 22,225	22,225			
2. Cellular Phones	\$ 3,419	3,419			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$ 908	908			
3. Resident Day User Fee	\$ 447,052	447,052			
Subtotal	\$ 1,548,379	1,548,379			

* 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)
Benefit Allocations	\$ 403	\$ -	\$ -
Union Health & Welfare	\$ 4,002	\$ -	\$ -
Total	\$ 4,405	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Sales Tax	\$ 908	\$ -	\$ -
Total	\$ 908	\$ -	\$ -

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	9/30/2020		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:		1,548,379	1,548,379		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	321	321		
5. Education Expenses Related to Seminars and Conventions	\$	400	400		
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>)	\$	180	180		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	11,710	11,710		
4. Fund-Raising***	\$				
5. Medical Records	\$	(0)	(0)		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	2,673	2,673		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	8,884	8,884		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	323	323		
10. Contributions*** See Attached Schedule	\$	1,201	1,201		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	25,529	25,529		
12. Administrative Management Services**	\$	588,719	588,719		
13. Other (<i>Specify</i>) See Attached Schedule	\$	104,253	104,253		
C-14 Total Administrative & General Expenditures		\$ 2,292,572	2,292,572		

* 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	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising	\$ 1,637	\$ -	\$ -
Marketing Expense	\$ 1,772	\$ -	\$ -
Marketing Exp- Corporate Spend	\$ 8,301	\$ -	\$ -
Marketing Exp- Corporate Spend	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
Total Other Advertising	\$ 11,710	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Licenses & Certifications	\$ 8,884	\$ -	\$ -
Dues to Chamber of Commerce	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
Total Dues	\$ 8,884	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Contributions	\$ -	\$ -	\$ -
Political Contributions	\$ 1,201	\$ -	\$ -
0	\$ -	\$ -	\$ -
Total Contributions	\$ 1,201	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Service Charges	\$ 6,701	\$ -	\$ -
Collection Fees	\$ 40,237	self-disallowed	\$ -
Education Expense	\$ 2	\$ -	\$ -
Employee Physicals	\$ 14,321	\$ -	\$ -
Employee Relations	\$ 2,722	\$ -	\$ -
Printing	\$ 2,062	\$ -	\$ -
Training Expense	\$ 170	\$ -	\$ -
Fines & Penalties	\$ (8,626)	self-disallowed	\$ -
Miscellaneous	\$ 161	\$ -	\$ -
Rental Expense	\$ 160	\$ -	\$ -
Accrued Expense Estimation	\$ 3,233	self-disallowed	\$ -
Landlord Operating Taxes	\$ 600	\$ -	\$ -
State Tax Annual Report Filing	\$ 20	\$ -	\$ -
Recruiting Fees	\$ 345	\$ -	\$ -
Recruiting Fees	\$ 42,080	\$ -	\$ -
Non-recurring Charges	\$ -	\$ -	\$ -
Uniforms	\$ 64	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
0	\$ -	\$ -	\$ -
Total Other Administrative and General	\$ 104,253	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Glen Hill Care and Rehabilitation Center	License No. 2217-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 #
Genesis Administrative Services LLC, 101 East St., Kennett Square, PA 19348	375,635	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12

*** 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 Glen Hill Care and Rehabilitation Center		License No. 2217-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	\$	146,105	146,105		
2. Non-Food Supplies	\$	25,079	25,079		
3. Other (Specify) _____	\$	1,656	1,656		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	506,689	506,689	
c. Other (Specify) _____		\$			
2D. Total Dietary Expenditures (2a + b + c + d)		\$	679,529	679,529	
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)					
J. 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)					
M. 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 Glen Hill Care and Rehabilitation Center		License No. 2217-C	Report for Year Ended 9/30/2020		Page 19	of 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. \$	4,485	4,485		
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. \$	6,416	6,416		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	89,484	89,484		
c. Other (Specify)		\$				
3D. Total Laundry Expenditures (3a + b + c)		\$	100,385	100,385		
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		License No.	Report for Year Ended		Page	of
Glen Hill Care and Rehabilitation Center		2217-C	9/30/2020		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	17,112	17,112		
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. \$	154,166	154,166		
	C. Other (<i>Specify</i>)		\$			
4D.	Total Housekeeping Expenditures (4a + b + c)		\$ 171,278	171,278		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	303,400	303,400		
b.	Medicine Cabinet Drugs	\$	(16,722)	(16,722)		
c.	Medical and Therapeutic Supplies	\$	119,755	119,755		
d.	Ambulance/Limousine***	\$	1,400	1,400		
e.	Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	7,734	7,734		
f.	X-rays and Related Radiological Procedures***	\$	21,611	21,611		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	8,817	8,817		
i.	Recreation	\$	34,939	34,939		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	49,330	49,330		
5M.	Total Resident Care Expenditures (5a - 5j)		\$ 530,265	530,265		

