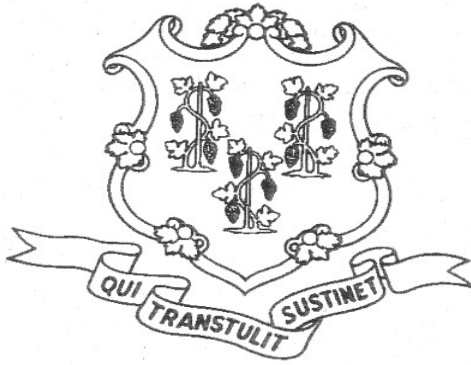


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2018

Name of Facility (as licensed) Advanced Center for Nursing & Rehabilitation, LLC	
Address (No. & Street, City, State, Zip Code) 169 Davenport Ave, New Haven, CT 06519	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2017	Report for Year Ending 9/30/2018

License Numbers:	CCNH 2434	RHNS	(Specify)	Medicare Provider 07-5348
------------------	--------------	------	-----------	------------------------------

Medicaid Provider Numbers:	CCNH 000000323	RHNS	ICF-IID
----------------------------	-------------------	------	---------

For Department Use Only

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

General Information

Name of Facility (as licensed) Advanced Center for Nursing & Rehabilitation, LLC	License No. 2434	Report for Year Ended 9/30/2018	Page 1	of 37
---	---------------------	------------------------------------	-----------	----------

Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT 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 Advanced Center for Nursing & Rehabilitation, LLC [facility name], for the cost report period beginning October 1, 2017 and ending September 30, 2018, 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
Printed Name (Administrator) Dan Brencher			Printed Name (Owner) Mordejai Salamon		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

Table of Contents

General Information - Administrator's/Owner's Certification	1
General Information and Questionnaire - Data Required for Real Wage Adjustment	1A
General Information and Questionnaire - Type of Facility - Organization Structure	2
General Information and Questionnaire - Partners/Members	3
General Information and Questionnaire - Corporate Owners	3A
General Information and Questionnaire - Individual Proprietorship	3B
General Information and Questionnaire - Related Parties	4
General Information and Questionnaire - Basis for Allocation of Costs	5
General Information and Questionnaire - Leases	6
General Information and Questionnaire - Accounting Basis	7
Schedule of Resident Statistics	8
Schedule of Resident Statistics (Cont'd)	9
A. Report of Expenditures - Salaries & Wages	10
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives	11
Schedule A1 - Salary Information for Operators/Owners; Administrators, Assistant Administrators and Other Relatives (Cont'd)	12
B. Report of Expenditures - Professional Fees	13
Report of Expenditures - Schedule B-1 - Information Required for Individual(s) Paid on Fee for Service Basis	14
C. Expenditures Other than Salaries - Administrative and General	15
C. Expenditures Other than Salaries (Cont'd) - Administrative and General	16
Schedule C-1 - Management Services	17
C. Expenditures Other than Salaries (Cont'd) - Dietary	18
C. Expenditures Other than Salaries (Cont'd) - Laundry	19
C. Expenditures Other than Salaries (Cont'd) - Housekeeping and Resident Care	20
Report of Expenditures - Schedule C-2 - Individuals or Firms Providing Services by Contract	21
C. Expenditures Other than Salaries (Cont'd) - Maintenance and Property	22
Depreciation Schedule	23
Amortization Schedule	24
C. Expenditures Other than Salaries (Cont'd) - Property Questionnaire	25
C. Expenditures Other than Salaries (Cont'd) - Interest	26
C. Expenditures Other than Salaries (Cont'd) - Interest and Insurance	27
D. Adjustments to Statement of Expenditures	28
D. Adjustments to Statement of Expenditures (Cont'd)	29
F. Statement of Revenue	30
G. Balance Sheet	31
G. Balance Sheet (Cont'd)	32
G. Balance Sheet (Cont'd)	33
G. Balance Sheet (Cont'd)	34
G. Balance Sheet (Cont'd) - Reserves and Net Worth	35
H. Changes in Total Net Worth	36
I. Preparer's/Reviewer's Certification	37

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Advanced Center for Nursing & Rehabilitation, LLC	Period Covered:	From 10/1/2017	To 9/30/2018	
Address of Facility 169 Davenport Ave, New Haven, CT 06519				
Report Prepared By Marcum LLP	Phone Number 203-781-9600	Date 1/4/2019		
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.

