State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2021

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 ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Report for Year Beginning 10/1/2020	Report for Year Ending 9/30/2021

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2203-C			07-5407

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	21668		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation Center	2203-C	9/30/2021	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for The Reservoir Care and Rehabilitation Center [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) Salvietti,Carol Anne			Printed Name (Owner) Diane Morris - VP Reimbursement	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility The Reservoir Care and Rehabilitation Center	Period Covered:		From 10/1/2020	To 9/30/2021
Address of Facility 1 Emily Way, West Hartford, CT 06107				
Report Prepared By Rick Fink	Phone Number 410-494-7657		Date 12/28/2021	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$				
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$	2,179,406	2,179,406		
5. All other wages paid	$	447,493	447,493		
6. ***Total Wages Paid***	$	2,626,899	2,626,899		
7. Total salaries paid	$	230,224	230,224		
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	2,857,123	2,857,123		

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-561-7022	9/30/2021	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
The Reservoir Care and Rehabilitation Center	1 Emily Way, West Hartford, CT 06107

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	2203-C			07-5407

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ◉ LLC ○ Partnership ○ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Salvietti,Carol Anne	001389

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
The Reservoir Care and Rehabilitation Center	101 East State Street, Kennett Square, PA 19348	PA

Name of Partners/Members	Business Address	Title	% Owned
See Attached			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
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			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ○ Yes ⊙ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Genesis Administrative Services LLC	101 East State Street, Kennett Square, PA 19348	⊙	○		Home Office	Pg 16/m12	356,569	356,569
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	⊙	○		PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	521,903	521,903
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	○	⊙		Staffing Pool	Pg 10/A12, p15-1	4,914	4,914
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	⊙	○		Medical Director /NP	Pg 13/B8, Pg 10/A12		
Career Staffing	101 East State Street, Kennett Square, PA 19348	⊙	○		Outside Agency	Pg 13/B11 pg 10-12, 1		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	⊙	○		Respiratory Therapy	Pg 13/B12, Pg 20/C5E	169	169
Genesis Healthcare Ins Program	101 East State Street, Kennett Square, PA 19348	⊙	○		Insurance	Pg 27/14	123,697	123,697
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

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

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

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

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

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

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
						Total ***	

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No

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

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General Information and Questionnaire
Accounting Basis

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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period? ⊙ Yes ○ No If "No," explain.

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 KPMG Peat Marwick	1600 Market Street, Philadelphia, PA 19103
2	
3	
4	

Services Provided by This Firm (*describe fully*)

1 Year end financial audit	$ 1,250
2	$
3	$
4	$
	Charge for Services Provided $ 1,250

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	Telephone Number
1	
2	
3	
4	
5	

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 Legal Fees pg. 15 1-e

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Schedule of Resident Statistics

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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	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	53	53			53	53						
B. As of midnight of THIS report period	59	59							59	59		
3. Total Number of Days Care Provided During Period												
A. Medicare	3,121	3,121			1,990	1,990			1,131	1,131		
B. Medicaid (Conn.)	9,141	9,141			6,552	6,552			2,589	2,589		
C. Medicaid (other states)												
D. Private Pay	1,097	1,097			465	465			632	632		
E. State SSI for RCH												
F. Other (Specify)	2,512	2,512			1,783	1,783			729	729		
G. Total Care Days During Period (3A thru F)	15,871	15,871			10,790	10,790			5,081	5,081		
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)**	15,871	15,871			10,790	10,790			5,081	5,081		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	16	27		16				
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.	595.17	284.46		529.17				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	877	877		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	707	707		
C. Other	9,425	9,425		
D. ***Total Physical Therapy Treatments***	11,009	11,009		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	199	199		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	152	152		
C. Other	1,149	1,149		
D. ***Total Speech Therapy Treatments***	1,500	1,500		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	436	436		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	526	526		
C. Other	8,246	8,246		
D. ***Total Occupational Therapy Treatments***	9,208	9,208		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	124,596	2,064				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	220,417	9,186				
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	48,987	1,912				
b. Other Maintenance Workers	9,799	472				
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	105,628	1,574				
b. RN						
1. Direct Care	519,203	10,702				
2. Administrative**	99,569	2,120				
c. LPN						
1. Direct Care	508,275	16,233				
2. Administrative**						
d. Aides and Attendants	965,580	44,779				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	55,838	2,586				
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	112,452	3,458				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	86,779	3,844				
A-13. Total Salary Expenditures	2,857,123	98,929				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
*** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Ward Clerks	$ 428	15	$ -	-	$ -	-
Central Supply	$ 127	7	$ -	-	$ -	-
Medical Records	$ 70,892	3,114	$ -	-	$ -	-
Coordinator-Staffing Centers	$ 15,332	708	$ -	-	$ -	-
Total	$ 86,779	3,844	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
1020620010 Consulting Fees	$ 416	n/a	$ -	-	$ -	-
3010620020 Purchased Services	$ -	n/a	$ -	-	$ -	-
3015620020 Purchased Services	$ -	n/a	$ -	-	$ -	-
3155620020 Purchased Services	$ 159	n/a	$ -	-	$ -	-
3080620020 Purchased Services	$ 212,212	n/a	$ -	-	$ -	-
Total	$ 212,788	-	$ -	-	$ -	-

