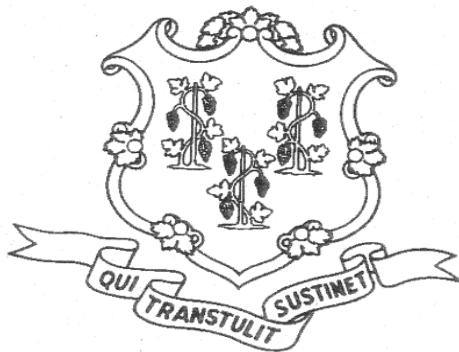


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2021

Name of Facility (as licensed) Pendleton Health and Rehabilitation	
Address (No. & Street, City, State, Zip Code) 44 Maritime Dr., Mystic, CT 06355	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH 2069-C	RHNS	(Specify)	Medicare Provider 07-5341
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Medicaid Provider Numbers:	CCNH 2069-C	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021	Page 1	of 37
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Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Pendleton Health and Rehabilitation [facility name], for the cost report period beginning October 1, 2020 and ending September 30, 2021, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)	Date	Signed (Owner)	Date
Printed Name (Administrator) Sue Peglow		Printed Name (Owner)	
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public			

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Pendleton Health and Rehabilitation	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 44 Maritime Dr., Mystic, CT 06355				
Report Prepared By Margaret Philen	Phone Number 832-467-6225	Date 2/15/2022		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

	Phone No. of Facility 860-5722-1700	Report for Year Ended 9/30/2021	Page 2
Name of Facility (as shown on license) Pendleton Health and Rehabilitation		Address (No. & Street, City, State, Zip) 44 Maritime Dr., Mystic, CT 06355	
License Numbers:	CCNH 2069-C	RHNS	(Specify)
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:		Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes	<input checked="" type="radio"/> No
If "Yes," explain fully.			
Administrator			
Name of Administrator Sue Peglow		Nursing Home Administrator's License No.:	001290
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name		License No.:	

General Information and Questionnaire Partners/Members

General Information and Questionnaire

Corporate Owners

General Information and Questionnaire

Individual Proprietorship

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

General Information and Questionnaire

Related Parties*

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input type="radio"/> Yes <input checked="" type="radio"/> No 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?				<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the following information:				
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party	
		Yes	No	%**				
SSC Administrative & Consulting Svcs, LLC	8601 Dunwoody Place, Ste775, Sandy Springs GA 30350	<input type="radio"/>	<input checked="" type="radio"/>		Back Office & Consulting Services	Page 16/C.1.2.12	782,715	782,715
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021	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.

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

⊕ No

Total ***

4,613

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

** Attach copies of newly acquired leases.

*** Amount should agree to Page 22, Line 6e.

General Information and Questionnaire
Accounting Basis

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021	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 Yes If "No," explain.
previous period? No

Independent Accounting Firm

Name of Accounting Firm 1 2 3 4	Address (No. & Street, City, State, Zip Code)
---	---

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
	Charge for Services Provided \$

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

Yes No

Legal Services Information

Name of Legal Firm or Independent Attorney 1 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 Pendleton Health and Rehabilitation			License No. 2069-C				Report for Year Ended 9/30/2021				Page 8	of 37
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					120	120						
A. On last day of PREVIOUS report period	120	120										
B. On last day of THIS report period	120	120							120	120		
2. Number of Residents					90	90						
A. As of midnight of PREVIOUS report period	90	90										
B. As of midnight of THIS report period	82	82							82	82		
3. Total Number of Days Care Provided During Period					6,087	6,087			1,695	1,695		
A. Medicare	7,782	7,782										
B. Medicaid (Conn.)	17,182	17,182			12,508	12,508			4,674	4,674		
C. Medicaid (other states)												
D. Private Pay	3,354	3,354			2,626	2,626			728	728		
E. State SSI for RCH												
F. Other (Specify) VA/Hospice	1,847	1,847			1,170	1,170			677	677		
G. Total Care Days During Period (3A thru F)	30,165	30,165			22,391	22,391			7,774	7,774		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	30,165	30,165			22,391	22,391			7,774	7,774		