General Information and Questionnaire

Type of Facility - Organization Structure

	Phone No. of Facility 203-789-1650	Report for Year Ended 9/30/2018	Page 2	of 37
Name of Facility (as shown on license) Advanced Center for Nursing & Rehabilitation, LLC		Address (No. & Street, City, State, Zip) 169 Davenport Ave, New Haven, CT 06519		
License Numbers:	CCNH 2434	RHNS (Specify)	Medicare Provider No. 07-5348	
Type of Facility (Check appropriate box(es))				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)				
Type of Ownership (Check appropriate box)				
<input type="radio"/> Proprietorship <input checked="" type="radio"/> LLC <input type="radio"/> Partnership <input type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.				
N/A				
Administrator				
Name of Administrator Dan Brencher		Nursing Home Administrator's License No.:	1913	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.				
Name		License No.:		
N/A				

General Information and Questionnaire
Partners/Members

Name of Facility Advanced Center for Nursing & Rehabilitation, LLC		License No. 2434	Report for Year Ended 9/30/2018	Page 3	of 37
Legal Name of Partnership/LLC Advanced Center for Nursing & Rehabilitation, LLC		Business Address 169 Davenport Ave, New Haven, CT 06519		State(s) and/or Town(s) in Which Registered CT	
Name of Partners/Members	Business Address	Title		% Owned	
Menajem Salamon	169 Davenport Ave, New Haven, CT 06519	Owner		0.025	
Yojevedt Salamon Recovable	169 Davenport Ave, New Haven, CT 06519	Owner		0.375	
Mordejai Salamon	169 Davenport Ave, New Haven, CT 06519	Owner		0.1	
Sari Landa	169 Davenport Ave, New Haven, CT 06519	Owner		0.1	
Esther Gewirtz	169 Davenport Ave, New Haven, CT 06519	Owner		0.08	
Joseph Landa	169 Davenport Ave, New Haven, CT 06519	Owner		0.08	
Joshua Landa	169 Davenport Ave, New Haven, CT 06519	Owner		0.08	
Alan Landa & Steven Landa (8	169 Davenport Ave, New Haven, CT 06519	Owner		0.16	

General Information and Questionnaire Corporate Owners

Name of Facility Advanced Center for Nursing & Rehabilitation	License No. 2434	Report for Year Ended 9/30/2018	Page 3A	of 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
N/A		

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
N/A			

Names of Stockholders Owning at Least 10% of Shares	Business Address	Title	No. Shares Held by Each
N/A			

General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Advanced Center for Nursing & Rehabilitation, LL	2434	9/30/2018	3B	37

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

Owner(s) of Facility

N/A

**General Information and Questionnaire
 Related Parties***

Name of Facility Advanced Center for Nursing & Rehabilitation, LLC	License No. 2434	Report for Year Ended 9/30/2018	Page 4	of 37
---	---------------------	------------------------------------	-----------	----------

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
169 Davenport Ave Realty, LLC	169 Davenport Ave, New Haven, CT 06519	<input type="radio"/>	<input checked="" type="radio"/>		Rent	Pg. 22 / Line 9	807,247	441,344
169 Davenport Ave Realty, LLC	169 Davenport Ave, New Haven, CT 06519	<input type="radio"/>	<input checked="" type="radio"/>		Real Estate Taxes	Pg. 22 / Line 10b	130,645	130,645
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.
 ** Provide the percentage amount of revenue received from non-related parties.

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Advanced Center for Nursing & Rehabilitation,	License No. 2434	Report for Year Ended 9/30/2018	Page 5	of 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 (<i>See listing page 13</i>)
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.

N/A

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

N/A

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

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

N/A

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
Advanced Center for Nursing & Rehabilitation, LLC		2434	9/30/2018			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Mercedes	<input type="radio"/>	<input checked="" type="radio"/>	Mercedes Vehicle Lease (Owner's)	N/A	N/A	3,230	3,230
Honda Leadership Leasing Clinton H2000LLC, 1511 Route 22 E, Annandale, NJ 08801 (See attached)	<input type="radio"/>	<input checked="" type="radio"/>	2016 Honda Accord (Owner's)	07/11/16	36 months	5,949	5,949
Chrysler	<input type="radio"/>	<input checked="" type="radio"/>	Chrysler	10/2016	72 months	19,704	19,704
PITNEY BOWES, P.O.BOX 371887, PITTSBURG, PA 15250	<input type="radio"/>	<input checked="" type="radio"/>	Postage Machine	01/01/16	24 Months	801	801
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?						<input type="radio"/> Yes	<input checked="" type="radio"/> No
Total ***						29,684	

* 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.