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

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

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Salvietti,Carol Anne 1/8/2019 - present	61,546				Management of Center	1,064	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			
Section IV - Assistant Administrators										

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian						
2. Dentist	5,410	37				
3. Pharmacist	7,797	159				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	472,295	6,470				
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	21,411	274				
b. Other						
10. Occupational Therapist						
a. Resident Care	26,595	364				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	277,186	4,623				
2. Administrative***						
b. LPN						
1. Direct Care	50,367	1,189				
2. Administrative***						
c. Aides	15,795	647				
d. Other						
12. Other (Specify)						
See Attached Schedule	212,788					
B-13 Total Fees Paid in Lieu of Salaries	1,150,603	14,086				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
		○	⊙	
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	⊙	○	Common Ownership
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	⊙	○	Common Ownership
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	⊙	○	Common Ownership
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	⊙	○	Common Ownership
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	
		○	⊙	

* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation Center	2203-C	9/30/2021	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	127,051	127,051		
2. Disability Insurance	$				
3. Unemployment Insurance	$	29,432	29,432		
4. Social Security (F.I.C.A.)	$	207,608	207,608		
5. Health Insurance	$	175,865	175,865		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$	20,194	20,194		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	46,783	46,783		
d. Accounting and Auditing	$	1,250	1,250		
e. Legal (*Services should be fully described on Page 7)*	$				
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	12,346	12,346		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	15,886	15,886		
2. Cellular Phones	$	1,722	1,722		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$	253	253		
See Attached Schedule					
3. Resident Day User Fee	$	225,124	225,124		
Subtotal	$	863,516	863,516		

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

(Carry Subtotals forward to next page)

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

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
1020520020 Union Health & Welfare	$ 208	$ -	$ -
3005520020 Union Health & Welfare	$ 51	$ -	$ -
3080520020 Union Health & Welfare	$ 482	$ -	$ -
3215520020 Union Health & Welfare	$ 6,253	$ -	$ -
3225520020 Union Health & Welfare	$ 12,560	$ -	$ -
5035520020 Union Health & Welfare	$ 148	$ -	$ -
1020520060 Benefit Allocations	$ 492	$ -	$ -
3005520060 Benefit Allocations	$ -	$ -	$ -
3080520060 Benefit Allocations	$ -	$ -	$ -
3165520060 Benefit Allocations	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
Total	$ 20,194	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
1020640110 Sales Tax	$ 253	$ -	$ -
1020640110 Sales Tax	$ -	$ -	$ -
	$ -	$ -	$ -
Total	$ 253	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation Center	2203-C	9/30/2021	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		863,516	863,516		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$	84	84		
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	7,511	7,511		
5. Education Expenses Related to Seminars and Conventions	$	750	750		
6. Automobile Expense (*not purchase or depreciation*)	$				
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	117	117		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	13,698	13,698		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	1,643	1,643		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	5,882	5,882		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$				
10. Contributions***	$	539	539		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	9,023	9,023		
12. Administrative Management Services**	$	430,447	430,447		
13. Other (*Specify*)	$	145,288	145,288		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	1,478,497	1,478,497		

