State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2017

Name of Facility (as licensed) Gladeview Health Care Center, LLC		
Address (No. & Street, City, State, Zip Code) 60 Boston Post Rd, Old Saybrook, CT 06475		
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
	2024C			07-5313

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	2024C		

For Department Use Only

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

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center, LLC	2024C	9/30/2017	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 Gladeview Health Care Center, LLC [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)		Date	Signed (Owner)	Date
Printed Name (Administrator) Paul Knutsen			Printed Name (Owner) Linda Silberstein	
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 Gladeview Health Care Center, LLC	Period Covered:		From 10/1/2016	To 9/30/2017
Address of Facility 60 Boston Post Rd, Old Saybrook, CT 06475				
Report Prepared By Gladeview Health Care Center	Phone Number 860-388-6696		Date 4/27/2018	

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
860-388-6696	9/30/2017	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Gladeview Health Care Center, LLC	60 Boston Post Rd, Old Saybrook, CT 06475

License Numbers:	CCNH	RHNS	(Specify)	Medicare Provider No.
	2024C			07-5313

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.:
Paul Knutsen	001500

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

Name	License No.:
Linda Silberstein	None

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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

Name of Partners/Members	Business Address	Title	% Owned
N/A			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center, LLC	2024C	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
Gladeview Health Care Center	60 Boston Post Road Old Saybrook, CT 06475	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Linda Silberstein	60 Boston Post Road Old Saybrook, CT 06475	President	100
Names of Stockholders Owning at Least 10% of Shares			
Same as above			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center, LLC	2024C	9/30/2017	3B	37

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

Owner(s) of Facility
N/A

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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	%**				
Gladeview LLC	60 Boston Post Road Old Saybrook, CT 06475	○	⊙		Lease of Real Property	Pg 22, Line 9	1,322,075	1,322,075
Linda Silberstein	60 Boston Post Road Old Saybrook, CT 06475	○	⊙		Salaries and Benefits	Pg 10, line A3Pg 15, li	133,006	133,006
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* 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.

Not required

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

N/A

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.

N/A

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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
Connecticut Business Systems, 50 Rockwell Rd, Newington, CT 06111	○	⊙	Copier	11/28/13	Month to Month	Various	3,609
Wells Fargo Leasing, PO Box 6434, Carol Stream, IL 60197	○	⊙	Copier	02/01/13			14,927
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					
	○	○					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ○ No **Total ***** 18,536

* 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
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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 Simione, Macca and Larrow	4130 Whitney Ave, Hamden, CT 06518
2 Craig J Lubiski and Company	
3	
4	

Services Provided by This Firm (*describe fully*)

1	401k Audit, tax return	$ 18,910
2	Medicare Cost report	$ 3,978
3		$
4		$
		Charge for Services Provided $ 22,888

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

⊙ Yes ○ No — PG 15 Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Shipman & Goodwin	860-251-1919
2 Littler Mendelson PC	203-974-8700
3 Murtha Cullina LLP	860-240-6000
4	
5	

Address (*No. & Street, City, State, Zip Code*)

1 One Constitution Plaza, Hartford, CT 06103
2 265 Church St, Suite 300, New Haven, CT 06510
3 185 Aslyum, Hartford, CT 06103
4
5

Services Provided by This Firm (*describe fully*)

1	Employer related issues	$ 1,329
2	Employer related issues	$ 10,887
3	Employer related issues	$ 1,200
4		$
5		$
		Charge for Services Provided $ 13,416

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

⊙ Yes ○ No — PG 15 Line 1e

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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	132	132			132	132			132	132		
B. On last day of THIS report period	132	132			132	132			132	132		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	125	125			125	125			118	118		
B. As of midnight of THIS report period	119	119			118	118			119	119		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,258	4,258			3,219	3,219			1,039	1,039		
B. Medicaid (Conn.)	30,366	30,366			22,674	22,674			7,692	7,692		
C. Medicaid (other states)												
D. Private Pay	5,122	5,122			3,814	3,814			1,308	1,308		
E. State SSI for RCH												
F. Other (Specify) Managed Care	3,916	3,916			2,907	2,907			1,009	1,009		
G. Total Care Days During Period (3A thru F)	43,662	43,662			32,614	32,614			11,048	11,048		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	271	271			209	209			62	62		
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	43,933	43,933			32,823	32,823			11,110	11,110		