Schedule of Resident Statistics (Cont'd)

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year? Yes No

If "YES", provide the following information:

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

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

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

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

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

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	10,928	10,928	(Specify)
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	21,655	21,655	
2. Restorative Treatments			
C. Other			
D. Total Physical Therapy Treatments	32,583	32,583	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	910	910	(Specify)
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	2,326	2,326	
2. Restorative Treatments			
C. Other			
D. Total Speech Therapy Treatments	3,236	3,236	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	8,671	8,671	(Specify)
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	21,118	21,118	
2. Restorative Treatments			
C. Other			
D. Total Occupational Therapy Treatments	29,789	29,789	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		2069-C	9/30/2021	10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes		<input type="radio"/> No	
		Total Cost and Hours			
Item		CCNH	Hours	RHNS	Hours
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	173,670	2,088			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	446,174	19,349			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor					
c. Dietary Workers	269,872	15,540			
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers					
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	65,579	2,046			
b. Other Maintenance Workers	21,855	1,284			
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	203,408	3,824			
b. RN					
1. Direct Care	1,107,974	26,472			
2. Administrative**	248,554	5,920			
c. LPN					
1. Direct Care	902,417	27,099			
2. Administrative**	254	8			
d. Aides and Attendants	1,052,564	50,756			
e. Physical Therapists	453,071	10,836			
f. Speech Therapists	77,861	1,786			
g. Occupational Therapists	323,416	8,639			
h. Recreation Workers	132,061	5,292			
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	115,689	4,172			
n. Marketing					
o. Other (Specify)					
See Attached Schedule	95,824	3,175			
<i>A-13. Total Salary Expenditures</i>	5,690,243	188,286			

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

** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and

Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

Schedule of Other Salaries and Wages (Page 10)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility Pendleton Health and Rehabilitation			License No. 2069-C		Report for Year Ended 9/30/2021			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Pendleton Health and Rehabilitation				2069-C		9/30/2021			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Sue Peglow	173,670			Standard Package	Administrative Responsibilities for day to day operations	2,088	A.2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021		Page 13	of 37
Item	Total Cost and Hours				
	CCNH	Hours	RHNS	Hours	(Specify)
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)					
1. Dietitian					
2. Dentist	4,400	Fee for Svc			
3. Pharmacist	12,050	Fee for Svc			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	54,754	240			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**	101,127	204			
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify)					
9. Speech Therapist					
a. Resident Care					
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	37,580	323			
2. Administrative***	7,944	150			
b. LPN					
1. Direct Care					
2. Administrative***	119,455	1,221			
c. Aides	975	15			
d. Other					
12. Other (Specify)					
See Attached Schedule					
B-13 Total Fees Paid in Lieu of Salaries	338,284	2,153			

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

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

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

Report of Expenditures

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

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
LTC Management LLP	Dentist	<input type="radio"/>	<input checked="" type="radio"/>		
Omnicare - Value Health Care/ LTCPCMS Inc	Pharmacy Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Biju Oommen	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Gaps Health Inc	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
IPC Hospitalists of New England PC	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>		
Health Quasar LLC	Resident Care Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Mystic Geriatrics LLC	Resident Care Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Northeast Medical Group Inc	Resident Care Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Connecticut Post Acute Medical Services	Resident Care Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Healthdrive Eye Care	Resident Care Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Healthdrive Podiatry Group	Resident Care Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Healthdrive Audiology Group	Resident Care Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Lawrence Memorial Hospital	Resident Care Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Dysphagia Management Systems LLC	Resident Care Physician	<input type="radio"/>	<input checked="" type="radio"/>		
William W Backus Hospital	Resident Care Physician	<input type="radio"/>	<input checked="" type="radio"/>		
Supplemental Health Care	R.N.	<input type="radio"/>	<input checked="" type="radio"/>		
Stability Professional	R.N.	<input type="radio"/>	<input checked="" type="radio"/>		
Omnicare - Value Health Care	Nurse Consultant	<input type="radio"/>	<input checked="" type="radio"/>		
Karen Terwilliger	R.N.	<input type="radio"/>	<input checked="" type="radio"/>		
Alegiant Services LLC	L.V.N.	<input type="radio"/>	<input checked="" type="radio"/>		
Bonneville Health Recruiters Inc	L.V.N.	<input type="radio"/>	<input checked="" type="radio"/>		
Centra Healthcare Solutions Inc	L.V.N.	<input type="radio"/>	<input checked="" type="radio"/>		