* 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)
1020630020 Advertising	$ 8,589	$ -	$ -
1020630330 Marketing Expense	$ 2,804	$ -	$ -
1020630331 Marketing Exp- Corporate Spend	$ 2,305	$ -	$ -
3165630330 Marketing Exp- Corporate Spend	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
Total Other Advertising	$ 13,698	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
1020630310 Licenses & Certifications	$ 5,882	$ -	$ -
1020630310 Dues to Chamber of Commerce	$ -	$ -	$ -
1020630310	$ -	$ -	$ -
1020630310	$ -	$ -	$ -
1020630310	$ -	$ -	$ -
Total Dues	$ 5,882	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
1020630130 Contributions	$ -	$ -	$ -
1020630135 Political Contributions	$ 539	$ -	$ -
Total Contributions	$ 539	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
1020630060 Bank Service Charges	$ 3,927	$ -	$ -
1020630120 Collection Fees	$ 13,017	self-disallowed	$ -
1020630140 Education Expense	$ 8	$ -	$ -
1020630180 Employee Physicals	$ (3,763)	$ -	$ -
1020630200 Employee Relations	$ 4,374	$ -	$ -
1020630380 Printing	$ 746	$ -	$ -
1020630610 Training Expense	$ 63	$ -	$ -
1020640080 Fines & Penalties	$ 6,000	self-disallowed	$ -
1020640090 Miscellaneous	$ 100,232	$ -	$ -
1020660080 Rental Expense	$ 6,175	$ -	$ -
1020660990 Accrued Expense Estimation	$ 777	self-disallowed	$ -
5095720090 Landlord Operating Taxes	$ -	$ -	$ -
1020720070 State Tax Annual Report Filing	$ 465	$ -	$ -
3080630440 Recruiting Fees	$ 3,200	$ -	$ -
3080630441 Recruiting Fees	$ 3,432	$ -	$ -
7010800030 Non-recurring Charges	$ -	$ -	$ -
1020630640 Uniforms	$ -	$ -	$ -
1020640060 Equipment Non-Capitalized	$ 6,634	$ -	$ -
	$ -	$ -	$ -
Total Other Administrative and General	$ 145,288	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
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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	356,569	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.**

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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	9/30/2021	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	77,926	77,926		
2. Non-Food Supplies	$	14,192	14,192		
3. Other (*Specify*)_____	$	187	187		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	522,798	522,798		
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	615,103	615,103		

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?	○ Yes	⊙ No	
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	○ Yes	⊙ No	If yes, specify cost.
K.	Is any revenue collected from these people?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⊙ 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.

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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 9/30/2021		Page 19 | of 37
Item	Total	CCNH	RHNS	(Specify)
3. Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Lbs.			
	Amt. $ 3,052	3,052		
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. $ 1,628	1,628		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$ 128,133	128,133		
c. Other (*Specify*)	$			
3D. ***Total Laundry Expenditures*** (3a + b + c)	$ 132,813	132,813		

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⊙ 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?	○ Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⊙ 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation Center	2203-C	9/30/2021	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	10,474	10,474		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	209,134	209,134		
C. Other (*Specify*)		$				
4D. ***Total Housekeeping Expenditures*** (4a + b + c)		$	219,608	219,608		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	183,573	183,573		
b. Medicine Cabinet Drugs		$	10,463	10,463		
c. Medical and Therapeutic Supplies		$	112,442	112,442		
d. Ambulance/Limousine***		$	2,480	2,480		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	9,388	9,388		
f. X-rays and Related Radiological Procedures***		$	7,286	7,286		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	32,095	32,095		
i. Recreation		$	14,729	14,729		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	48,591	48,591		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	421,047	421,047		

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
3060610160 Incontinency	$ 19,420	$ -	$ -
3060610161 Advertising-Help Wanted	$ (314)	$ -	$ -
3080630030 Advertising-Help Wanted	$ 5,272	$ -	$ -
3080630080 Books, Dues & Subscriptions	$ -	$ -	$ -
3080630140 Education Expense	$ 121	$ -	$ -
3120630530 Supplies	$ 866	$ -	$ -
3155630530 Supplies	$ 3,260	$ -	$ -
3170630530 Supplies	$ -	$ -	$ -
3090630535 Office Supplies	$ 27	$ -	$ -
3120630535 Office Supplies	$ -	$ -	$ -
3165630535 Office Supplies	$ -	$ -	$ -
3080630610 Training Expense	$ -	$ -	$ -
3120660080 Rental Expense	$ 380	$ -	$ -
3155660080 Rental Expense	$ 622	$ -	$ -
3010610300 Consolidated Billing	$ 12,152	$ -	$ -
3080630630 Tuition Reimbursement	$ -	$ -	$ -
3210630630 Tuition Reimbursement	$ -	$ -	$ -
3225630630 Tuition Reimbursement	$ -	$ -	$ -
Miscellaneous	$ -	$ -	$ -
3080630310 Licenses & Certifications	$ -	$ -	$ -
3165630530 Supplies	$ -	$ -	$ -
3080630550 T&E-Lodging/Transportation	$ 6,786	$ -	$ -
	$ -	$ -	$ -
Total Other Resident Care	$ 48,591	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation Center	2203-C	9/30/2021	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Laundry Purchased Services	128,133			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Housekeeping Purchased Services	209,134			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	○	⊙	Vendor Contracted	Dietary Purchased Services	522,798			18	2b
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							
		○	⊙							