* 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)
Incontinency	\$ 34,747	\$ -	\$ -
Incontinency - Rebates	\$ (51)	\$ -	\$ -
Advertising-Help Wanted	\$ 1,579	\$ -	\$ -
Books, Dues & Subscriptions	\$ 62	\$ -	\$ -
Education Expense	\$ 403	\$ -	\$ -
Supplies	\$ 657	\$ -	\$ -
Supplies	\$ 2,764	\$ -	\$ -
Supplies	\$ 33	\$ -	\$ -
Office Supplies	\$ -	\$ -	\$ -
Office Supplies	\$ -	\$ -	\$ -
Office Supplies	\$ -	\$ -	\$ -
Training Expense	\$ 1,500	\$ -	\$ -
Rental Expense	\$ -	\$ -	\$ -
Rental Expense	\$ 423	\$ -	\$ -
Consolidated Billing	\$ 7,642	\$ -	\$ -
Tuition Reimbursement	\$ -	\$ -	\$ -
Tuition Reimbursement	\$ -	\$ -	\$ -
Tuition Reimbursement	\$ (623)	\$ -	\$ -
Miscellaneous	\$ -	\$ -	\$ -
Licenses & Certifications	\$ -	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -
Licenses & Certifications	\$ 195	\$ -	\$ -
	0	\$ -	\$ -
Total Other Resident Care	\$ 49,330	\$ -	\$ -

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

Name of Facility Glen Hill Care and Rehabilitation Center			License No. 2217-C	Report for Year Ended 9/30/2020	Page of 21 37					
Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Laundry Purchased Services	89,484			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	154,166			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Dietary Purchased Services	503,929			18	2b
		<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"/>							
		<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"/>							

* 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	License No.	Report for Year Ended			Page	of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2020			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 212,025	212,025				
b. Heat	\$ 43,498	43,498				
c. Light & Power	\$ 102,705	102,705				
d. Water	\$ 44,156	44,156				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$					
f. Other (<i>itemize</i>)	\$					
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 402,384	402,384				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$ 576	576				
b. Building & Building Improvements	\$ 8,084	8,084				
c. Non-Movable Equipment	\$ 352	352				
d. Movable Equipment	\$ 11,904	11,904				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 20,916	20,916				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,495,848	1,495,848				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 145,047	145,047				
c. Personal property taxes	\$					
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,661,811	1,661,811				

* 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	\$ -	\$ -	\$ -

Depreciation Schedule

Name of Facility Glen Hill Care and Rehabilitation Center			License No. 2217-C			Report for Year Ended 9/30/2020			Page 23	of 37		
Property Item			Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals		
A. Land Improvements												
1. Acquired prior to this report period			518		518		S/L	Various	56			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)			2,338		2,338				520			
A-4. Subtotal										576		
B. Building and Building Improvements												
1. Acquired prior to this report period			9,053		9,053	165	S/L	Various	980			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)			403,837		403,837				7,104			
B-4. Subtotal										8,084		
C. Non-Movable Equipment												
1. Acquired prior to this report period			3,374		3,374	117	S/L	Various	352			
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal										352		
		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. 2015 Honda 2HKRM4H52FH67228					7,839		7,839	1,960			5,879	
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					17,985		17,985	1,011	S/L	Various	4,634	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					31,082		31,082				1,392	
D-3. Subtotal												11,904
E. Total Depreciation												20,916

