State of Connecticut

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Annual Report of Long-Term Care Facility

Cost Year 2015

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DEPT. OF SOCIAL SERVICES
OFFICE OF CON AND RATE SETTINGS

Name of Facility (as licensed) Gladeview Health Care Center, LLC	
Address (No. & Street, City, State, Zip Code) 60 Boston Post Road, Old Saybrook, CT 06477	
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)	
Report for Year Beginning 10/1/2014	Report for Year Ending 9/30/2015

License Numbers: 2024-C	CCNH 2024C	RHNS	(Specify)	Medicare Provider 07-5313

Medicaid Provider Numbers:	CCNH 2024C	RHNS	ICF-IID

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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Gladeview Health Care Center, LLC	2024C	9/30/2015	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Gladeview Health Care Center, LLC [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (~~Administrator~~)	Date	Signed (Owner)	Date
[signature]	2/12/16	Linda Silberstein	2/12/16
Printed Name (Administrator) Paul Knutsen		Printed Name (Owner) Linda Silberstein	

Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires
Stacy M. LaCasse	Connecticut	2/12/16	[signature]	3/31/16

Address of Notary Public
2 Melody Ridge Rd. Deep River, CT 06417

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Gladeview Health Care Center, LLC	Period Covered:		From 10/1/2014	To 9/30/2015
Address of Facility 60 Boston Post Road, Old Saybrook, CT 06477				
Report Prepared By Gladeview Health Care Center	Phone Number 860-388-6696		Date	

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	9/30/2015	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Gladeview Health Care Center, LLC	60 Boston Post Road, Old Saybrook, CT 06477

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
Gladeview Health Care Center, LLC	2024C	9/30/2015	3	37

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

Name of Partners/Members	Business Address	Title	% Owned
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	9/30/2015	3A	37

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

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
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	9/30/2015	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	1,470,000	1,470,000
Linda Silberstein	60 Boston Post Road Old Saybrook, CT 06475	○	⊙		Salaries and Benefits	Pg 10, line A3,Pge 15,li	132,641	132,641
Linda Silberstein	60 Boston Post Road Old Saybrook, CT 06475	○	⊙		Loan Payable	Pg 34, line b3		
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					
		○	○					

* 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
Gladeview Health Care Center, LLC	2024C	9/30/2015	5	37

If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

Not applicable

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

Not applicable

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.

Not applicable - no non-nursing home cost centers

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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
Pitney Bowes Global Financial, PO Box 371896, Pittsburgh, PA 15250	O	⊙	Postage Meter	03/05/10	51 Months	2,101	1,970
Connecticut Business Systems, 50 Rockwell Road, Newington, CT 06111	O	⊙	Copier	11/28/13	month to month	Various	894
Wells Fargo Leasing, P.O. Box 6434, Carol Stream, IL 60197	O	⊙	Copier	02/01/13	48 Months	21,536	12,612
Advantage Leasing, Department 59475, Milwaukee, Wisconsin, 52259	O	⊙	Security System	02/08/10	60 months	1,406	355
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					
	O	O					

Is a Mileage Log Book Maintained for All Leased Vehicles ? O Yes O No **Total** *** 15,831

* 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	$ 8,700
2	Medicare Cost Report	$ 2,000
3		$
4		$
		Charge for Services Provided $ 10,700

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	860-251-5000
2	
3	
4	
5	

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

1 1 Constitution Plaza, Hartford, CT 06103
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Nursing supervisor lawsuit (disallow)	$ 495
2		$
3		$
4		$
5		$
		Charge for Services Provided $ 495

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	120	120			120	120			117	117		
B. As of midnight of THIS report period	119	119			117	117			119	119		
3. Total Number of Days Care Provided During Period												
A. Medicare	6,362	6,362			5,134	5,134			1,228	1,228		
B. Medicaid (Conn.)	28,839	28,839			21,206	21,206			7,633	7,633		
C. Medicaid (other states)												
D. Private Pay	4,126	4,126			3,216	3,216			910	910		
E. State SSI for RCH												
F. Other (Specify) Managed care	3,561	3,561			2,630	2,630			931	931		
G. Total Care Days During Period (3A thru F)	42,888	42,888			32,186	32,186			10,702	10,702		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	370	370			278	278			92	92		
B. Other Bed Reserve Days												
5. ***Total Resident Days*** **(3G + 4A + 4B)**	43,258	43,258			32,464	32,464			10,794	10,794		

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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
				Lost			Gained						
	CCNH (1)	RHNS (2)	(Specify) (3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	6	77		36				
Per Diem Rate								
a. One bed rm.	var	234.64		381.00				
b. Two bed rms.	var	234.60		361.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	1,449	1,449		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	458	458		
2. Restorative Treatments				
C. Other	10,811	10,811		
D. ***Total Physical Therapy Treatments***	12,718	12,718		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	321	321		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	33	33		
2. Restorative Treatments				
C. Other	1,582	1,582		
D. ***Total Speech Therapy Treatments***	1,936	1,936		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	1,389	1,389		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments	342	342		
2. Restorative Treatments				
C. Other	10,546	10,546		
D. ***Total Occupational Therapy Treatments***	12,277	12,277		

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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)	194,952	2,160				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	147,812	2,948				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	226,445	9,978				
5. Dietary Service						
a. Head Dietitian	38,145	1,436				
b. Food Service Supervisor	7,316	442				
c. Dietary Workers	385,952	27,670				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	117,562	4,294				
b. Other Maintenance Workers	5,644	114				
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	218,452	4,478				
b. RN						
1. Direct Care	1,067,224	31,793				
2. Administrative**	268,087	9,325				
c. LPN						
1. Direct Care	560,834	20,513				
2. Administrative**						
d. Aides and Attendants	1,506,231	94,312				
e. Physical Therapists	340,590	7,133				
f. Speech Therapists	69,375	1,584				
g. Occupational Therapists	191,159	4,632				
h. Recreation Workers	137,764	7,636				
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	222,691	6,500				
n. Marketing						
o. Other (Specify) See Attached Schedule						
A-13. Total Salary Expenditures	5,706,235	236,948				

* 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*

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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	9/30/2015	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	194,952			Health & Life insurance. Payroll taxes	Day to day operations of the nursing home	2,160	A2			
Section IV - Assistant Administrators										
Linda Silberstein	132,641			Health & Life insurance. Payroll taxes	None - disallowed on page 28	2,080	A3			
Matthew McCormick	15,171					868				

