

# State of Connecticut



## Annual Report of Long-Term Care Facility Cost Year 2020

Name of Facility (as licensed) Harborside CT Limited Partnership- d/b/a: Governor's House	
Address (No. & Street, City, State, Zip Code) 36 Firetown Road, Simsbury, CT 06070	
Type of Facility <input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020

License Numbers:	CCNH 2200-C	RHNS	(Specify)	Medicare Provider 07-5338
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Medicaid Provider Numbers:	CCNH 20628	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) Harborside CT Limited Partnership- d/b/a: Governor's	License No. 2200-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 Harborside CT Limited Partnership- d/b/a: Governor's House [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) McClurg, Jarrett			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

<b>Data Required for Real Wage Adjustment</b>			Page 1A	of 37
Name of Facility Harborside CT Limited Partnership- d/b/a: Governor's House		Period Covered:	From 10/1/2019	To 9/30/2020
Address of Facility 36 Firetown Road, Simsbury, CT 06070				
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	\$	2,232,688	2,232,688	
5. All other wages paid	\$	412,357	412,357	
6. <b>Total Wages Paid</b>	\$	2,645,045	2,645,045	
7. Total salaries paid	\$	273,876	273,876	
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$	2,918,921	2,918,921	

Wages - Compensation computed on an hourly wage rate.

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

**DO NOT include Fringe Benefit Costs.**

**General Information and Questionnaire**  
**Type of Facility - Organization Structure**

Phone No. of Facility 860-658-1018		Report for Year Ended 9/30/2020		Page 2	of 37
Name of Facility (as shown on license) Harborside CT Limited Partnership- d/b/a: Governor's House			Address (No. & Street, City, State, Zip) 36 Firetown Road, Simsbury, CT 06070		
License Numbers:		CCNH 2200-C	RHNS (Specify)	Medicare Provider No. 07-5338	
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No      If "Yes," explain fully.					
<b>Administrator</b>					
Name of Administrator McClurg, Jarrett			Nursing Home Administrator's License No.:	2075	
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 Harborside CT Limited Partnership- d/b/a: G	License No. 2200-C	Report for Year Ended 9/30/2020	Page 3A	of 37
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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
Harborside CT Limited Partnership- d/b/a: Governor's House	101 East State Street, Kennett Square, PA 19348	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			





**Harborside Connecticut Limited Partnership**  
**d/b/a Governor's House**  
**OWNERSHIP DISCLOSURE**

**LICENSEE**

**Harborside Connecticut LP**

FEIN: 06-1496629

Provider Location: Governors House, 36 Firetown Road, S

AGENT FOR SERVICE: Corporation Service Company, 5

Harborside Health I LLC 101 East State Street Kennett Square PA 19348 FEIN: 51-0304578
Harborside Healthcare Advisors, LP 101 East State Street Kennett Square PA 19348 FEIN: 04-2985690
Harborside Healthcare LLC 101 East State Street Kennett Square PA 19348 FEIN: 04-3307188
KHI, LLC* 101 East State Street Kennett Square PA 19348
SunBridge Healthcare LLC 101 East State Street Kennett Square PA 19348 FEIN: 85-0370802
Genesis Holdings LLC 101 East State Street Kennett Square PA 19348 FEIN: 30-0843337  100% Owned by Genesis Healthcare LLC

**Genesis HealthCare LLC**

EIN: 27-3237296

101 East State Street

Kennett Square, PA 19348

Ownership

GEN Operations II, LLC (100%)

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**GEN Operations II, LLC**

EIN: 27-3237225

101 East State Street

Kennett Square, PA 19348

Ownership

GEN Operations I, LLC (100%)

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**GEN Operations I, LLC**

EIN: 27-3237090

101 East State Street

Kennett Square, PA 19348

Ownership

FC-GEN Operations Investment, LLC (100%)

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**FC-GEN Operations Investment, LLC**

EIN: 27-3237005

101 East State Street

Kennett Square, PA 19348

Ownership

Sun Healthcare Group, Inc. (approximately 59.295%)

Sundance Rehabilitation Holdco, Inc. (5.5444%)

Other members that are disclosed herein as owners c

Other members that do not trigger 5% ownership tes

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**Sundance Rehabilitation Holdco, Inc.**

EIN: 38-3954180

101 East State Street

Kennett Square, PA 19348

Ownership

Sun Healthcare Group, Inc. (100%)

**Sun Healthcare Group, Inc.**

EIN: 13-4230695

101 East State Street

Kennett Square, PA 19348

Ownership

Genesis Healthcare, Inc. (100%)

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**Genesis Healthcare, Inc.**

(publicly traded company on the New York Stock Exchange  
(f/k/a Skilled Healthcare Group, Inc.)