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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	11	81		27				
Per Diem Rate								
a. One bed rm.	Var	244.00		381.00				
b. Two bed rms.	Var	244.00		361.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	1,893	1,893		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	360	360		
2. Restorative Treatments				
C. Other	9,505	9,505		
D. ***Total Physical Therapy Treatments***	11,758	11,758		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	345	345		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	31	31		
2. Restorative Treatments				
C. Other	1,170	1,170		
D. ***Total Speech Therapy Treatments***	1,546	1,546		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,591	1,591		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	341	341		
2. Restorative Treatments				
C. Other	9,664	9,664		
D. ***Total Occupational Therapy Treatments***	11,596	11,596		

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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)	198,300	2,160				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	133,006	2,040				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	326,746	12,179				
5. Dietary Service						
a. Head Dietitian	48,487	1,632				
b. Food Service Supervisor	13,118	414				
c. Dietary Workers	469,591	27,461				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	68,599	2,101				
b. Other Maintenance Workers	21,387	1,356				
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	329,316	4,295				
b. RN						
1. Direct Care	1,245,964	35,124				
2. Administrative**	231,780	7,695				
c. LPN						
1. Direct Care	393,943	12,917				
2. Administrative**						
d. Aides and Attendants	1,737,245	95,347				
e. Physical Therapists	338,706	6,716				
f. Speech Therapists	87,873	2,054				
g. Occupational Therapists	181,130	4,390				
h. Recreation Workers	163,296	9,138				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
Inhalation Therapist	18,919	891				
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	117,138	4,126				
n. Marketing	`					
o. Other (Specify)						
See Attached Schedule						
A-13. Total Salary Expenditures	6,124,544	232,036				

* 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**
Total	$ -	-	$ -	-	$ -	-

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
Gladeview Health Care Center, LLC	2024C	9/30/2017	12	37

Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Paul Knutsen	198,300			Health & Life insurance. Payroll taxes	Day to day operations of the nursing home	2,160	A2			
Section IV - Assistant Administrators										
Linda Silberstein	133,006			Health & Life insurance. Payroll taxes	Day to day operations of the nursing home	2,040	A3			

*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
Gladeview Health Care Center, LLC	2024C	9/30/2017	13	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						
2. Dentist	3,892	86				
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker	2,400	32				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	34,800	607				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	40,888	448				
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	2,880	8				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	148,957	3,453				
2. Administrative***						
c. Aides	184,521	8,051				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	418,338	12,685				

* 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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CSP-14 Rev. 6/95

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
Gladeview Health Care Center, LLC	2024C	9/30/2017	14	37

Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
William H. Johnson MSW, Inc. PO Box 1354, Belchertown, MA 01007	Social Worker	○	⊙	
Prakash Huded MS, 28 Marlboro, Rd., Portland CT	Medical Director, Physician Services	○	⊙	
Med Options, PO Box 5023, New Britain, CT 06050	Physician Services	○	⊙	
SDX Swallowing Diagnostics, PO Box 484, Avon, CT 06001	Speech Therapy	○	⊙	
HealthDrive Dental Group, One Prestige Dr., Suite 107, Meriden, CT 06450	Dental Services	○	⊙	
The Nurse Network, PO Box 982, Southington, CT 06489	Nursing Pool	○	⊙	
Dr. Mukerjee, 71 Quail Run, Madison, CT 06443	Cardiac Services	○	⊙	
Dr Balsamo, 687 Cambell Ave, West Haven, CT 06516	Physician Services	○	⊙	
Pact LLC 322 East Main St, Branford, CT 06405	Physician Services	○	⊙	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	
		○	○	