*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	9/30/2015	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	5,830					
2. Dentist	11,286					
3. Pharmacist						
4. Podiatrist						
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker	2,400					
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	34,800					
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	52,180					
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	2,520					
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	33,342					
2. Administrative***						
c. Aides	121,766					
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	264,124					

* 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	
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	○	◉	
		○	○	
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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
Gladeview Health Care Center, LLC	2024C	9/30/2015	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	302,191	302,191		
2. Disability Insurance	$				
3. Unemployment Insurance	$	136,026	136,026		
4. Social Security (F.I.C.A.)	$	401,745	401,745		
5. Health Insurance	$	453,412	453,412		
6. Life Insurance (employees only) (not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	$	19,103	19,103		
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*	$	100,000	100,000		
d. Accounting and Auditing	$	9,700	9,700		
e. Legal (*Services should be fully described on Page 7)*	$	495	495		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$				
g. Office Supplies	$	48,458	48,458		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	17,250	17,250		
2. Cellular Phones	$	5,734	5,734		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*) See Attached Schedule	$				
3. Resident Day User Fee	$	762,731	762,731		
Subtotal	$	2,256,845	2,256,845		

* 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

Gladeview Health Care Center, LLC
9/30/2015

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

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

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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	9/30/2015	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,256,845	2,256,845		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	12,200	12,200		
4. Employee Travel	$	3,596	3,596		
5. Education Expenses Related to Seminars and Conventions	$	7,385	7,385		
6. Automobile Expense (*not purchase or depreciation*)	$	10,526	10,526		
7. Other (*Specify*) See Attached Schedule	$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$				
2. Advertising Telephone Directory (*all such expenses*)***	$	707	707		
3. Advertising Other (*Specify*)*** See Attached Schedule	$	23,035	23,035		
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	$	6,202	6,202		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	15,925	15,925		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	1,508	1,508		
9. Subscriptions	$	223	223		
10. Contributions*** See Attached Schedule	$	3,061	3,061		
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	231,964	231,964		
12. Administrative Management Services**	$				
13. Other (*Specify*) See Attached Schedule	$	35,797	35,797		
C-14 Total Administrative & General Expenditures	$	2,608,974	2,608,974		

* 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)
Promotional	$ 23,035		
Total Other Advertising	$ 23,035	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Academy of Nutrition and Dietetics	$ 234		
ALTCFM	$ 640		
CT Association of Health Care Facilities	$ 9,731		
Paul Knutsen	$ 3,400		
Xavus Solutions (Disallowed)	$ 1,000		
State of CT - Boiler Division	$ 400		
Treasurer St of CT	$ 190		
CT River Health District	$ 330		
Total Dues	$ 15,925	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Exchange Club	$ 611		
Gladeview Health Care Resident Counsil	$ 2,450		
Total Contributions	$ 3,061	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Employee physicals	$ 17,126		
Bank fees	$ 4,674		
Department of Public Health Penalty	$ 2,320		
Center for Medicare and Medicaid Penalty	$ 11,550		
Finance Fees	$ 127		
Total Other Administrative and General	$ 35,797	$ -	$ -

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CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Gladeview Health Care Center, LLC	License No. 2024C	Report for Year Ended 9/30/2015	Page 17 of 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 #
Not Applicable			

*** 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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CSP-18 Rev. 9/2002

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	9/30/2015	18	37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	298,296	298,296		
2. Non-Food Supplies	$	85,624	85,624		
3. Other (*Specify*) Supplements	$	2,023	2,023		
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)	$	385,943	385,943		
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*		363	363		

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	9/30/2015	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)*	$	99,581	99,581		
c. Management Services**	$				
d. Other (*Specify*) Suuplies	$	35,569	35,569		
3E. ***Total Laundry Expenditures*** (3a + b + c + d)	$	135,150	135,150		

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	9/30/2015	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.	$	29,899	29,899		
b. Purchased Services (*by contract other than through Management Services*) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel					
	Amt.	$	292,801	292,801		
c. Management Services*		$				
d. Other (*Specify*)		$				
4E. ***Total Housekeeping Expenditures*** (4a + b + c + d)		$	322,700	322,700		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Partners Pharmacy		$	267,067	267,067		
b. Medicine Cabinet Drugs		$	10,828	10,828		
c. Medical and Therapeutic Supplies		$	232,202	232,202		
d. Ambulance/Limousine***		$	20,893	20,893		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	21,383	21,383		
f. X-rays and Related Radiological Procedures***		$	18,686	18,686		
g. Dental (*Not dentists who should be included under salaries or fees*)		$				
h. Laboratory***		$	29,715	29,715		
i. Recreation		$	16,165	16,165		
j. Other (Specify)**** See Attached Schedule		$	62,679	62,679		
5K. ***Total Resident Care Expenditures*** (5a - 5j)		$	679,618	679,618		

* 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)
CABLE TV EXPENSE	$ 19,926		
PHYSICAL THERAPY SUPPLIES	$ -		
THERAPY EQUIP RENTAL	$ 19,415		
INHAL\OXYGEN EQUIP RENTAL	$ 12,692		
OT-SUPPLIES	$ 2,499		
MEDICAL EQUIPMENT RENTAL	$ 8,147		
Total Other Resident Care	$ 62,679	$ -	$ -

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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	9/30/2015	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	267,067			20	5a2
Integrity Health Care Management	33 Chesterfield Road, Amston, CT 06231	⊙	○	Owner is the administrator of the Facility	Financial Services Agreement	96,653			16	M11
PointClickCare	Suite 4, Mississauga, ON L5N 8E9	○	⊙		Computer services	33,943			16	M11
Peoples Payroll	850 Main Street, Bridgeport, CT 06604	○	⊙		Payroll processing	33,165			16	M11
CT Waste Processing	PO Box 99, Plainville, CT 06062	○	⊙		Rubbish removal	23,500			22	6f
Sullivan Lawn Service	8 Piney Branch Road, Ivorytown, CT	○	⊙		Groundskeeping	46,905			22	6f
Controlled Air	21 Thompson Rd, Branford, CT 06405	○	⊙		Maintenance	10,722			22	6a
Heritage Health Care Services	1009 Reservior Ave., Cranston, RI 02910	○	⊙		Housekeeping and Laundry	392,382			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	9/30/2015			22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	133,285	133,285		
b. Heat	$	30,142	30,142		
c. Light & Power	$	135,825	135,825		
d. Water	$	54,406	54,406		
e. Equipment Lease (*Provide detail on page 6*)	$	15,831	15,831		
f. Other (*itemize*)	$	88,761	88,761		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	458,250	458,250		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	15,774	15,774		
d. Movable Equipment	$	37,178	37,178		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	52,952	52,952		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	10,202	10,202		
c. Leasehold Improvements	$	28,829	28,829		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	39,031	39,031		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	1,492,952	1,492,952		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	16,118	16,118		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,601,053	1,601,053		