EIN: 20-3934755

101 East State Street

Kennett Square, PA 19348

Ownership

HCCF Management Group XI, LLC (approximately

Senior Care Genesis, LLC (approximately 5.3%)

ZAC Properties XI, LLC (approximately 8.1%)

Welltower, Inc. (approximately 5.9%)

Others that do not trigger 5% ownership test

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**HCCF Management Group XI, LLC**

EIN: 20-8751674

3820 Mansell Road

Suite 280

Alpharetta, GA 30022

Ownership

[Arnold M. Whitman\[1\]](#)

3820 Mansell Road

Suite 280

Alpharetta, GA 30022

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**ZAC Properties XI, LLC**

EIN: 20-8794579

1617 JFK Boulevard

Suite 545

Philadelphia, PA 19103

Ownership

[Steven E. Fishman\[2\]](#)

1617 JFK Boulevard

Suite 545

Philadelphia, PA 19103

Other members that do not trigger 5% ownership tes

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**Welltower Inc.**

EIN: 34-1096634  
4500 Dorr Street  
Toledo, OH 43615

*Ownership*

(publicly traded company on the New York Stock Ex

**Senior Care Genesis, LLC**

EIN: 20-8282470  
234 Church Street, Suite 901  
New Haven, CT 06510

*Ownership*

[David Reis<sup>\[3\]</sup>](#)

234 Church Street, Suite 901  
New Haven, CT 06510

*The information included in this memorandum supersedes a*

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[\[1\] HCCF is a privately-held company that is not affiliate](#)

[\[2\] ZAC Properties is a privately-held company that is no](#)

<sup>3</sup> Senior Care is a privately-held company that is not affiliated with Genesis, however,

Simbury, CT 06070-1965  
50 Weston Street, Hartford CT 06120

99% General Partner of: Harborside Connecticut LP
100% Member of Harborside Health I, LLC
99% Partner of: Harborside Healthcare Advisors, LP
1% Partner of Harborside Healthcare Advisors LP
100% Member of Harborside Healthcare LLC
100% Owner of SunBridge Healthcare LLC

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7%)

of Genesis Healthcare, Inc.

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14.0%)

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change)

*All previously submitted ownership information for the Operator as well as all officer/director/manager info.*

and with Genesis, however, it is our understanding that Mr. Whitman may be considered the beneficial owner of the shares held by Senior Care. Similarly, Mr. Fishman is affiliated with Genesis, however, it is our understanding that Mr. Fishman may be considered the beneficial owner of the shares held by Senior Care.

, it is our understanding that Mr. Reis may be considered the beneficial owner of the shares held by Senior Care.









*Information for the Operator and its 5% or more direct and indirect owners.*

Owner of the shares held by HCCF

Official owner of the shares held by ZAC Properties

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

Name of Facility Harborside CT Limited Partnership- d/b/a: Governor's H	License No. 2200-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	231,623	231,623
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	161,996	161,996
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	453	453
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	6,895	6,895
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	88	88
Genesis Healthcare Ins Program	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	108,052	108,052
		<input checked="" type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

\* Use additional sheets if necessary.

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

**General Information and Questionnaire**  
**Basis for Allocation of Costs**

Name of Facility Harborside CT Limited Partnership- d/b/a: Gov	License No. 2200-C	Report for Year Ended 9/30/2020	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

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

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

Name of Facility Harborside CT Limited Partnership- d/b/a: Governor's Hous			License No. 2200-C		Report for Year Ended 9/30/2020		Page of 6   37	
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
	<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"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?								<input type="radio"/> Yes <input checked="" type="radio"/> No
<b>Total ***</b>								

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

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

Name of Facility Harborside CT Limited Partnership	License No. 2200-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
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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 2 3 4 5	Telephone Number
---	------------------

Address (*No. & Street, City, State, Zip Code*)  
 1  
 2  
 3  
 4  
 5

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
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 Harborside CT Limited Partnership- d/b/a: Governor's House		License No. 2200-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	73	73			73	73							
B. On last day of THIS report period	70	70							70	70			
2. Number of Residents													
A. As of midnight of PREVIOUS report period	51	51			51	51							
B. As of midnight of THIS report period	42	42							42	42			
3. Total Number of Days Care Provided During Period													
A. Medicare	1,749	1,749			1,478	1,478			271	271			
B. Medicaid (Conn.)	13,705	13,705			10,360	10,360			3,345	3,345			
C. Medicaid (other states)													
D. Private Pay	2,337	2,337			1,890	1,890			447	447			
E. State SSI for RCH													
F. Other (Specify)	186	186			174	174			12	12			
G. Total Care Days During Period (3A thru F)	17,977	17,977			13,902	13,902			4,075	4,075			
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds													
A. Medicaid Bed Reserve Days	35	35			34	34			1	1			
B. Other Bed Reserve Days													
5. <b>Total Resident Days (3G + 4A + 4B)</b>	18,012	18,012			13,936	13,936			4,076	4,076			

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

Name of Facility Harborside CT Limited Partnership- d/b/a: G			License No. 2200-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? <span style="float: right;"><input type="radio"/> Yes <input checked="" type="radio"/> No</span>													
If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days									CCNH	RHNS	(Specify)		
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	3		34		5								
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	609.56		218.22		503.17								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									2,109	2,109			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									415	415			
C. Other									2,329	2,329			
D. <b>Total Physical Therapy Treatments</b>									4,853	4,853			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									57	57			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									234	234			
C. Other									351	351			
D. <b>Total Speech Therapy Treatments</b>									642	642			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									858	858			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									438	438			
C. Other									2,075	2,075			
D. <b>Total Occupational Therapy Treatments</b>									3,371	3,371			