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021	Page 15	of 37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ (45,025)	(45,025)		
2. Disability Insurance	\$			
3. Unemployment Insurance	\$ 43,464	43,464		
4. Social Security (F.I.C.A.)	\$ 418,457	418,457		
5. Health Insurance	\$ 72,098	72,098		
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 4,331	4,331		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$ 9,624	9,624		
9. Other (Specify) See Attached Schedule	\$ 2,962	2,962		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 173,776	173,776		
d. Accounting and Auditing	\$			
e. Legal (Services should be fully described on Page 7)	\$			
f. Insurance on Lives of Owners and Operators (Specify)*	\$			
g. Office Supplies	\$ 34,468	34,468		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 18,607	18,607		
2. Cellular Phones	\$ 1,498	1,498		
i. Appraisal (Specify purpose and attach copy)*	\$			
j. Corporation Business Taxes (franchise tax)	\$ 550	550		
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$			
2. Other (Specify) See Attached Schedule	\$ 26,569	26,569		
3. Resident Day User Fee	\$ 471,394	471,394		
Subtotal	\$ 1,232,772	1,232,772		

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

Schedule of Other Employee Benefits

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Sales Tax	\$ 26,569		
Total	\$ 26,569	\$ -	\$ -

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

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		1,232,772	1,232,772		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$	40,255	40,255		
4. Employee Travel	\$	401	401		
5. Education Expenses Related to Seminars and Conventions	\$	14,261	14,261		
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>)	\$	10,612	10,612		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	11,820	11,820		
4. Fund-Raising***	\$				
5. Medical Records	\$	2,232	2,232		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$	247	247		
7. Postage	\$	2,755	2,755		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	10,839	10,839		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	1,147	1,147		
9. Subscriptions	\$	53	53		
10. Contributions*** See Attached Schedule	\$	79	79		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	58,034	58,034		
12. Administrative Management Services**	\$	618,903	618,903		
13. Other (<i>Specify</i>) See Attached Schedule	\$	(316,027)	(316,027)		
<i>C-14 Total Administrative & General Expenditures</i>	\$	1,688,387	1,688,387		

* Do not include Subscriptions, which should go in item 9.

** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Marketing Supplies	\$ 859		
Contract Services - Marketing	\$ 2,214		
Advertising- Marketing	\$ 8,748		
Total Other Advertising	\$ 11,820	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
AMDA	\$ 371		
CT Assn of HC Facilities	\$ 8,189		
AHCA	\$ 1,200		
Dues Physical Plant	\$ 1,080		
Total Dues	\$ 10,839	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Donations	\$ 79		
Total Contributions	\$ 79	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Director & Trustee Fees	\$ 532		
Employee Background Screening	\$ 8,394		
Administrative License	\$ 5,575		
Penalties & Late Filings	\$ 14,305		
Bank Charges	\$ 5,710		
Surety Bonds	\$ 1,350		
Lost Resident Property/Resident Reimbursed Purchases	\$ 412		
Interest Expense	\$ 912,596		
Extraordinary Gain/Loss Debt Exiting	\$ (1,264,900)		
Total Other Administrative and General	\$ (316,027)	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021	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 #
SSC Administrative & Consulting Svc. LLC 8601 Dunwoody Place, Ste 775, Sandy Springs GA 30350	782,715	Back Office & Consulting Services	Page 16, line C.1.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 Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021	Page 18	of 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 2,823	2,823		
2. Non-Food Supplies	\$ 11,389	11,389		
3. Other (Specify) _____ Lease Expense	\$ 2,206	2,206		
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 380,804	380,804		
c. Other (Specify) _____	\$			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 397,222	397,222		
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 Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021		Page of 19 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$	4,682	4,682	
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. \$	9,821	9,821	
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	220,904	220,904	
c. Other (Specify)	\$			
3D. Total Laundry Expenditures (3a + b + c)	\$	235,406	235,406	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
K. Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel				
a. In-House Care	Amt.	\$ 22,416	22,416		
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel				
	Amt.	\$ 269,893	269,893		
C. Other (<i>Specify</i>)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	292,309	292,309		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Omnicare	\$	335,883	335,883		
b. Medicine Cabinet Drugs	\$	23,806	23,806		
c. Medical and Therapeutic Supplies	\$	156,493	156,493		
d. Ambulance/Limousine***	\$	66,239	66,239		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	15,846	15,846		
f. X-rays and Related Radiological Procedures***	\$	29,768	29,768		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	62,494	62,494		
i. Recreation	\$	2,917	2,917		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	273,242	273,242		
5M. Total Resident Care Expenditures (5a - 5j)	\$	966,689	966,689		