* 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)
Supplies	$ 18,356		
Groundskeeping	$ 46,905		
Rubbish Removal	$ 23,500		
Total Other Repairs and Maintenance	$ 88,761	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center, LLC	2024C	9/30/2015	23	37

Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
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	234,052		234,052	134,060	S/L	Various	15,774	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)	25,550							
C-4. Subtotal								15,774

	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	4,410	S/L	5 yrs	490	
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period			9	2012	572,100		572,100	370,607			36,688	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)					50,747							
D-3. Subtotal												37,178
E. ***Total Depreciation***												52,952

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:					
10/14/2014	Outdoor storage	$ 2.957			
12/12/2014	Refridgerator	$ 3.652			
6/16/2015	Smoke walls	6453			
8/19/2015	Doors	5694			
8/29/2015	Preasure relief values	3795			
1/28/2015	Dutch over	2999			
Total additions for Non-Movable Equipment		$ 25,550		$ -	*
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:					
11/25/2014	Chest's and cabinets	$ 40,257			
11/30/2014	Computer equipment	$ 6,790			
8/1/2015	Cubicle curtains and tables	3,700.00			
Total additions for Movable Equipment		$ 50,747		$ -	*
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:					
8/31/2015	Architectural fees	$ 1,961			
	Paving	$ 14,615			
Total additions for Leasehold Improvement		$ 16,576		$ -	*
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
Gladeview Health Care Center, LLC			2024C		9/30/2015			24	37
Item	Date of Acquisition Month	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	228,055			10,202	
2.									
3.									
B-4. Subtotal									10,202
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2012		917,757	752,562			28,829	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				16,576					
C-4. Subtotal									28,829
D. ***Total Amortization***									39,031

* 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	9/30/2015	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	Fixed		
b. Date Mortgage Obtained	12/07/11	12/07/12		
c. Interest Rate for the Cost Year	5.16%	4.48		
d. Term of Mortgage (number of years)	10	5		
e. Amount of Principal Borrowed	8,070,000	1,380,000		
f. Principal balance outstanding as of 9/30/15				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)	Fixed			
h. Date of Refinancing	12/27/14			
i. New Interest Rate	372.00%			
j. Term of Mortgage (number of years)	30			
k. Amount of Principal Borrowed	9,670,400			
l. Principal Outstanding on Note Paid-Off	9,579,571			

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	9/30/2015	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	9/30/2015	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*) $	16,855	16,855		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	16,855	16,855		
14. Insurance				
a. Insurance on Property (buildings only) $	95,972	95,972		
b. Insurance on Automobiles $	19,246	19,246		
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)*** $	115,218	115,218		
15. ***Total All Expenditures (A-13 thru C-14)*** $	12,294,120	12,294,120		

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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	9/30/2015	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 $	191,159	191,159		
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians ** $	52,180	52,180		
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.	15	1a5	Discriminatory Benefits $				
9.	15	1c	Bad Debts $	100,000	100,000		
10.	15	1e	Accounting & Legal $	495	495		
11.			Telephone $				
12.	15	1h2	Cellular Telephone $	4,654	4,654		
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators $	6,626	6,626		
14.	16	L3	Gifts, flowers and coffee shops $	12,200	12,200		
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.	16	L6	Automobile Expense (e.g. personal use) $	10,526	10,526		
18.	16	M2&	Unallowable Advertising * $	23,742	23,742		
19.			Income Tax / Corporate Business Tax $				
20.	16	M10	Fund Raising / Contributions $	3,061	3,061		
21.			Unallowable Management Fees $				
22.	16	M6	Barber and Beauty $				
23.			Other - See attached Schedule $	4,761	4,761		
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) $	409,404	409,404		

* 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)
16	M13	Finance fee	$ 127		
16	8a	Disallowed dues	$ 4,634		
Total Other A&G Adjustments			$ 4,761	$ -	$ -

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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	9/30/2015	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	409,404	409,404		
Page 20 - Resident Care Supplies***								
27.	20	5a2	Prescription Drugs	$	267,067	267,067		
28.	20	5d	Ambulance/Limousine	$	20,893	20,893		
29.	20	5f	X-rays, etc	$	18,686	18,686		
30.	20	5h	Laboratory	$	29,715	29,715		
31.	20	5c	Medical Supplies	$	11,610	11,610		
32.	20	5e2	Oxygen (non emergency)	$	21,383	21,383		
33.	20	5j	Occupational Therapy	$	2,499	2,499		
34.			Other - See Attached Schedule	$				
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$				
36.	22	7d	Depreciation on Unallowable Motor Vehicles	$	1,960	1,960		
37.	22	10c	Unallowable Property and Real Estate Taxes	$	138	138		
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	$	83,805	83,805		
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)***			$	867,160	867,160		

*** 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
9/30/2015

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	$ 19,926		
30	IV8	Misc income	$ 63,879		
Total Other Adjustments			$ 83,805	$ -	$ -

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	9/30/2015	30	37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	10,544,090	10,544,090		
b. Medicaid Room and Board Contractual Allowance **	$	(3,763,596)	(3,763,596)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	1,992,394	1,992,394		
b. Medicare Room and Board Contractual Allowance **	$	367,066	367,066		
4. a. Private-Pay Residents and Other	$	3,064,170	3,064,170		
b. Private-Pay Room and Board Contractual Allowance **	$				
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$	247,959	247,959		
b. Prescription Drugs - Medicare Contractual Allowance **	$	(225,775)	(225,775)		
c. Prescription Drugs - Non-Medicare	$	137,560	137,560		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$	(137,560)	(137,560)		
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	$	622,718	622,718		
b. Physical Therapy - Medicare Contractual Allowance **	$	(577,869)	(577,869)		
c. Physical Therapy - Non-Medicare	$	246,744	246,744		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(246,744)	(246,744)		
4. a. Speech Therapy - Medicare	$	187,987	187,987		
b. Speech Therapy - Medicare Contractual Allowance **	$	(164,312)	(164,312)		
c. Speech Therapy - Non-Medicare	$	52,314	52,314		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(52,314)	(52,314)		
5. a. Occupational Therapy - Medicare	$	643,782	643,782		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(599,487)	(599,487)		
c. Occupational Therapy - Non-Medicare	$	226,528	226,528		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(226,528)	(226,528)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	12,339,127	12,339,127		
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*)	$	63,879	63,879		
V. Total Other Revenue (1 thru 8)	$	63,879	63,879		
VI. Total All Revenue (III+V)	$	12,403,006	12,403,006		

