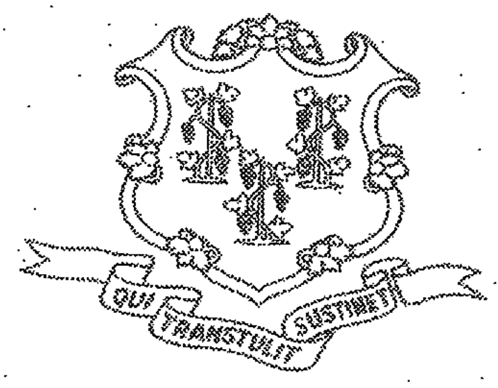
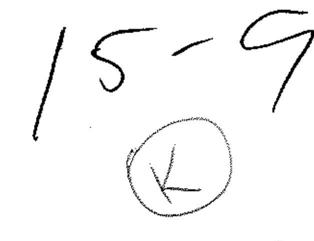
State of Connecticut





Annual Report of Long-Term Care Facility

Cost Year 2015

RECEIVED
DEC 31 2015
DEPT. OF SOCIAL SERVICES
OFFICE OF CON AND RATE SETTINGS

Name of Facility (as licensed) Glen Hill Care and Rehabilitation Center	
Address (No. & Street, City, State, Zip Code) 1 Glen Hill Road, Danbury, CT 06811	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2217-C			07-5031

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	7153		

For Department Use Only

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

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State of Connecticut
Annual Report of Long-Term Care Facility
CSP-1 Rev.9/2002

General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	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 Glen Hill Care and Rehabilitation Center [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, 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
			[signature]	11/13/2015
Printed Name (Administrator) Talamona,Marnie			Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare	
Subscribed and Sworn to before me:	State of PA	Date 11/13/15	Signed (Notary Public) [signature]	Comm. Expires / /
Address of Notary Public				

COMMONWEALTH OF PENNSYLVANIA
NOTARIAL SEAL
OLUSEGUN A. OMOLAJA, Notary Public
Upper Darby Twp., Delaware County
My Commission Expires May 28, 2017

(Notary Seal)

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Administrator's/Owner's Certification

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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) Talamona,Marnie			Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

State of Connecticut
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CSP-1A Rev. 6/95

State of Connecticut
Department of Social Services
25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjustment						Page 1A	of 37
Name of Facility Glen Hill Care and Rehabilitation Center			Period Covered:			From 10/1/2014	To 9/30/2015
Address of Facility 1 Glen Hill Road, Danbury, CT 06811							
Report Prepared By Thomas Farnan			Phone Number 978-247-5029			Date 12/21/2015	
	Item		Total	CCNH	RHNS	(Specify)	
1.	Dietary wages paid	$	353,459	353,459			
2.	Laundry wages paid	$					
3.	Housekeeping wages paid	$					
4.	Nursing wages paid	$	3,323,441	3,323,441			
5.	All other wages paid	$	534,397	534,397			
6.	***Total Wages Paid***	$	4,211,297	4,211,297			
7.	Total salaries paid	$	232,941	232,941			
8.	***Total Wages and Salaries Paid*** (As per page 10 of Report)	$	4,444,238	4,444,238			

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
203-744-2840	9/30/2015	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Glen Hill Care and Rehabilitation Center	1 Glen Hill Road, Danbury, CT 06811

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2217-C			07-5031

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.:
Talamona,Marnie	1575

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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	3 | 37

Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered

Name of Partners/Members	Business Address	Title	% Owned
Harborside Health I Corporatio	101 Sun Ave. NE, Albuquerque, NM 87109		1
Harborside Healthcare Limited	101 Sun Ave. NE, Albuquerque, NM 87109		99

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CSP-3A Rev. 10/2005

General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	3A	37

If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Glen Hill 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
N/A			
Names of Stockholders Owning at Least 10% of Shares			
N/A			

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CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	3B	37

If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

General Information and Questionnaire

Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	4	37

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 Health Ventures	101 East State Street, Kennett Square, PA 19348	⊙	○		Home Office	Pg 16/m12	449,230	449,230
Genesis ElderCare Rehabilitation Services	101 East State Street, Kennett Square, PA 19348	⊙	○	63%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	1,501,809	1,501,809
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	⊙	○	55%	Staffing Pool	Pg 10/A12	1,876	1,876
Genesis ElderCare Physician Services	101 East State Street, Kennett Square, PA 19348	⊙	○	85%	Case Management	Pg 13/B8, Pg 10/A12	40,140	40,140
Career Staffing	101 East State Street, Kennett Square, PA 19348	⊙	○		Staffing Pool	Pg 13/B11 a,b,c		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	⊙	○	43%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	31,866	31,866
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Insurance	Pg 27/14	131,721	131,721
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	⊙	○		Capital Interest	Page 17, page 26-12A	44,774	44,774
		○	○					

* 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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	5	37

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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	6 of 37

Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
						Total ***	

Is a Mileage Log Book Maintained for All Leased Vehicles ? O Yes O 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

Name of Facility	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation	2217-C	9/30/2015	7	37

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

⊙ Accrual O Cash O Modified Cash

Is the accounting basis for this period the same as for the previous period? ⊙ Yes O 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	$
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.