* 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
Gladeview Health Care Center, LLC	2024C	9/30/2017	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	225,736	225,736		
2. Disability Insurance	$				
3. Unemployment Insurance	$	106,534	106,534		
4. Social Security (F.I.C.A.)	$	435,890	435,890		
5. Health Insurance	$	489,477	489,477		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	27,482	27,482		
(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*	$	120,000	120,000		
d. Accounting and Auditing	$	22,888	22,888		
e. Legal (*Services should be fully described on Page 7)*	$	13,416	13,416		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	45,472	45,472		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	18,279	18,279		
2. Cellular Phones	$	8,612	8,612		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$	930	930		
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$	20,887	20,887		
See Attached Schedule					
3. Resident Day User Fee	$	818,271	818,271		
Subtotal	$	2,353,874	2,353,874		

* 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)
Total	$ -	$ -	$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Sales tax audit	$ 20,887		
Total	$ 20,887	$ -	$ -

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center, LLC	2024C	9/30/2017	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,353,874	2,353,874		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	11,094	11,094		
4. Employee Travel	$				
5. Education Expenses Related to Seminars and Conventions	$	5,146	5,146		
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*)	$	2,969	2,969		
2. Advertising Telephone Directory (*all such expenses*)***	$	54	54		
3. Advertising Other (*Specify*)***	$	13,170	13,170		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	4,054	4,054		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	9,968	9,968		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	1,665	1,665		
9. Subscriptions	$				
10. Contributions***	$	1,035	1,035		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	133,321	133,321		
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	20,128	20,128		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,556,478	2,556,478		

* 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)
Advertising Promotional	$ 13,170		
Total Other Advertising	$ 13,170	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Academy of Nutrition and Diet	$ 234		
ALTCFM	$ 160		
CAHCF	$ 9,144		
CT Department of Administrative Services	$ 320		
State of CT Department on Consumer Protection	$ 40		
Connecticut River Area Health District	$ 70		
Total Dues	$ 9,968	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Chabad on the Shoreline	$ 1,000		
Exchange Club	$ 35		
Total Contributions	$ 1,035	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Employee physicals	$ 10,307		
Bank charge	$ 8,590		
Background checks	$ 1,231		
Total Other Administrative and General	$ 20,128	$ -	$ -

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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 #
N/A			

*** 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
Gladeview Health Care Center, LLC	2024C	9/30/2017	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	329,253	329,253		
2. Non-Food Supplies	$	48,678	48,678		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Management Services**	$				
d. Other (*Specify*)_____	$				
2E. ***Total Dietary Expenditures*** (2a + b + c + d)	$	377,931	377,931		

2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals:	Total no. of meals served per day:*	396	396		

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
Gladeview Health Care Center, LLC	2024C	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. $				
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. $				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$	159,554	159,554		
c. Management Services**	$				
d. Other (*Specify*) Laundry supplies	$	2,965	2,965		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	162,519	162,519		

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
Gladeview Health Care Center, LLC	2024C	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.	$	29,615	29,615		
b. Purchased Services (*by contract other than through Management Services)*	Sq. Ft. Serviced by Personnel					
(Complete Schedule C-2 att. Page 21)	Amt.	$	353,170	353,170		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	382,785	382,785		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Partners Pharmacy		$	272,938	272,938		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	229,491	229,491		
d. Ambulance/Limousine***		$	40,945	40,945		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	25,584	25,584		
f. X-rays and Related Radiological Procedures***		$	13,867	13,867		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	58,684	58,684		
i. Recreation		$	18,624	18,624		
j. Other (Specify)**** See Attached Schedule		$	57,459	57,459		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	717,592	717,592		

* 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)
Therapy Equipment rental	$ 19,551		
Cable TV	$ 25,162		
OT-Supplies	$ 1,252		
Medical equipment	$ 11,494		
Total Other Resident Care	$ 57,459	$ -	$ -