General Information and Questionnaire

Accounting Basis

Name of Facility Advanced Center for Nursing & Re	License No. 2434	Report for Year Ended 9/30/2018	Page 7	of 37
The records of this facility for the period covered by this report were maintained on the following basis:				
<input checked="" type="radio"/> Accrual <input type="radio"/> Cash <input type="radio"/> Modified Cash				
Is the accounting basis for this period the same as for the previous period? <input checked="" type="radio"/> Yes <input type="radio"/> No If "No," explain.				
N/A				
Independent Accounting Firm				
Name of Accounting Firm		Address (No. & Street, City, State, Zip Code)		
1 Marcum LLP		555 Long Wharf Drive, New Haven, CT 06511		
2 Stephen O'Neil, CPA, LLC		958 Church Street, Baldwin, NY 11510		
3 Jacob Glick & Associates		3611 14th Ave, Brooklyn, NY 11218		
4				
Services Provided by This Firm (<i>describe fully</i>)				
1 Cost report and advisory services				\$ 33,773
2 Accounting services, tax return, financials statements				\$ 57,750
3 Evacuation / Insurance Defense				\$ 15,000
4				\$
			Charge for Services Provided	
			\$ 106,523	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No Page 15, Line 1d				
Legal Services Information				
Name of Legal Firm or Independent Attorney			Telephone Number	
1 Jackson Lewis P.C.			860-522-0404	
2 Murtha Cullina LLP			203-772-7700	
3 American Arbitration Association			800-778-7879	
4 Chubb Insurance			215-640-1000	
5 Beverly Hodgson			203-497-8571	
Address (<i>No. & Street, City, State, Zip Code</i>)				
1 90 State House Square, 8th Floor, Hartford, CT 06103				
2 265 Church Street, New Haven, CT 06510				
3 Various				
4 436 Walnut Street, Philadelphia, PA 19106				
5 17 Temple Court, New Haven, CT 06511				
Services Provided by This Firm (<i>describe fully</i>)				
1 General matters, union matters (Disallowed \$16,270 on Pg. 28)				\$ 36,604
2 General matters				\$ 4,529
3 Arbitration for union employees				\$ 2,200
4 CHRO defense for employee lawsuits (Favorable outcomes)				\$ 17,831
5 Arbitration				\$ 2,040
			Charge for Services Provided	
			\$ 63,204	
Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.				
<input checked="" type="radio"/> Yes <input type="radio"/> No Page 15, Line 1e				

Schedule of Resident Statistics

Name of Facility Advanced Center for Nursing & Rehabilitation, LLC			License No. 2434		Report for Year Ended 9/30/2018				Page 8	of 37		
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	226	226			226	226			226	226		
B. On last day of THIS report period	226	226			226	226			226	226		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	185	185			185	185			213	213		
B. As of midnight of THIS report period	222	222			213	213			222	222		
3. Total Number of Days Care Provided During Period												
A. Medicare	8,360	8,360			6,744	6,744			1,616	1,616		
B. Medicaid (Conn.)	63,787	63,787			46,298	46,298			17,489	17,489		
C. Medicaid (other states)												
D. Private Pay	2,207	2,207			1,724	1,724			483	483		
E. State SSI for RCH												
F. Other (Specify) Other Ins.	607	607			423	423			184	184		
G. Total Care Days During Period (3A thru F)	74,961	74,961			55,189	55,189			19,772	19,772		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	187	187							187	187		
B. Other Bed Reserve Days	25	25							25	25		
5. Total Resident Days (3G + 4A + 4B)	75,173	75,173			55,189	55,189			19,984	19,984		

Schedule of Resident Statistics (Cont'd)

Name of Facility Advanced Center for Nursing & Rehabilitation			License No. 2434			Report for Year Ended 9/30/2018			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
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	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	20		194		8								
Per Diem Rate													
a. One bed rm.	Various		269.81		355.00								
b. Two bed rms.	Various		269.81		320.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								5,858	5,858				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								2,489	2,489				
2. Restorative Treatments								4,622	4,622				
C. Other								23,880	23,880				
D. Total Physical Therapy Treatments								36,849	36,849				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								1,003	1,003				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								493	493				
2. Restorative Treatments								265	265				
C. Other								28,914	28,914				
D. Total Speech Therapy Treatments								30,675	30,675				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								6,185	6,185				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								2,318	2,318				
2. Restorative Treatments								4,306	4,306				
C. Other								24,670	24,670				
D. Total Occupational Therapy Treatments								37,479	37,479				