* 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)
Supplies	\$ 63,752		
Supplies - IV Therapy	\$ 3,876		
Incontinent Care Supplies	\$ 37,258		
Personal Protection Equipment	\$ 125,462		
Pandemic Testing & Vaccine	\$ 24,979		
Equipment Lease	\$ 10,638		
Minor Equipment	\$ 7,278		
Total Other Resident Care	\$ 273,242	\$ -	\$ -

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

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

** Refer to Page 4 for definition of related.

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

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

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	149,453	149,453			
b. Heat	\$	120,611	120,611			
c. Light & Power	\$	152,373	152,373			
d. Water	\$	61,573	61,573			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$	4,613	4,613			
f. Other <i>(itemize)</i>	\$	126,321	126,321			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	614,945	614,945			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$					
b. Building & Building Improvements	\$	503,938	503,938			
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$	16,278	16,278			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	520,216	520,216			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	210,038	210,038			
c. Personal property taxes	\$	6,314	6,314			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	736,568	736,568			

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Physical Plant Supplies	\$ 11,616		
Infectious Waste Disposal	\$ 4,488		
Garbage Service	\$ 22,297		
Contract Services - Periodic Maintenance	\$ 34,752		
Equipment Lease	\$ 2,379		
Offsite Storage	\$ 11,968		
Minor Equipment Purchase	\$ 22,730		
TV Cable/Dish	\$ 13,865		
Network WAN	\$ 2,227		
Total Other Repairs and Maintenance	\$ 126,321	\$ -	\$ -

Depreciation Schedule

Name of Facility Pendleton Health and Rehabilitation				License No. 2069-C			Report for Year Ended 9/30/2021			Page 23	of 37	
Property Item				Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals	
A. Land Improvements												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
A-4. Subtotal												
B. Building and Building Improvements												
1. Acquired prior to this report period				11,038,968			11,038,968			501,197		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)				49,190						2,741		
B-4. Subtotal											503,938	
C. Non-Movable Equipment												
1. Acquired prior to this report period												
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)												
C-4. Subtotal												
	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. Movable Equipment												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					709,523		709,523			15,503		
b. Disposals (attach schedule)					(5,161)							
c. Acquired during this report period (attach schedule)					20,033					775		
D-3. Subtotal											16,278	
E. Total Depreciation											520,216	

Schedule of Land Improvements Acquired during this report period

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
9/24/2020	TraneConsoleWSHeat Pump Rm211	\$ 5,572	120	\$ 604
9/11/2020	WS Heat Pump Rm 215	\$ 5,572	120	\$ 604
1/13/2021	1T Trane WSHP Rm 117	\$ 2,664	120	\$ 200
1/28/2021	Trane WS heata Pump - Install	\$ 2,727	120	\$ 205
4/22/2021	Trane Console WSHP Rm113	\$ 5,794	120	\$ 290
4/29/2021	Trane Console WSHP Rm113	\$ 5,794	120	\$ 290
5/28/2021	28 GPS Needlepoint Ionization	\$ 14,789	180	\$ 411
6/28/2021	GPS Needlepoint Ion-Install	\$ 6,279	180	\$ 140
Total additions for Building Improvement:		\$ 49,190		\$ 2,741 *
Deletions:				
Total deletions for Building Improvement		\$ -		\$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