O Yes ⊙ No

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 GOLDMAN GRUDER & WOOD, LLC	(203) 899-8900
2 Schettino and Temchin Attorneys at Law	(860) 621-4352
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1 200 Connecticut Ave. Norwalk, CT 06854
2 18 Peck st, North Haven, CT 06473
3
4
5

Services Provided by This Firm (*describe fully*)

1 Draft applications for PJR, telephone conferences, property searches, correspondence with clients	$
2 Probate claim and court fees	$
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 O No Legal Fees pg. 15 1-e

Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	8	37

	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	100	100			100	100			100	100		
B. On last day of THIS report period	100	100			100	100			100	100		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	88	88			88	88			89	89		
B. As of midnight of THIS report period	88	88			89	89			88	88		
3. Total Number of Days Care Provided During Period												
A. Medicare	11,358	11,358			8,882	8,882			2,476	2,476		
B. Medicaid (Conn.)	17,071	17,071			12,902	12,902			4,169	4,169		
C. Medicaid (other states)												
D. Private Pay	2,394	2,394			1,553	1,553			841	841		
E. State SSI for RCH												
F. Other (Specify)	2,821	2,821			1,962	1,962			859	859		
G. Total Care Days During Period (3A thru F)	33,644	33,644			25,299	25,299			8,345	8,345		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	12	12			12	12						
B. Other Bed Reserve Days	20	20			17	17			3	3		
5. ***Total Resident Days*** (3G + 4A + 4B)	33,676	33,676			25,328	25,328			8,348	8,348		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	9	37

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
				Lost			Gained						
	CCNH (1)	RHNS (2)	(Specify) (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-IID
No. of Residents	25	45		18				
Per Diem Rate								
a. One bed rm.				468.00				
b. Two bed rms.	630.08	202.80		450.37				
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	1,396	1,396		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	29	29		
C. Other	35,481	35,481		
D. ***Total Physical Therapy Treatments***	36,906	36,906		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	269	269		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	1,863	1,863		
D. ***Total Speech Therapy Treatments***	2,132	2,132		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,505	1,505		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	32	32		
C. Other	34,375	34,375		
D. ***Total Occupational Therapy Treatments***	35,912	35,912		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	10	37

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)	144,024	2,086				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	196,703	9,010				
5. Dietary Service						
a. Head Dietitian	34,588	1,109				
b. Food Service Supervisor	59,939	2,212				
c. Dietary Workers	258,932	18,802				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	54,643	2,065				
b. Other Maintenance Workers	33,530	2,064				
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	88,917	1,738				
b. RN						
1. Direct Care	1,406,026	41,525				
2. Administrative**	1,910	37				
c. LPN						
1. Direct Care	619,103	22,867				
2. Administrative**						
d. Aides and Attendants	1,225,920	76,906				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists						
h. Recreation Workers	97,036	4,271				
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	152,484	5,967				
n. Marketing						
o. Other (Specify) See Attached Schedule	70,482	4,178				
A-13. Total Salary Expenditures	4,444,238	194,835				

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

Schedule of Other Salaries and Wages (Page 10)

Position		CCNH $	CCNH Hours	RHNS $	RHNS Hours	(Specify) $	(Specify) Hours
Ward Clerks	-	0	0			0	0
Coordinator-Staffing Centers	-	$ 20,887	1,230			0	0
Central Supply	-	$ 14,844	874			0	0
Medical Records	-	$ 34,752	2,073			0	0
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
-	-	$ -	-				
Total		$ 70,482.36	4,178	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

Service		CCNH $	CCNH Hours	RHNS $	RHNS Hours	(Specify) $	(Specify) Hours
1020620010	Consulting Fees	148.85	n/a			-	
1020620010	Consulting Fees	409.70	n/a				
1020620010	Consulting Fees	919.85	n/a				
3010620020	Purchased Services	4,985.50	n/a				
3155620020	Purchased Services	8,907.99	n/a				
3155620020	Purchased Services	1,582.68	n/a				
0	0	-	-				
0	0	-	-				
0	0	-	-				
0	0	-	-				
Total		$ 16,955	0	$ -	-	$ -	-

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

Name of Facility				License No.		Report for Year Ended			Page	of
Glen Hill Care and Rehabilitation Center				2217-C		9/30/2015			11	37

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

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

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

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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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	12	37

Name	Salary Paid CCNH	Salary Paid RHNS	Salary Paid (Specify)	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
Section III - Administrators* **										
Marnie Tetreault	144,024				Management of Center	2,086	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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CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility Glen Hill Care and Rehabilitation Center	License No. 2217-C		Report for Year Ended 9/30/2015		Page 13	of 37
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	980	26				
2. Dentist	11,866	81				
3. Pharmacist	8,881	181				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	1,433,205	19,633				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	40,140	212				
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	30,769	394				
b. Other						
10. Occupational Therapist						
a. Resident Care	46,835	642				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	5,625	87				
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	16,955					
B-13 Total Fees Paid in Lieu of Salaries	1,595,256	21,257				

