State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) Pendleton Health and Rehabilitaton Center	
Address (No. & Street, City, State, Zip Code) 44 Maritime Dr., Mystic, CT 06355	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2016	Report for Year Ending 9/30/2017

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider
	2069-C			07-5341

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	2069-C		

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

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Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 Pendleton Health and Rehabilitaton Center [facility name], for the cost report period beginning October 1, 2016 and ending September 30, 2017, 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) N/A Administrator is not responsible for Cost Reporting		Date	Signed (Owner)	Date
Printed Name (Administrator)			Printed Name (Owner) Chris S. Stenger, SVP, Operations Financ SavaSeniorCare Admin. Svc. LLC	on behalf of Pendleton Health & Rehab
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Pendleton Health and Rehabilitaton Center	Period Covered:		From 10/1/2016	To 9/30/2017
Address of Facility 44 Maritime Dr., Mystic, CT 06355				
Report Prepared By Margaret Philen	Phone Number 832-467-6225		Date 2/13/2018	

Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid $				
2. Laundry wages paid $				
3. Housekeeping wages paid $				
4. Nursing wages paid $				
5. All other wages paid $				
6. ***Total Wages Paid*** $				
7. Total salaries paid $				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report) $				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-572-1700	9/30/2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Pendleton Health and Rehabilitaton Center	44 Maritime Dr., Mystic, CT 06355

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2069-C			07-5341

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.:
Susan Peglow	001290

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
See attached		

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
Pendleton Health and Rehabilitaton Center	2069-C	9/30/2017	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

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Names of Stockholders Owning at Least 10% of Shares			

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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	%**				
SSC Administrative Svc, LLC	One Ravinia Dr., Suite 1500, Atlanta, GA 30346	○	⊙		Back Office Services	Page 16/ C.1.m.12	589,451	589,451
SSC Consulting Svc, LLC	One Ravinia Dr., Suite 1500, Atlanta, GA 30346	○	⊙		Consulting Services	Page 16/ C.1.m.12	206,058	206,058
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* 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
Canon Financial Services	○	⊙	Copier	expired	month to month	3,593	3,593
Krystal Kleer LLC	○	⊙	Water Cooler			972	972
Pitney Bowes	○	⊙	Postage Meter			1,501	1,501
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No **Total ***** 6,066

* 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	
2	
3	
4	

Services Provided by This Firm (*describe fully*)	
1	$
2	$
3	$
4	$
	Charge for Services Provided: $

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

○ Yes ○ No

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Shaw Rosenthal LLP	410-752-1040
2 Hooper Lundy & Bookman	310-5515-8111
3 Cooney Scully & Dowling	860-527-1141
4 Sciacca Law Group LLC	617-322-1555
5	

Address (*No. & Street, City, State, Zip Code*)
1 One South St. 1800, Baltimore, MD 21202
2 1875 Century Park E, Ste 1600, Los Angeles, CA 90067
3 Hartford Sq.N, Ten Columbus Blvd, Harford, CT 06106
4 P.O. Box 870126, Milton Village, MA 02187
5

Services Provided by This Firm (*describe fully*)		
1	Legal Rep - Union Issues	$ 43,277
2	Legal Rep - NLRB brief & writ of certiorari	$ 19,059
3	Legal Rep - Lawsuit	$ 7,770
4	Legal Rep - guardianship and title issues	$ 1,287
5		$
		Charge for Services Provided: $ 71,393

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

○ Yes ○ No Legal, page 15, line 1.e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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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	120	120			120	120			120	120		
B. On last day of THIS report period	120	120			120	120			120	120		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	112	112			112	112			103	103		
B. As of midnight of THIS report period	107	107			103	103			107	107		
3. Total Number of Days Care Provided During Period												
A. Medicare	8,709	8,709			6,912	6,912			1,797	1,797		
B. Medicaid (Conn.)	25,741	25,741			19,196	19,196			6,545	6,545		
C. Medicaid (other states)												
D. Private Pay	2,795	2,795			2,248	2,248			547	547		
E. State SSI for RCH												
F. Other (Specify) VA/Hospice/Insurance	2,277	2,277			1,773	1,773			504	504		
G. Total Care Days During Period (3A thru F)	39,522	39,522			30,129	30,129			9,393	9,393		
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)**	39,522	39,522			30,129	30,129			9,393	9,393		

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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								
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.								
c. Three or more bed rms.								