### Report of Expenditures - Salaries & Wages

Name of Facility Harborside CT Limited Partnership- d/b/a: Governor's House	License No. 2200-C	Report for Year Ended 9/30/2020	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
Total Cost and Hours						
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>A. Salaries and Wages*</b>						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	141,572	2,144				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	152,526	6,936				
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	62,142	2,163				
b. Other Maintenance Workers						
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	132,304	2,249				
b. RN						
1. Direct Care	573,103	12,316				
2. Administrative**	910	23				
c. LPN						
1. Direct Care	671,748	19,433				
2. Administrative**						
d. Aides and Attendants	932,272	45,583				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	60,098	2,539				
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	137,590	4,482				
n. Marketing						
o. Other (Specify) See Attached Schedule	54,654	2,767				
<i>A-13. Total Salary Expenditures</i>	2,918,921	100,635				

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

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

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



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

Name of Facility				License No.	Report for Year Ended			Page	of	
Harborside CT Limited Partnership- d/b/a: Governor's House				2200-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)							
<b>Section I - Operators/Owners</b>										
<b>Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).</b>										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended			Page	of	
Harborside CT Limited Partnership- d/b/a: Governor's House				2200-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)							
<b>Section III - Administrators***</b>										
McClurg, Jarrett	64,790				Management of Center	864	2			
Cyr, Raymond 12/26/2019-5/27/20	45,920				Management of Center	744	2			
Moriarty, Teri Ann 10/1/2019-12/25/2019	30,862				Management of Center	536	2			
<b>Section IV - Assistant Administrators</b>										

\*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		
Harborside CT Limited Partnership- d/b/a: Governo	2200-C	9/30/2020	13	37		
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
<b>*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)</b>						
1. Dietitian						
2. Dentist	2,282	16				
3. Pharmacist	6,759	138				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	135,764	1,860				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	18,396	97				
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	4,760	61				
b. Other						
10. Occupational Therapist						
a. Resident Care	22,192	304				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	31,454	525				
2. Administrative***						
b. LPN						
1. Direct Care	11,657	275				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	2,962					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>236,227</b>	<b>3,276</b>				

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

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

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





**C. Expenditures Other Than Salaries - Administrative and General**

Name of Facility	License No.	Report for Year Ended	Page	of
Harborside CT Limited Partnership- d/b/a: Govern	2200-C	9/30/2020	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 143,961	143,961		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 34,875	34,875		
4. Social Security (F.I.C.A.)	\$ 216,018	216,018		
5. Health Insurance	\$ 205,490	205,490		
6. Life Insurance (employees only) (not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 99,269	99,269		
8. Uniform Allowance	\$			
9. Other ( <i>Specify</i> ) See Attached Schedule	\$ 15,928	15,928		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 43,430	43,430		
d. Accounting and Auditing	\$			
e. Legal ( <i>Services should be fully described on Page 7</i> )	\$ 0	0		
f. Insurance on Lives of Owners and Operators ( <i>Specify</i> )*	\$			
g. Office Supplies	\$ 14,190	14,190		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 20,238	20,238		
2. Cellular Phones	\$ 1,376	1,376		
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	\$ 382	382		
3. Resident Day User Fee	\$ 336,552	336,552		
<b>Subtotal</b>	\$ 1,131,711	1,131,711		

\* 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**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
Benefit Allocations	\$ 403	\$ -	\$ -
Union Health & Welfare	\$ 497	\$ -	\$ -
Union Health & Welfare	\$ 16	\$ -	\$ -
Union Health & Welfare	\$ (5)	\$ -	\$ -
Union Health & Welfare	\$ (2)	\$ -	\$ -
Union Health & Welfare	\$ 834	\$ -	\$ -
Union Health & Welfare	\$ 4,889	\$ -	\$ -
Union Health & Welfare	\$ 9,297	\$ -	\$ -
Union Health & Welfare	\$ (1)	\$ -	\$ -
	0 \$ -	\$ -	\$ -
<b>Total</b>	\$ 15,928	\$ -	\$ -

**Schedule of Other Taxes**

<b>Description</b>	<b>CCNH</b>	<b>RHNS</b>	<b>(Specify)</b>
Sales Tax	\$ 382	\$ -	\$ -
Sales Tax	\$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
<b>Total</b>	\$ 382	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended		Page	of
Harborside CT Limited Partnership- d/b/a: Governor's	2200-C	9/30/2020		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>		1,131,711	1,131,711		
i. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	1,886	1,886		
5. Education Expenses Related to Seminars and Conventions	\$				
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> )	\$				
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$	105	105		
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	8,535	8,535		
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	\$	3,529	3,529		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	5,766	5,766		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	111	111		
10. Contributions*** See Attached Schedule	\$	1,540	1,540		
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$	2,042	2,042		
12. Administrative Management Services**	\$	314,668	314,668		
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	31,805	31,805		
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$	1,501,699	1,501,699		

\* 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)
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
<b>Total Other Travel and Entertainment</b>	\$ -	\$ -	\$ -

## Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising	\$ 3,640	\$ -	\$ -
Marketing Expense	\$ 1,058	\$ -	\$ -
Marketing Exp- Corporate Spend	\$ 4,088	\$ -	\$ -
Marketing Exp- Corporate Spend	\$ -	\$ -	\$ -
Marketing Expense	\$ (250)	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
<b>Total Other Advertising</b>	\$ 8,535	\$ -	\$ -

## Schedule of Dues

Description	CCNH	RHNS	(Specify)
Licenses & Certifications	\$ 5,766	\$ -	\$ -
Dues to Chamber of Commerce	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
<b>Total Dues</b>	\$ 5,766	\$ -	\$ -

## Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Contributions	\$ 300	\$ -	\$ -
Political Contributions	\$ 1,240	\$ -	\$ -
	\$ -	\$ -	\$ -
<b>Total Contributions</b>	\$ 1,540	\$ -	\$ -

## Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Service Charges	\$ 2,722	\$ -	\$ -
Collection Fees	\$ 11,631	self-disallowed	\$ -
Education Expense	\$ 2	\$ -	\$ -
Employee Physicals	\$ 8,814	\$ -	\$ -
Employee Relations	\$ 6,312	\$ -	\$ -
Printing	\$ 375	\$ -	\$ -
Training Expense	\$ 159	\$ -	\$ -
Fines & Penalties	\$ -	self-disallowed	\$ -
Miscellaneous	\$ 172	\$ -	\$ -
Rental Expense	\$ 721	\$ -	\$ -
Accrued Expense Estimation	\$ 300	self-disallowed	\$ -
Landlord Operating Taxes	\$ 600	\$ -	\$ -
State Tax Annual Report Filing	\$ -	\$ -	\$ -
Recruiting Fees	\$ -	\$ -	\$ -
Recruiting Fees	\$ -	\$ -	\$ -
Non-recurring Charges	\$ -	\$ -	\$ -
Interest Expense	\$ (3)	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
	\$ -	\$ -	\$ -
<b>Total Other Administrative and General</b>	\$ 31,805	\$ -	\$ -

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

Name of Facility Harborside CT Limited Partnership- d/b/a	License No. 2200-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	231,623	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		License No.	Report for Year Ended	Page	of
Harborside CT Limited Partnership- d/b/a: Governor's		2200-C	9/30/2020	18	37
Item	Total	CCNH	RHNS	(Specify)	
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$ 89,548	89,548			
2. Non-Food Supplies	\$ 13,194	13,194			
3. Other (Specify) _____	\$ 2,075	2,075			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 443,713	443,713			
c. Other (Specify) _____	\$				
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>	<b>\$ 548,530</b>	<b>548,530</b>			
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		License No.	Report for Year Ended	Page	of
Harborside CT Limited Partnership- d/b/a: Governor's H		2200-C	9/30/2020	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. \$	2,939	2,939		
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. \$	16,967	16,967		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	123,260	123,260		
c. Other (Specify)	\$				
<b>3D. Total Laundry Expenditures (3a + b + c)</b>	<b>\$</b>	<b>143,167</b>	<b>143,167</b>		
<b>3E. Laundry Questionnaire</b>					
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
Harborside CT Limited Partnership- d/b/a: Gov		2200-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. \$	10,485	10,485		
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. \$	210,211	210,211		
C. Other ( <i>Specify</i> )			\$			
<b>4D. Total Housekeeping Expenditures (4a + b + c)</b>			\$ 220,696	220,696		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from	\$	55,846	55,846		
	b. Medicine Cabinet Drugs	\$	5,996	5,996		
	c. Medical and Therapeutic Supplies	\$	81,496	81,496		
	d. Ambulance/Limousine***	\$				
	e. Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	597	597		
	f. X-rays and Related Radiological Procedures***	\$	3,714	3,714		
	g. Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
	h. Laboratory***	\$	22,918	22,918		
	i. Recreation	\$	23,635	23,635		
	j. Direct Management Services*	\$				
	k. Indirect Management Services*	\$				
	l. Other ( <i>Specify</i> )**** See Attached Schedule	\$	38,253	38,253		
<b>5M. Total Resident Care Expenditures (5a - 5j)</b>			\$ 232,455	232,455		

\* 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	\$ 18,005	\$ -	\$ -
Advertising-Help Wanted	\$ (213)	\$ -	\$ -
Advertising-Help Wanted	\$ 3,126	\$ -	\$ -
Books, Dues & Subscriptions	\$ 62	\$ -	\$ -
Education Expense	\$ 182	\$ -	\$ -
Supplies	\$ 51	\$ -	\$ -
Supplies	\$ 1,918	\$ -	\$ -
Supplies	\$ -	\$ -	\$ -
Office Supplies	\$ 34	\$ -	\$ -
Office Supplies	\$ -	\$ -	\$ -
Office Supplies	\$ 165	\$ -	\$ -
Training Expense	\$ -	\$ -	\$ -
Rental Expense	\$ -	\$ -	\$ -
Rental Expense	\$ 192	\$ -	\$ -
Consolidated Billing	\$ 14,170	\$ -	\$ -
Tuition Reimbursement	\$ -	\$ -	\$ -
Tuition Reimbursement	\$ -	\$ -	\$ -
Tuition Reimbursement	\$ -	\$ -	\$ -
Miscellaneous	\$ -	\$ -	\$ -
Licenses & Certifications	\$ -	\$ -	\$ -
Supplies	\$ 206	\$ -	\$ -
T&E-Lodging/Transportation	\$ 355	\$ -	\$ -
	0	\$ -	\$ -
<b>Total Other Resident Care</b>	<b>\$ 38,253</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility Harborside CT Limited Partnership- d/b/a: Governor's House			License No. 2200-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	123,260			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	210,211			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Dietary Purchased Services	442,416			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"/>							