* 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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers: Yes	Related** to Owners, Operators, Officers: No	Explanation of Relationship
Genesis Eldercare Hospitality Services, 101 East State Street, Kennett Square, PA 19348	Dietary Services	⊙	○	Common Ownership
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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015		15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	268,702	268,702		
2. Disability Insurance	$				
3. Unemployment Insurance	$	87,617	87,617		
4. Social Security (F.I.C.A.)	$	318,731	318,731		
5. Health Insurance	$	347,894	347,894		
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*) See Attached Schedule	$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	54,698	54,698		
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	$	28,377	28,377		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	36,926	36,926		
2. Cellular Phones	$	3,947	3,947		
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*) See Attached Schedule	$	917	917		
3. Resident Day User Fee	$	444,636	444,636		
Subtotal	$	1,592,445	1,592,445		

* 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**

Glen Hill Care and Rehabilitation Center
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Schedule of Other Employee Benefits

Description		CCNH	RHNS	(Specify)
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
0	0	$ -	$ -	
Total		$ -	$ -	$ -

Schedule of Other Taxes

Description		CCNH	RHNS	(Specify)
1020640110	Sales & Use Tax Exp	$ 917	$ -	0
1020640110	Sales Tax	$ -	$ -	0
1020640110	Sales Tax	$ -	$ -	0
0	0	$ -		
Total		$ 917	$ -	$ -

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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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		1,592,445	1,592,445		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$				
4. Employee Travel	$	1,376	1,376		
5. Education Expenses Related to Seminars and Conventions	$	2,396	2,396		
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*)	$	66	66		
2. Advertising Telephone Directory (*all such expenses*)***	$	1,133	1,133		
3. Advertising Other (*Specify*)*** See Attached Schedule	$	9,849	9,849		
4. Fund-Raising***	$				
5. Medical Records	$	890	890		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	2,674	2,674		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	7,843	7,843		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$				
9. Subscriptions	$	120	120		
10. Contributions*** See Attached Schedule	$	1,384	1,384		
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	4,485	4,485		
12. Administrative Management Services**	$	587,006	587,006		
13. Other (*Specify*) See Attached Schedule	$	43,891	43,891		
C-14 Total Administrative & General Expenditures	$	2,255,560	2,255,560		

* 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.

Glen Hill Care and Rehabilitation Center
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Schedule of Other Travel and Entertainment

Description		CCNH	RHNS	(Specify)
				0
				0
				0
				0
				0
				0
Total Other Travel and Entertainment		$ -	$ -	$ -

Schedule of Other Advertising

Description		CCNH	RHNS	(Specify)
1020630020	Advertising	$ 195	$ -	0
1020630020	Advertising	$ 385	$ -	0
1020630020	Advertising	$ 1,016	$ -	0
1020630330	Marketing Expense	$ 2,656	$ -	0
1020630330	Marketing Expense	$ 26	$ -	0
1020630330	Marketing Expense	$ 139	$ -	0
1020630331	Marketing Exp- Corpc	$ 903	$ -	0
1020630331	Marketing Exp- Corpc	$ 4,530	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0
Total Other Advertising		$ 9,849	$ -	$ -

Schedule of Dues

Description		CCNH	RHNS	(Specify)
1020630310	Licenses & Certificatic	$ 7,843	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0

0	0	$ -	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0
0	0	$ -	$ -	0
Total Dues		$ 7,843	$ -	$ -

Schedule of Contributions

Description		CCNH	RHNS	(Specify)
1020630130	Contributions	$ 1,384	$ -	$ -
1020630135	Political Contributions	$ -	$ -	$ -
0	0	$ -	$ -	$ -
Total Contributions		$ 1,384	$ -	$ -

Schedule of Other Administrative and General

Description		CCNH	RHNS	(Specify)
1020630060	Bank Service Charges	5,133.34	-	-
1020630120	Collection Fees	(390.80)	self-disallowed	-
1020630120	Collection Fees	22.97	self-disallowed	-
1020630120	Collection Fees	66.38	self-disallowed	-
1020630120	Collection Fees	5,294.00	self-disallowed	-
1020630140	Education Expense	249.85	-	-
1020630140	Education Expense	38.89	-	-
1020630180	Employee Physicals	12,798.36	-	-
1020630200	Employee Relations	3,996.40	-	-
1020630200	Employee Relations	212.10	-	-
1020630380	Printing	1,856.26	-	-
1020630380	Printing	154.48	-	-
1020630610	Training Expense	214.47	-	-
1020630610	Training Expense	84.03	-	-
1020630610	Training Expense	652.20	-	-
1020630640	Uniforms	1,381.67	-	-
1020640080	Fines & Penalties	2.45	self-disallowed	-
1020640090	Miscellaneous	(28.74)	-	-
1020640090	Miscellaneous	(5.89)	-	-
1020660990	Accrued Expense Esti	1,591.66	self-disallowed	-
5095720020	Cap Stk/Franchise Tax	1,150.80	-	-
5095720090	Landlord Operating Ta	2,400.00	-	-
1020630200	Employee Relations	50.00	-	-
3080630440	Foreign Recruitment C	5,787.00	-	-
3080630440	Foreign Recruitment C	1,179.00	-	-
Total Other Administrative and General		$ 43,891	$ -	$ -