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
1/31/2020	Line Striping Parking Lot for 5 spaces AD	\$ 2,338	3	\$ 520
		\$ -	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
Total additions for Land Improvements		\$ 2,338		\$ 520
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:				
12/31/2019	Balance pmt for 2 Fire Doors 1st floor dum	\$ 2,273	09 00	\$ 189
1/31/2020	Smoke & Co Detectors for all rooms & do	\$ 3,377	08 11	\$ 253
2/29/2020	Electrical work for Building, Conduits, Ele	\$ 20,635	08 10	\$ 1,363
3/31/2020	Install New Electrical Panels and Conduit	\$ 6,153	08 09	\$ 352
3/31/2020	Marking of Electrical Panels	\$ 3,072	08 09	\$ 176
3/31/2020	Delete Electrical Panels in BR & Termina	\$ 7,750	08 09	\$ 443
3/31/2020	Install Conduit and Wiring for Boiler Room	\$ 10,704	08 09	\$ 612
4/30/2020	Wiring install for new panels & Install Trou	\$ 13,570	08 08	\$ 652
4/30/2020	Collecting info for new generator	\$ 1,809	08 08	\$ 87
4/30/2020	New Trough System in Kitchen Area whic	\$ 2,989	08 08	\$ 144
4/30/2020	New Electrical Panels and Wiring for Pan	\$ 38,764	08 08	\$ 1,864
4/30/2020	Professional Engineering Services - Con	\$ 12,500	08 08	\$ 601
4/30/2020	New Electrical Panels and Wiring for Pan	\$ 7,694	08 08	\$ 370
9/30/2020	Sept Accruals	\$ 272,546	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
Total additions for Building Improvements		\$ 403,837		\$ 7,104
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

Amortization Schedule*

Name of Facility Glen Hill Care and Rehabilitation Center			License No. 2217-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	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year			Year's Operations				
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 Glen Hill Care and Rehabilitation Center	License No. 2217-C	Report for Year Ended 9/30/2020	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.	
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.					
Description	Total				
1. Date Land Purchased	n/a				
2. Date Structure Completed	n/a				
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	n/a				
b. Building	n/a				
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	
GMF-CT	Facility Lease	12/21/2018-12	10 years	1,495,848	
650 Madison Avenue New York, NY 10022					

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
Glen Hill Care and Rehabilitation Cd		2217-C	9/30/2020			26	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		Page	of
Glen Hill Care and Rehabilitation		2217-C		9/30/2020		27	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)				\$ 1,768	1,768		
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$ 179,740	179,740		
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$ 181,508	181,508		
15. Total All Expenditures (A-13 thru C-14)				\$ 11,721,574	11,721,574		

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	9/30/2020	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.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 44,861	44,861		
Page 13 - Professional Fees							
5.	13	B-8-c	Resident Care Physicians **	\$			
6.		B-10	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 1,108,119	1,108,119		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 123,313	123,313		
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	m-2 &	Unallowable Advertising *	\$ 11,710	11,710		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 1,201	1,201		
21.			Unallowable Management Fees	\$ 213,084	213,084		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ (118,712)	(118,712)		
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)				\$ 1,383,577	1,383,577		

* 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	\$ 44,861	\$ -	\$ -
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			\$ 44,861	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	\$ 78,457	\$ -	\$ -
13	5	Rehabilitation Services	\$ 888,228	\$ -	\$ -
13	9	Speech Therapist	\$ 59,338	\$ -	\$ -
13	10	Occupational Therapist	\$ 81,924	\$ -	\$ -
13	12	Other	\$ 172	\$ -	\$ -
13	12	Other	\$ -	\$ -	\$ -
13	12	Respiratory Purchased Servies	\$ -	\$ -	\$ -
Total Other Fees Adjustments			\$ 1,108,119	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	\$ 40,237	\$ -	\$ -
16	m-13	Estimated Accrual	\$ 3,233	\$ -	\$ -
16	m-13	Non-recurring Charges	\$ -	\$ -	\$ -
16	m-13	Dues to Chamber of Commerce	\$ -	\$ -	\$ -
16	m-13	Penalty	\$ (8,626)	\$ -	\$ -
16	m-12		0 \$ -	\$ -	\$ -
15	1-a-1	adj workers comp	\$ (153,557)	\$ -	\$ -
Total Other A&G Adjustments			\$ (118,712)	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Center				2217-C	9/30/2020	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 1,383,577	1,383,577		
Page 20 - Resident Care Supplies***							
27.	20	5-a-2	Prescription Drugs	\$ 303,400	303,400		
28.	20	5-d	Ambulance/Limousine	\$ 1,400	1,400		
29.	20	5-f	X-rays, etc	\$ 21,611	21,611		
30.	20	5-h	Laboratory	\$ 8,817	8,817		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 7,734	7,734		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 10,829	10,829		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ (79,797)	(79,797)		
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$ 18,859	18,859		
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 102,055	102,055		
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)			\$ 1,778,486	1,778,486		