* List all contracted services over $10,000. Use additional sheets if necessary.
** Refer to Page 4 for definition of related.
*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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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	9/30/2021	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	335,040	335,040		
b. Heat	$	27,673	27,673		
c. Light & Power	$	141,225	141,225		
d. Water	$	27,815	27,815		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	531,752	531,752		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	4,740	4,740		
b. Building & Building Improvements	$	20,408	20,408		
c. Non-Movable Equipment	$	647	647		
d. Movable Equipment	$	10,510	10,510		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	36,305	36,305		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$				
c. Leasehold Improvements	$				
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$				
9. Rental payments on leased real property less real estate taxes included in item 10b	$				
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	225,650	225,650		
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	261,955	261,955		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
	$ -	$ -	$ -
Total Other Repairs and Maintenance	$ -	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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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	14,219		14,219	4,740	S/L	Various	4,740	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	78		78					
A-4. Subtotal								4,740
B. **Building and Building Improvements**								
1. Acquired prior to this report period	46,330		46,330	5,241	S/L	Various	4,746	
2. Disposals (attach schedule)	(1,937)		(1,937)					
3. Acquired during this report period (attach schedule)	289,246		289,246				15,662	
B-4. Subtotal								20,408
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	6,312		6,312	971	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								
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					44,697		44,697	7,045	S/L	Various	6,570	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					43,850		43,850				3,940	
D-3. Subtotal												10,510
E. ***Total Depreciation***												36,305

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
9/30/2021	September 2021 DSSI Accrual	$ 78	3	$ -	
Total additions for Land Improvement		$ 78		$ -	*
Deletions:					
			-		
Total deletions for Land Improvement		$ -		$ -	**

***Ties to Page 23, Line A3**

****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
11/30/2020	3 - Water Source Heat Pumps and required wrk/hardware for Kitchen, Gym, &	$ 33,062	08 01	$ 3,408	
3/31/2021	Electrical Work for Center & Electrical Permit	$ 48,743	07 09	$ 3,145	
5/31/2021	Reconstruction Work for Sprinkler Break	$ 206,558	07 07	$ 9,079	
6/30/2021	Video Surveillance Digital Systems	$ 883	07 06	$ 29	
Total additions for Building Improvement		$ 289,246		$ 15,662	*
Deletions:					
9/30/2020	Sept 2020 Accruals	$ (1,937)			
Total deletions for Building Improvement		$ (1,937)		$ -	**

***Ties to Page 23, Line B3**

****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report peri

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

Total deletions for Non-Movable Equipmen		$ -		$ -	**

***Ties to Page 23, Line C3**
****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
10/31/2020	Genesis 76ix72i Stationary Safety Partitio	$ 324.37	05 00	$ 64.87	
1/31/2021	Heated 2 Stack Dish Dispenser	$ 2,967.03	07 11	$ 249.85	
2/28/2021	Mini Rooter Pro Cable in Drum & Cutter S	$ 897.58	05 00	$ 104.72	
3/31/2021	40 - Panacea Custom Foam Mattresses	$ 8,592.23	03 00	$ 1,432.04	
3/31/2021	1 - 310 Series Vertical File Cabinet	$ 444.53	07 09	$ 28.68	
4/30/2021	35 - Panacea Custom Foam Mattresses	$ 7,518.20	03 00	$ 1,044.19	
5/31/2021	18 - Window set Cushion Seats	$ 21,126.43	07 07	$ 928.63	
5/31/2021	Medium Duty Manual Slicer w/ 12" Blade	$ 1,979.15	07 07	$ 86.99	
Total additions for Movable Equipmen		$ 43,850		$ 3,940	*
Deletions:					
Total deletions for Movable Equipmen		$ -		$ -	**

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report peri

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

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation Center	2203-C	9/30/2021	24	37

Item	Date of Acquisition Month	Date of Acquisition Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense** 1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense** 1.									
2.									
3.									
B-4. Subtotal									
C. **Leasehold Improvements and Other** 1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. ***Total Amortization***									

* Straight-line method must be used.

** Specify which of the following bases were used:

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation	2203-C	9/30/2021	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ No

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

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

Description	Total
1. Date Land Purchased	n/a
2. Date Structure Completed	n/a
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	
5. Total Licensed Bed Capacity	75
6. Square Footage	
7. Acquisition Cost	
a. Land	n/a
b. Building	n/a

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
GMF-CT	Facility Lease	12/21/2018-12	10 years	
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.