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of		
Advanced Center for Nursing & Rehabilitation, LLC	2434	9/30/2018	10	37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> 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)	25,220	1,640				
2. Administrator(s) (Complete also Sec. III of Schedule A1)	174,690	3,484				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)						
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	449,115	14,448				
5. Dietary Service						
a. Head Dietitian	58,171	2,244				
b. Food Service Supervisor	6,058	210				
c. Dietary Workers	695,720	37,257				
6. Housekeeping Service						
a. Head Housekeeper	34,710	1,560				
b. Other Housekeeping Workers	668,051	41,642				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	15,299	699				
b. Other Maintenance Workers	136,085	8,063				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	227,961	12,452				
9. Barber and Beautician Services						
10. Protective Services	143,331	11,618				
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	177,524	2,080				
b. RN						
1. Direct Care	1,279,726	23,177				
2. Administrative**		9,109				
c. LPN						
1. Direct Care	2,341,976	73,537				
2. Administrative**						
d. Aides and Attendants	3,796,387	213,751				
e. Physical Therapists	316,544	6,551				
f. Speech Therapists	73,467	1,338				
g. Occupational Therapists	441,226	13,359				
h. Recreation Workers	107,289	5,841				
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	331,710	10,191				
n. Marketing						
o. Other (Specify)						
See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	11,500,260	494,251				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

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

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

Schedule of Other Salaries and Wages (Page 10)

Position	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
	-					
Total	\$ -	-	\$ -	-	\$ -	-

Schedule of Other Fees (Page 13)

Service	CCNH		RHNS		(Specify)	
	\$	Hours	\$	Hours	\$	Hours
	-					
Nursing Consultant	\$ 143,475	1,139				
Physician Services	1,800	12				
Total	\$ 145,275	1,151	\$ -	-	\$ -	-

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

Name of Facility				License No.	Report for Year Ended			Page	of	
Advanced Center for Nursing & Rehabilitation, LLC				2434	9/30/2018			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Mordejai Salamon	25,220			Non Discrim	Oversees facility	1,640	A1			
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.

**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	
Advanced Center for Nursing & Rehabilitation, LLC				2434	9/30/2018			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***										
Patricia King (10/1/2017 - 11/24/2017)	27,486			Non Discrim	Administrator	212	A2			
Dan Brencher (12/23/2017 - Current)	147,204			Non Discrim	Administrator	1,640	A2			
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of		
Advanced Center for Nursing & Rehabilitation, LLC	2434	9/30/2018	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	54,463	669				
2. Dentist	19,813	96				
3. Pharmacist	33,636	435				
4. Podiatrist						
5. Physical Therapy						
a. Resident Care	415,567	4,416				
b. Other						
6. Social Worker						
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	70,244	288				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**						
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care						
b. Other						
10. Occupational Therapist						
a. Resident Care	340	4				
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care	59,544	728				
2. Administrative***	81,708	1,467				
b. LPN						
1. Direct Care						
2. Administrative***						
c. Aides						
d. Other						
12. Other (Specify) See Attached Schedule	145,275	1,151				
B-13 Total Fees Paid in Lieu of Salaries	880,590	9,254				

* 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.

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

Name of Facility Advanced Center for Nursing & Rehabilitation, LLC		License No. 2434		Report for Year Ended 9/30/2018	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
Ton Ramjit, 10110 220th Street, Queens Village, NY 11429	Dietician	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
NutraSource	Dietician	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Poonam Avashti, 126 Candlewood Drive, Yonkers, NY	Dietician	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Healthdrive Dental, 888 Worcester St, Wellesley, MA 02482	Dentist	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Guardian Consultant Services, 3333 New Hyde Park Rd, St 202, New Hyde Park, NY 11042	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
RN Staff-Rehabilitation, PO Box 823461, Philadelphia, PA	Therapy Services	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Infinite Services, Inc., 49 Montrose Ave Brooklyn NY 11206	Therapy Services	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Dr. Hafsa Nawaz, WH Medical Group, 17 Carriage Hill Rd, Woodbridge, CT	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Dr. Lazaros Lazarides, 1453 Whalley Ave, New Haven, CT 06515	Medical Director / Physician	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Dr. Adedayo O. Adetola, 1453 Whalley Ave, New Haven, CT 06515	Medical Director / Physician	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Stephanie Carull-Deixler	Occupational Therapy	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Pristine Nursing Care, Inc.	Nursing Agency	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Medfirst Staffing Services, Inc.	Nursing Agency	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Emily Enrade	RN Nurse Consultant	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Bonnie Blake	RN Nurse Consultant	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Celtic Consulting, 507 East Main Street, Torrington, CT	MDS Consultant	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Linda Paolillo D'onofrio	Infection Control	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
Maureen Canil, 506 Huntington Ridge Place, Stamford, CT 06903	Independent Nurse Consultant	<input type="radio"/>	<input checked="" type="radio"/>	N/A		
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			

