

# State of Connecticut



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

Name of Facility (as licensed) The Reservoir Care and Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 1 Emily Way, West Hartford, CT 06107	
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 2203-C	RHNS	(Specify)	Medicare Provider 07-5407
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Medicaid Provider Numbers:	CCNH 21668	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) The Reservoir Care and Rehabilitation Center	License No. 2203-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 The Reservoir 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) Molly Narvaez			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 The Reservoir Care and Rehabilitation Center	Period Covered:	From 10/1/2019	To 9/30/2020	
Address of Facility 1 Emily Way, West Hartford, CT 06107				
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	\$ 2,821,544	2,821,544		
5. All other wages paid	\$ 546,410	546,410		
6. <b>Total Wages Paid</b>	\$ 3,367,953	3,367,953		
7. Total salaries paid	\$ 287,291	287,291		
8. <b>Total Wages and Salaries Paid</b> (As per page 10 of Report)	\$ 3,655,244	3,655,244		

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 860-561-7022		Report for Year Ended 9/30/2020	Page 2	of 37
Name of Facility (as shown on license) The Reservoir Care and Rehabilitation Center		Address (No. & Street, City, State, Zip ) 1 Emily Way, West Hartford, CT 06107		
License Numbers:	CCNH 2203-C	RHNS (Specify)	Medicare Provider No. 07-5407	
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 Molly Narvaez		Nursing Home Administrator's License No.:	00-2001	
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 The Reservoir Care and Rehabilitation Center	License No. 2203-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	Business Address		State(s) in Which Incorporated	
The Reservoir Care and Rehabilitation Center	101 East State Street, Kennett Square, PA 19348		PA	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
See Attached				
Names of Stockholders Owning at Least 10% of Shares				
See Attached				





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

Name of Facility The Reservoir Care and Rehabilitation Center	License No. 2203-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	320,598	320,598
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	618,300	618,300
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	20,320	20,320
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, 1		
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/C5E	407	407
Genesis Healthcare Ins Program	101 East State Street, Kennett Square, PA 19348	<input checked="" type="radio"/>	<input type="radio"/>		Insurance	Pg 27/14	131,299	131,299
		<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 The Reservoir Care and Rehabilitation Center	License No. 2203-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 The Reservoir Care and Rehabilitation Center			License No. 2203-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
							<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 The Reservoir Care and Rehabilitat	License No. 2203-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 Goldman Gruder & Woods LLC 2 Mark J. Witkin 3 4 5	Telephone Number 203-899-8900 617-367-2500
---	--

Address (*No. & Street, City, State, Zip Code*)  
 1 200 Connecticut Ave Norwalk, CT 06854  
 2 One Boston Place -37th Floor Boston,MA 02108  
 3  
 4  
 5

Services Provided by This Firm (*describe fully*)

1 Property Ownership search	\$
2 Saving the R.E Taxes Assetsment Reduction	\$
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 The Reservoir Care and Rehabilitation Center			License No. 2203-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	75	75			75	75						
B. On last day of THIS report period	75	75							75	75		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	69	69			69	69						
B. As of midnight of THIS report period	53	53							53	53		
3. Total Number of Days Care Provided During Period												
A. Medicare	2,111	2,111			1,709	1,709			402	402		
B. Medicaid (Conn.)	15,276	15,276			11,894	11,894			3,382	3,382		
C. Medicaid (other states)												
D. Private Pay	1,074	1,074			984	984			90	90		
E. State SSI for RCH												
F. Other (Specify)	2,347	2,347			1,635	1,635			712	712		
G. Total Care Days During Period (3A thru F)	20,808	20,808			16,222	16,222			4,586	4,586		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	44	44			44	44						
B. Other Bed Reserve Days	11	11			11	11						
5. <b>Total Resident Days (3G + 4A + 4B)</b>	20,863	20,863			16,277	16,277			4,586	4,586		

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

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

Name of Facility The Reservoir Care and Rehabilitation Center			License No. 2203-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)				
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	(Specify)	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR			
No. of Residents	6		36			11							
Per Diem Rate													
a. One bed rm.													
b. Two bed rms.	710.48		264.11			564.20							
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments									TOTAL	CCNH	RHNS	(Specify)	
A. Medicare - Part B									1,214	1,214			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									273	273			
C. Other									7,683	7,683			
D. <b>Total Physical Therapy Treatments</b>									9,170	9,170			
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B									154	154			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									31	31			
C. Other									1,625	1,625			
D. <b>Total Speech Therapy Treatments</b>									1,810	1,810			
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B									848	848			
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments													
2. Restorative Treatments									226	226			
C. Other									7,050	7,050			
D. <b>Total Occupational Therapy Treatments</b>									8,124	8,124			