*Ties to Page 23, Line C3

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
9/17/2020	Epson M30 Printer POC Test	\$ 4	96	\$ 1
9/22/2020	Epson M30 Printer POC Test	\$ 10	96	\$ 1
10/5/2020	Epson M30 Printer POC Test	278.64	96	34.83
10/8/2020	DS Meal Deliv Cart 36 Tray	3865.8	120	386.58
10/19/2020	Digital Rolling Chair Scale	1028.37	120	102.84
3/29/2021	DS Meal Deliv Cart 36 Tray	3865.8	120	225.51
5/25/2021	Trunnion & Bearing Dryer #1	2480.49	120	103.36
9/1/2021	Reclining Shower Commode Chair	754.54	120	6.29
7/9/2020	15 Wire Shelving Unit	-3605.27	195	-277.33
8/17/2021	4:VS Monitor, 2 WC Scale	11150.43	120	185.84
9/22/2021	3:Ipod Otterbox Case	200.84	36	5.58
Total additions for Movable Equipment		\$ 20,033		\$ 775 *
Deletions:				
11/30/2020	PCC Services	\$ (1,537)		
4/30/2021	6 MD Galaxy Tab	\$ (1,758)		
4/30/2021	GRI Powerdoc 5 IOS	\$ (1,306)		
5/31/2021	2015 PCC	\$ (560)		
Total deletions for Movable Equipment		\$ (5,161)		\$ - **

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Pendleton Health and Rehabilitation			License No. 2069-C		Report for Year Ended 9/30/2021			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021	Page 25	of 37
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11. Property Questionnaire

Part A

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

Yes

No

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

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

Description	Total			
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	120			
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				

Part B - Owner and Related Parties

1st Mortgage 2nd Mortgage 3rd Mortgage 4th Mortgage

1. Financing
 - a. Type of Financing (e.g., fixed, variable)
 - b. Date Mortgage Obtained
 - c. Interest Rate for the Cost Year
 - d. Term of Mortgage (number of years)
 - e. Amount of Principal Borrowed
 - f. Principal balance outstanding as of _____

Complete if Mortgage was Refinanced

During Current Cost Year

- g. Type of Financing (e.g., fixed, variable)
- h. Date of Refinancing
- i. New Interest Rate
- j. Term of Mortgage (number of years)
- k. Amount of Principal Borrowed
- l. Principal Outstanding on Note Paid-Off

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage		\$				
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount		\$				
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$				

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended 9/30/2021			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$				
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$				
14. Insurance						
a. Insurance on Property (buildings only)		\$ 44,652	44,652			
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$				
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$ 33,464	33,464			
General & Professional Liability						
14d. Total Insurance Expenditures (14a + b + c)		\$ 78,117	78,117			
15. Total All Expenditures (A-13 thru C-14)		\$ 11,038,170	11,038,170			