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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
Gladeview Health Care Center, LLC	2024C	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
Partners Pharmacy	PO Box 9689, Uniondale, NY 11555	○	⊙		Pharmacy supplies and service	272,938			20	5a2
PointClickCare	Suite 4, Mississauga, ON L5N 8E9	○	⊙		Computer services	41,902			16	M11
Paycom	Oklahoma City, OK 73142	○	⊙		Payroll processing	29,421			16	M11
CT Waste Processing	PO Box 99, Plainville, CT 06062	○	⊙		Rubbish removal	27,654			22	6f
Sullivan Lawn Service	8 Piney Branch Road, Ivorytown, CT	○	⊙		Groundskeeping	28,106			22	6f
Controlled Air	21 Thompson Rd, Branford, CT 06405	○	⊙		Maintenance	19,685			22	6a
Heritage Health Care Services	1009 Reservior Ave., Cranston, RI 02910	○	⊙		Housekeeping and Laundry	512,724			19,20	3b,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
Gladeview Health Care Center, LLC	2024C	9/30/2017	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	93,331	93,331		
b. Heat	$	43,908	43,908		
c. Light & Power	$	115,576	115,576		
d. Water	$	46,617	46,617		
e. Equipment Lease (*Provide detail on page 6*)	$	18,536	18,536		
f. Other (*itemize*)	$	91,578	91,578		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	409,546	409,546		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	17,798	17,798		
d. Movable Equipment	$	28,817	28,817		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	46,615	46,615		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	10,202	10,202		
c. Leasehold Improvements	$	24,192	24,192		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	34,394	34,394		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	1,322,075	1,322,075		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	8,492	8,492		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,411,576	1,411,576		

* 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 supples	$ 19,865		
Groundskeeping	$ 44,059		
Rubbish removal	$ 27,654		
Total Other Repairs and Maintenance	$ 91,578	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
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								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	259,602		259,602	163,433			17,798	
2. Disposals (attach schedule)	(21,800)			(1,889)				
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								17,798

	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. 2005 Ford Starttrans Bus	x		2	2011	4,900		4,900	4,900	SL	5 years		
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			9	2016	653,049		653,049	449,267	SL	Var	22,775	
b. Disposals (attach schedule)					(66,510)			(8,662)				
c. Acquired during this report period (attach schedule)					23,699						6,042	
D-3. Subtotal												28,817
E. ***Total Depreciation***												46,615

Gladeview Health Care Center, LLC
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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:					
Total additions for Building Improvements		$ -		$ -	*
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:					
9/30/2017	HUD Cost moved to Realty	$ (21,800)			
Total deletions for Non-Movable Equipment		$ (21,800)		$ -	**

***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:					
11/30/2016	Ipad	$ 10,634	5	$ 2,127	
3/8/2017	Wireless pointss	$ 1,414	5	$ 283	
3/7/2017	Office 2013	1343	3	$ 448	
6/29/2017	Wireless pointss	1895	5	$ 379	
6/30/2017	Network server	6593	3	$ 2,198	
8/30/2017	Computers	1820	3	$ 607	
Total additions for Movable Equipment		$ 23,699		$ 6,042	*
Deletions:					
9/30/2017	HUD Cost moved to Realty	$ (66,510)			
Total deletions for Movable Equipment		$ (66,510)		$ -	**

***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:					
9/30/2017	HUD Cost moved to Realty	$ (48,765)			
Total deletions for Leasehold Improvement		$ (48,765)		$ -	**

***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
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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. Mortgage cost	12	2011	10	269,173	248,459	SL		10,202	
2.									
3.									
B-4. Subtotal									10,202
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2017		971,752	807,139	SL		24,192	
2. Disposals (attach schedule)				(48,765)	(4,745)				
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									24,192
D. ***Total Amortization***									34,394