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

CSP-10 Rev. 9/2002

**Report of Expenditures - Salaries & Wages**

Name of Facility The Reservoir Care and Rehabilitation Center	License No. 2203-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)	140,362	2,112				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	220,877	9,888				
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	57,787	2,085				
b. Other Maintenance Workers	30,569	1,780				
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	146,929	2,264				
b. RN						
1. Direct Care	697,253	16,159				
2. Administrative**	81,602	1,797				
c. LPN						
1. Direct Care	836,474	25,830				
2. Administrative**						
d. Aides and Attendants	1,132,037	58,904				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	66,319	3,326				
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	170,858	5,436				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	74,177	3,515				
<i>A-13. Total Salary Expenditures</i>	3,655,244	133,096				

\* 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	\$ 7,462	\$ 390	\$ -	\$ -	\$ -	\$ -
Medical Records	\$ 25,664	\$ 1,170	\$ -	\$ -	\$ -	\$ -
Coordinator-Staffing Centers	\$ 41,051	\$ 1,954	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	\$ 74,177	3,515	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
Consulting Fees	\$ 948	n/a	\$ -	\$ -	\$ -	\$ -
Purchased Services	\$ -	n/a	\$ -	\$ -	\$ -	\$ -
Purchased Services	\$ 3,836	n/a	\$ -	\$ -	\$ -	\$ -
Purchased Services	\$ 483	n/a	\$ -	\$ -	\$ -	\$ -
Purchased Services	\$ 157	n/a	\$ -	\$ -	\$ -	\$ -
	0 \$ -	n/a	\$ -	\$ -	\$ -	\$ -
<b>Total</b>	\$ 5,424	-	\$ -	-	\$ -	-



**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
The Reservoir Care and Rehabilitation Center				2203-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	
The Reservoir Care and Rehabilitation Center				2203-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>										
Molly Narvaez	77,312				Management of Center	1,112	2			
Archambault, Tania 11/27/19-3/25/20	40,385				Management of Center	600	2			
Schutz, Amanda 10/1/2019-11/27/2019	22,665				Management of Center	400	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		
The Reservoir Care and Rehabilitation Center	2203-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	7,747	53				
3. Pharmacist	7,916	162				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	527,159	7,221				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	60,960	323				
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	37,505	481				
b. Other						
10. Occupational Therapist						
a. Resident Care	42,940	588				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	20,104	335				
2. Administrative***						
b. LPN						
1. Direct Care	15,816	373				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	5,424					
<b>B-13 Total Fees Paid in Lieu of Salaries</b>	<b>725,571</b>	<b>9,536</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
The Reservoir Care and Rehabilitation Center	2203-C	9/30/2020	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 178,585	178,585		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 45,218	45,218		
4. Social Security (F.I.C.A.)	\$ 263,189	263,189		
5. Health Insurance	\$ 227,719	227,719		
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	\$ 403	403		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 116,368	116,368		
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	\$ 13,974	13,974		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 16,042	16,042		
2. Cellular Phones	\$ 2,045	2,045		
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	\$ 368	368		
3. Resident Day User Fee	\$ 351,981	351,981		
<b>Subtotal</b>	\$ 1,215,892	1,215,892		

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

(Carry Subtotals forward to next page)



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

Name of Facility	License No.	Report for Year Ended		Page	of
The Reservoir Care and Rehabilitation Center	2203-C	9/30/2020		16	37
Item	Total	CCNH	RHNS	(Specify)	
<b>Subtotals Brought Forward:</b>					
	1,215,892	1,215,892			
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	1,519	1,519		
5. Education Expenses Related to Seminars and Conventions	\$	712	712		
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> )	\$	266	266		
2. Advertising Telephone Directory ( <i>all such expenses</i> )***	\$				
3. Advertising Other ( <i>Specify</i> )*** See Attached Schedule	\$	8,539	8,539		
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	1,588	1,588		
* 8. Dues and Membership Fees to Professional Associations ( <i>Specify</i> ) See Attached Schedule	\$	5,633	5,633		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$	267	267		
10. Contributions*** See Attached Schedule	\$	1,856	1,856		
11. Services Provided by Contract ( <i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i> )	\$	8,717	8,717		
12. Administrative Management Services**	\$	363,999	363,999		
13. Other ( <i>Specify</i> ) See Attached Schedule	\$	34,854	34,854		
<b>C-14 Total Administrative &amp; General Expenditures</b>	\$	1,643,841	1,643,841		

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

## Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Advertising	\$ 2,122	\$ -	\$ -
Marketing Expense	\$ 2,272	\$ -	\$ -
Marketing Exp- Corporate Spend	\$ 4,145	\$ -	\$ -
Marketing Exp- Corporate Spend	\$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
<b>Total Other Advertising</b>	\$ 8,539	\$ -	\$ -

## Schedule of Dues

Description	CCNH	RHNS	(Specify)
Licenses & Certifications	\$ 5,633	\$ -	\$ -
Dues to Chamber of Commerce	\$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
<b>Total Dues</b>	\$ 5,633	\$ -	\$ -

## Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Contributions	\$ -	\$ -	\$ -
Political Contributions	\$ 1,856	\$ -	\$ -
	0 \$ -	\$ -	\$ -
<b>Total Contributions</b>	\$ 1,856	\$ -	\$ -

## Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Bank Service Charges	\$ 2,156	\$ -	\$ -
Collection Fees	\$ 7,253	self-disallowed	\$ -
Education Expense	\$ 154	\$ -	\$ -
Employee Physicals	\$ 14,442	\$ -	\$ -
Employee Relations	\$ 3,655	\$ -	\$ -
Printing	\$ 292	\$ -	\$ -
Training Expense	\$ 162	\$ -	\$ -
Fines & Penalties	\$ -	self-disallowed	\$ -
Miscellaneous	\$ (46)	\$ -	\$ -
Rental Expense	\$ 5,902	\$ -	\$ -
Accrued Expense Estimation	\$ (182)	self-disallowed	\$ -
Landlord Operating Taxes	\$ 600	\$ -	\$ -
State Tax Annual Report Filing	\$ 465	\$ -	\$ -
Recruiting Fees	\$ -	\$ -	\$ -
Recruiting Fees	\$ -	\$ -	\$ -
Non-recurring Charges	\$ -	\$ -	\$ -
Uniforms	\$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
	0 \$ -	\$ -	\$ -
<b>Total Other Administrative and General</b>	\$ 34,854	\$ -	\$ -



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

Name of Facility	License No.	Report for Year Ended	Page of
The Reservoir Care and Rehabilitation Ce	2203-C	9/30/2020	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	320,598	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
The Reservoir Care and Rehabilitation Center		2203-C	9/30/2020	18	37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 102,345	102,345		
2.	Non-Food Supplies	\$ 17,847	17,847		
3.	Other ( <i>Specify</i> ) _____	\$ 2,739	2,739		
b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )					
c. Other ( <i>Specify</i> ) _____		\$			
<b>2D. Total Dietary Expenditures (2a + b + c + d)</b>		\$ 653,584	653,584		
2E. Dietary Questionnaire					
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 The Reservoir Care and Rehabilitation Center		License No. 2203-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. \$	2,995	2,995		
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. \$	4,348	4,348		
b. Purchased Services ( <i>by contract other than through Management Services</i> ) ( <i>Complete Schedule C-2 att. Page 21</i> )		\$	132,194	132,194		
c. Other ( <i>Specify</i> )		\$				
3D. <b>Total Laundry Expenditures</b> (3a + b + c)		\$	139,537	139,537		
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
The Reservoir Care and Rehabilitation Center		2203-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. \$	10,123	10,123		
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. \$	215,128	215,128		
C.	Other ( <i>Specify</i> )	\$				
4D.	<b>Total Housekeeping Expenditures</b> (4a + b + c)	\$	225,251	225,251		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from	\$	118,474	118,474		
b.	Medicine Cabinet Drugs	\$	(12,111)	(12,111)		
c.	Medical and Therapeutic Supplies	\$	78,390	78,390		
d.	Ambulance/Limousine***	\$	328	328		
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	20,996	20,996		
f.	X-rays and Related Radiological Procedures***	\$	7,432	7,432		
g.	Dental ( <i>Not dentists who should be included under salaries or fees</i> )	\$				
h.	Laboratory***	\$	40,841	40,841		
i.	Recreation	\$	13,851	13,851		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	50,032	50,032		
5M.	<b>Total Resident Care Expenditures</b> (5a - 5j)	\$	318,233	318,233		

\* 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	\$ 28,673	\$ -	\$ -
Advertising-Help Wanted	\$ (344)	\$ -	\$ -
Advertising-Help Wanted	\$ 1,647	\$ -	\$ -
Books, Dues & Subscriptions	\$ 126	\$ -	\$ -
Education Expense	\$ 1,273	\$ -	\$ -
Supplies	\$ 2,317	\$ -	\$ -
Supplies	\$ 5,290	\$ -	\$ -
Supplies	\$ 76	\$ -	\$ -
Office Supplies	\$ 37	\$ -	\$ -
Office Supplies	\$ -	\$ -	\$ -
Office Supplies	\$ -	\$ -	\$ -
Training Expense	\$ -	\$ -	\$ -
Rental Expense	\$ 380	\$ -	\$ -
Rental Expense	\$ 2,615	\$ -	\$ -
Consolidated Billing	\$ 7,586	\$ -	\$ -
Tuition Reimbursement	\$ -	\$ -	\$ -
Tuition Reimbursement	\$ -	\$ -	\$ -
Tuition Reimbursement	\$ -	\$ -	\$ -
Miscellaneous	\$ -	\$ -	\$ -
Licenses & Certifications	\$ -	\$ -	\$ -
Supplies	\$ 271	\$ -	\$ -
T&E-Lodging/Transportation	\$ 84	\$ -	\$ -
	0	\$ -	\$ -
<b>Total Other Resident Care</b>	<b>\$ 50,032</b>	<b>\$ -</b>	<b>\$ -</b>