D. Adjustments to Statement of Expenditures

Name of Facility Pendleton Health and Rehabilitation			License No. 2069-C	Report for Year Ended 9/30/2021		Page 28	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
<i>Page 10 - Salaries and Wages</i>							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A.12.	Occupational Therapy	\$ 323,416	323,416		
4.			Other - See attached Schedule	\$ 58,145	58,145		
<i>Page 13 - Professional Fees</i>							
5.	13	B.8.c	Resident Care Physicians **	\$ 101,127	101,127		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
<i>Pages 15 & 16 - Administrative and General</i>							
8.			Discriminatory Benefits	\$			
9.	15	C.1.c	Bad Debts	\$ 173,776	173,776		
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.	16	C.1.I.	Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$ 2,500	2,500		
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	C.1.m	Unallowable Advertising *	\$ 11,820	11,820		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.	16	C.1.m	Unallowable Management Fees	\$ (782,715)	(782,715)		
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ (990,132)	(990,132)		
<i>Page 18 - Dietary Expenditures</i>							
24.	18	C.2.a	Meals to employees, guests and others who are not residents	\$ (9,389)	(9,389)		
<i>Page 19 - Laundry Expenditures</i>							
25.			Laundry services to employees, guests and others who are not residents	\$			
<i>Page 20 - Housekeeping Expenditures</i>							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)			\$ (1,111,452)	(1,111,452)			

* 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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	C.1.m.12	Remove Management Fee per General Ledger	\$ 618,903		
15	C.1.a.1	Remove Workers Comp Reserve, Include Paid Claims	\$ (308,596)		
15	C.1.a.5	Remove Self Insured Health Ins, Include Paid Claims	\$ (53,760)		
16	C.1.m.6	Barber and Beauty	\$ 247		
15	C.1.j	Franchise Tax in Excesss of \$250	\$ 300		
16	C.1.m.8a	Civic Dues	1147		
16	C.1.m.10	Donation/Contributions	79.41		
16	C.1.m.13	Penalties & Late Filings Director and Trustee Fees	14837.24		
16	C.1.m.13	Extraordinary Gain/Loss	-1264900		
16	C.1.m.13	Interest Income	1055.92		
16	C.1.m.13	Lost Resident Property	555.25		
Total Other A&G Adjustments			\$ (990,132)	\$ -	\$ -

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

Name of Facility Pendleton Health and Rehabilitation			License No. 2069-C	Report for Year Ended 9/30/2021		Page 29	of 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ (1,111,452)	(1,111,452)		
Page 20 - Resident Care Supplies***							
27.	20	C.5.a.	Prescription Drugs	\$ 335,883	335,883		
28.	20	C.5.d	Ambulance/Limousine	\$ 66,239	66,239		
29.	20	C.5.f	X-rays, etc	\$ 29,768	29,768		
30.	20	C.5.h	Laboratory	\$ 62,494	62,494		
31.			Medical Supplies	\$			
32.	20	C.5.e.	Oxygen (non emergency)	\$ 15,846	15,846		
33.	20	C.5.c	Occupational Therapy	\$ 3,010	3,010		
34.			Other - See Attached Schedule	\$ 141,284	141,284		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.	27	C.14.	Property Insurance	\$ (161,132)	(161,132)		
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$			
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49.	Total Amount of Decrease (Items 1 - 48)		\$	\$ (618,059)	(618,059)		