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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 Health Ventures, 101 East St., Kennett Square, PA 19348	449,230	Mgmt Services, Property Mgmt Assisting, MIS, Personnel, Compliance	pg 16 m-12
Genesis Health Ventures, 101 East St., Kennett Square, PA 19348	44,774	Capital Interest	pg 26 12-A-1

*** 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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	162,827	162,827		
2. Non-Food Supplies	$	19,783	19,783		
3. Other (*Specify*)_______________	$	(3,738)	(3,738)		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	2,877	2,877		
c. Management Services**	$				
d. Other (*Specify*)_______________	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	181,749	181,749		

2F. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*				

	Question	Yes	No	
H.	Is cost of employee meals included in 2E?	○ Yes	⊙ No	
I.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
K.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E?	○ Yes	⊙ No	If yes, specify cost.
L.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
M.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
N.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E?	○ Yes	⊙ No	If yes, specify cost.
O.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
P.	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.

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

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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	License No.	Report for Year Ended	Page of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	19 | 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. $	4,262	4,262		
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. $	5,093	5,093		
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	80,977	80,977		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	90,332	90,332		

3F. Laundry Questionnaire

G.	Is cost of employee laundry included in 3E?	○ Yes	⊙ No	If yes, specify cost.
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 laundry provided to persons other than employees or residents included in 3E?	○ Yes	⊙ No	If yes, specify cost.
K.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	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 3E.
** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.
*** 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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel					
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	14,685	14,685		
b. Purchased Services (*by contract other than through Management Services*)	Sq. Ft. Serviced by Personnel					
(*Complete Schedule C-2 att. Page 21*)	Amt.	$	121,512	121,512		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	136,197	136,197		
5. Resident Care (Supplies)** a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	376,951	376,951		
b. Medicine Cabinet Drugs		$	13,528	13,528		
c. Medical and Therapeutic Supplies		$	110,604	110,604		
d. Ambulance/Limousine***		$	138	138		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	22,204	22,204		
f. X-rays and Related Radiological Procedures***		$	34,086	34,086		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	31,113	31,113		
i. Recreation		$	30,746	30,746		
j. Other (Specify)**** See Attached Schedule		$	62,704	62,704		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	682,074	682,074		

* 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.

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Schedule of Other Resident Care

Description		CCNH	RHNS	(Specify)
3060610160	Incontinency	$ 43,568.84	$ -	$ -
3060610161	Incontinency - Rebate:	$ (3,139.77)	$ -	$ -
3080630030	Advertising-Help Wan	$ 662.54	$ -	$ -
3080630140	Education Expense	$ 435.33	$ -	$ -
3080630140	Education Expense	$ 151.08	$ -	$ -
3080630140	Education Expense	$ 590.37	$ -	$ -
3120630530	Supplies	$ 2,264.52	$ -	$ -
3155630530	Supplies	$ 925.51	$ -	$ -
3155630530	Supplies	$ 4,515.00	$ -	$ -
3090630535	Office Supplies	$ 1,650.23	$ -	$ -
3155660080	Rental Expense	$ 137.03	$ -	$ -
3155660080	Rental Expense	$ 4,985.00	$ -	$ -
3010610300	Consolidated Billing	$ 5,957.94	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
0	0	$ -	$ -	$ -
Total Other Resident Care		$ 62,704	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	21 of 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	80,977			19	3b
Healthcare Services Group	Drive, Bensalem, PA 19020	⊙	○	Vendor Contracted	Housekeeping Purchased Services	121,512			20	4b
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015			22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	158,926	158,926		
b. Heat	$	90,870	90,870		
c. Light & Power	$	111,757	111,757		
d. Water	$	14,824	14,824		
e. Equipment Lease (*Provide detail on page 6*)	$				
f. Other (*itemize*)	$				
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	376,378	376,378		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$	468	468		
b. Building & Building Improvements	$	14,644	14,644		
c. Non-Movable Equipment	$	14,307	14,307		
d. Movable Equipment	$	15,945	15,945		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	45,364	45,364		
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	$	1,639,265	1,639,265		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	118,168	118,168		
c. Personal property taxes	$				
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,802,797	1,802,797		

* 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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	23	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	5,976		5,976	456	S/L	Various	468	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								468
B. **Building and Building Improvements**								
1. Acquired prior to this report period	175,540		175,540	16,779	S/L	Various	13,996	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	18,619		18,619				648	
B-4. Subtotal								14,644
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	130,874		130,874	24,982	S/L	Various	14,307	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								14,307