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

Name of Facility The Reservoir Care and Rehabilitation Center			License No. 2203-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	132,194			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Housekeeping Purchased Services	215,128			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	<input type="radio"/>	<input checked="" type="radio"/>	Vendor Contracted	Dietary Purchased Services	530,653			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"/>							
		<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
The Reservoir Care and Rehabilitation Center	2203-C	9/30/2020			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 143,730	143,730				
b. Heat	\$ 42,720	42,720				
c. Light & Power	\$ 170,372	170,372				
d. Water	\$ 32,338	32,338				
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>	\$ 389,160	389,160				
7. Depreciation ( <i>complete schedule page 23*</i> )						
a. Land Improvements	\$ 4,740	4,740				
b. Building & Building Improvements	\$ 4,549	4,549				
c. Non-Movable Equipment	\$ 647	647				
d. Movable Equipment	\$ 5,648	5,648				
<b>*7e. Total Depreciation Costs (7a + b + c + d)</b>	\$ 15,584	15,584				
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>	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 231,324	231,324				
c. Personal property taxes	\$					
<b>11. Total Property Expenses (7e + 8e + 9 + 10)</b>	\$ 246,908	246,908				

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





### Depreciation Schedule

Name of Facility The Reservoir Care and Rehabilitation Center			License No. 2203-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			
<b>A. Land Improvements</b>													
1. Acquired prior to this report period			14,219		14,219		S/L	Various	4,740				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
A-4. Subtotal										4,740			
<b>B. Building and Building Improvements</b>													
1. Acquired prior to this report period			22,729		22,729	692	S/L	Various	2,382				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)			23,601		23,601				2,166				
B-4. Subtotal										4,549			
<b>C. Non-Movable Equipment</b>													
1. Acquired prior to this report period			6,312		6,312	324	S/L	Various	647				
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal										647			
		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								
<b>D. Movable Equipment</b>													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period						29,851		29,851	1,397	S/L	Various	4,065	
b. Disposals (attach schedule)													
c. Acquired during this report period (attach schedule)						14,846		14,846				1,584	
D-3. Subtotal													5,648
<b>E. Total Depreciation</b>													15,584

## Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
<b>Additions:</b>				
1/0/1900		1/0/1900 \$ -	3	\$ -
1/0/1900		1/0/1900 \$ -	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
<b>Total additions for Land Improvement</b>		\$ -		\$ -
<b>Deletions:</b>				
		\$ -	\$ -	\$ -
<b>Total deletions for Land Improvement</b>		\$ -		\$ -

\*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
<b>Additions:</b>				
10/31/2019	New Carpeting & Flooring	\$ 21,665	09 02	\$ 2,166
9/30/2020	Sept 2020 Accruals	\$ 1,937	-	\$ -
1/0/1900		0 \$ -	-	\$ -
1/0/1900		0 \$ -	-	\$ -
1/0/1900		0 \$ -	-	\$ -
1/0/1900		0 \$ -	-	\$ -
1/0/1900		0 \$ -	20	\$ -
1/0/1900		0 \$ -	10	\$ -
1/0/1900		0 \$ -	-	\$ -
1/0/1900		0 \$ -	-	\$ -
		\$ -	-	\$ -
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		\$ -	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
		\$ -	-	\$ -
<b>Total additions for Building Improvement</b>		\$ 23,601		\$ 2,166
<b>Deletions:</b>				
1/0/1900		0 \$ -	\$ -	\$ -
1/0/1900		0 \$ -	\$ -	\$ -
<b>Total deletions for Building Improvement</b>		\$ -		\$ -

\*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
<b>Additions:</b>				
1/0/1900		1/0/1900 \$ -	\$ -	\$ -

1/0/1900	1/0/1900	\$ -	\$ 10	\$ -	
1/0/1900	1/0/1900	\$ -	\$ -	\$ -	
1/0/1900	1/0/1900	\$ -	\$ -	\$ -	
		\$ -	\$ -	\$ -	
		\$ -	\$ -	\$ -	
<b>Total additions for Non-Movable Equipmen</b>		\$ -		\$ -	*
<b>Deletions:</b>					
1/0/1900	1/0/1900	\$ -	\$ -		
<b>Total deletions for Non-Movable Equipmen</b>		\$ -		\$ -	**