*** 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	5-j	Consolidated Billing	\$ 7,642	\$ -	\$ -
20	5-j	Respiratory Supplies	\$ 2,764	\$ -	\$ -
20	5-j	Respiratory Rental	\$ 423	\$ -	\$ -
0	0		0 \$	\$ -	\$ -
0	0		0 \$	\$ -	\$ -
0	0		0 \$	\$ -	\$ -
0	0		0 \$	\$ -	\$ -
Total Other Ancillary Costs			\$ 10,829	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Page 22	7a	Land Imp	\$ (6,699)	\$ -	\$ -
Page 22	7b	Bldg Imp	\$ (32,553)	\$ -	\$ -
Page 22	7c	Non Movable Equip	\$ (16,664)	\$ -	\$ -
Page 22	7d	Movable Equip	\$ (23,881)	\$ -	\$ -
0	0		0 \$	\$ -	\$ -
0	0		0 \$	\$ -	\$ -
Total Excess Movable Equipment Depreciation			\$ (79,797)	\$ -	\$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-i	Cable TV - Allowable \$3,600 Account#3005660130	\$ 18,859	\$ -	\$ -
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 Adjustments			\$ 18,859	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14c1	General liability Insurance Adjust	\$ 102,055	\$ -	\$ -
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 Adjustments			\$ 102,055	\$ -	\$ -

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2020		30	37
Item	Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 8,976,635	8,976,635			
b. Medicaid Room and Board Contractual Allowance **	\$ (4,950,799)	(4,950,799)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 4,135,876	4,135,876			
b. Medicare Room and Board Contractual Allowance **	\$ (832,532)	(832,532)			
4. a. Private-Pay Residents and Other	\$ 2,886,858	2,886,858			
b. Private-Pay Room and Board Contractual Allowance **	\$ (871,510)	(871,510)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 198,899	198,899			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (40,037)	(40,037)			
c. Prescription Drugs - Non-Medicare	\$ 114,176	114,176			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (35,706)	(35,706)			
2. a. Medical Supplies - Medicare	\$ 6,763	6,763			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (1,361)	(1,361)			
c. Medical Supplies - Non-Medicare	\$ 290	290			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (142)	(142)			
3. a. Physical Therapy - Medicare	\$ 684,729	684,729			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (137,833)	(137,833)			
c. Physical Therapy - Non-Medicare	\$ 236,007	236,007			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (72,770)	(72,770)			
4. a. Speech Therapy - Medicare	\$ 215,802	215,802			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (43,440)	(43,440)			
c. Speech Therapy - Non-Medicare	\$ 143,872	143,872			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (43,971)	(43,971)			
5. a. Occupational Therapy - Medicare	\$ 741,888	741,888			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (149,339)	(149,339)			
c. Occupational Therapy - Non-Medicare	\$ 264,227	264,227			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (81,250)	(81,250)			
6. a. Other (<i>Specify</i>) - Medicare	\$ 27,878	27,878			
b. Other (<i>Specify</i>) - Non-Medicare	\$ 3,763	3,763			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 11,376,973	11,376,973			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$ 105	105			
5. Interest Income (<i>Specify</i>)	\$ 672	672			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$ 668,405	668,405			
V. Total Other Revenue (1 thru 8)	\$ 669,182	669,182			
VI. Total All Revenue (III +V)	\$ 12,046,155	12,046,155			