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

Name of Facility	License No.	Report for Year Ended	Page of
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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*)

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

Name of Facility	License No.	Report for Year Ended	Page of
The Reservoir Care and Rehabilitati	2203-C	9/30/2021	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment 1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $				
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $				
14. Insurance				
a. Insurance on Property (buildings only) $	8,935	8,935		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $	114,762	114,762		
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	123,697	123,697		
15. ***Total All Expenditures (A-13 thru C-14)*** $	7,792,198	7,792,198		

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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	9/30/2021	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.			Occupational Therapy $				
4.			Other - See attached Schedule $	39,797	39,797		
Page 13 - Professional Fees							
5.	13	B-8-c	Resident Care Physicians ** $				
6.		B-10	Occupational Therapy $				
7.			Other - See attached Schedule $	520,460	520,460		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1-c	Bad Debts $	46,783	46,783		
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 * $	13,698	13,698		
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $	539	539		
21.			Unallowable Management Fees $	73,878	73,878		
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	96,652	96,652		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $	23,893	23,893		
			Subtotal (Items 1 - 26) $	815,699	815,699		

* 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	$ 39,797	$ -	$ -
Total Other Salaries Adjustment			$ 39,797	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	$ 64,326	$ -	$ -
13	5	Rehabilitation Services	$ 407,968	$ -	$ -
13	9	Speech Therapist	$ 21,411	$ -	$ -
13	10	Occupational Therapist	$ 26,595	$ -	$ -
13	12	Other	$ -	$ -	$ -
13	12	Other	$ -	$ -	$ -
13	12	Respiratory Purchased Servies	$ 159	$ -	$ -
Total Other Fees Adjustments			$ 520,460	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	$ 13,017	$ -	$ -
16	m-13	Estimated Accrual	$ 777	$ -	$ -
16	m-13	Non-recurring Charges	$ -	$ -	$ -
16	m-13	Dues to Chamber of Commerce	$ -	$ -	$ -
16	m-13	Penalty	$ 6,000	$ -	$ -
16	m-12	Management Fee disallowed	$ -	$ -	$ -
15	1-a-1	adj workers comp	$ (72,283)	$ -	$ -
22	6.a	10.88% disallowed regional office	$ 36,452	$ -	$ -
22	6.b	10.88% disallowed regional office	$ 3,011	$ -	$ -
22	6.c	10.88% disallowed regional office	$ 15,365	$ -	$ -
22	6.d	10.88% disallowed regional office	$ 3,026	$ -	$ -
22	6.f	10.88% disallowed regional office	$ -	$ -	$ -
13	B12	adj to SNAP Strike Cost (disallowable)	$ 91,286	$ -	$ -
Total Other A&G Adjustments			$ 96,652	$ -	$ -

Schedule of Housekeeping Exp adjs

Page Ref	Line Ref	Description		CCNH	RHNS	(Specify)
20	4. b	10.88% disallowed regional office-Housekeeping	$ 22,753.78			
20	4.a.1	10.88% disallowed regional office-Housekeeping-Other	$ 1,139.58			
Total Housekeeping Expenditures ad			$ 23,893			

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

Name of Facility	License No.	Report for Year Ended	Page of
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Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	815,699	815,699		
Page 20 - Resident Care Supplies***								
27.	20	5-a-2	Prescription Drugs	$	183,573	183,573		
28.	20	5-d	Ambulance/Limousine	$	2,480	2,480		
29.	20	5-f	X-rays, etc	$	7,286	7,286		
30.	20	5-h	Laboratory	$	32,095	32,095		
31.			Medical Supplies	$				
32.	20	5-e-2	Oxygen (non emergency)	$	9,388	9,388		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	16,034	16,034		
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$	(2,019)	(2,019)		
36.			Depreciation on Unallowable Motor Vehicles	$				
37.			Unallowable Property and Real Estate Taxes	$				
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$				
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.			Property Insurance	$				
Other - Miscellaneous								
42.			Other - Indirect	$	8,998	8,998		
43.			Interest Income on Account Rec.	$				
44.			Other - Miscellaneous Administrative	$	97,912	97,912		
45.			Management Fees Direct	$				
46.			Management Fees Indirect	$				
47.			Other - Direct	$				
Not For Profit Providers Only								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
49.	***Total Amount of Decrease (Items 1 - 48)***			$	1,171,447	1,171,447		

*** 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.

Attachment Page 29

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	$ 12,152	$ -	$ -
20	5-j	Respiratory Supplies	$ 3,260	$ -	$ -
20	5-j	Respiratory Rental	$ 622	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
0	0-Jan	0	$ -	$ -	$ -
Total Other Ancillary Costs			$ 16,034	$ -	$ -