\*Ties to Page 23, Line C3

\*\*Ties to Page 23, Line C2



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

CSP-24 Rev. 10/2006

**Amortization Schedule\***

Name of Facility The Reservoir Care and Rehabilitation Center			License No. 2203-C		Report for Year Ended 9/30/2020			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
<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 The Reservoir Care and Rehabilitation	License No. 2203-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		75			
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	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					
<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	12/21/2018-12	10 years	
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
The Reservoir Care and Rehabilitation	2203-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
The Reservoir Care and Rehabilitati		2203-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)				\$ 2,716	2,716		
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$ 128,584	128,584		
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. <b>Total Insurance Expenditures (14a + b + c)</b>				\$ 131,300	131,300		
15. <b>Total All Expenditures (A-13 thru C-14)</b>				\$ 8,128,630	8,128,630		



### D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation Center				2203-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	\$ 57,026	57,026		
<b>Page 13 - Professional Fees</b>							
5.	13	B-8-c	Resident Care Physicians **	\$			
6.		B-10	Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 611,924	611,924		
<b>Pages 15 &amp; 16 - Administrative and General</b>							
8.			Discriminatory Benefits	\$			
9.	15	1-c	Bad Debts	\$ 116,368	116,368		
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 *	\$ 8,539	8,539		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$ 1,856	1,856		
21.			Unallowable Management Fees	\$ 43,401	43,401		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 60,819	60,819		
<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	\$ 24,507	24,507		
Subtotal (Items 1 - 26)				\$ 924,439	924,439		

\* 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	\$ 57,026	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
0	0		\$ -	\$ -	\$ -
<b>Total Other Salaries Adjustment</b>			\$ 57,026	\$ -	\$ -

## Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	\$ 61,082	\$ -	\$ -
13	5	Rehabilitation Services	\$ 466,077	\$ -	\$ -
13	9	Speech Therapist	\$ 37,505	\$ -	\$ -
13	10	Occupational Therapist	\$ 42,940	\$ -	\$ -
13	12	Other	\$ -	\$ -	\$ -
13	12	Other	\$ 3,836	\$ -	\$ -
13	12	Respiratory Purchased Services	\$ 483	\$ -	\$ -
<b>Total Other Fees Adjustments</b>			\$ 611,924	\$ -	\$ -

## Schedule of Other A&amp;G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	\$ 7,253	\$ -	\$ -
16	m-13	Estimated Accrual	\$ (182)	\$ -	\$ -
16	m-13	Non-recurring Charges	\$ -	\$ -	\$ -
16	m-13	Dues to Chamber of Commerce	\$ -	\$ -	\$ -
16	m-13	Penalty	\$ -	\$ -	\$ -
16	m-12	Management Fee disallowed	\$ -	\$ -	\$ -
15	1-a-1	adj workers comp	\$ 11,407	\$ -	\$ -
22	6.a	10.88% disallowed regional office	\$ 15,638	\$ -	\$ -
22	6.b	10.88% disallowed regional office	\$ 4,648	\$ -	\$ -
22	6.c	10.88% disallowed regional office	\$ 18,536	\$ -	\$ -
22	6.d	10.88% disallowed regional office	\$ 3,518	\$ -	\$ -
<b>Total Other A&amp;G Adjustments</b>			\$ 60,819	\$ -	\$ -

## Schedule of Housekeeping Exp adjs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	4. b	10.88% disallowed regional office-Housekeeping	\$ 23,406	\$ -	\$ -
20	4.a.1	10.88% disallowed regional office-Housekeeping-Other	\$ 1,101	\$ -	\$ -
<b>Total Housekeeping Expenditures adj</b>			\$ 24,507	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation Center				2203-C	9/30/2020	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 924,439	924,439		
<b>Page 20 - Resident Care Supplies***</b>							
27.	20	5-a-2	Prescription Drugs	\$ 118,474	118,474		
28.	20	5-d	Ambulance/Limousine	\$ 328	328		
29.	20	5-f	X-rays, etc	\$ 7,432	7,432		
30.	20	5-h	Laboratory	\$ 40,841	40,841		
31.			Medical Supplies	\$			
32.	20	5-e-2	Oxygen (non emergency)	\$ 20,996	20,996		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 15,491	15,491		
<b>Page 22 - Maintenance and Property</b>							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$ (2,432)	(2,432)		
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	\$ 7,355	7,355		
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$ 139,851	139,851		
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>				\$ 1,272,774	1,272,774		

\*\*\* 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	\$ 7,586	\$ -	\$ -
20	5-j	Respiratory Supplies	\$ 5,290	\$ -	\$ -
20	5-j	Respiratory Rental	\$ 2,615	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
<b>Total Other Ancillary Costs</b>			\$ 15,491	\$ -	\$ -

## Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Page 22	7a	Land Imp	\$ 0	\$ -	\$ -
Page 22	7b	Bldg Imp	\$ (3,418)	\$ -	\$ -
Page 22	7c	Non Movable Equip	\$ (1,847)	\$ -	\$ -
Page 22	7d	Movable Equip	\$ (22,336)	\$ -	\$ -
22	10.b	10.88% disallowed regional office-Real Estate Tax	\$ 25,168	\$ -	\$ -
0	0-Jan		0 \$ -	\$ -	\$ -
<b>Total Excess Movable Equipment Depreciation</b>			\$ (2,432)	\$ -	\$ -