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

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
Advanced Center for Nursing & Rehabilitation, I	2434	9/30/2018		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 1,010,432	1,010,432			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 305,420	305,420			
4. Social Security (F.I.C.A.)	\$ 846,010	846,010			
5. Health Insurance	\$ 1,572,972	1,572,972			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 530,512	530,512			
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$ 67,777	67,777			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 53,446	53,446			
d. Accounting and Auditing	\$ 106,523	106,523			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 63,204	63,204			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 63,206	63,206			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 12,109	12,109			
2. Cellular Phones	\$ 4,979	4,979			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 582	582			
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$ 15,760	15,760			
2. Other (<i>Specify</i>) See Attached Schedule	\$ 71,439	71,439			
3. Resident Day User Fee	\$ 1,409,472	1,409,472			
Subtotal	\$ 6,133,843	6,133,843			

* 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**

Advanced Center for Nursing & Rehabilitation, LLC
9/30/2018

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
	-		
Union Training Fund	\$ 67,777		
Total	\$ 67,777	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
	-		
Sales Tax	\$ 71,439		
Total	\$ 71,439	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended		Page	of
Advanced Center for Nursing & Rehabilitation, LLC	2434	9/30/2018		16	37
Item	Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:	6,133,843	6,133,843			
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 55	55			
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 26,934	26,934			
5. Education Expenses Related to Seminars and Conventions	\$ 2,400	2,400			
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$				
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$ 16,969	16,969			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 67,426	67,426			
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	\$ 13,510	13,510			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 15,903	15,903			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$ 168,342	168,342			
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$ 185,627	185,627			
C-14 Total Administrative & General Expenditures	\$ 6,631,009	6,631,009			

* Do not include Subscriptions, which should go in item 9.

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
	-		
Advertising	\$ 67,426		
Total Other Advertising	\$ 67,426	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	-		
CT Association of Health Care Facilities Dues	\$ 15,903		
Total Dues	\$ 15,903	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	-		
License Renewals	\$ 480		
Bank Charges	15,439		
Licenses & Permits	2,345		
Criminal Background Checks	7,734		
Other Direct	11,872		
CMS Fines & Penalties	9,699		
Penalties	35,980		
Bed Tax - Penalty	46,372		
Interest - Bed Tax	11,573		
Deductible Interest	4,823		
Employee Physical	45		
Legal Settlement Payment	3,000		
Prior Period Settlement Cost	10,241		
Lobbying	26,024		
Total Other Administrative and General	\$ 185,627	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Advanced Center for Nursing & Rehabilit	License No. 2434	Report for Year Ended 9/30/2018	Page of 17 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #

*** 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.**

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

Name of Facility Advanced Center for Nursing & Rehabilitation, LLC		License No. 2434	Report for Year Ended 9/30/2018	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	\$	437,497	437,497		
2. Non-Food Supplies	\$	(3,121)	(3,121)		
3. Other (Specify) _____	\$				
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	1,933	1,933	
c. Other (Specify) _____		\$			
2D. Total Dietary Expenditures (2a + b + c + d)		\$	436,309	436,309	
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*					
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No					
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> 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? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> 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.

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
Advanced Center for Nursing & Rehabilitation, LLC		2434	9/30/2018	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)	\$				
c. Other (Specify) Laundry Supplies	\$	30,370	30,370		
3D. Total Laundry Expenditures (3a + b + c)	\$	30,370	30,370		
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
H. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
K. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> 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.

*** Pounds of Laundry only required for multi-level facilities.

**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
Advanced Center for Nursing & Rehabilitation,		2434	9/30/2018		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
1.	Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	57,269	57,269		
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$	15,454	15,454		
C.	Other (<i>Specify</i>)	\$				
4D.	Total Housekeeping Expenditures (4a + b + c)	\$	72,723	72,723		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
1.	Own Pharmacy	\$				
2.	Purchased from	\$	418,763	418,763		
b.	Medicine Cabinet Drugs	\$				
c.	Medical and Therapeutic Supplies	\$	234,812	234,812		
d.	Ambulance/Limousine***	\$	360	360		
e.	Oxygen					
1.	For Emergency Use	\$				
2.	Other***	\$	24,872	24,872		
f.	X-rays and Related Radiological Procedures***	\$	25,264	25,264		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	42,014	42,014		
i.	Recreation	\$	28,721	28,721		
j.	Direct Management Services*	\$				
k.	Indirect Management Services*	\$				
l.	Other (Specify)**** See Attached Schedule	\$	64,770	64,770		
5M.	Total Resident Care Expenditures (5a - 5j)	\$	839,576	839,576		