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	$ (4,532)	$ -	$ -
Page 22	7c	Non Movable Equip	$ (1,847)	$ -	$ -
Page 22	7d	Movable Equip	$ (20,191)	$ -	$ -
22	10.b	10.88% disallowed regional office-Real Estate Tax	$ 24,551	$ -	$ -
Total Excess Movable Equipment Depreciation			$ (2,019)	$ -	$ -

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-i	Cable TV - Allowable $3,600 Account#3005660130	$ 8,998	$ -	$ -
Total Other Adjustments			$ 8,998	$ -	$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14c1	General liability Insurance Adjust	$ 97,912	$ -	$ -
Total Other Adjustments			$ 97,912	$ -	$ -

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page	of
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Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	4,619,256	4,619,256		
b. Medicaid Room and Board Contractual Allowance **	$	(2,059,775)	(2,059,775)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,692,697	1,692,697		
b. Medicare Room and Board Contractual Allowance **	$	(348,159)	(348,159)		
4. a. Private-Pay Residents and Other	$	1,931,540	1,931,540		
b. Private-Pay Room and Board Contractual Allowance **	$	(658,758)	(658,758)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	82,710	82,710		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(17,012)	(17,012)		
c. Prescription Drugs - Non-Medicare	$	108,381	108,381		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(37,534)	(37,534)		
2. a. Medical Supplies - Medicare	$	1,151	1,151		
b. Medical Supplies - Medicare Contractual Allowance **	$	(237)	(237)		
c. Medical Supplies - Non-Medicare	$	82	82		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(35)	(35)		
3. a. Physical Therapy - Medicare	$	281,213	281,213		
b. Physical Therapy - Medicare Contractual Allowance **	$	(57,841)	(57,841)		
c. Physical Therapy - Non-Medicare	$	292,251	292,251		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(102,956)	(102,956)		
4. a. Speech Therapy - Medicare	$	97,273	97,273		
b. Speech Therapy - Medicare Contractual Allowance **	$	(20,007)	(20,007)		
c. Speech Therapy - Non-Medicare	$	92,931	92,931		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(32,943)	(32,943)		
5. a. Occupational Therapy - Medicare	$	244,817	244,817		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(50,355)	(50,355)		
c. Occupational Therapy - Non-Medicare	$	258,046	258,046		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(90,311)	(90,311)		
6. a. Other *(Specify)* - Medicare	$	19,694	19,694		
b. Other *(Specify)* - Non-Medicare	$	19,892	19,892		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	6,266,011	6,266,011		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	698	698		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	815,926	815,926		
V. Total Other Revenue (1 thru 8)	$	816,624	816,624		
VI. Total All Revenue (III +V)	$	7,082,634	7,082,634		

* *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	$ 3,369	$ -	$ -
II-6-a	Medicare -Laboratory	$ 14,692	$ -	$ -
II-6-a	Medicare -Respiratory Therapy & Supplies	$ 195	$ -	$ -
II-6-a	Medicare -Nursing Treatment Supplies	$ -	$ -	$ -
II-6-a	Medicare -Audiology	$ -	$ -	$ -
II-6-a	Medicare -Incontinency	$ -	$ -	$ -
II-6-a	Medicare -Oxygen & Supplies	$ -	$ -	$ -
II-6-a	Medicare -Physician Visit	$ -	$ -	$ -
II-6-a	Medicare -Ambulance	$ 2,786	$ -	$ -
II-6-a	Medicare -Flu Shot	$ 3,752	$ -	$ -
II-6-a	Medicare Contractual-X-Ray	$ (693)	$ -	$ -
II-6-a	Medicare Contractual-Laboratory	$ (3,022)	$ -	$ -
II-6-a	Medicare Contractual-Respiratory Therapy & Supplies	$ (40)	$ -	$ -
II-6-a	Medicare Contractual-Nursing Treatment Supplies	$ -	$ -	$ -
II-6-a	Medicare Contractual-Audiology	$ -	$ -	$ -
II-6-a	Medicare Contractual-Incontinency	$ -	$ -	$ -
II-6-a	Medicare Contractual-Oxygen & Supplies	$ -	$ -	$ -
II-6-a	Medicare Contractual-Physician Visit	$ -	$ -	$ -
II-6-a	Medicare Contractual-Ambulance	$ (573)	$ -	$ -
II-6-a	Medicare Contractual-Flu Shot	$ (772)	$ -	$ -
Total Other Resident Revenue - Medicare		$ 19,694	$ -	$ -