## Schedule of Other Property Adjustments

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-i	Cable TV - Allowable \$3,600 Account#3005660130	\$ 7,355	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
<b>Total Other Adjustments</b>			\$ 7,355	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14c1	General liability Insurance Adjust	\$ 81,965	\$ -	\$ -
0	0-Jan	10.88% disallowed regional office-Land Fair Rent	\$ 816	\$ -	\$ -
0	0-Jan	10.88% disallowed regional office-Real Property Fair Rent	\$ 56,774	\$ -	\$ -
27	14.a	10.88% disallowed regional office-Property Insurance	\$ 296	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
0	0-Jan		\$ -	\$ -	\$ -
<b>Total Other Adjustments</b>			\$ 139,851	\$ -	\$ -

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
The Reservoir Care and Rehabilitation Ce	2203-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> )	\$ 7,884,019	7,884,019			
b. Medicaid Room and Board Contractual Allowance **	\$ (3,921,206)	(3,921,206)			
2. a. Medicaid ( <i>All other states</i> )	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents ( <i>all inclusive</i> )	\$ 1,087,005	1,087,005			
b. Medicare Room and Board Contractual Allowance **	\$ (148,291)	(148,291)			
4. a. Private-Pay Residents and Other	\$ 1,815,107	1,815,107			
b. Private-Pay Room and Board Contractual Allowance **	\$ (607,294)	(607,294)			
<b>II. Other Resident Revenue</b>					
1. a. Prescription Drugs - Medicare	\$ 47,546	47,546			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (6,486)	(6,486)			
c. Prescription Drugs - Non-Medicare	\$ 77,184	77,184			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (26,645)	(26,645)			
2. a. Medical Supplies - Medicare	\$ 919	919			
b. Medical Supplies - Medicare Contractual Allowance **	\$ (125)	(125)			
c. Medical Supplies - Non-Medicare	\$ 340	340			
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (117)	(117)			
3. a. Physical Therapy - Medicare	\$ 199,875	199,875			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (27,267)	(27,267)			
c. Physical Therapy - Non-Medicare	\$ 276,856	276,856			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (94,793)	(94,793)			
4. a. Speech Therapy - Medicare	\$ 68,978	68,978			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (9,410)	(9,410)			
c. Speech Therapy - Non-Medicare	\$ 154,270	154,270			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (51,941)	(51,941)			
5. a. Occupational Therapy - Medicare	\$ 169,220	169,220			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (23,085)	(23,085)			
c. Occupational Therapy - Non-Medicare	\$ 269,087	269,087			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (91,692)	(91,692)			
6. a. Other ( <i>Specify</i> ) - Medicare	\$ 29,546	29,546			
b. Other ( <i>Specify</i> ) - Non-Medicare	\$ 15,878	15,878			
<b>III. Total Resident Revenue</b> (Section I. thru Section II.)	\$ 7,087,478	7,087,478			
<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> )	\$ 1,542	1,542			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$ 4,206	4,206			
8. Other ( <i>Specify</i> )	\$ 395,289	395,289			
<b>V. Total Other Revenue</b> (1 thru 8)	\$ 401,037	401,037			
<b>VI. Total All Revenue</b> (III +V)	\$ 7,488,515	7,488,515			

\* 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	\$ 10,073	\$ -	\$ -
II-6-a	Medicare	Laboratory	\$ 15,887	\$ -	\$ -
II-6-a	Medicare	Respiratory Thera	\$ 66	\$ -	\$ -
II-6-a	Medicare	Nursing Treatmen	\$ -	\$ -	\$ -
II-6-a	Medicare	Audiology	\$ -	\$ -	\$ -
II-6-a	Medicare	Incontinency	\$ -	\$ -	\$ -
II-6-a	Medicare	Oxygen & Supplis	\$ -	\$ -	\$ -
II-6-a	Medicare	Physician Visit	\$ 139	\$ -	\$ -
II-6-a	Medicare	Ambulance	\$ 3,852	\$ -	\$ -
II-6-a	Medicare	Flu Shot	\$ 4,196	\$ -	\$ -
II-6-a	Medicare Contractual	X-Ray	\$ (1,374)	\$ -	\$ -
II-6-a	Medicare Contractual	Laboratory	\$ (2,167)	\$ -	\$ -
II-6-a	Medicare Contractual	Respiratory Thera	\$ (9)	\$ -	\$ -
II-6-a	Medicare Contractual	Nursing Treatmen	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual	Audiology	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual	Incontinency	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual	Oxygen & Supplis	\$ -	\$ -	\$ -
II-6-a	Medicare Contractual	Physician Visit	\$ (19)	\$ -	\$ -
II-6-a	Medicare Contractual	Ambulance	\$ (526)	\$ -	\$ -
II-6-a	Medicare Contractual	Flu Shot	\$ (572)	\$ -	\$ -
II-6-a	Medicare Contractual		\$ -	\$ -	\$ -
		0	\$ -	\$ -	\$ -
<b>Total Other Resident Revenue - Medicare</b>			\$ 29,546	\$ -	\$ -