* 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)
	-		
Purchased Services - Nursing Equipment Inspections	\$ 5,546		
Equipment Rental	49,170		
Resident Medical Bills	6,355		
PT Supplies	111		
Medical Waste	3,538		
Patient Specific Bills	50		
Total Other Resident Care	\$ 64,770	\$ -	\$ -

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

Name of Facility Advanced Center for Nursing & Rehabilitation, LLC			License No. 2434		Report for Year Ended 9/30/2018			Page of 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
Alert Security Systems, Inc	308 Blake Street, New Haven, CT 06515	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Fire Alarm System Services	10,036			22	6f
All American Waste, LLC	19 Wheeler Street, New Haven, CT 06512	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Waste Removal	48,414			22	6f
Asantino Consulting	N/A	<input type="radio"/>	<input checked="" type="radio"/>	N/A	IT	17,201			16	m11
Extreme Paving & Sealing	747 Forest Road, Northford, CT 06472	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Snow Removal	16,718			22	6f
Facility Compliance Services	221 West Main Street, Plantsville, CT 06479	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Maintenance	113,650			22	6f
Kone Elevator	16 Old Forge Road, Rocky Hill, CT 06067	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Elevator Service	56,949			22	6f
MatrixCare	Floor, New York, NY 10018	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Computer Software	66,914			16	m11
S & R Landscaping	327 Pepper Street, Monroe, CT 06468	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Landscaping	16,161			22	6f
Waltham Services	Suite A, Milford, CT 06460	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Pest Control	13,630			22	6f
Skycare media	149 South Pkwy, Clifton, NJ 07014	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Marketing	19,700			16	m3
Przybysz & Associates	4200 Jenny Lind Rd, Ste B, Fort Smith, AR 72901	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Lobbying	26,024			16	m13
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

* 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).

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

Name of Facility	License No.	Report for Year Ended			Page	of
Advanced Center for Nursing & Rehabilitation	2434	9/30/2018			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 6,801	6,801				
b. Heat	\$ 80,637	80,637				
c. Light & Power	\$ 410,832	410,832				
d. Water	\$ 108,209	108,209				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 29,684	29,684				
f. Other (<i>itemize</i>)	\$ 689,987	689,987				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 1,326,150	1,326,150				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$					
d. Movable Equipment	\$ 217,369	217,369				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 217,369	217,369				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$ 355,015	355,015				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 355,015	355,015				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 807,247	807,247				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$ 130,645	130,645				
c. Personal property taxes	\$ 20,071	20,071				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,530,347	1,530,347				

* 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 & Materials	\$ 94,619		
Contracted Services	545,604		
Elevator Maintenance	1,350		
Waste Removal	48,414		
Total Other Repairs and Maintenance	\$ 689,987	\$ -	\$ -

Depreciation Schedule

Name of Facility Advanced Center for Nursing & Rehabilitation, LLC				License No. 2434			Report for Year Ended 9/30/2018			Page 23	of 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													
2. Disposals (attach schedule)													
3. Acquired during this report period (attach schedule)													
C-4. Subtotal													
		Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
		Yes	No	Month	Year								
D. Movable Equipment													
1. Motor Vehicles (Specify name, model and year of each vehicle)													
a.													
b.													
c.													
d.													
2. Movable Equipment													
a. Acquired prior to this report period				Var	Var	1,106,825		1,106,825	411,932	S/L	Var	209,171	
b. Disposals (attach schedule)				Var	Var	(1,342)		(1,342)	(536)	S/L	Var		
c. Acquired during this report period (attach schedule)				Var	Var	61,467		61,467		S/L	Var	8,198	
D-3. Subtotal													217,369
E. Total Depreciation													217,369

Advanced Center for Nursing & Rehabilitation, LLC
9/30/2018

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
Total additions for Non-Movable Equipment		\$ -		\$ - *
Deletions:				
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:				
6/30/2018	Computers	\$ 9,081	5	\$ 1,816
6/30/2018	MME	20,903	5	2,090
6/30/2018	F&F	20,042	5	2,004
6/30/2017	Equipment	7,167	5	1,433
6/30/2017	F&F	4,274	5	855
Total additions for Movable Equipment		\$ 61,467		\$ 8,198 *
Deletions:				
6/30/2017	Computers	\$ (1,342)	5	\$ -
Total deletions for Movable Equipment		\$ (1,342)		\$ - **