* *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)
30iv8	Donations	$ 1,521		
30iv8	Other	$ 62,358		
Total Other Revenue		$ 63,879	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center, LLC	2024C	9/30/2015	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 583,030
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,137,512
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 106,409
4 Inventories				$ 24,951
5. Prepaid Expenses				$ 102,014
a. Prepaid insurance		65,116		
b. Expenses		3,835		
c. Deposits		33,063		
d.				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 1,953,916
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	572,853		$ 152,942
	Accum. Depreciation	419,911	Net	
5. Non-Movable Equipment	*Historical Cost	259,602		$ 109,768
	Accum. Depreciation	149,834	Net	
6. Movable Equipment	*Historical Cost	622,847		$ 215,552
	Accum. Depreciation	407,295	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)				$ 478,262

* 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	9/30/2015	32	37

Account			Amount
		Total Brought Forward:	$ 2,432,178
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*)			$ 67,877
Deffered financing fee		67,877	
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)			$ 67,877
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)			$ 2,500,055

* 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	9/30/2015	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 712,895
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*)					$ 246,915
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 11,869
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*)					$ 382,930
Accrued expenses	32,852	Due to Realty	133,295		
Property taxes	11,612				
Pension	10,694				
Due to Medicaid	194,477				
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 1,354,609

* 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	9/30/2015	34	37

Account	Amount
Total Brought Forward:	1,354,609
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)	$ 1,354,609

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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	9/30/2015	35	37

Account		Amount
A. **Reserves**		
1. Reserve for value of leased land		$
2. Reserve for depreciation value of leased buildings and appurtenances to be amortized		$
3. Reserve for depreciation value of leased personal property (*Equity)*		$
4. Reserve for leasehold real properties on which fair rental value is based		$
5. Reserve for funds set aside as donor restricted		$
6. Total Reserves		$
B. **Net Worth**		
1. Owner's Capital		$
2. Capital Stock		$ 1,000
3. Paid-in Surplus		$
4. Treasury Stock		$
5. Cumulated Earnings		$ 1,035,560
6. Gain or Loss for Period	10/1/2014 thru 9/30/2015	$ 108,886
7. Total Net Worth		$ 1,145,446
C. ***Total Reserves and Net Worth***		$ 1,145,446
D. ***Total Liabilities, Reserves, and Net Worth***		$ 2,500,055

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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	9/30/2015	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2014			$ 1,036,560
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 12,403,006
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 12,294,120
D.	Net Income or Deficit			$ 108,886
E.	Balance			$ 1,145,446
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/15			$ 1,145,446

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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	9/30/2015	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

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

Error Check

Level	Item	Reported as		
	Page 24 - Historical Cost of Leasehold Imp.	934,333	is inconsistent with Page 31	572,853
	Page 24 - Accumulated Amort. of Leasehold Imp.	781,391	is inconsistent with Page 31	419,911

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center, LL	2024C	9/30/2015	7	37

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	$ 8,700
2	Medicare Cost Report	$ 2,000
3		$
4		$
		Charge for Services Provided $ 10,700

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	860-251-5000
2	
3	
4	
5	

Address (*No. & Street, City, State, Zip Code*)
1 1 Constitution Plaza, Hartford, CT 06103
2
3
4
5

Services Provided by This Firm (*describe fully*)

1	Nursing supervisor lawsuit (disallow)	$ 495
2		$
3		$
4		$
5		$
		Charge for Services Provided $ 495

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

NOTE:
If amended pages are necessary, please submit the amended pages with changes highlighted in yellow, along with a signed and notarized Page 1. As a reminder, if any expense pages have changed, which result in a net increase or decrease to total expenses, please submit the necessary amended Pages 27, 35 and 36. If any depreciation and/or amortization expenses have changed, please submit the corresponding Page 23 or 24 along with the corresponding

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center, LL	2392	9/30/2015	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Greensprings Healthcare and Rehabilitation Center, LLC [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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.

{a} Subject to Desk Audit Review

Signed (Administrator)		Date	Signed (Owner)	Date
		2/16/16		2/17/16
Printed Name (Administrator) Marc Lei			Printed Name (Owner) David Blumenkrantz	
Subscribed and Sworn to before me: Robert A. Hanson Jr	State of CT	Date 2/17/16	Signed (Notary Public)	Comm. Expires 9/30/16
Address of Notary Public 854 Forbes Street East Hartford CT 06118				

(Notary Seal)

ROBERT A. HANSON JR.
NOTARY PUBLIC
MY COMMISSION EXPIRES 9/30/2016

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Greensprings Healthcare and Rehabilitation Center, LL	2392	9/30/2015	1	37

Administrator's/Owner's Certification

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

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Greensprings Healthcare and Rehabilitation Center, LLC [facility name], for the cost report period beginning October 1, 2014 and ending September 30, 2015, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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.

{a} Subject to Desk Audit Review

Signed (Administrator)		Date	Signed (Owner)	Date
		2/17/16		2/17/16
Printed Name (Administrator) Marc Lei			Printed Name (Owner) David Blumenkrantz	
Subscribed and Sworn to before me: Robert A. Hanson	State of CT	Date 2/17/16	Signed (Notary Public)	Comm. Expires 9-30-16
Address of Notary Public 854 Forbes St. East Hartford CT 06118				

(Notary Seal)

ROBERT A. HANSON JR.
NOTARY PUBLIC
MY COMMISSION EXPIRES 9/30/2016

General Information

Cover

Name of Facility	Address	Phone Number
Gladeview Health Care Center, LLC	60 Boston Post Road, Old Saybrook, CT 06477	860-388-6696

Type of Facility and License Number(s)

	☑ CCNH	☐ RHNS	(Specify)
License Number	2024C		
Medicaid Provider Number	2024C		

Report for Year Beginning	Report for Year Ending
10/1/2014	9/30/2015

Page 1

Medicare Provider Number
07-5313

Printed Name (Administrator)	Printed Name (Owner)
Paul Knutsen	Linda Silberstein

Page 1A

Report Prepared By	Phone Number	Date
Gladeview Health Care Center	860-388-6696	

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? If "Yes," explain fully.