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

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	C.5.c	Ancillary Cost of Goods Sold P.E.N. Therapy	\$ 2,500		
20	C.5.c	Respiratory Therapy	\$ 3,505		
20	C.5.c	Ancillary Cost of Goods Sold IV Therapy	\$ 39,503		
20	C.5.c	Ancillary Cost of Goods Sold Equipment Rental	\$ 42,420		
20	C.5.c	Oxygen Concentrators	\$ 12,735		
20	C.5.c	Adjust Medical Supplies to Proper Cost- to-Charge Ratio	\$ 40,622		
Total Other Ancillary Costs			\$ 141,284	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021			Page 30 37
Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (<i>CT only</i>)	\$ 13,661,922	13,661,922			
b. Medicaid Room and Board Contractual Allowance **	\$ (9,166,062)	(9,166,062)			
2. a. Medicaid (<i>All other states</i>)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 7,443,089	7,443,089			
b. Medicare Room and Board Contractual Allowance **	\$ (4,761,092)	(4,761,092)			
4. a. Private-Pay Residents and Other	\$ 4,560,101	4,560,101			
b. Private-Pay Room and Board Contractual Allowance **	\$ (2,129,520)	(2,129,520)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 280,940	280,940			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (278,521)	(278,521)			
c. Prescription Drugs - Non-Medicare	\$ 167,504	167,504			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (101,478)	(101,478)			
2. a. Medical Supplies - Medicare	\$				
b. Medical Supplies - Medicare Contractual Allowance **	\$				
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$				
3. a. Physical Therapy - Medicare	\$ 1,316,834	1,316,834			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (639,524)	(639,524)			
c. Physical Therapy - Non-Medicare	\$ 218,325	218,325			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (143,627)	(143,627)			
4. a. Speech Therapy - Medicare	\$ 437,494	437,494			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (180,866)	(180,866)			
c. Speech Therapy - Non-Medicare	\$ 48,371	48,371			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (35,850)	(35,850)			
5. a. Occupational Therapy - Medicare	\$ 1,266,026	1,266,026			
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (648,772)	(648,772)			
c. Occupational Therapy - Non-Medicare	\$ 208,366	208,366			
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (141,917)	(141,917)			
6. a. Other (<i>Specify</i>) - Medicare	\$ 835,129	835,129			
b. Other (<i>Specify</i>) - Non-Medicare	\$ (66,980)	(66,980)			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 12,149,891	12,149,891			
IV. Other Revenue*					
1. Meals sold to guests, employees & others	\$ (9,389)	(9,389)			
2. Rental of rooms to non-residents	\$				
3. Telephone	\$				
4. Rental of Television and Cable Services	\$				
5. Interest Income (<i>Specify</i>)	\$ 935	935			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$				
8. Other (<i>Specify</i>)	\$				
V. Total Other Revenue (1 thru 8)	\$ (8,454)	(8,454)			
VI. Total All Revenue (III +V)	\$ 12,141,437	12,141,437			

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

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

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

Page Ref	Description	CCNH	RHNS	(Specify)
30.II.6.a	Medicare Ancillary General	\$ 834,822		
	Medicare Contra Adjustment	\$ (80,142)		
	Medicare IV Therapy	\$ 38,975		
	Medicare Laboratory	\$ 28,197		
	Medicare X/Ray	\$ 13,276		
Total Other Resident Revenue - Medicare		\$ 835,129	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
30.II.6.b	HMO/MGD, Insurance and VA X/Ray	\$ 1,539		
	Insurance and VA Laboratory	\$ 3,421		
	Medicaid and HMO/MGD IV Therapy	\$ 1,458		
	Other Residen Revenue Contra Adjustment	\$ (73,399)		
Total Other Resident Revenue		\$ (66,980)	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30. IV.5	Interest Income - Administrative	\$ 935			
Total Interest Income		\$ 935	\$ -	\$ -	

Schedule of Other Revenue

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

G. Balance Sheet

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021	Page 31	of 37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$ 2,700	
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 1,083,565	
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$ 1,776	
a. Prepaid Insurance	900			
b. Prepaid Licenses	260			
c. Prepaid Dues & Subscriptions	525			
d. See Schedule	91			
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$ 1,088,042	
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost		\$	
	Accum. Depreciation	Net		
3. Buildings	*Historical Cost	11,088,158	\$	7,078,389
	Accum. Depreciation	4,009,769 Net		
4. Leasehold Improvements	*Historical Cost		\$	
	Accum. Depreciation	Net		
5. Non-Movable Equipment	*Historical Cost		\$	
	Accum. Depreciation	Net		
6. Movable Equipment	*Historical Cost	724,396	\$	103,820
	Accum. Depreciation	620,575 Net		
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	23,457
Asset Clearing Acct	23,457			
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	7,205,666

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

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

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

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

Schedule of Other Assets Page 32 Line D7

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

Page Ref	Line Ref	Description	
33	G.A.12	PLGL Post Petition Claims	\$ 72,475
		Self Funded Health Insurance Accrual	\$ 18,774
		Accrued Property Taxes	\$ 240,628
		Accrued Other Taxes	127759.56
		Accrued CMP	6633.25
		Accrued Interest/ CLO Current Portion	220655.62
Total Other Current Liabilities (Itemize)			\$ 686,925