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-a	Medicare	X-Ray	\$ 17,317	\$ -	\$ -
II-6-a	Medicare	Laboratory	\$ 9,143	\$ -	\$ -
II-6-a	Medicare	Respiratory Therap	\$ -	\$ -	\$ -
II-6-a	Medicare	Nursing Treatment	\$ -	\$ -	\$ -
II-6-a	Medicare	Audiology	\$ 37	\$ -	\$ -
II-6-a	Medicare	Incontinency	\$ -	\$ -	\$ -
II-6-a	Medicare	Oxygen & Supplie	\$ -	\$ -	\$ -
II-6-a	Medicare	Physician Visit	\$ -	\$ -	\$ -
II-6-a	Medicare	Ambulance	\$ 2,081	\$ -	\$ -
II-6-a	Medicare	Flu Shot	\$ 6,325	\$ -	\$ -
II-6-a	Medicare Contractual	X-Ray	\$ (3,486)	\$ -	\$ -
II-6-a	Medicare Contractual	Laboratory	\$ (1,840)	\$ -	\$ -
II-6-a	Medicare Contractual	Respiratory Therap	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual	Nursing Treatment	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual	Audiology	\$ (7)	\$ -	\$ -
II-6-a	Medicare Contractual	Incontinency	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual	Oxygen & Supplie	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual	Physician Visit	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual	Ambulance	\$ (419)	\$ -	\$ -
II-6-a	Medicare Contractual	Flu Shot	\$ (1,273)	\$ -	\$ -
		0	0	\$ -	\$ -
Total Other Resident Revenue - Medicare			\$ 27,878	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	\$ -	\$ -	\$ -
II-6-b	Medicaid	Laboratory	\$ -	\$ -	\$ -
II-6-b	Medicaid	Respiratory Therap	\$ -	\$ -	\$ -
II-6-b	Medicaid	Nursing Treatment	\$ -	\$ -	\$ -
II-6-b	Medicaid	Audiology	\$ -	\$ -	\$ -
II-6-b	Medicaid	Incontinency	\$ -	\$ -	\$ -
II-6-b	Medicaid	Oxygen & Supplie	\$ -	\$ -	\$ -
II-6-b	Medicaid	Physician Visit	\$ -	\$ -	\$ -
II-6-b	Medicaid	Ambulance	\$ -	\$ -	\$ -
II-6-b	Medicaid	Flu Shot	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid	X-Ray	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid	Laboratory	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid	Respiratory Therap	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid	Nursing Treatment	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid	Audiology	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid	Incontinency	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid	Oxygen & Supplie	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid	Physician Visit	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid	Ambulance	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid	Flu Shot	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	X-Ray	\$ 4,986	\$ -	\$ -
II-6-b	Non-Medicaid	Laboratory	\$ 31	\$ -	\$ -
II-6-b	Non-Medicaid	Respiratory Therap	\$ 361	\$ -	\$ -
II-6-b	Non-Medicaid	Nursing Treatment	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	Audiology	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	Incontinency	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	Oxygen & Supplie	\$ 12	\$ -	\$ -
II-6-b	Non-Medicaid	Physician Visit	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	Ambulance	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	Flu Shot	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	Capitation Contrac	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	X-Ray	\$ (1,505)	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Laboratory	\$ (9)	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Respiratory Therap	\$ (109)	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Audiology	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Incontinency	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplie	\$ (4)	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Physician Visit	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Ambulance	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Flu Shot	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Capitation Contrac	\$ -	\$ -	\$ -
		0	0	\$ -	\$ -
Total Other Resident Revenue			\$ 3,763	\$ -	\$ -

Interest Income

Page Ref	Account	Account Balance	CCNH	RHNS	(Specify)
IV-5	Interest On Overdue Accounts	0	\$ 672	\$ -	\$ -
Total Interest Income			\$ 672	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
IV-8	Rehab settlement	0	\$ 100	\$ -	\$ -
IV-8	Payspan Test Payment EFT	0	\$ 0	\$ -	\$ -
IV-8	Telehealth Facility Fee	0	\$ 843	\$ -	\$ -
IV-8	Federal Stimulus 1	400090	\$ 367,162	\$ -	\$ -
IV-8	Federal Stimulus 3	400100	\$ 300,000	\$ -	\$ -
IV-8	Rental Income	100860	\$ 300	\$ -	\$ -
Total Other Revenue			\$ 668,405	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Cent	2217-C	9/30/2020	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	15,045
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,337,351
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(20,366)
4. Inventories			\$	65,289
5. Prepaid Expenses			\$	87,127
a. _____				
b. _____				
c. _____				
d. See Schedule		87,127		
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)			\$	1,484,446
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost	2,856		
	Accum. Depreciation	576		
		Net	\$	2,280
3. Buildings	*Historical Cost	412,890		
	Accum. Depreciation	8,249		
		Net	\$	404,641
4. Leasehold Improvements	*Historical Cost			
	Accum. Depreciation			
		Net	\$	
5. Non-Movable Equipment	*Historical Cost	3,374		
	Accum. Depreciation	469		
		Net	\$	2,905
6. Movable Equipment	*Historical Cost	49,067		
	Accum. Depreciation	7,036		
		Net	\$	42,031
7. Motor Vehicles	*Historical Cost	7,839		
	Accum. Depreciation	7,839		
		Net	\$	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	451,857