\* 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
Harborside CT Limited Partnership- d/b/a: Go	2200-C	9/30/2020			22	37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	197,586	197,586			
b. Heat	\$	26,003	26,003			
c. Light & Power	\$	127,717	127,717			
d. Water	\$	50,579	50,579			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$					
f. Other <i>(itemize)</i>	\$					
See Attached Schedule						
<b>6g. Total Maint. &amp; Operating Expense (6a - 6f)</b>	<b>\$</b>	<b>401,885</b>	<b>401,885</b>			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$					
b. Building & Building Improvements	\$	13,240	13,240			
c. Non-Movable Equipment	\$	1,154	1,154			
d. Movable Equipment	\$	1,086	1,086			
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	<b>\$</b>	<b>15,479</b>	<b>15,479</b>			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
<b>*8e. Total Amortization Costs (8a + b + c + d)</b>	<b>\$</b>					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	(379,453)	(379,453)			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	126,293	126,293			
c. Personal property taxes	\$					
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	<b>\$</b>	<b>(237,681)</b>	<b>(237,681)</b>			

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









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

**Amortization Schedule\***

Name of Facility			License No.		Report for Year Ended			Page	of
Harborside CT Limited Partnership- d/b/a: Governor's House			2200-C		9/30/2020			24	37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<b>A. Organization Expense</b>									
1.									
2.									
3.									
A-4. Subtotal									
<b>B. Mortgage Expense</b>									
1.									
2.									
3.									
B-4. Subtotal									
<b>C. Leasehold Improvements and Other</b>									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
<b>D. Total Amortization</b>									

\* Straight-line method must be used.

\*\* Specify which of the following bases were used:

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



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

Name of Facility Harborside CT Limited Partnership- d	License No. 2200-C	Report for Year Ended 9/30/2020	Page 25	of 37
<b>11. Property Questionnaire</b>				
<b>Part A</b>				
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description	Total			
1. Date Land Purchased	n/a			
2. Date Structure Completed	n/a			
3. If <b>NOT</b> Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	70			
6. Square Footage				
7. Acquisition Cost				
a. Land	n/a			
b. Building	n/a			
<b>Part B - Owner and Related Parties</b>		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of				
<b>Complete if Mortgage was Refinanced During Current Cost Year</b>				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
<b>Part C - Arms-Length Leases for Real Property Improvements Only</b>				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
GMF-CT	Facility Lease	7/1/2019-12/31	10 years	-379,453
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
Harborside CT Limited Partnership-d		2200-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. <b>Total Building Interest Expense</b> (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
Harborside CT Limited Partnership		2200-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. <b>Total All Interest Expense (12B7 + 12C3 + 12D)</b>				\$				
14. Insurance								
a. Insurance on Property (buildings only)				\$ 9,539	9,539			
b. Insurance on Automobiles				\$				
c. Insurance other than Property (as specified above)								
1. Umbrella (Blanket Coverage)			\$ 98,513	98,513				
2. Fire and Extended Coverage			\$					
3. Other (Specify)			\$					
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$ 108,052	108,052			
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$ 6,073,951	6,073,951			

### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Harborside CT Limited Partnership- d/b/a: Governor's House				2200-C	9/30/2020	28	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<b>Page 10 - Salaries and Wages</b>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$ 60,151	60,151		
<b>Page 13 - Professional Fees</b>							
5.	13	B-8-c	Resident Care Physicians **	\$			
6.		B-10	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 165,033	165,033		
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 43,430	43,430		
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 *	\$ 8,640	8,640		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 1,540	1,540		
21.			Unallowable Management Fees	\$ 83,045	83,045		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 23,006	23,006		
<b>Page 18 - Dietary Expenditures</b>							
24.			Meals to employees, guests and others who are not residents	\$			
<b>Page 19 - Laundry Expenditures</b>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<b>Page 20 - Housekeeping Expenditures</b>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 384,845	384,845		

\* 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	\$ 60,151	\$ -	\$ -
0	0		0 \$ -	\$ -	\$ -
0	0		0 \$ -	\$ -	\$ -
0	0		0 \$ -	\$ -	\$ -
0	0		0 \$ -	\$ -	\$ -
0	0		0 \$ -	\$ -	\$ -
0	0		0 \$ -	\$ -	\$ -
0	0		0 \$ -	\$ -	\$ -
<b>Total Other Salaries Adjustment</b>			\$ 60,151	\$ -	\$ -

## Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	\$ 57,626	\$ -	\$ -
13	5	Rehabilitation Services	\$ 78,138	\$ -	\$ -
13	9	Speech Therapist	\$ 4,760	\$ -	\$ -
13	10	Occupational Therapist	\$ 22,192	\$ -	\$ -
13	12	Other	\$ -	\$ -	\$ -
13	12	Other	\$ 2,229	\$ -	\$ -
13	12	Respiratory Purchased Servies	\$ 88	\$ -	\$ -
<b>Total Other Fees Adjustments</b>			\$ 165,033	\$ -	\$ -

## Schedule of Other A&amp;G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	\$ 11,631	\$ -	\$ -
16	m-13	Estimated Accrual	\$ 300	\$ -	\$ -
16	m-13	Non-recurring Charges	\$ -	\$ -	\$ -
16	m-13	Dues to Chamber of Commerce	\$ -	\$ -	\$ -
16	m-13	Penalty	\$ -	\$ -	\$ -
16	m-12		0 \$ -	\$ -	\$ -
15	1-a-1	adj workers comp	\$ 11,075	\$ -	\$ -
<b>Total Other A&amp;G Adjustments</b>			\$ 23,006	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Harborside CT Limited Partnership- d/b/a: Governor's House				2200-C	9/30/2020	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 384,845	384,845		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5-a-2	Prescription Drugs	\$ 55,846	55,846		
28.	20	5-d	Ambulance/Limousine	\$			
29.	20	5-f	X-rays, etc	\$ 3,714	3,714		
30.	20	5-h	Laboratory	\$ 22,918	22,918		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 597	597		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 16,280	16,280		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ (46,876)	(46,876)		
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	\$			
<b>Page 27 - Insurance</b>							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
<b>Other - Miscellaneous</b>							
42.			Other - Indirect	\$ 18,115	18,115		
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 61,143	61,143		
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
<b>Not For Profit Providers Only</b>							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
<b>49. Total Amount of Decrease (Items 1 - 48)</b>				\$ 516,581	516,581		

\*\*\* 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	\$ 14,170	\$ -	\$ -
20	5-j	Respiratory Supplies	\$ 1,918	\$ -	\$ -
20	5-j	Respiratory Rental	\$ 192	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
<b>Total Other Ancillary Costs</b>			\$ 16,280	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0	0-Jan		0 \$ -	\$ -	\$ -
Page 22	7a	Land Imp	\$ -	\$ -	\$ -
Page 22	7b	Bldg Imp	\$ (18,871)	\$ -	\$ -
Page 22	7c	Non Movable Equip	\$ (3,140)	\$ -	\$ -
Page 22	7d	Movable Equip	\$ (24,866)	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
<b>Total Excess Movable Equipment Depreciation</b>			\$ (46,876)	\$ -	\$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-i	Cable TV - Allowable \$3,600 Account#3005660130	\$ 18,115	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
<b>Total Other Adjustments</b>			\$ 18,115	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14c1	General liability Insurance Adjust	\$ 61,143	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
<b>Total Other Adjustments</b>			\$ 61,143	\$ -	\$ -

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
<b>Total Other Adjustments</b>			\$ -	\$ -	\$ -

Schedule of Unallowable Building Interest

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

## F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended		Page	of
Harborside CT Limited Partnership- d/b/a 2200-C		9/30/2020		30	37
Item	Total	CCNH	RHNS	(Specify)	
<b>I. Resident Room, Board &amp; Routine Care Revenue</b>					
1. a. Medicaid Residents ( <i>CT only</i> )	\$ 7,350,699	7,350,699			
b. Medicaid Room and Board Contractual Allowance **	\$ (3,736,286)	(3,736,286)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 949,527	949,527			
b. Medicare Room and Board Contractual Allowance **	\$ (193,441)	(193,441)			
4. a. Private-Pay Residents and Other	\$ 1,395,064	1,395,064			
b. Private-Pay Room and Board Contractual Allowance **	\$ (101,601)	(101,601)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 48,303	48,303			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (9,840)	(9,840)			
c. Prescription Drugs - Non-Medicare	\$ 11,169	11,169			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (2,918)	(2,918)			
2. a. Medical Supplies - Medicare	\$ 159	159			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (32)	(32)			
c. Medical Supplies - Non-Medicare	\$ 155	155			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (79)	(79)			
3. a. Physical Therapy - Medicare	\$ 199,496	199,496			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (40,642)	(40,642)			
c. Physical Therapy - Non-Medicare	\$ 40,556	40,556			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (11,014)	(11,014)			
4. a. Speech Therapy - Medicare	\$ 46,721	46,721			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (9,518)	(9,518)			
c. Speech Therapy - Non-Medicare	\$ 32,661	32,661			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (14,602)	(14,602)			
5. a. Occupational Therapy - Medicare	\$ 141,985	141,985			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (28,926)	(28,926)			
c. Occupational Therapy - Non-Medicare	\$ 37,839	37,839			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (12,682)	(12,682)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 8,457	8,457			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 128	128			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 6,101,339	6,101,339			
<b>IV. Other Revenue*</b>					
1. Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income ( <i>Specify</i> )	\$ (109)	(109)			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$ 2,235	2,235			
8. Other ( <i>Specify</i> )	\$ 346,070	346,070			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 348,196	348,196			
<b>VI. Total All Revenue</b> (III +V)	\$ 6,449,535	6,449,535			