○ Yes ◉ No

Page 2

Name of Administrator
Paul Knutsen

Nursing Home Administrator's License No.	001500

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

Name	License #
Linda Silberstein	None

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

Page 3

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

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

Page 3A

Names of Stockholders Owning at Least 10% of Shares			
Same as above			

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

Owner(s) of Facility
N/A

Page 3B

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.

Page 4

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
Gladeview LLC	60 Boston Post Road Old Saybrook, CT 06475	○ Yes ◉ No	Lease of real property	Pg 22, Line 9	1,470,000	1,470,000
	Percentage Non-Related	0.00%				
Linda Silberstein	60 Boston Post Road Old Saybrook, CT 06475	○ Yes ◉ No	Salaries and Benefits	Pg 10, line A3, Pge 15 line 5	132,641	132,641
	Percentage Non-Related	0.00%				
Linda Silberstein	60 Boston Post Road Old Saybrook, CT 06475	○ Yes ◉ No	Loan Payable	Pg 34, line b3		
	Percentage Non-Related	0.00%				
		○ Yes ○ No				
	Percentage Non-Related	0.00%				
		○ Yes ○ No				
	Percentage Non-Related	0.00%				
		○ Yes ○ No				
	Percentage Non-Related	0.00%				
		○ Yes ○ No				
	Percentage Non-Related	0.00%				
		○ Yes ○ No				
	Percentage Non-Related	0.00%				
		○ Yes ○ No				
	Percentage Non-Related	0.00%				

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

○ Yes ◉ No

Not applicable

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

Not applicable

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.) If "No," explain fully why such allocation was not made.

○ Yes ○ No

Not applicable - no non-nursing home cost centers

Page 6

A 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 and Address of Lessor	Description of Items Leased	Date of Lease	Term of Lease	Annual Amount of Lease	Amount Claimed	Related to Owners
Pitney Bowes Global Financial, PO Box 371896, Pittsburgh, PA 15250	Postage Meter	3/5/2010	51 Months	2,101	1,970	○ Yes ◉ No
Connecticut Business Systems, 50 Rockwell Road, Newington, CT 06111	Copier	11/28/2013	month to month	Various	894	○ Yes ◉ No
Wells Fargo Leasing, P.O. Box 6434, Carol Stream, IL 60197	Copier	2/1/2013	48 Months	21,536	12,612	○ Yes ◉ No
Advantage Leasing, Department 59475, Milwaukee, Wisconsin, 52259	Security System	2/8/2010	60 months	1,406	355	○ Yes ◉ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
						○ Yes ○ No
				Total	15,831	

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

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? If "No," explain.

◉ Yes ○ No

	Name of Accounting Firm	Address of Accounting Firm
1	Simione Mucca and Larrow	4130 Whitney Ave, Hamden, CT 06518
2	Craig J Lubiski and Company	
3		
4		

Page 7

	Services Provided by This Firm (describe fully)	Charge for Service Provided
1	401k audit, tax return	8,700
2	Medicare Cost Report	2,000
3		
4		

Are these charges reflected in the expenditure portion of this report? If Yes, specify expense classification and line number.

◉ Yes ○ No

Pg 15 Line 1d

	Name of Legal Firm or Independent Attorney	Address	Telephone Number
1	Shipman & Goodwin	1 Constitution Plaza, Hartford, CT 06103	860-251-5000
2			
3			
4			
5			

	Services Provided by This Firm	Charge for Service Provided
1	Nursing supervisor lawsuit (disallow)	495
2		
3		
4		
5		

Are these charges reflected in the expenditure portion of this report? If Yes, specify expense classification and line number.

◉ Yes ○ No

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Pg 15 Line 1e

Are time records maintained by all individuals receiving compensation? ◉ Yes ○ No

Name & Address of Individual	Full Explanation of Services	Explanation of Relationship	Related to Owners, Operators, Officers
William H. Johnson MSW, Inc, PO Box 1354, Palmchurch, MA 01097	Social Worker		○ Yes ◉ No
Prakash Huded MS, 28 Marlboro, Rd., Portland CT	Medical Director, Physician Services		○ Yes ◉ No
Med Options, PO Box 5023, New Britain, CT 06050	Physician Services		○ Yes ◉ No
SDX Swallowing Diagnostics, PO Box 484, Avon, CT 06001	Speech Therapy		○ Yes ◉ No
HealthDrive Dental Group, One Prestige Dr., Suite 107, Meriden, CT 06450	Dental Services		○ Yes ◉ No
The Nurse Network, PO Box 982, Southington, CT 06489	Nursing Pool		○ Yes ◉ No
Dr. Mukerjee, 71 Quail Run, Madison, CT 06443	Cardiac Services		○ Yes ◉ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No
			○ Yes ○ No

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Name & Address of Individual or Company Supplying Service	Cost of Management Services	Full Description of Management Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
Not Applicable			

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2H	Is the cost of employee meals included in 2E?	◉ Yes ○ No			
2I	Did you receive revenue from employees?	○ Yes ◉ No	If yes, specify amt.		
2J	Where is the revenue received reported in the Cost Report?		(Page/Line Item)		
2K	Is the 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.		
2L	Is any revenue collected from these people?	○ Yes ◉ No	If yes, specify amt.		
2M	Where is the revenue received reported in the Cost Report?		(Page/Line Item)		
2N	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.		
2O	Is any revenue collected from employees?	○ Yes ◉ No	If yes, specify amt.		
2P	Where is the revenue received reported in the Cost Report?		(Page/Line Item)		
3G	Is cost of employee laundry included in 3E?	○ Yes ◉ No	If yes, specify cost.		
3H	Did you receive revenue from employees?	○ Yes ◉ No	If yes, specify amt.		
3I	Where is the revenue received reported in the Cost Report?		(Page/Line Item)		
3J	Is cost of laundry provided to persons other than employees or residents included in 3E?	○ Yes ◉ No	If yes, specify cost.		
3K	Did you receive revenue from these people?	○ Yes ◉ No	If yes, specify amt.		
3L	Where is the revenue received reported in the Cost Report?		(Page/Line Item)		

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	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.