	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.									S/L	Various		
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					85,967		85,967	37,264	S/L	Various	13,855	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					26,471		26,471				2,089	
D-3. Subtotal												15,945
E. *Total Depreciation*												45,364

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9/30/2015

Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Land Improvements		0		0 *
Deletions:				
Total deletions for Land Improvements		$ -		$ - **

***Ties to Page 23, Line A3**
****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
12/31/2014	Silent Knight IFP-1000 addressable fi	3,860.00	20.00	144.75
3/31/2015	Material and labor to replace doors	4,487.71	20.00	112.19
4/30/2015	Install new C.B. wrining conduit	3,728.39	20.00	77.67
2/28/2015	Granite countertops	4,635.00	10.00	270.38
5/31/2015	Johnsonite Reveal Millwork	1,089.02	10.00	36.30
8/31/2015	Johnsonite Revel Millwork Moulding	819.32	10.00	6.83

Total additions for Building Improvements		$ 18,619		$ 648 *
Deletions:				
Total deletions for Building Improvements		$ -		$ - **

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
12/31/2014	Left and right leg set for patient lifter	670.01	7.00	71.79
3/31/2015	Sales and Use Tax March 2015	294.00	7.00	21.00
3/31/2015	Medium Duty Microwave with Dial C	395.81	7.00	28.27

6/30/2015	Reliant 450 & 600 Series Floor Lifts s	8,505.30	7.00	303.76
12/31/2014	Direct Choice Overbed Table	69.35	10.00	5.20
12/31/2014	1.6 cu ft medical grade refrigerator	527.54	10.00	39.57
1/31/2015	Direct Choice Overbed Table	73.57	10.00	4.90
2/28/2015	KleanSteam System on Cleveland ste	1,090.09	10.00	63.59
3/31/2015	Direct Choice Overbed Table	134.46	10.00	6.72
4/30/2015	Evaporator and parts for Victory cool	2,003.12	10.00	83.46
5/31/2015	1 Tracer SX5 and 2 Tracer EX2 whe	725.94	10.00	24.20
12/31/2014	5 MATTRESS,GENESIS VISCO SE	1,568.66	3.00	392.17
3/31/2015	2 Dermfloat LAL	5,385.59	3.00	897.60
Total additions for Movable Equipment		$ 26,471		$ 2,089 *
Deletions:				
Total deletions for Movable Equipment		$ -		$ - **

***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 Improvement		$ -		$ - *
Deletions:				
Total deletions for Leasehold Improvement		$ -		$ - **

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

Amortization Schedule*

Name of Facility Glen Hill Care and Rehabilitation Center			License No. 2217-C		Report for Year Ended 9/30/2015			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.

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

Name of Facility	License No.	Report for Year Ended	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	100
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
SABRA, 101 Sun Ave. NE, Albuquerque, NM 87107	Facility Lease	11/15/10 - 6/30	127 months	1,639,265

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 Glen Hill Care and Rehabilitation Cen	License No. 2217-C	Report for Year Ended 9/30/2015	Page of 26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest A. Building, Land Improvement & Non-Movable Equipment 1. First Mortgage	$	44,774	44,774		
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)	$	44,774	44,774		

(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 27 of 37
Glen Hill Care and Rehabilitation (	2217-C	9/30/2015	

Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:			44,774	44,774		
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)		$	44,774	44,774		
14. Insurance a. Insurance on Property (buildings only)		$	4,527	4,527		
b. Insurance on Automobiles		$				
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*)		$	127,194	127,194		
2. Fire and Extended Coverage		$				
3. Other (*Specify*)		$				
14d. ***Total Insurance Expenditures (14a + b + c)***		$	131,721	131,721		
15. ***Total All Expenditures (A-13 thru C-14)***		$	11,741,076	11,741,076		

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D. Adjustments to Statement of Expenditures

Name of Facility Glen Hill Care and Rehabilitation Center	License No. 2217-C	Report for Year Ended 9/30/2015	Page 28 of 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	$	59,977	59,977		
Page 13 - Professional Fees								
5.	13	B-8-c	Resident Care Physicians **	$				
6.		B-10	Occupational Therapy	$				
7.			Other - See attached Schedule	$	1,526,285	1,526,285		
Pages 15 & 16 - Administrative and General								
8.			Discriminatory Benefits	$				
9.	15	1-c	Bad Debts	$	54,698	54,698		
10.			Accounting & 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 *	$	10,982	10,982		
19.			Income Tax / Corporate Business Tax	$				
20.			Fund Raising / Contributions	$	1,384	1,384		
21.			Unallowable Management Fees	$	631,780	631,780		
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	6,587	6,587		
Page 18 - Dietary Expenditures								
24.			Meals to employees, guests and others who are not residents	$				
Page 19 - Laundry Expenditures								
25.			Laundry services to employees, guests and others who are not residents	$				
Page 20 - Housekeeping Expenditures								
26.			Housekeeping services to employees, guests and others who are not residents	$				
			Subtotal (Items 1 - 26)	$	2,291,694	2,291,694		

(Carry Subtotal forward to next page)

* All except "Help Wanted".