* 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
Gladeview Health Care Center, LLC	2024C	9/30/2017	25	37

11. Property Questionnaire

Part A

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

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

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

Description	Total
1. Date Land Purchased	01/01/85
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	11/20/87
5. Total Licensed Bed Capacity	132
6. Square Footage	
7. Acquisition Cost	
a. Land	450,000
b. Building	7,222,138

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	12/27/14			
c. Interest Rate for the Cost Year	372.00%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	9,670,400			
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Gladeview Health Care Center, LLC	2024C	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
Gladeview Health Care Center, LL	2024C	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*) $			2,434	2,434		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $			2,434	2,434		
14. Insurance a. Insurance on Property (buildings only) $			88,128	88,128		
b. Insurance on Automobiles $						
c. Insurance other than Property (as specified above) 1. Umbrella (*Blanket Coverage*) $						
2. Fire and Extended Coverage $						
3. Other (*Specify*) $						
14d. ***Total Insurance Expenditures (14a + b + c)*** $			88,128	88,128		
15. ***Total All Expenditures (A-13 thru C-14)*** $			12,651,871	12,651,871		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Gladeview Health Care Center, LLC	2024C	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.	10	A12g	Occupational Therapy	$	181,130	181,130		
4.			Other - See attached Schedule	$				
Page 13 - Professional Fees								
5.	13	B8c	Resident Care Physicians **	$	40,888	40,888		
6.			Occupational Therapy	$				
7.			Other - See attached Schedule	$				
Pages 15 & 16 - Administrative and General								
8.	15	1a5	Discriminatory Benefits	$	6,526	6,526		
9.	15	1c	Bad Debts	$	120,000	120,000		
10.			Accounting & Legal	$				
11.			Telephone	$				
12.	15	1h2	Cellular Telephone	$	7,532	7,532		
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators	$	5,035	5,035		
14.	16	L3	Gifts, flowers and coffee shops	$	11,094	11,094		
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	M2&	Unallowable Advertising *	$	13,224	13,224		
19.			Income Tax / Corporate Business Tax	$				
20.	16	M10	Fund Raising / Contributions	$	1,035	1,035		
21.			Unallowable Management Fees	$				
22.			Barber and Beauty	$				
23.			Other - See attached Schedule	$	20,887	20,887		
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)	$	407,351	407,351		

* 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)
15	k2	Sales tax audit	$ 20,887		
Total Other A&G Adjustments			$ 20,887	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Gladeview Health Care Center, LLC	2024C	9/30/2017	29 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward $	407,351	407,351		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs $	272,938	272,938		
28.	20	5d	Ambulance/Limousine $	40,945	40,945		
29.	20	5f	X-rays, etc $	13,867	13,867		
30.	20	5h	Laboratory $	58,684	58,684		
31.	20	5c	Medical Supplies $	11,475	11,475		
32.	20	5e2	Oxygen (non emergency) $	25,584	25,584		
33.	20	5j	Occupational Therapy $	2,418	2,418		
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.	22	10c	Unallowable Property and Real Estate Taxes $	199	199		
38.			Rental of Building Space or Rooms $				
39.			Other - See Attached Schedule $				
Page 27 - Insurance							
40.			Mortgage Insurance $				
41.	27	14b	Property Insurance $	10,591	10,591		
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 $	39,164	39,164		
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)*** $	883,216	883,216		

*** 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

Gladeview Health Care Center, LLC
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)
20	5j	Cable TV	$ 22,312		
30	IV8	Misc income	$ 16,852		
Total Other Adjustments			$ 39,164	$ -	$ -