	Description	Total
11A1	Date Land Purchased	1/1/1985
11A2	Date Structure Completed	
11A3	If NOT Original Owner, Date of Purchase	
11A4	Date of Initial Licensure	11/20/1987
11A5	Total Licensed Bed Capacity	132
11A6	Square Footage	
11A7a	Original Cost - Land	450,000
11A7b	Original Cost - Building	7,222,138

	Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
11B1a	Type of Financing (e.g., fixed, variable)	Fixed	Fixed		
11B1b	Date Mortgage Obtained	12/7/2011	12/7/2012		
11B1c	Interest Rate for the Cost Year	5.16%	4.48		
11B1d	Term of Mortgage (number of years)	10	5		
11B1e	Amount of Principal Borrowed	8,070,000	1,380,000		
11B1f	Principal balance outstanding as of 9/30/15	-	-		
	Complete if Mortgage was Refinanced During Current Cost Year				
11B1g	Type of Financing (e.g., fixed, variable)	Fixed			
11B1h	Date of Refinancing	12/27/2014			
11B1i	New Interest Rate	3.72			
11B1j	Term of Mortgage (number of years)	30			
11B1k	Amount of Principal Borrowed	9,670,400			
11B1l	Principal Outstanding on Note Paid-Off	9,579,571			

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	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
C	Arms-length leases					
	Arms-length leases					
	Arms-length leases					
	Arms-length leases					
	Arms-length leases					

Printed Name of Preparer
Gladeview Health Care Center

Address of Preparer
60 Boston Post Road, Old Saybrook, CT 06475

Phone Number of Preparer
860-388-6696

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355		27	Prescription Drugs	267,067	267,067			20	5a2
356		28	Ambulance/Limousine	20,893	20,893			20	5d
357		29	X-rays, etc.	18,686	18,686			20	5f
358		30	Laboratory	29,715	29,715			20	5h
359		31	Medical Supplies	11,610	11,610			20	5c
360		32	Oxygen (not emergency)	21,383	21,383			20	5e2
361		33	Occupational Therapy	2,499	2,499			20	5j
362		34	Other Ancillary Costs (Page 29 Schedule)	0	-	-	-		
363			***Page 22 - Maintenance and Property***						
364		35	Excess Movable Equipment Depreciation (Page 29 Schedule)	0	-	-	-		
365		36	Depreciation on Unallowable Motor Vehicles	1,960	1,960			22	7d
366		37	Unallowable Property and Real Estate Taxes	138	138			22	10c
367	Page 29	38	Rental of Building Space or Rooms	0					
368		39	Other Property Costs (Page 29 Schedule)	0	-	-	-		
369			***Page 27 - Insurance***						
370		40	Mortgage Insurance	0					
371		41	Property Insurance	0					
372			***Other - Miscellaneous***						
373		42	Research or Experimental Activities	0					
374		43	Radio and Television Revenue	0					
375		44	Vending Machine Revenue	0					
376		45	Purchase Discounts and Allowances	0					
377		46	Duplication of functions or services	0					
378		47	Expenditures for protection, promotion of provider interest	0					
379		48	Interest Income on Account Rec.	0					
380		49	Other Adjustments to Expense (Page 29 Schedule)	83,805	83,805	-	-		
381			***Not For Profit Providers Only***						
382		50	Building/Non Movable Eq. Depreciation Unallowable Build Int (Page 29 Schedule)	0	-	-	-		
383									
384		51	***Total Amount of Decrease***	867,160	867,160	0	0		
385									

		Line #	Description	Total	CCNH	RHNS	(Specify)
386							
387			*Resident Room, Board & Routine Care Revenue*				
388		I1a	Medicaid Residents (*CT Only*)	10,544,090	10,544,090		
389		I1b	Medicaid Room and Board Contractual Allowance	(3,763,596)	(3,763,596)		
390		I2a	Medicaid (*All Other States*)	0			
391		I2b	Other States Room and Board Contractual Allowance	0			
392		I3a	Medicare Residents *(all inclusive)*	1,992,394	1,992,394		
393		I3b	Medicare Room and Board Contractual Allowance	367,066	367,066		
394		I4a	Private-Pay Residents and Other	3,064,170	3,064,170		
395		I4b	Private-Pay Room and Board Contractual Allowance	0			
396			*Other Resident Revenue*				
397		II1a	Prescription Drugs - Medicare	247,959	247,959		
398		II1b	Prescription Drugs - Medicare Contractual Allowance	(225,775)	(225,775)		
399		II1c	Prescription Drugs - Non-Medicare	137,560	137,560		
400		II1d	Prescription Drugs - Non-Medicare Contractual Allowance	(137,560)	(137,560)		
401		II2a	Medical Supplies - Medicare	0			
402		II2b	Medical Supplies - Medicare Contractual Allowance	0			
403		II2c	Medical Supplies - Non-Medicare	0			
404		II2d	Medical Supplies - Non-Medicare Contractual Allowance	0			
405		II3a	Physical Therapy - Medicare	622,718	622,718		
406	Page 30	II3b	Physical Therapy - Medicare Contractual Allowance	(577,869)	(577,869)		
407		II3c	Physical Therapy - Non-Medicare	246,744	246,744		
408		II3d	Physical Therapy - Non-Medicare Contractual Allowance	(246,744)	(246,744)		
409		II4a	Speech Therapy - Medicare	187,987	187,987		
410		II4b	Speech Therapy - Medicare Contractual Allowance	(164,312)	(164,312)		
411		II4c	Speech Therapy - Non-Medicare	52,314	52,314		
412		II4d	Speech Therapy - Non-Medicare Contractual Allowance	(52,314)	(52,314)		
413		II5a	Occupational Therapy - Medicare	643,782	643,782		
414		II5b	Occupational Therapy - Medicare Contractual Allowance	(599,487)	(599,487)		
415		II5c	Occupational Therapy - Non-Medicare	226,528	226,528		
416		II5d	Occupational Therapy - Non-Medicare Contractual Allowance	(226,528)	(226,528)		
417		II6a	Other (Specify) - Medicare (Other Resident Rev)	0	-	-	-
418		II6b	Other (Specify) - Non-Medicare	0	-	-	-
419		III	***Total Resident Revenue***	12,339,127	12,339,127	0	0
420			*Other Revenue*				
421		IV1	Meals sold to guests, employees & others	0			
422		IV2	Rental of rooms to non-residents	0			
423		IV3	Telephone and Telegraph	0			
424		IV4	Rental of Televisions and Cable Services	0			
425		IV5	Interest Income (Specify) (Interest Income)	0	-	-	-
426		IV6	Private Duty Nurses' Fees	0			
427		IV7	Barber, Coffee, Beauty & Gift shops	0			
428		IV8	Other (Specify) (Other Revenue)	63,879	63,879	-	-
429			**See Attached Schedule**				
430		V	***Total Other Revenue***	63,879	63,879	0	0
431	30	VI	***Total All Revenue***	12,403,006	12,403,006	0	0