** 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	0	$ 59,977	0	0
10	A-12d	unallowed C.N.A no license period s	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	0
Total Other Salaries Adjustment				$ 59,977	$ -	$ -

Schedule of Fees Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	$ 55,130	0	0
13	5	Rehabilitation Services	3195620020	$ 1,378,075	0	0
13	9	Speech Therapist	3170620020	$ 30,769	0	0
13	10	Occupational Therapist	3105620020	$ 46,835	0	0
13	12	Other	3010620020	$ 4,986	0	0
13	12	Other	3015620020	$ -	0	0
13	12	Respiratory Purchased Servies	3155620020	$ 10,491	0	0
					0	0
					0	0
					0	0
					0	0
					0	0
Total Other Fees Adjustments				$ 1,526,285	$ -	$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	1020630120	$ 4,993	$ -	$ -
16	m-8a	Chamber of Commerce	1020630310	$ -	$ -	$ -
16	m-13	Estimated Accrual	1020660990	$ 1,592	$ -	$ -
16	m-13	Fines	1020640080	$ 2	$ -	$ -
16	m-13	Non-recurring Charges	7010800030	$ -	$ -	$ -
16	m-12	Management Fee disallowed	CBO service Fee	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
0	0	0	0	$ -	$ -	$ -
Total Other A&G Adjustments				$ 6,587	$ -	$ -

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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	$	2,291,694	2,291,694		
Page 20 - Resident Care Supplies*								
27.	20	5-a-2	Prescription Drugs	$	376,951	376,951		
28.	20	5-d	Ambulance/Limousine	$	138	138		
29.	20	5-f	X-rays, etc	$	34,086	34,086		
30.	20	5-h	Laboratory	$	31,113	31,113		
31.			Medical Supplies	$				
32.	20	5-e-2	Oxygen (non emergency)	$	22,204	22,204		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$	25,910	25,910		
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.			Property Insurance	$				
Other - Miscellaneous								
42.			Research or Experimental Activities	$				
43.			Radio and Television Revenue	$				
44.			Vending Machine Revenue	$				
45.			Purchase Discounts and Allowances	$				
46.			Duplications of functions or services	$				
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	$				
48.			Interest Income on Accounts Rec	$				
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	$	111,244	111,244		
Not For Profit Providers Only								
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
51.			***Total Amount of Decrease (Items 1 - 50)***	$	2,893,340	2,893,340		

*** 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

Glen Hill Care and Rehabilitation Center
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Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5-j	Consolidated Billing	5957.94	3010610300	0
20	5-j	Respiratory Supplies	5440.51	3155630530	0
20	5-j	Respiratory Rental	5122.03	3155660080	0
20	5-i	Cable TV	9389.05	3005660130	allow $3600
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Other Ancillary Costs			$ 25,910	$ -	$ -

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
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 Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14 ol	General liability Insurance Adjust	$ 111,244	$ -	$ -
0	0	0	$ -	$ -	$ -
0	0	0	$ -	$ -	$ -
0	0	0	$ -	$ -	$ -
0	0	0	$ -	$ -	$ -
0	0	0	$ -	$ -	$ -
0	0	0	$ -	$ -	$ -
0	0	0	$ -	$ -	$ -
0	0	0	$ -	$ -	$ -
0	0	0	$ -	$ -	$ -
Total Other Adjustments			$ 111,244	$ -	$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Unallowable Building Interest			$ -	$ -	$ -

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Glen Hill Care and Rehabilitation Cente	2217-C	9/30/2015	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	7,239,197	7,239,197		
b. Medicaid Room and Board Contractual Allowance **	$	(3,823,317)	(3,823,317)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	5,988,635	5,988,635		
b. Medicare Room and Board Contractual Allowance **	$	(1,572,148)	(1,572,148)		
4. a. Private-Pay Residents and Other	$	2,659,173	2,659,173		
b. Private-Pay Room and Board Contractual Allowance **	$	(884,614)	(884,614)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	321,610	321,610		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(84,430)	(84,430)		
c. Prescription Drugs - Non-Medicare	$	104,885	104,885		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(36,046)	(36,046)		
2. a. Medical Supplies - Medicare	$	59,103	59,103		
b. Medical Supplies - Medicare Contractual Allowance **	$	(15,516)	(15,516)		
c. Medical Supplies - Non-Medicare	$	96,048	96,048		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(46,726)	(46,726)		
3. a. Physical Therapy - Medicare	$	1,577,532	1,577,532		
b. Physical Therapy - Medicare Contractual Allowance **	$	(414,137)	(414,137)		
c. Physical Therapy - Non-Medicare	$	361,587	361,587		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(120,593)	(120,593)		
4. a. Speech Therapy - Medicare	$	230,881	230,881		
b. Speech Therapy - Medicare Contractual Allowance **	$	(60,611)	(60,611)		
c. Speech Therapy - Non-Medicare	$	37,270	37,270		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(12,398)	(12,398)		
5. a. Occupational Therapy - Medicare	$	1,634,090	1,634,090		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(428,985)	(428,985)		
c. Occupational Therapy - Non-Medicare	$	369,865	369,865		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(123,398)	(123,398)		
6. a. Other *(Specify)* - Medicare	$	43,061	43,061		
b. Other *(Specify)* - Non-Medicare	$	11,036	11,036		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	13,111,054	13,111,054		
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)*	$	737	737		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	3,757	3,757		
V. Total Other Revenue (1 thru 8)	$	4,495	4,495		
VI. Total All Revenue (III +V)	$	13,115,549	13,115,549		