\* 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	\$ 1,092	\$ -	\$ -
II-6-a	Medicare	Laboratory	\$ 1,727	\$ -	\$ -
II-6-a	Medicare	Respiratory Therap	\$ 88	\$ -	\$ -
II-6-a	Medicare	Nursing Treatment	\$ -	\$ -	\$ -
II-6-a	Medicare	Audiology	\$ -	\$ -	\$ -
II-6-a	Medicare	Incontinency	\$ -	\$ -	\$ -
II-6-a	Medicare	Oxygen & Supplie	\$ -	\$ -	\$ -
II-6-a	Medicare	Physician Visit	\$ -	\$ -	\$ -
II-6-a	Medicare	Ambulance	\$ -	\$ -	\$ -
II-6-a	Medicare	Flu Shot	\$ 7,714	\$ -	\$ -
II-6-a	Medicare Contractual	X-Ray	\$ (222)	\$ -	\$ -
II-6-a	Medicare Contractual	Laboratory	\$ (352)	\$ -	\$ -
II-6-a	Medicare Contractual	Respiratory Therap	\$ (18)	\$ -	\$ -
II-6-a	Medicare Contractual	Nursing Treatment	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual	Audiology	\$ -	\$ -	\$ -
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	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual	Flu Shot	\$ (1,572)	\$ -	\$ -
		0	\$ 0	\$ -	\$ -
<b>Total Other Resident Revenue - Medicare</b>			<b>\$ 8,457</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	\$ 156	\$ -	\$ -
II-6-b	Medicaid	Laboratory	\$ 105	\$ -	\$ -
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	\$ (79)	\$ -	\$ -
II-6-b	Contractuals-Medicaid	Laboratory	\$ (53)	\$ -	\$ -
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	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	Laboratory	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	Respiratory Therap	\$ -	\$ -	\$ -
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	\$ -	\$ -	\$ -
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	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Laboratory	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Respiratory Therap	\$ -	\$ -	\$ -
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	\$ -	\$ -	\$ -
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	\$ -	\$ -
<b>Total Other Resident Revenue</b>			<b>\$ 128</b>	<b>\$ -</b>	<b>\$ -</b>

Interest Income

Page Ref	Account	Account	Balance	CCNH	RHNS	(Specify)
IV-5	Interest On Overdue Accounts		0	\$ (109)	\$ -	\$ -
<b>Total Interest Income</b>				<b>\$ (109)</b>	<b>\$ -</b>	<b>\$ -</b>

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
IV-8	RehabCare Settlement Administrator		\$ 1,096	\$ -	\$ -
IV-8	Telehealth Facility Fee		\$ 586	\$ -	\$ -
IV-8	Federal Stimulus 1		\$ 53,432	\$ -	\$ -
IV-8	Federal Stimulus 2		\$ 58,456	\$ -	\$ -
IV-8	Federal Stimulus 3		\$ 232,500	\$ -	\$ -
		0	\$ -	\$ -	\$ -
		0	\$ -	\$ -	\$ -
		0	\$ -	\$ -	\$ -
<b>Total Other Revenue</b>			<b>\$ 346,070</b>	<b>\$ -</b>	<b>\$ -</b>

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Harborside CT Limited Partnership- d/b	2200-C	9/30/2020	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	5,373
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	427,054
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(122,785)
4. Inventories			\$	23,936
5. Prepaid Expenses			\$	58,322
a. _____				
b. _____				
c. _____				
d. See Schedule		58,322		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
See Schedule				
<b>A-9. Total Current Assets</b> (Lines A1 thru 8)			\$	391,900
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____	132,655	\$	113,915
	Accum. Depreciation _____	18,740	Net	
4. Leasehold Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
5. Non-Movable Equipment	*Historical Cost _____	11,044	\$	9,517
	Accum. Depreciation _____	1,527	Net	
6. Movable Equipment	*Historical Cost _____	8,749	\$	7,134
	Accum. Depreciation _____	1,615	Net	
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets ( <i>itemize</i> )			\$	
_____				
See Schedule				
<b>B-10. Total Fixed Assets</b> (Lines B1 thru 9)			\$	130,566

\* 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 Expenses	\$ 27,909
30	A5	Prepaid Prop Taxes	\$ 28,264
30	A5	Prepaid Escrow Real Estate	\$ 2,149
30	A5	Prepaid Escrow Insurance	
30	A5	Prepaid Escrow Replace Reserve	
30	A5	Prepaid Personal Property Tax	
30	A5		
<b>Total Prepaid Expenses</b>			<b>\$ 58,322</b>

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

Page Ref	Line Ref	Description	
<b>Total Other Current Assets (Itemize)</b>			<b>\$ -</b>

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

Page Ref	Line Ref	Description	
<b>Total Other Fixed Assets (Itemize)</b>			<b>\$ -</b>

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
32	D7	ROU Bldg Asset-Oper Lease	
32	D7	AccumAmort-ROU Bldg OprLease	
<b>Total Other Assets</b>			<b>\$ -</b>

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
<b>Total Notes Payable</b>			<b>\$ -</b>