	B	C	D	E	F	G
46	7A	**Physical Therapy - Medicare Part B**	**1,449**	1,449		
47	7B1	**Maintenance Treatments**	**458**	458		
48	7B2	**Restorative Treatments**	**0**			
49	7C	**Physical Therapy - Other**	**10,811**	10,811		
50	7D	***Total Physical Therapy Treatments***	**12,718**	**12,718**	**0**	**0**
51	8A	**Speech Therapy - Medicare Part B**	**321**	321		
52	8B1	**Maintenance Treatments**	**33**	33		
53	8B2	**Restorative Treatments**	**0**			
54	8C	**Speech Therapy - Other**	**1,582**	1,582		
55	8D	***Total Speech Therapy Treatments***	**1,936**	**1,936**	**0**	**0**
56	9A	**Occupational Therapy - Medicare Part B**	**1,389**	1,389		
57	9B1	**Maintenance Treatments**	**342**	342		
58	9B2	**Restorative Treatments**	**0**			
59	9C	**Occupational Therapy - Other**	**10,546**	10,546		
60	9D	***Total Occupational Therapy Treatments***	**12,277**	**12,277**	**0**	**0**
61						

Page 11 & 12

Line #

Please fill out the following information for all Operators/Owners, Administrators, Assistant Administrators and other relatives of Owners employed in and paid by facility.

	Name	CCNH	RHNS	(Specify)	Total Hours Worked	Line Where Claimed on Page 10	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Section I-Operators/Owners											
Section II-Other Related Parties											
Section III-Administrators	Paul Knutsen	194,952			2,160	A2	Health & Life insurance. Payroll	Day to day operations of the nursing home			
Section IV-Assistant Administrators	Linda Silberstein	132,641			2,080	A3	Health & Life insurance. Payroll	None - disallowed on page 28			
	Matthew McCormick	15,171			868						

List all contracted services - not just those you consider pertain to resident care.

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Name of Individual/Company	Address	Related to Owner: Operators, Officers	Explanation of Relationship	Full Explanation of Services Provided	Total Cost/Page Ref.: CCNH	RHNS	(Specify)	Page	Line
Partners Pharmacy	PO Box 9689, Uniondale, NY 11555	○ Yes ◉ No		Pharmacy supplies and service	267,067			20	5a2
Integrity Health Care Management	33 Chesterfield Road, Amston, CT 06231	◉ Yes ○ No	Owner is the administrator of the Facility	Financial Services Agreement	96,653			16	M11
PointClickCare	Suite 4, Mississauga, ON L5N 8E9	○ Yes ◉ No		Computer services	33,943			16	M11
Peoples Payroll	850 Main Street, Bridgeport, CT 06604	○ Yes ◉ No		Payroll processing	33,165			16	M11
CT Waste Processing	PO Box 99, Plainville, CT 06062	○ Yes ◉ No		Rubbish removal	23,500			22	6f
Sullivan Lawn Service	8 Piney Branch Road, Ivorytown, CT	○ Yes ◉ No		Groundskeeping	46,905			22	6f
Controlled Air	21 Thompson Rd, Branford, CT 06405	○ Yes ◉ No		Maintenance	10,722			22	6a
Heritage Health Care Services	1009 Reservior Ave., Cranston, RI 02910	○ Yes ◉ No		Housekeeping and Laundry	392,382			19,20	3b,4b
		○ Yes ◉ No							
		○ Yes ○ No							
		○ Yes ○ No							
		○ Yes ○ No							
		○ Yes ○ No							
		○ Yes ○ No							

Line #

Please fill in the Depreciation Schedule as follows:

Page 23

	Asset Addition Schedule	Historical Cost Exclusive of Land	Less Salvage Value	Cost to be Depreciated	Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year
A1	Land Improvements - Acquired prior to report period							
A2	Land Improvements - Disposals	-						-
A3	Land Improvements - Acquired during this report period (attach schedule)							-
B1	Building Improvements - Acquired prior to this report period							
B2	Building Improvements - Disposals	-						-
B3	Building Improvements - Acquired during this report period (attach schedule)							-
C1	Non-Movable Equipment - Acquired prior to this report period	234,052		234,052	134,060	S/L	Various	15,774
C2	Non-Movable Equipment -Disposals	-						-
C3	Non-Movable Equipment - Acquired during this report period (attach schedule)	25,550						-

	Movable Equipment - Motor vehicles (specify name, model and year of each vehicle)	Is a mileage logbook maintained? Yes	No	Date of Acquisition Month	Year	Historical Cost Exclusive of Land	Less Salvage Value	Cost to be Depreciated	Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year
D1a	2005 Ford Startrans Bus	x		2	2,011	4,900		4,900	4,410	S/L	5 yrs	490
D1b												
D1c												
D1d												
D2a	period			9	2,012	572,100		572,100	370,607			36,688
D2b	Disposals					-						-
D2c	Movable Equipment - Acquired during this report period (attach schedule)					50,747						-

Please fill in the Amortization Schedule as follows:

Page 24

	Organization Expense	Date of Acquisition Month	Year	Length of Amortization	Cost to be Amortized	Accumulated Amortization to Beginning of Year's Operations	Basis for Computing Amortization	Rate %	Amortization for This Year
A1									
A2									
A3									
	Mortgage Expense								
B1	Mortgage cost	12	2,011	10	269,173	228,055			10,202
B2									
B3									
C1	Leasehold Improvements and Other - Acquired prior to this report period	9	2,012		917,757	752,562			28,829
C2	Leasehold Improvements and Other - Disposals				-				-
C3	Leasehold Improvements and Other - Acquired during this report period (attach schedule)				16576				-