* *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 Part A	X-Ray	$ 24,002	-	$ -
II-6-a	Medicare Part A	Radiology Service	$ -	-	$ -
II-6-a	Medicare Part A	Outpatient Therapy Program	$ -	-	$ -
II-6-a	Medicare Part A	Laboratory	$ 23,647	-	$ -
II-6-a	Medicare Part A	Respiratory Therapy & Supplie	$ 1,809	-	$ -
II-6-a	Medicare Part A	Nursing Treatment Supplies	$ -	-	$ -
II-6-a	Medicare Part A	Audiology	$ -	-	$ -
II-6-a	Medicare Part A	Incontinency	$ -	-	$ -
II-6-a	Medicare Part A	Oxygen & Supplies	$ 4,663	-	$ -
II-6-a	Medicare Part A	Physician Visit	$ -	-	$ -
II-6-a	Medicare Part A	Ambulance	$ -	-	$ -
II-6-a	Medicare Part A	Flu Shot	$ 4,270	-	$ -
II-6-a	Contractuals-Medicare	X-Ray	$ (6,301)	-	$ -
II-6-a	Contractuals-Medicare	Radiology Service	$ -	-	$ -
II-6-a	Contractuals-Medicare	Outpatient Therapy Program	$ -	-	$ -
II-6-a	Contractuals-Medicare	Laboratory	$ (6,208)	-	$ -
II-6-a	Contractuals-Medicare	Respiratory Therapy & Supplie	$ (475)	-	$ -
II-6-a	Contractuals-Medicare	Nursing Treatment Supplies	$ -	-	$ -
II-6-a	Contractuals-Medicare	Audiology	$ -	-	$ -
II-6-a	Contractuals-Medicare	Incontinency	$ -	-	$ -
II-6-a	Contractuals-Medicare	Oxygen & Supplies	$ (1,224)	-	$ -
II-6-a	Contractuals-Medicare	Physician Visit	$ -	-	$ -
II-6-a	Contractuals-Medicare	Ambulance	$ -	-	$ -
II-6-a	Contractuals-Medicare	Flu Shot	$ (1,121)	-	$ -
Total Other Resident Revenue - Medicare			$ 43,061	$ -	$ -

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	Radiology Service	$ -	$ -	$ -
II-6-b	Medicaid	Outpatient Therapy Program	$ -	$ -	$ -
II-6-b	Medicaid	Laboratory	$ 42	$ -	$ -
II-6-b	Medicaid	Respiratory Therapy & Supplie	$ 1,374	$ -	$ -
II-6-b	Medicaid	Nursing Treatment Supplies	$ -	$ -	$ -
II-6-b	Medicaid	Audiology	$ -	$ -	$ -
II-6-b	Medicaid	Incontinency	$ -	$ -	$ -
II-6-b	Medicaid	Oxygen & Supplies	$ 4,429	$ -	$ -
II-6-b	Medicaid	Physician Visit	$ -	$ -	$ -
II-6-b	Medicaid	Ambulance	$ -	$ -	$ -
II-6-b	Medicaid	Flu Shot	$ -	$ -	$ -
II-6-b	Contractuals Medicaid	X-Ray	$ -	$ -	$ -
II-6-b	Contractuals Medicaid	Radiology Service	$ -	$ -	$ -
II-6-b	Contractuals Medicaid	Outpatient Therapy Program	$ -	$ -	$ -
II-6-b	Contractuals Medicaid	Laboratory	$ (22)	$ -	$ -
II-6-b	Contractuals Medicaid	Respiratory Therapy & Supplie	$ (726)	$ -	$ -
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	$ (2,339)	$ -	$ -
II-6-b	Contractuals Medicaid	Physician Visit	$ -	$ -	$ -
II-6-b	Contractuals Medicaid	Ambulance	$ -	$ -	$ -
II-6-b	Contractuals Medicaid	Flu Shot	$ -	$ -	$ -
II-6-b	Private and Other	X-Ray	$ 5,712	$ -	$ -
II-6-b	Private and Other	Radiology Service	$ -	$ -	$ -
II-6-b	Private and Other	Outpatient Therapy Program	$ -	$ -	$ -
II-6-b	Private and Other	Laboratory	$ 5,943	$ -	$ -
II-6-b	Private and Other	Respiratory Therapy & Supplie	$ 123	$ -	$ -
II-6-b	Private and Other	Nursing Treatment Supplies	$ -	$ -	$ -
II-6-b	Private and Other	Audiology	$ -	$ -	$ -
II-6-b	Private and Other	Incontinency	$ -	$ -	$ -
II-6-b	Private and Other	Oxygen & Supplies	$ 627	$ -	$ -
II-6-b	Private and Other	Physician Visit	$ -	$ -	$ -
II-6-b	Private and Other	Ambulance	$ -	$ -	$ -
II-6-b	Private and Other	Flu Shot	$ -	$ -	$ -
II-6-b	Private and Other	Capitation Contracts	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	X-Ray	$ (1,900)	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Radiology Service	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Outpatient Therapy Program	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Laboratory	$ (1,977)	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplie	$ (41)	$ -	$ -
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	$ (209)	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Physician Visit	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Ambulance	$ -	$ -	$ -
II-6-b	Contractuals-Non-Medicaid	Flu Shot	$ -	$ -	$ -
			$ -		
Total Other Resident Revenue			$ 11,036	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
Pg 30 line 1	430055	Interest On Overdue Accounts	$ 737	0	0
0	0	0	-	0	0
0	0	0	-	0	0
Total Interest Income			$ 737	$ -	$ -