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

Page Ref	Line Ref	Description	
33	A12	Accr Gross Rec Tax-FY11	\$ 2,640
33	A12	Accr Gross Rec Tax-FY12	\$ 2,400
33	A12	Accr Gross Rec Tax-FY13	\$ 2,400
33	A12	Accr Gross Rec Tax-FY14	\$ 2,400
33	A12	Accr Gross Rec Tax-FY15	\$ 2,400
33	A12	Accr Gross Rec Tax-FY16	\$ 2,400
33	A12	Accr Gross Rec Tax-FY17	\$ 2,400
33	A12	Accr Gross Rec Tax-FY18	\$ 4,800
33	A12	Accr Sales and Use Tax - FY18	\$ 49
33	A12	Accrued Provider/Bed Tax	\$ 79,098
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ 100,987</b>

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

Page Ref	Line Ref	Description	
<b>Total Other Current Liabilities (Itemize)</b>			<b>\$ -</b>

### G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Harborside CT Limited Partnership- d/b	2200-C	9/30/2020	32	37
Account			Amount	
Total Brought Forward:			\$	522,466
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
3. Buildings			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
4. Non-Movable Equipment			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
5. Movable Equipment			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
6. Motor Vehicles			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 <b>Total Leasehold or Like Properties</b> (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			*Historical Cost _____	
			Accum. Depreciation _____	Net
			\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care ( <i>itemize</i> )			\$	
_____				
6. Loans to Owners or Related Parties ( <i>itemize</i> )			\$	
Name and Address		Amount	Loan Date	
7. Other Assets ( <i>itemize</i> )			\$	(4,348,295)
I/C Due to/Due From Owned			(4,348,295)	
I/C Due to/Due From Multicare				
See Schedule				
D-8. <b>Total Investments and Other Assets</b> (Lines D1 thru 7)			\$	(4,348,295)
D-9. <b>Total All Assets</b> (Lines A9 + B10 + C8 + D8)			\$	(3,825,829)

\* 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
Harborside CT Limited Partnership- d/b/a: Go	2200-C	9/30/2020	33	37
Account			Amount	
<b>Liabilities</b>				
A. Current Liabilities				
1. Trade Accounts Payable			\$	191,253
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> )			\$	128,748
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )			\$	
6. Accrued Payroll Taxes Payable			\$	578
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> )			\$	549,726
Accr Exp Other	8,172	Accr Exp Nursing Purch:	247,678	
Accr Exp Water and Sewer	766	Deferred Revenue	134,958	
Accr Exp Gas	1,313	A/R Credit Gross Up Lia	54,546	
Accr Exp Electricity	1,306	See Schedule	100,987	
<b>A-13. Total Current Liabilities (Lines A1 thru 12)</b>			<b>\$</b>	<b>870,305</b>

\* 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 Harborside CT Limited Partnership- d/b/a: C		License No. 2200-C	Report for Year Ended 9/30/2020	Page 34	of 37
Account				Amount	
Total Brought Forward:				870,305	
<b>Liabilities (cont'd)</b>					
B. Long-Term Liabilities					
1. Loans Payable-Equipment ( <i>itemize</i> )					
\$					
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable				\$	
3. Loans from Owners or Related Parties ( <i>itemize</i> )				\$	
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities ( <i>itemize</i> )				\$ 978,773	
LT Debt-Financing Obligation		978,773			
Escheatable Funds					
See Schedule					
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 978,773	
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 1,849,078	

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

Name of Facility	License No.	Report for Year Ended	Page	of
Harborside CT Limited Partnership- d	2200-C	9/30/2020	35	37
Account			Amount	
<b>A. Reserves</b>				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property ( <i>Equity</i> )			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
<b>B. Net Worth</b>				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(6,050,492)
6. Gain or Loss for Period	10/1/2019	thru 9/30/2020	\$	375,583
7. Total Net Worth			\$	(5,674,909)
<b>C. Total Reserves and Net Worth</b>			\$	(5,674,909)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	(3,825,831)

### H. Changes in Total Net Worth

Name of Facility Harborside CT Limited Partnership- d/b/	License No. 2200-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			\$	(6,050,494)
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	6,449,534
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	6,073,949
D. Net Income or Deficit			\$	375,585
E. Balance			\$	(5,674,909)
F. Additions				
1. Additional Capital Contributed <i>(itemize)</i>				
2. Other <i>(itemize)</i>				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners <i>(Specify)</i>			\$	
Name and Address <i>(No., City, State, Zip)</i>		Title	Amount	
2. Other Withdrawings <i>(Specify)</i>			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. <b>Balance at End of Period</b>			\$	(5,674,909)
				09/30/20



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

Name of Facility Harborside CT Limited Partnership- d/b/a:	License No. 2200-C	Report for Year Ended 9/30/2020	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
<b>Preparer/Reviewer Certification</b>				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Thomas Farnan				
Address Address			Phone Number	
200 Brickstone Square, Andover, MA 01810			978-247-5029	
Contacted Person Regarding Additional Information Needed Regarding This Report			Phone Number	
Thomas Farnan			978-247-5029	
Contact Email Address				
thomas.farnan@genesishcc.com				