	A	B	C	D	E
1		**Line #**	**Description**	**Subtotal**	**Total**
2			*Current Assets*		
3		A1	Cash (*on hand and in banks*)		583,030
4		A2	Resident Accounts Receivable		1,137,512
5		A3	Other Accounts Receivable		106,409
6		A4	Inventories		24,951
7		A5	Prepaid Expenses (*itemize*)		102,014
8		a	**Prepaid insurance**	65,116	
9		b	**Expenses**	3,835	
10		c	**Deposits**	33,063	
11		d			
12		A6	Interest Receivable		
13		A7	Medicare Final Settlement Receivable		
14		A8	Other Current Assets (*itemize*)		0
15					
16					
17					
18					
19		A9	***Total Current Assets*** (Lines A1 thru 8)		1,953,916
20					
21			*Fixed Assets*		
22		B1	Land		
23		B2	Land Improvements		0
24	**Page 31**		Historical Cost		
25			Accumulated Depreciation		
26		B3	Buildings		0
27			Historical Cost		
28			Accumulated Depreciation		
29		B4	Leasehold Improvements		152,942
30			Historical Cost	572,853	
31			Accumulated Depreciation	419,911	
32		B5	Non-Movable Equipment		109,768
33			Historical Cost	259,602	
34			Accumulated Depreciation	149,834	
35		B6	Movable Equipment		215,552
36			Historical Cost	622,847	
37			Accumulated Depreciation	407,295	
38		B7	Motor Vehicles		0
39			Historical Cost	4,900	
40			Accumulated Depreciation	4,900	
41		B8	Minor Equipment-Not Depreciable		
42		B9	Other Fixed Assets (*itemize*)		0
43					
44					
45		B10	***Total Fixed Assets*** (Lines B1 thru 9)		478,262
46				**Total Brought Forward**	2,432,178
47			*Leasehold or like property recorded for Equity Purposes*		
48		C1	Land		
49		C2	Land Improvements		0
50			Historical Cost		
51			Accumulated Depreciation		
52		C3	Buildings		0
53			Historical Cost		
54			Accumulated Depreciation		
55		C4	Non-Movable Equipment		0
56			Historical Cost		
57			Accumulated Depreciation		
58		C5	Movable Equipment		0
59			Historical Cost		
60			Accumulated Depreciation		
61		C6	Motor Vehicles		0
62			Historical Cost		
63			Accumulated Depreciation		
64		C7	Minor Equipment -Not Depreciable		
65		C8	***Total Leasehold or Like Properties*** (C1 thru 7)		0
66	**Page 32**				
67			*Investment and Other Assets*		
68		D1	Deferred Deposits		
69		D2	Escrow Deposits		
70		D3	Organization Expense		0

71			Historical Cost		
72			Accumulated Depreciation		
73		D4	Goodwill		
74		D5	Investments Related to Resident Care		0
75					
76					
77		D6	Loans to Owners or Related Parties		0
78			Name and Address		
79			Amount		
80			Loan Date		
81					
82		D7	Other Assets		67,877
83			Deffered financing fee	67,877	
84					
85					
86		D8	***Total Investments and Other Assets*** (Lines D1 thru 7)		67,877
87		D9	***Total All Assets*** (Lines A9 + B10 + C8 + D8)		2,500,055
88					
89		*Current Liabilities*			
90		A1	Trade Accounts Payable		712,895
91		A2	Notes Payable (itemize)		0
92					
93					
94					
95					
96		A3	Loans Payable for Equipment		0
97			Name of Lender		
98			Purpose		
99			Amount		
100			Date Due		
101					
102			Name of Lender		
103			Purpose		
104			Amount		
105			Date Due		
106					
107		A4	Accrued Payroll (*Exclusive of Owners & Stockholders*)		246,915
108		A5	Accrued Payroll (*Owners & Stockholders only*)		
109		A6	Accrued Payroll Taxes Payable		11,869
110		A7	Medicare Final Settlement Payable		
111		A8	Medicare Current Financing Payable		
112		A9	Mortgage Payable		
113		A10	Interest Payable		
114		A11	Accrued Income Taxes		
115		A12	Other Current Liabilities (itemize)		382,930
116			Accrued expenses	32,852	
117			Property taxes	11,612	
118			Pension	10,694	
119			Due to Medicaid	194,477	
120			Due to Realty	133,295	
121					
122					
123					
124		A13	***Total Current Liabilities*** Lines A1 thru 12)		1,354,609
125				**Total Brought Forward**	1,354,609
126		*Long-Term Liabilities*			
127		B1	Loans Payable-Equipment		
128			Name of Lender		
129			Purpose		
130			Amount		
131			Date Due		
132					
133			Name of Lender		
134			Purpose		
135			Amount		
136			Date Due		
137					
138		B2	Mortgages Payable		
139		B3	Loans from Owners or Related Parties		0
140			Name and Address of Lender		

	A	B	C	D	E
141	Pa		Amount		
142			Loan Date		
143					
144			Name and Address of Lender		
145			Amount		
146			Loan Date		
147					
148		B4	Other Long-Term Liabilities (itemize)		0
149					
150					
151					
152					
153		B5	***Total Long-Term Liabilities*** (Lines B1 thru 4)		0
154		C	***Total All Liabilities*** (Lines A13 + B5)		1,354,609
155					
156		*Reserves*			
157		A1	Reserve for value of leased land		
158		A2	Reserve for depreciation value of leased buildings and appurtenances to be amortized		
159		A3	Reserve for depreciation value of leased personal property (Equity)		
160		A4	Reserve for leasehold real properties on which fair rental value is based		
161		A5	Reserve for funds set aside as donor restricted		
162	Page 35	A6	***Total Reserves***		0
163		*Net Worth*			
164		B1	Owner's Capital		
165		B2	Capital Stock		1,000
166		B3	Paid-in Surplus		
167		B4	Treasury Stock		
168		B5	Cumulated Earnings		1,035,560
169		B6	Gain or Loss for Period 10/1/2014 thru 09/30/2015		108,886
170		B7	***Total Net Worth***		1,145,446
171		C	***Total Reserves and Net Worth***		1,145,446
172		D	***Total Liabilities, Reserves, and Net Worth***		2,500,055
173					
174		A	Balance at End of Prior Period		1,036,560
175		B	Total Revenue		12,403,006
176		C	Total Expenditures		12,294,120
177		D	Net Income or Deficit		108,886
178		E	Balance		1,145,446
179		F1	Additional Capital Contributed (itemize)		
180					
181					
182					
183					
184		F2	Other (itemize)		
185					
186					
187					
188					
189	Page 36	F3	***Total Additions***		0
190		G1	Drawings of Owners/Operators/Partners		
191			Name and Address		
192			Title		
193			Amount		
194					
195			Name and Address		
196			Title		
197			Amount		
198		G2	Other Withdrawings		
199			Purpose		
200			Amount		
201					
202			Purpose		
203			Amount		
204		G3	Total Deductions		
205		H	***Balance at End of Period***		1,145,446