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 Thera	\$ 176	\$ -	\$ -
II-6-b	Medicaid	Nursing Treatmen	\$ -	\$ -	\$ -
II-6-b	Medicaid	Audiology	\$ -	\$ -	\$ -
II-6-b	Medicaid	Incontinency	\$ -	\$ -	\$ -
II-6-b	Medicaid	Oxygen & Supplis	\$ -	\$ -	\$ -
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 Thera	\$ (88)	\$ -	\$ -
II-6-b	Contractuals-Medicaid	Nursing Treatmen	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid	Audiology	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid	Incontinency	\$ -	\$ -	\$ -
II-6-b	Contractuals-Medicaid	Oxygen & Supplis	\$ -	\$ -	\$ -
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	\$ 3,644	\$ -	\$ -
II-6-b	Non-Medicaid	Laboratory	\$ 15,783	\$ -	\$ -
II-6-b	Non-Medicaid	Respiratory Thera	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	Nursing Treatmen	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	Audiology	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	Incontinency	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	Oxygen & Supplis	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	Physician Visit	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	Ambulance	\$ 4,303	\$ -	\$ -
II-6-b	Non-Medicaid	Flu Shot	\$ -	\$ -	\$ -
II-6-b	Non-Medicaid	Capitation Contra	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	X-Ray	\$ (1,219)	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Laboratory	\$ (5,280)	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Respiratory Thera	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Nursing Treatmen	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Audiology	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Incontinency	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplis	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Physician Visit	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Ambulance	\$ (1,440)	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Flu Shot	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid	Capitation Contra	\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid		\$ -	\$ -	\$ -
II-6-b	Contractuals-Non-Medicaid		\$ -	\$ -	\$ -
		0	\$ -	\$ -	\$ -
		0	\$ -	\$ -	\$ -
		0	\$ -	\$ -	\$ -
		0	\$ -	\$ -	\$ -
		0	\$ -	\$ -	\$ -
		0	\$ -	\$ -	\$ -
<b>Total Other Resident Revenue</b>			\$ 15,878	\$ -	\$ -

Interest Income

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
IV-5	Interest On Overdue Accounts	0	\$ 1,542	\$ -	\$ -
<b>Total Interest Income</b>			\$ 1,542	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
IV-8	Federal Stimulus 1		\$ 91,610	\$ -	\$ -
IV-8	Federal Stimulus 2		\$ 65,151	\$ -	\$ -
IV-8	Federal Stimulus 3		\$ 237,500	\$ -	\$ -
IV-8	REHAB SETTLEMENT		\$ 600	\$ -	\$ -
IV-8	REHAB SETTLEMENT		\$ 428	\$ -	\$ -
0		0	\$ -	\$ -	\$ -
0		0	\$ -	\$ -	\$ -
0		0	\$ -	\$ -	\$ -
<b>Total Other Revenue</b>			\$ 395,289	\$ -	\$ -

### G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation Center	2203-C	9/30/2020	31	37
Account			Amount	
<b>Assets</b>				
A. Current Assets				
1. Cash ( <i>on hand and in banks</i> )			\$	10,075
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	722,797
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(140,680)
4. Inventories			\$	30,774
5. Prepaid Expenses			\$	60,503
a. _____				
b. _____				
c. _____				
d. See Schedule		60,503		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets ( <i>itemize</i> )			\$	
_____				
_____				
See Schedule				
<b>A-9. Total Current Assets (Lines A1 thru 8)</b>			\$	683,469
B. Fixed Assets				
1. Land				
2. Land Improvements	*Historical Cost	14,219	\$	9,479
	Accum. Depreciation	4,740		Net
3. Buildings	*Historical Cost	46,330	\$	41,089
	Accum. Depreciation	5,241		Net
4. Leasehold Improvements	*Historical Cost	_____	\$	
	Accum. Depreciation	_____		Net
5. Non-Movable Equipment	*Historical Cost	6,312	\$	5,341
	Accum. Depreciation	971		Net
6. Movable Equipment	*Historical Cost	44,697	\$	37,652
	Accum. Depreciation	7,045		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 (Lines B1 thru 9)</b>			\$	93,561

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

(Carry Total forward to next page)



Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description		
30	A5	Prepaid Expenses	\$	4,322
30	A5	Prepaid Prop Taxes	\$	53,399
30	A5	Prepaid Personal Property Tax	\$	2,781
30	A5			
30	A5			
30	A5			
30	A5			
<b>Total Prepaid Expenses</b>			\$	60,503

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

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

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

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

Schedule of Notes Payable (Itemize) Page 33 Line A2

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

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

Page Ref	Line Ref	Description			
33	A12	Deferred Revenue	\$	74,342	Deferred Revenue
33	A12	Accrued Provider/Bed Tax	\$	76,198	Accrued Provider/Bed Tax
33	A12	Accr Gross Rec Tax-FY11	\$	2,640	Accr Gross Rec Tax-FY11
33		Accr Gross Rec Tax-FY12	\$	2,400	Accr Gross Rec Tax-FY12
33		Accr Gross Rec Tax-FY13	\$	2,400	Accr Gross Rec Tax-FY13
33		Accr Gross Rec Tax-FY14	\$	2,400	Accr Gross Rec Tax-FY14
33		Accr Gross Rec Tax-FY15	\$	2,400	Accr Gross Rec Tax-FY15
33		Accr Gross Rec Tax-FY16	\$	2,400	Accr Gross Rec Tax-FY16
33		Accr Gross Rec Tax-FY17	\$	2,400	Accr Gross Rec Tax-FY17
33		Accr Gross Rec Tax-FY18		4800	Accr Gross Rec Tax-FY18
		Accr Sales and Use Tax - FY18		40	Accr Sales and Use Tax - FY18
<b>Total Other Current Liabilities (Itemize)</b>			\$	172,420	Accr Sales and Use Tax - FY18

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation Center	2203-C	9/30/2020	32	37
Account			Amount	
Total Brought Forward:			\$	777,030
<b>C. Leasehold or like property recorded for Equity Purposes.</b>				
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			\$	
<b>C-8 Total Leasehold or Like Properties (C1 thru 7)</b>			\$	
<b>D. Investment and Other Assets</b>				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense			*Historical Cost _____	
Accum. Depreciation _____			Net	
			\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (itemize)			\$	
_____				
6. Loans to Owners or Related Parties (itemize)			\$	
Name and Address		Amount	Loan Date	
_____				
7. Other Assets (itemize)			\$	(264,524)
I/C Due to/Due From Owned		(264,524)		
I/C Due to/Due From Multicare				
See Schedule				
<b>D-8. Total Investments and Other Assets (Lines D1 thru 7)</b>			\$	(264,524)
<b>D-9. Total All Assets (Lines A9 + B10 + C8 + D8)</b>			\$	512,507

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

## Annual Report of Long-Term Care Facility

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## G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation Center		2203-C	9/30/2020	33	37
Account				Amount	
<b>Liabilities</b>					
A. Current Liabilities					
1. Trade Accounts Payable				\$	253,422
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> )				\$	197,286
5. Accrued Payroll ( <i>Owners and/or Stockholders only</i> )				\$	
6. Accrued Payroll Taxes Payable				\$	430
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> )				\$	632,036
Accr Exp Other		6,281	Accr Exp Suspense	(110)	
Accr Exp Water and Sewer		2,196	Accr Exp Nursing Purch	301,338	
Accr Exp Gas		6,147	Deferred Revenue	125,494	
Accr Exp Electricity		18,270	See Schedule	172,420	
A-13. <b>Total Current Liabilities</b> (Lines A1 thru 12)				\$	1,083,174

\* 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 The Reservoir Care and Rehabilitation Center	License No. 2203-C	Report for Year Ended 9/30/2020	Page 34	of 37
Account			Amount	
Total Brought Forward:			1,083,174	
<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> )				\$ 34
LT Debt-Financing Obligation				
Escheatable Funds		34		
See Schedule				
B-5. <b>Total Long-Term Liabilities</b> (Lines B1 thru 4)				\$ 34
C. <b>Total All Liabilities</b> (Lines A-13 + B-5)				\$ 1,083,208

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation	2203-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			\$	69,417
6. Gain or Loss for Period			\$	(640,115)
	10/1/2019	thru 9/30/2020		
7. Total Net Worth			\$	(570,698)
<b>C. Total Reserves and Net Worth</b>			\$	(570,698)
<b>D. Total Liabilities, Reserves, and Net Worth</b>			\$	512,510

### H. Changes in Total Net Worth

Name of Facility The Reservoir Care and Rehabilitation C	License No. 2203-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			\$	69,417
B. Total Revenue <i>(From Statement of Revenue Page 30)</i>			\$	7,488,515
C. Total Expenditures <i>(From Statement of Expenditures Page 27)</i>			\$	8,128,630
D. Net Income or Deficit			\$	(640,115)
E. Balance			\$	(570,698)
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>			\$	(570,698)

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

Name of Facility The Reservoir Care and Rehabilitation	License No. 2203-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				