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
Pg 30 line 1	Donation	0	1,866.00	-	-
0	Medical Record	0	1,891.31	-	-
0	0	0	-	-	-
0	0	0	-	-	-
0	0	0	-	-	-
0	0	0	-	-	-
Total Other Revenue			$ 3,757	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Cente	2217-C	9/30/2015	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 5,440
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,086,077
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 7,106
4 Inventories				$ 62,355
5. Prepaid Expenses				$
a. Prepaid Expenses				
b. Prepaid Property Tax				
c. Prepaid Personal Property Tax				
d. Prepaid Personal Property Tax				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,160,977
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost	5,976		$ 5,052
	Accum. Depreciation	924	Net	
3. Buildings	*Historical Cost	194,159		$ 162,736
	Accum. Depreciation	31,423	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost	130,874		$ 91,585
	Accum. Depreciation	39,289	Net	
6. Movable Equipment	*Historical Cost	112,438		$ 59,229
	Accum. Depreciation	53,209	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 318,602

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

(*Carry Total forward to next page*)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Glen Hill Care and Rehabilitation Cente	2217-C	9/30/2015	32 of 37

Account				Amount
			Total Brought Forward:	$ 1,479,579
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 (*temize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 3,079,063
I/C Due to/Due From Owned		3,079,063		
I/C Due to/Due From Multicare				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 3,079,063
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 4,558,642

* 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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 310,734
2. Notes Payable (*itemize*)	$
3. Loans Payable for Equipment (*Current portion*) (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

Account	Amount
4. Accrued Payroll(*Exclusive of Owners and/or Stockholders only*)	$ 286,485
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$
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*)	$ 236,454

Item	Amount	Item	Amount
Accrued Provider/Bed Tax	110,271	Accr Exp Electricity	5,563
Accr Exp Other	(2,671)	Deferred Revenue	61,427
Accr Exp Water and Sewer	4,217	A/R Credit Gross Up Lia	46,007
Accr Exp Cable TV		Accr Sales and Use Tax -	11,640

Account	Amount
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 833,673

* 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
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	34	37

Account	Amount
Total Brought Forward:	833,673
Liabilities (cont'd) B. Long-Term Liabilities 1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

Account		Amount
4. Other Long-Term Liabilities (*itemize*)		$ 785,605
LT Debt-Financing Obligation	785,605	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 785,605
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 1,619,278

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

Name of Facility	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Cen	2217-C	9/30/2015	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				$ 1,564,890
6. Gain or Loss for Period	10/1/2014	thru	9/30/2015	$ 1,374,475
7. Total Net Worth				$ 2,939,365
C. ***Total Reserves and Net Worth***				$ 2,939,365
D. ***Total Liabilities, Reserves, and Net Worth***				$ 4,558,643

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Glen Hill Care and Rehabilitation Center	2217-C	9/30/2015	36	37

Account			Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2014			$ 1,564,893
B. Total Revenue *(From Statement of Revenue Page 30)*			$ 13,115,548
C. Total Expenditures *(From Statement of Expenditures Page 27)*			$ 11,741,076
D. Net Income or Deficit			$ 1,374,472
E. Balance			$ 2,939,365
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*** 09/30/15			$ 2,939,365

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I. Preparer's/Reviewer's Certification

Name of Facility Glen Hill Care and Rehabilitation Center	License No. 2217-C	Report for Year Ended 9/30/2015	Page 37 of 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. 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
Thomas Farnan	Sr. Director of Reimbursement	12/28/2015

Printed Name of Preparer

Thomas Farnan Title -Sr. Director of Reimbursement

Addres Address	Phone Number
200 Brickstone Square, Andover, MA 01810	978-247-5029