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

G. Balance Sheet (cont'd)

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021	Page 32	of 37
Account		Amount		
		Total Brought Forward:		\$ 8,293,707
C. Leasehold or like property recorded for Equity Purposes.				
1. Land			\$	
2. Land Improvements	*Historical Cost _____ Accum. Depreciation _____	Net	\$	
3. Buildings	*Historical Cost _____ Accum. Depreciation _____	Net	\$	
4. Non-Movable Equipment	*Historical Cost _____ Accum. Depreciation _____	Net	\$	
5. Movable Equipment	*Historical Cost _____ Accum. Depreciation _____	Net	\$	
6. Motor Vehicles	*Historical Cost _____ Accum. Depreciation _____	Net	\$	
7. Minor Equipment-Not Depreciable			\$	
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$	
D. Investment and Other Assets				
1. Deferred Deposits			\$	
2. Escrow Deposits			\$	
3. Organization Expense	*Historical Cost _____ Accum. Depreciation _____	Net	\$	
4. Goodwill (Purchased Only)			\$	
5. Investments Related to Resident Care (<i>itemize</i>)			\$	
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	10,509
Refundable Deposits	10,509			
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	10,509
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	8,304,217

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

G. Balance Sheet (cont'd)

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021	Page 33	of 37
Account			Amount	
Liabilities				
A. Current Liabilities				
1. Trade Accounts Payable			\$ 598,955	
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>)			\$ 350,221	
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$	
6. Accrued Payroll Taxes Payable			\$ 129,822	
7. Medicare Final Settlement Payable			\$	
8. Medicare Current Financing Payable			\$	
9. Mortgage Payable (<i>Current Portion</i>)			\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)			\$	
11. Accrued Income Taxes*			\$ 412	
12. Other Current Liabilities (<i>itemize</i>)			\$ 1,699,662	
Utility Accrual - Electric	4,275	Unclaimed Patient Balan	376,242	
Utility Accrual - Water	26,973	Medicare Accelerated Py	496,699	
AP Other	4,741	Medicaid Accelerated Py	99,000	
Agency Payable	4,808	See Schedule	686,925	
A-13. Total Current Liabilities (Lines A1 thru 12)			\$ 2,779,073	

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021	Page 34	of 37
Account			Amount	
			Total Brought Forward:	2,779,073
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)			\$	(8,938,858)
Name and Address of Lender	Amount	Loan Date		
Intercompany Revolver	(8,938,858)			
4. Other Long-Term Liabilities (<i>itemize</i>)			\$	9,666,427
PLGL Post-Petition Claims	431,691			
Worker's Comp Post-Petition Claims	(192,343)			
Capital Lease Obligation	9,763,406			
See Schedule	(336,327)			
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	727,570
C. Total All Liabilities (Lines A-13 + B-5)			\$	3,506,643

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

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021	Page 35	of 37
Account			Amount	
A. Reserves				
1. Reserve for value of leased land			\$	
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized			\$	
3. Reserve for depreciation value of leased personal property (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	3,694,307
6. Gain or Loss for Period	10/1/2020	thru	9/30/2021	\$ 1,103,267
7. Total Net Worth			\$	4,797,574
C. Total Reserves and Net Worth			\$	4,797,574
D. Total Liabilities, Reserves, and Net Worth			\$	8,304,217

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Pendleton Health and Rehabilitation	2069-C	9/30/2021	36	37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2020				\$ 3,694,307
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 12,141,437
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 11,038,170
D. Net Income or Deficit				\$ 1,103,267
E. Balance				\$ 4,797,574
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions				\$
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)				\$
Name and Address (No., City, State, Zip)	Title	Amount		
2. Other Withdrawings (<i>Specify</i>)				\$
Purpose	Amount			
3. Total Deductions				\$
H. Balance at End of Period				\$ 4,797,574

I. Preparer's/Reviewer's Certification

Name of Facility Pendleton Health and Rehabilitation	License No. 2069-C	Report for Year Ended 9/30/2021	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

Preparer/Reviewer Certification

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

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