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	$ 324	$ -	$ -
II-6-b	Medicaid-Respiratory Therapy & Supplies	$ -	$ -	$ -
II-6-b	Medicaid-Nursing Treatment Supplies	$ -	$ -	$ -
II-6-b	Medicaid-Audiology	$ -	$ -	$ -
II-6-b	Medicaid-Incontinency	$ -	$ -	$ -
II-6-b	Medicaid-Oxygen & Supplies	$ -	$ -	$ -
II-6-b	Medicaid-Physician Visit	$ -	$ -	$ -
II-6-b	Medicaid-Ambulance	$ 11	$ -	$ -
II-6-b	Medicaid-Flu Shot	$ -	$ -	$ -
II-6-b	Contractuals-Medicaid-X-Ray	$ -	$ -	$ -
II-6-b	Contractuals-Medicaid-Laboratory	$ (145)	$ -	$ -
II-6-b	Contractuals-Medicaid-Respiratory Therapy & Supplies	$ -	$ -	$ -
II-6-b	Contractuals-Medicaid-Nursing Treatment Supplies	$ -	$ -	$ -
II-6-b	Contractuals-Medicaid-Audiology	$ -	$ -	$ -
II-6-b	Contractuals-Medicaid-Incontinency	$ -	$ -	$ -
II-6-b	Contractuals-Medicaid-Oxygen & Supplies	$ -	$ -	$ -
II-6-b	Contractuals-Medicaid-Physician Visit	$ -	$ -	$ -
II-6-b	Contractuals-Medicaid-Ambulance	$ (5)	$ -	$ -
II-6-b	Contractuals-Medicaid-Flu Shot	$ -	$ -	$ -
II-6-b	Non-Medicaid-X-Ray	$ 2,890	$ -	$ -
II-6-b	Non-Medicaid-Laboratory	$ 16,318	$ -	$ -
II-6-b	Non-Medicaid-Respiratory Therapy & Supplies	$ -	$ -	$ -
II-6-b	Non-Medicaid-Nursing Treatment Supplies	$ -	$ -	$ -
II-6-b	Non-Medicaid-Audiology	$ -	$ -	$ -
II-6-b	Non-Medicaid-Incontinency	$ -	$ -	$ -
II-6-b	Non-Medicaid-Oxygen & Supplies	$ -	$ -	$ -
II-6-b	Non-Medicaid-Physician Visit	$ -	$ -	$ -
II-6-b	Non-Medicaid-Ambulance	$ 10,697	$ -	$ -
II-6-b	Non-Medicaid-Flu Shot	$ -	$ -	$ -
II-6-b	Non-Medicaid-Capitation Contracts	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid-X-Ray	$ (986)	$ -	$ -
II-6-b	Contractuals-Non-Medicaid-Laboratory	$ (5,565)	$ -	$ -
II-6-b	Contractuals-Non-Medicaid-Respiratory Therapy & Supplies	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid-Nursing Treatment Supplies	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid-Audiology	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid-Incontinency	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid-Oxygen & Supplies	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid-Physician Visit	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid-Ambulance	$ (3,648)	$ -	$ -
II-6-b	Contractuals-Non-Medicaid-Flu Shot	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid-Capitation Contracts	$ -	$ -	$ -
Total Other Resident Revenue		$ 19,892	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
IV-5	Interest On Overdue Accounts	430055	$ 698	$ -	$ -
Total Interest Income			$ 698	$ -	$ -

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
IV-8	Elim Basic Healthcare Revenue		$ 538,387	$ -	$ -
IV-8	Federal Stimulus 4		$ 129,500	$ -	$ -
IV-8	Federal Stimulus 4 - Part 2		$ -	$ -	$ -
IV-8	State COVID Support - Other		$ 140,943	$ -	$ -
IV-8	REHAB SETTLEMENT and Telehealth Facility Fees		$ 5,901	$ -	$ -
IV-8	Nursing Home Provide Tax Refund		$ 910	$ -	$ -
IV-8	MISC INCOME		$ 285	$ -	$ -
0		0	$ -	$ -	$ -
0		0	$ -	$ -	$ -
0		0	$ -	$ -	$ -
0		0	$ -	$ -	$ -
0		0	$ -	$ -	$ -
0		0	$ -	$ -	$ -
Total Other Revenue			$ 815,926	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation C	2203-C	9/30/2021	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 4,270
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 932,768
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (37,444)
4 Inventories				$ 35,636
5. Prepaid Expenses				$ 57,109
a. Prepaid Expenses				
b. Prepaid Property Tax		54,192		
c. Prepaid Personal Property Tax		2,917		
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 992,339
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	14,297		$ 4,818
	Accum. Depreciation	9,479	Net	
3. Buildings	*Historical Cost	333,640		$ 307,991
	Accum. Depreciation	25,649	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	6,312		$ 4,694
	Accum. Depreciation	1,618	Net	
6. Movable Equipment	*Historical Cost	88,547		$ 70,992
	Accum. Depreciation	17,555	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 388,495

* 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	
Total Prepaid Expenses			$ -

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description		
32	D7	ROU Bldg Asset-Oper Lease	150510	#VALUE!
32	D7	AccumAmort-ROU Bldg OprLease	150511	#VALUE!
Total Other Assets				#VALUE!