	TOTAL	CCNH	RHNS	(Specify)
7. Total Number of Physical Therapy Treatments				
A. Medicare - Part B	252,454	252,454		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	255,810	255,810		
D. ***Total Physical Therapy Treatments***	508,264	508,264		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	67,246	67,246		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	87,044	87,044		
D. ***Total Speech Therapy Treatments***	154,289	154,289		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	187,263	187,263		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments				
C. Other	189,032	189,032		
D. ***Total Occupational Therapy Treatments***	376,295	376,295		

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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)	133,486	2,080				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	301,635	15,807				
5. Dietary Service						
a. Head Dietitian						
b. Food Service Supervisor						
c. Dietary Workers	304,200	22,732				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	65,894	2,080				
b. Other Maintenance Workers	33,472	2,151				
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	199,655	4,160				
b. RN						
1. Direct Care	1,204,015	34,238				
2. Administrative**	292,289	7,601				
c. LPN						
1. Direct Care	927,368	32,117				
2. Administrative**	2,531	80				
d. Aides and Attendants	1,117,156	76,112				
e. Physical Therapists	582,859	15,745				
f. Speech Therapists	111,774	2,632				
g. Occupational Therapists	366,550	9,651				
h. Recreation Workers	144,937	6,370				
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	103,308	4,102				
n. Marketing						
o. Other (Specify)						
See Attached Schedule	97,964	3,472				
A-13. Total Salary Expenditures	5,989,093	241,130				

* 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**
Respiratory Therapist	$ 66,080	1,502				
Medical Records Clerk	$ 31,884	1,970				
Total	$ 97,964	3,472	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

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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
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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* **										
Susan Peglow	133,486			Standard package	Admin. Over day to day operations	2,080		N/A		
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	4,400					
3. Pharmacist	9,798					
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	52,875					
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	77,613					
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	6,269					
2. Administrative***	12,171					
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	163,127					

* 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	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
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		○	○	

* 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
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Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	319,866	319,866		
2. Disability Insurance	$				
3. Unemployment Insurance	$	70,207	70,207		
4. Social Security (F.I.C.A.)	$	446,258	446,258		
5. Health Insurance	$	188,920	188,920		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$	3,552	3,552		
7. Pensions (Non-Discriminatory)	$				
(not-owners and not-operators)					
8. Uniform Allowance	$	6,262	6,262		
9. Other (*Specify*)	$	4,608	4,608		
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	320,103	320,103		
d. Accounting and Auditing	$				
e. Legal (*Services should be fully described on Page 7)*	$	71,338	71,338		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	23,420	23,420		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	27,458	27,458		
2. Cellular Phones	$	1,003	1,003		
i. Appraisal (*Specify purpose and attach copy*)*	$	550	550		
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$	33,201	33,201		
See Attached Schedule					
3. Resident Day User Fee	$	656,436	656,436		
Subtotal	$	2,173,183	2,173,183		

* 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)
Employee Innnoculations	$ 3,847		
Outsource Service for Activities	$ 761		
Total	$ 4,608	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Sales Tax	$ 33,201		
Total	$ 33,201	$ -	$ -

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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
Pendleton Health and Rehabilitaton Center	2069-C	9/30/2017	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,173,183	2,173,183		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	7,106	7,106		
4. Employee Travel	$	4,290	4,290		
5. Education Expenses Related to Seminars and Conventions	$	8,825	8,825		
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*)	$	9,008	9,008		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	22,098	22,098		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$	46	46		
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	4,245	4,245		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	9,391	9,391		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	797	797		
9. Subscriptions	$	202	202		
10. Contributions*** See Attached Schedule	$	525	525		
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	55,937	55,937		
12. Administrative Management Services**	$	656,781	656,781		
13. Other (*Specify*) See Attached Schedule	$	1,155,526	1,155,526		
C-14 Total Administrative & General Expenditures	$	4,107,960	4,107,960		

* 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)
Unallowable Advertising - Deducted on page 28	$ 22,098		
Total Other Advertising	$ 22,098	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Connecticut Assn of HC Facilities	$ 8,539		
AMDA	$ 557		
	$ 296		
Total Dues	$ 9,391	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
	$ 525		
Total Contributions	$ 525	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Employee Background Checks	$ 10,112		
Director & Trustee fees	$ 888		
Staff Meetings	$ 122		
Credit Card Fees	$ 3,985		
Petty Cash	$ 63		
RFMS Service Charge	$ 2,101		
Interest Expense	$ 1,134,811		
Licenses	$ 748		
Penalties, Surety Bonds, Patient Trust Over/Under	$ 1,766		
Lost Resident Property	$ 788		
Memoriam/Benevolence	$ 141		
Total Other Administrative and General	$ 1,155,526	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility	License No.	Report for Year Ended	Page of
Pendleton Health and Rehabilitaton Cente	2069-C	9/30/2017	17 | 37

Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
SSC Administrative Svc, LLC, One Ravinia Dr, Ste 1500, Atlanta, GA 30346			Page 16, line C.1.m.12
SSC Consulting Svc, LLC, One Ravinia Dr, Ste 1500 Atlanta, GA 30346			Page 28, item #21

*** 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
Pendleton Health and Rehabilitaton Center	2069-C	9/30/2017	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	5,154	5,154		
2. Non-Food Supplies	$	4,920	4,920		
3. Other (*Specify*)_____ Lease Expense	$	2,738	2,738		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	402,137	402,137		
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	414,948	414,948		

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

H.	Is cost of employee meals included in 2E?	⊙ Yes	○ No	
I.	Did you receive revenue from employees?	⊙ Yes	○ No	If yes, specify amt. $5,561
J.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			Page 30, IV.1
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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CSP-19 Rev. 9/2002

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
Pendleton Health and Rehabilitaton Center	2069-C	9/30/2017	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $	89	89		
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. $	11,740	11,740		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	218,392	218,392		
c. Management Services**	$				
d. Other (*Specify*)	$				
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	230,221	230,221		

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
Pendleton Health and Rehabilitaton Center	2069-C	9/30/2017	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.	$	23,855	23,855		
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21*)	Sq. Ft. Serviced by Personnel					
	Amt.	$	248,759	248,759		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	272,614	272,614		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from		$	308,461	308,461		
b. Medicine Cabinet Drugs		$	32,633	32,633		
c. Medical and Therapeutic Supplies		$	264,645	264,645		
d. Ambulance/Limousine***		$	34,210	34,210		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	60,028	60,028		
f. X-rays and Related Radiological Procedures***		$	40,314	40,314		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	46,981	46,981		
i. Recreation		$	6,149	6,149		
j. Other (Specify)**** See Attached Schedule		$	164,486	164,486		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	957,906	957,906		

* 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)
Incontinent Supplies	$ 48,306		
Equipment Lease Expense - Nursing	$ 21,821		
Minor Equipment Purchase Nursing	$ 11,905		
Nursing Supplies	$ 82,454		
Total Other Resident Care	$ 164,486	$ -	$ -

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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
Pendleton Health and Rehabilitaton Center	2069-C	9/30/2017	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
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							
		○	○							

* 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
Pendleton Health and Rehabilitaton Center	2069-C	9/30/2017	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	169,987	169,987		
b. Heat	$	83,651	83,651		
c. Light & Power	$	149,490	149,490		
d. Water	$	70,924	70,924		
e. Equipment Lease (*Provide detail on page 6*)	$	6,067	6,067		
f. Other (*itemize*)	$	94,899	94,899		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	575,018	575,018		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$	679,983	679,983		
c. Non-Movable Equipment	$				
d. Movable Equipment	$	30,564	30,564		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	710,546	710,546		
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	$	(26,583)	(26,583)		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$	194,205	194,205		
c. Personal property taxes	$	5,529	5,529		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	883,698	883,698		

* 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)
Maintenance Supplies	$ 4,299		
Infectious Waste Disposal	$ 1,542		
Garbage Service	$ 20,596		
Contract Services - Periodic Maintenance	$ 29,206		
Equipment Lease Exp -Physical Plant	$ 99		
Lease Exp - Offsite Storage	$ 9,656		
Minor Equipment Purchase	$ 13,527		
TV Cable/Dish	$ 12,482		
Network - WAN	$ 3,492		
Total Other Repairs and Maintenance	$ 94,899	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Pendleton Health and Rehabilitaton Center	2069-C	9/30/2017	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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period	1,307,841		1,307,841	1,143,605			41,917	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	12,738,146						638,066	
B-4. Subtotal								679,983
C. **Non-Movable Equipment**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					621,379		621,378	547,766			24,150	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					36,987						6,413	
D-3. Subtotal												30,564
E. ***Total Depreciation***												710,546