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
Gladeview Health Care Center, LLC	2024C	9/30/2017	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	10,947,226	10,947,226		
b. Medicaid Room and Board Contractual Allowance **	$	(3,713,008)	(3,713,008)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,660,272	1,660,272		
b. Medicare Room and Board Contractual Allowance **	$	411,981	411,981		
4. a. Private-Pay Residents and Other	$	3,204,774	3,204,774		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	205,975	205,975		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(195,892)	(195,892)		
c. Prescription Drugs - Non-Medicare	$	164,674	164,674		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(164,674)	(164,674)		
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	584,578	584,578		
b. Physical Therapy - Medicare Contractual Allowance **	$	(524,426)	(524,426)		
c. Physical Therapy - Non-Medicare	$	189,121	189,121		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(189,121)	(189,121)		
4. a. Speech Therapy - Medicare	$	187,962	187,962		
b. Speech Therapy - Medicare Contractual Allowance **	$	(161,888)	(161,888)		
c. Speech Therapy - Non-Medicare	$	49,910	49,910		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(49,910)	(49,910)		
5. a. Occupational Therapy - Medicare	$	623,393	623,393		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(570,482)	(570,482)		
c. Occupational Therapy - Non-Medicare	$	171,547	171,547		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(171,547)	(171,547)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	12,660,465	12,660,465		
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)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	9,303	9,303		
V. Total Other Revenue (1 thru 8)	$	9,303	9,303		
VI. Total All Revenue (III +V)	$	12,669,768	12,669,768		

* *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)
Total Other Resident Revenue - Medicare		$ -	$ -	$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
P30 L30IV	Miscellaneous	$ 9,303		
Total Other Revenue		$ 9,303	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center, LLC	2024C	9/30/2017	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 822,180
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,775,990
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ (22,596)
4 Inventories				$ 24,951
5. Prepaid Expenses				$ 33,444
a. Insurance		1,411		
b. Other		3,835		
c. Deposits		28,198		
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 2,633,969
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	922,987		$ 96,401
	Accum. Depreciation	826,586	Net	
5. Non-Movable Equipment	*Historical Cost	237,802		$ 56,571
	Accum. Depreciation	181,231	Net	
6. Movable Equipment	*Historical Cost	610,238		$ 132,154
	Accum. Depreciation	478,084	Net	
7. Motor Vehicles	*Historical Cost	4,900		$
	Accum. Depreciation	4,900	Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 285,126

* 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
Gladeview Health Care Center, LLC	2024C	9/30/2017	32	37

Account				Amount
			Total Brought Forward:	$ 2,919,095
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*)				$ 47,473
Deferred financing fee		47,473		
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 47,473
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 2,966,568

* 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
Gladeview Health Care Center, LLC	2024C	9/30/2017	33	37

Account	Amount
Liabilities	
A. Current Liabilities	
1. Trade Accounts Payable	$ 947,699
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*)	$ 365,653
5. Accrued Payroll (*Owners and/or Stockholders only*)	$
6. Accrued Payroll Taxes Payable	$ 8,702
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*)	$ 354,354

Accounting	15,100	Provider fee	200,739
Property taxes	4,542	Other	132,680
Refunds	1,293		
Pension			

A-13. ***Total Current Liabilities*** (Lines A1 thru 12)	$ 1,676,408

* 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
Gladeview Health Care Center, LLC	2024C	9/30/2017	34	37

Account	Amount
Total Brought Forward:	1,676,408
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

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

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 1,676,408

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

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center, LLC	2024C	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	$ 1,000
	2. Capital Stock	$
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 1,271,263
	6. Gain or Loss for Period 10/1/2016 thru 9/30/2017	$ 17,897
	7. Total Net Worth	$ 1,290,160
C.	***Total Reserves and Net Worth***	$ 1,290,160
D.	***Total Liabilities, Reserves, and Net Worth***	$ 2,966,568

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center, LLC	2024C	9/30/2017	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2016			$ 1,272,263
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 12,669,768
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 12,651,871
D.	Net Income or Deficit			$ 17,897
E.	Balance			$ 1,290,160
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			$ 1,290,160

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center, LLC	2024C	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

Gladeview Health Care Center

Address	Phone Number
60 Boston Post Road, Old Saybrook, CT 06475	860-388-6696