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

Page Ref	Line Ref	Description		
33	A12	Accr Exp Other	210010	#VALUE!
33	A12	Accr Exp Water and Sewer	210090	#VALUE!
33	A12	Accr Exp Gas	210100	#VALUE!
33	A12	Accr Exp Electricity	210110	#VALUE!
33	A12	Accr Exp Suspense	210240	#VALUE!
33	A12	Accr Exp Nursing Purchased Ser	210310	#VALUE!
33	A12	Deferred Revenue	210340	#VALUE!
33	A12	A/R Credit Gross Up Liability	210345	#VALUE!
33	A12	Accrued Provider/Bed Tax	210350	#VALUE!
33	A12	Accr Gross Rec Tax-FY11	215311	#VALUE!
33	A12	Accr Gross Rec Tax-FY12	215312	#VALUE!
33	A12	Accr Gross Rec Tax-FY13	215313	#VALUE!
33	A12	Accr Gross Rec Tax-FY14	215314	#VALUE!
33	A12	Accr Gross Rec Tax-FY15	215315	#VALUE!
33	A12	Accr Gross Rec Tax-FY16	215316	#VALUE!
33	A12	Accr Gross Rec Tax-FY17	215317	#VALUE!
33	A12	Accr Gross Rec Tax-FY18	215318	#VALUE!
33	A12	Accr Sales and Use Tax - FY18	215418	#VALUE!
Total Other Current Liabilities (Itemize)				#VALUE!

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

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

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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 C	2203-C	9/30/2021	32	37

Account				Amount
			Total Brought Forward:	$ 1,380,834
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 (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ #VALUE!
I/C Due to/Due From Owned		(1,683,379)		
I/C Due to/Due From Multicare				
See Schedule		#VALUE!		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ #VALUE!
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ #VALUE!

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

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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	9/30/2021	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 475,189
2. Notes Payable (*itemize*)	$
See Schedule	
3. Loans Payable for Equipment (*Current portion*) (*itemize*)	$
Name of Lender / Purpose / Amount / Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)	$ 100,279
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$ 1,295
7. Medicare Final Settlement Payable	$
8. Medicare Current Financing Payable	$
9. Mortgage Payable (*Current Portion*)	$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)	$
11. Accrued Income Taxes*	$
12. Other Current Liabilities (*itemize*)	$ #VALUE!
See Schedule #VALUE!	
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ #VALUE!

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

(Carry Total forward to next page)

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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 Cente	2203-C	9/30/2021	34	37

Account	Amount
Total Brought Forward:	#VALUE!
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)		$ 34
LT Debt-Financing Obligation		
Escheatable Funds	34	
See Schedule		
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 34
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ #VALUE!

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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	9/30/2021	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*Equity)*	$
	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	$ (570,698)
	6. Gain or Loss for Period 10/1/2020 thru 9/30/2021	$ (709,562)
	7. Total Net Worth	$ (1,280,260)
C.	***Total Reserves and Net Worth***	$ (1,280,260)
D.	***Total Liabilities, Reserves, and Net Worth***	$ #VALUE!

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation C	2203-C	9/30/2021	36	37

	Account	Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2020	$ (570,697)
B.	Total Revenue (*From Statement of Revenue Page 30*)	$ 7,082,635
C.	Total Expenditures (*From Statement of Expenditures Page 27*)	$ 7,792,198
D.	Net Income or Deficit	$ (709,563)
E.	Balance	$ (1,280,260)
F.	Additions	
	1. Additional Capital Contributed (*itemize*)	
	2. Other (*itemize*)	
F-3.	Total Additions	$
G.	Deductions	
	1. Drawings of Owners/Operators/Partners (*Specify*)	$

Name and Address (*No., City, State, Zip*)	Title	Amount

	2. Other Withdrawings *(Specify)*	$

Purpose	Amount

	3. Total Deductions		$
H.	***Balance at End of Period***	09/30/21	$ (1,280,260)

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
The Reservoir Care and Rehabilitation	2203-C	9/30/2021	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. 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
Rick Fink

Addres Address	Phone Number
200 Brickstone Square, Andover, MA 01810	410-494-7657

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Rick Fink	410-494-7657

Contact Email Address
Rick.Fink@genesishcc.com