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Schedule of Land Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Land Improvements		$ -		$ -	*
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:					
	various see attached	$ 12,738,146			
Total additions for Building Improvements		$ 12,738,146		$ -	*
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:					
	various see attached	$ 36,987			
Total additions for Movable Equipment		$ 36,987		$ -	*
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**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
Pendleton Health and Rehabilitaton Center	2069-C	9/30/2017	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
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11. Property Questionnaire

Part A

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

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

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

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

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

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

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease
SMV Mystic, Inc.	Building and Land	12/10/04		

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
Pendleton Health and Rehabilitaton C	2069-C	9/30/2017	26 | 37

Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
1. First Mortgage	$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage	$				
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	$				
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	$				
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount	$				
2. Loan Origination Date					
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense					
12 B7. ***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
Pendleton Health and Rehabilitato	2069-C	9/30/2017	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) $	16,550	16,550		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $ Gen & Pro Liability, Crime/Kidnap Insurances	(30,857)	(30,857)		
14d. ***Total Insurance Expenditures (14a + b + c)*** $	(14,306)	(14,306)		
15. ***Total All Expenditures (A-13 thru C-14)*** $	13,580,279	13,580,279		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Pendleton Health and Rehabilitaton Center	2069-C	9/30/2017	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 $				
Page 13 - Professional Fees							
5.			Resident Care Physicians ** $				
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.			Bad Debts $				
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.			Unallowable Advertising * $				
19.			Income Tax / Corporate Business Tax $				
20.			Fund Raising / Contributions $				
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $				
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) $				

* 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)
Total Other Salaries Adjustment			$ -	$ -	$ -

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Pendleton Health and Rehabilitaton Center	2069-C	9/30/2017	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $				
Page 20 - Resident Care Supplies***							
27.			Prescription Drugs $				
28.			Ambulance/Limousine $				
29.			X-rays, etc $				
30.			Laboratory $				
31.			Medical Supplies $				
32.			Oxygen (non emergency) $				
33.			Occupational Therapy $				
34.			Other - See Attached Schedule $				
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 $				
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)*** $				

*** 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

Pendleton Health and Rehabilitaton Center
9/30/2017

Schedule of Other Ancillary Costs

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

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other 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
Pendleton Health and Rehabilitaton Cente	2069-C	9/30/2017	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	21,547,135	21,547,135		
b. Medicaid Room and Board Contractual Allowance **	$	(15,109,829)	(15,109,829)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	6,169,577	6,169,577		
b. Medicare Room and Board Contractual Allowance **	$	(1,699,789)	(1,699,789)		
4. a. Private-Pay Residents and Other	$	4,159,663	4,159,663		
b. Private-Pay Room and Board Contractual Allowance **	$	(2,296,117)	(2,296,117)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	333,395	333,395		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(331,981)	(331,981)		
c. Prescription Drugs - Non-Medicare	$	124,231	124,231		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(104,389)	(104,389)		
2. a. Medical Supplies - Medicare	$	2,063	2,063		
b. Medical Supplies - Medicare Contractual Allowance **	$	(1,915)	(1,915)		
c. Medical Supplies - Non-Medicare	$	21,818	21,818		
d. Medical Supplies - Non-Medicare Contractual Allowance **	$	(17,113)	(17,113)		
3. a. Physical Therapy - Medicare	$	982,005	982,005		
b. Physical Therapy - Medicare Contractual Allowance **	$	(776,086)	(776,086)		
c. Physical Therapy - Non-Medicare	$	255,810	255,810		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(237,995)	(237,995)		
4. a. Speech Therapy - Medicare	$	239,781	239,781		
b. Speech Therapy - Medicare Contractual Allowance **	$	(183,917)	(183,917)		
c. Speech Therapy - Non-Medicare	$	87,044	87,044		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(76,551)	(76,551)		
5. a. Occupational Therapy - Medicare	$	902,296	902,296		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(750,122)	(750,122)		
c. Occupational Therapy - Non-Medicare	$	189,032	189,032		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(176,607)	(176,607)		
6. a. Other *(Specify)* - Medicare	$	694	694		
b. Other *(Specify)* - Non-Medicare	$	(35,363)	(35,363)		
III. *Total Resident Revenue* (Section I. thru Section II.)	$	13,216,770	13,216,770		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$	(5,561)	(5,561)		
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$	37	37		
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	502	502		
V. Total Other Revenue (1 thru 8)	$	(5,022)	(5,022)		
VI. Total All Revenue (III +V)	$	13,211,748	13,211,748		