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

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
30	A5	Prepaid Expense	\$ 5,581
30	A5	Prepaid Prop Taxes	\$ (66,004)
30	A5	Prepaid Escrow Real Estate	\$ 88,005
30	A5	Prepaid Escrow Replace Reserve	\$ 16,209
30	A5	Prepaid Personal Property Tax	\$ 43,336
30	A5		
30	A5		
Total Prepaid Expenses			\$ 87,127

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	ROU Bldg Asset-Oper Lease	\$ 9,116,967
		AccumAmort-ROU Bldg OprLease	\$ (1,012,632)
Total Other Assets			\$ 8,104,336

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	A12	Acer Exp Nursing Purchased Ser	\$ 1,178,909
33	A12	Acer Gross Rec Tax-FY11	\$ 2,640
33	A12	Acer Gross Rec Tax-FY12	\$ 2,400
33	A12	Acer Gross Rec Tax-FY13	\$ 2,400
33	A12	Acer Gross Rec Tax-FY14	\$ 2,400
33	A12	Acer Gross Rec Tax-FY15	\$ 2,400
33	A12	Acer Gross Rec Tax-FY16	\$ 2,400
33	A12	Acer Gross Rec Tax-FY17	\$ 2,400
33	A12	Acer Gross Rec Tax-FY18	\$ 4,800
33	A12	A/R Credit Gross Up Liability	162331.67
Total Other Current Liabilities (Itemize)			\$ 1,363,081

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

Page Ref	Line Ref	Description	
Total Other Current Liabilities (Itemize)			\$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Cent	2217-C	9/30/2020	32	37
Account			Amount	
Total Brought Forward:			\$	1,936,303
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
3. Buildings				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Non-Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
5. Movable Equipment				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
6. Motor Vehicles				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense				
	*Historical Cost	_____		
	Accum. Depreciation	_____	Net	\$
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	
_____			\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	13,891,059
	I/C Due to/Due From Owned	5,786,723		
	I/C Due to/Due From Multicare			
	See Schedule	8,104,336		
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	13,891,059
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	15,827,363

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of	
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2020	33	37	
Account			Amount		
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable			\$	614,675	
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>)			\$	212,357	
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$		
6. Accrued Payroll Taxes Payable			\$	432	
7. Medicare Final Settlement Payable			\$		
8. Medicare Current Financing Payable			\$		
9. Mortgage Payable (<i>Current Portion</i>)			\$		
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)			\$		
11. Accrued Income Taxes*			\$		
12. Other Current Liabilities (<i>itemize</i>)			\$	1,731,512	
Accrued Provider/Bed Tax		106,634	Accr Exp Electricity	2,275	
Accr Exp Other		14,616	Deferred Revenue	234,689	
Accr Exp Water and Sewer		8,059	Accr Sales and Use Tax	205	
Accr Exp Gas		1,953	See Schedule	1,363,081	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$	2,558,976	

* 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 Glen Hill Care and Rehabilitation Center	License No. 2217-C	Report for Year Ended 9/30/2020	Page 34	of 37
Account				Amount
Total Brought Forward:				2,558,976
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>)				\$
Name and Address of Lender	Amount	Loan Date		
4. Other Long-Term Liabilities (<i>itemize</i>)				\$ 8,310,893
CP OprLease-Bldg Obligation		639,117		
LT OprLease-Bldg Obligation		7,671,775		
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 8,310,893
C. Total All Liabilities (Lines A-13 + B-5)				\$ 10,869,869

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

Name of Facility	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2020	35	37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<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			\$	4,632,910
6. Gain or Loss for Period	10/1/2019	thru 9/30/2020	\$	324,583
7. Total Net Worth			\$	4,957,493
C. Total Reserves and Net Worth			\$	4,957,493
D. Total Liabilities, Reserves, and Net Worth			\$	15,827,362

H. Changes in Total Net Worth

Name of Facility Glen Hill Care and Rehabilitation Center	License No. 2217-C	Report for Year Ended 9/30/2020	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2019			\$	4,632,911
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	12,046,155
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	11,721,573
D. Net Income or Deficit			\$	324,582
E. Balance			\$	4,957,493
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period			\$	4,957,493