* *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)
	Medicare A Revenue - Oxygen - SNF Anc Revenue	$ 11,626		
	Medicare A Revenue - IV Therapy - SNF Anc Revenue	$ 42,947		
	Medicare A Revenue - Laboratory - SNF Anc Revenue	$ 105,681		
	Medicare A Revenue - X-Ray - SNF Anc Revenue	$ 11,294		
	Medicare Ancillary Revenue - Contractual Adjustment	$ (170,853)		
	Medicare Ancillary Revenue - Contractual Adjustment			
Total Other Resident Revenue - Medicare		$ 694	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
	Oxygen - Medicaid, VA and Private	$ 24,280		
	IV Therapy - Medicaid, HMO, VA	$ 16,160		
	X-Ray - HMO, VA, Private	$ 1,578		
	Laboratory - HMO, VA	$ 18,040		
	Contractual Adjustments	$ (95,420)		
Total Other Resident Revenue		$ (35,363)	$ -	$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
	Interest Income Realty		$ 37		
Total Interest Income			$ 37	$ -	$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
	Miscellaneous Receipts	$ 502		
Total Other Revenue		$ 502	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Pendleton Health and Rehabilitaton Cer	2069-C	9/30/2017	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 31,972
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,535,147
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$
4 Inventories				$
5. Prepaid Expenses				$ 3,845
a. Prepaid License & Software		775		
b. Prepaid Insurances		(334)		
c. Prepaid Dues and Subscriptions		3,403		
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,570,963
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost	14,045,988		$ 12,222,400
	Accum. Depreciation	1,823,588	Net	
4. Leasehold Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
5. Non-Movable Equipment	*Historical Cost			$
	Accum. Depreciation		Net	
6. Movable Equipment	*Historical Cost	658,365		$ 80,036
	Accum. Depreciation	578,330	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$ 19,499
Asset Clearing		19,499		
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 12,321,935

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

(*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
Pendleton Health and Rehabilitaton Cer	2069-C	9/30/2017	32	37

Account				Amount
			Total Brought Forward:	$ 13,892,898
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*)				$ 10,509
Refundable Deposits		10,509		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 10,509
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 13,903,408

* 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
Pendleton Health and Rehabilitaton Center	2069-C	9/30/2017	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 534,802
2. Notes Payable (*itemize*)					$
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*)					$ 393,603
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 68,720
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*					$ 662
12. Other Current Liabilities (*itemize*)					$ 521,519
Accrued Utilities	22,334	Accrued Resident Day U:	161,581		
Accrued PL/GL Post Petition	70,492	Accrued Interest	96,031		
Accrued Insurances	32,208	Accrued CLO - Current	34,589		
Accrued Property Taxes	36,908	Deferred Income CLO G:	67,376		
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 1,519,306

* 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
Pendleton Health and Rehabilitaton Center	2069-C	9/30/2017	34	37

Account	Amount
Total Brought Forward:	1,519,306
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$ 12,536,677
3. Loans from Owners or Related Parties (*itemize*)	$ (6,791,352)

Name and Address of Lender	Amount	Loan Date
Intercompany Revolver - SSC	(6,791,352)	

4. Other Long-Term Liabilities (*itemize*)		$ 1,475,899
L/T Reserve Workers Comp Post Petition	295,970	
L/T Reserve PL/GL Post Petition	170,963	
Deferred Income	(155,940)	
Deferred CLO Gain/Loss	1,164,906	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)		$ 7,221,223
C. ***Total All Liabilities*** (Lines A-13 + B-5)		$ 8,740,529

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

Name of Facility	License No.	Report for Year Ended	Page	of
Pendleton Health and Rehabilitaton C	2069-C	9/30/2017	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	$ 5,531,773
	6. Gain or Loss for Period 10/1/2016 thru 9/30/2017	$ (368,895)
	7. Total Net Worth	$ 5,162,878
C.	***Total Reserves and Net Worth***	$ 5,162,878
D.	***Total Liabilities, Reserves, and Net Worth***	$ 13,903,408

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Pendleton Health and Rehabilitaton Cent	2069-C	9/30/2017	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2016			$
B.	Total Revenue (*From Statement of Revenue Page 30*)			$
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$
D.	Net Income or Deficit			$
E.	Balance			$
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*** 09/30/17			$

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Pendleton Health and Rehabilitaton Center	2069-C	9/30/2017	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. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed

Printed Name of Preparer	
Margaret Philen	
Address	**Phone Number**
5300 W. Sam Houston Pkwy N, Ste 100, Houston, TX 77041	832-467-6225