*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:				
6/30/2018	LI	\$ 189,783	20	\$ 9,489
Total additions for Leasehold Improvement		\$ 189,783		\$ 9,489 *
Deletions:				
6/30/2017	LI	\$ (308,902)	20	\$ (15,445)
Total deletions for Leasehold Improvement		\$ (308,902)		\$ (15,445) **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Advanced Center for Nursing & Rehabilitation, LLC			License No. 2434		Report for Year Ended 9/30/2018			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	Var	Var	Various	4,263,738	877,212	S/L	Var	360,971	
2. Disposals (attach schedule)	Var	Var	Various	(308,902)		S/L	Var	(15,445)	
3. Acquired during this report period (attach schedule)	Var	Var	Various	189,783		S/L	Var	9,489	
C-4. Subtotal									355,015
D. Total Amortization									355,015

* 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.

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

Name of Facility Advanced Center for Nursing & Rehabil	License No. 2434	Report for Year Ended 9/30/2018	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description		Total		
1. Date Land Purchased				
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity		226		
6. Square Footage				
7. Acquisition Cost				
a. Land				
b. Building				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)		Fixed		
b. Date Mortgage Obtained		01/14/16		
c. Interest Rate for the Cost Year		4.63%		
d. Term of Mortgage (number of years)		20 Years		
e. Amount of Principal Borrowed		4,500,000		
f. Principal balance outstanding as of 9/30/18		4,218,898		
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility		License No.	Report for Year Ended			Page	of
Advanced Center for Nursing & Reha		2434	9/30/2018			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)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Advanced Center for Nursing & Re		2434		9/30/2018		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) Capital Debt & Loan Interest				\$	114,588	114,588	
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	114,588	114,588	
14. Insurance							
a. Insurance on Property (buildings only)				\$	37,331	37,331	
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify) General Insurance				\$	215,384	215,384	
14d. Total Insurance Expenditures (14a + b + c)				\$	252,715	252,715	
15. Total All Expenditures (A-13 thru C-14)				\$	23,614,637	23,614,637	

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Advanced Center for Nursing & Rehabilitation, LLC				2434	9/30/2018	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	\$ 441,226	441,226		
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$ 340	340		
7.			Other - See attached Schedule	\$ 145,275	145,275		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 53,446	53,446		
10.			Accounting	\$			
10a.	15	1e	Legal	\$ 16,270	16,270		
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 3,179	3,179		
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.	16	L4	Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$ 26,877	26,877		
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m2/3	Unallowable Advertising *	\$ 67,426	67,426		
19.	15	1J/1k	Income Tax / Corporate Business Tax	\$ 16,092	16,092		
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$ 161,432	161,432		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents	\$			
Page 19 - Laundry Expenditures							
25.	19	3c	Laundry services to employees, guests and others who are not residents	\$ 1,379	1,379		
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents	\$			
Subtotal (Items 1 - 26)				\$ 932,942	932,942		

* 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)
13	B12	Independent Nursing consultant	\$ 143,475		
13	B12	Physician Services	1,800		
Total Other Fees Adjustments			\$ 145,275	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
15	1k2	Prior Period Expenses - Sales Tax	\$ 633		
16	m13	Non Routine Bank Charges	1,215		
16	m13	Fine / Penalty	11,872		
16	m13	CMS Fines & Penalties	9,699		
16	m13	Penalties	35,980		
16	m13	Bed Tax - Penalties	46,372		
16	m13	Interest - Bed Tax	11,573		
16	m13	Deductible Interest	4,823		
16	m13	Legal Settlement Payment	3,000		
16	m13	Prior Period Settlement Costs	10,241		
16	m13	Lobbying	26,024		
Total Other A&G Adjustments			\$ 161,432	\$ -	\$ -

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

Name of Facility				License No.	Report for Year Ended	Page	of
Advanced Center for Nursing & Rehabilitation, LLC				2434	9/30/2018	29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 932,942	932,942		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 418,763	418,763		
28.	20	5d	Ambulance/Limousine	\$ 360	360		
29.	20	5f	X-rays, etc	\$ 25,264	25,264		
30.	20	5h	Laboratory	\$ 42,014	42,014		
31.	20	5c	Medical Supplies	\$ (204)	(204)		
32.	20	5e2	Oxygen (non emergency)	\$ 24,872	24,872		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 45,350	45,350		
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.			Unallowable Property and Real Estate Taxes	\$			
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$ 6,522	6,522		
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$ 65,564	65,564		
Not For Profit Providers Only							
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
49. Total Amount of Decrease (Items 1 - 48)				\$ 1,561,447	1,561,447		

*** Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

Advanced Center for Nursing & Rehabilitation, LLC
9/30/2018

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5i	Cable TV Disallowances (See attached)	\$ 11,692		
20	5l	Prior Period Expense - Purchased Services	2,802		
20	5l	Prior Period Expense - Equipment Rental	7,106		
20	5l	Equipment Rental - Wound Vac	14,270		
20	5l	Equipment Rental - Trapeze	30		
20	5l	Equipment Rental - Tube Feeding Pumps	3,045		
20	5l	Resident Medical Bills	6,355		
20	5l	Pateint Specific Bills	50		
Total Other Ancillary Costs			\$ 45,350	\$ -	\$ -

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)
22	6e	Auto Leases for Employee Travel	\$ 9,179		
22	6f	Prior Period Expense - Contracted Service	\$ (2,657)		
Total Other Property Adjustments			\$ 6,522	\$ -	\$ -

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV 8	Antenna Income	\$ 21,359		
30	IV 8	Misc. Income	42,120		
30	IV 8	Medical Record Income	496		
30	IV 8	Discounts Earned (Medfirst Staffing Services)	1,589		
Total Other Adjustments			\$ 65,564	\$ -	\$ -

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Advanced Center for Nursing & Rehabilit	2434	9/30/2018			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 17,731,846	17,731,846				
b. Medicaid Room and Board Contractual Allowance **	\$ (1,206,389)	(1,206,389)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 7,533,900	7,533,900				
b. Medicare Room and Board Contractual Allowance **	\$ (4,409,676)	(4,409,676)				
4. a. Private-Pay Residents and Other	\$ 1,013,711	1,013,711				
b. Private-Pay Room and Board Contractual Allowance **	\$ 212,754	212,754				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ (2,103)	(2,103)				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 47,423	47,423				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
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	\$ 1,135,281	1,135,281				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 304,052	304,052				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 172,466	172,466				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 59,400	59,400				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 1,261,124	1,261,124				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 305,147	305,147				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$ (49,317)	(49,317)				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 817	817				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 24,110,436	24,110,436				
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 (<i>Specify</i>)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 1,267,356	1,267,356				
V. Total Other Revenue (1 thru 8)	\$ 1,267,356	1,267,356				
VI. Total All Revenue (III +V)	\$ 25,377,792	25,377,792				

* 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)
		-		
30 II 6a	Medicare A - X-Ray	\$ 23,321		
30 II 6a	Medicare A - Lab	29,552		
30 II 6a	Medicare B - Contractual Adjustment	(102,190)		
Total Other Resident Revenue - Medicare		\$ (49,317)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 II 6b	Private Cert - Lab	\$ 817		
Total Other Resident Revenue		\$ 817	\$ -	\$ -

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
		-		
30 IV 8	Antenna Income	\$ 21,359		
30 IV 8	Misc Income	42,120		
30 IV 8	Medical Records Income	496		
30 IV 8	Small Balance Adjustments	(33)		
30 IV 8	Discounts Earned (Medfirst Staffing Services)	1,589		
30 IV 8	Insurane Proceeds - Asset Reduction on Depreciation Schedule	499,803		
30 IV 8	Insurane Proceeds - Phone System (Pending Purchase)	93,600		
30 IV 8	Insurane Proceeds - Loss on Business	608,422		
Total Other Revenue		\$ 1,267,356	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Advanced Center for Nursing & Rehabil	2434	9/30/2018	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	334,834
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	3,131,618
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4 Inventories			\$	36,386
5. Prepaid Expenses			\$	435,842
a. _____				
b. _____				
c. _____				
d. See Schedule		435,842		
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	3,938,680
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 <u>4,144,619</u>		\$	2,912,392
	Accum. Depreciation <u>1,232,227</u>	Net		
5. Non-Movable Equipment	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
6. Movable Equipment	*Historical Cost <u>1,166,950</u>		\$	538,185
	Accum. Depreciation <u>628,765</u>	Net		
7. Motor Vehicles	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	169,622
F/S vs C/R NBV		(549,240)		
See Schedule		718,862		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	3,620,199

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Advanced Center for Nursing & Rehabi	2434	9/30/2018	32	37
Account			Amount	
Total Brought Forward:			\$	7,558,879
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 (<i>itemize</i>)			\$	

6. Loans to Owners or Related Parties (<i>itemize</i>)			\$	194,580
Name and Address		Amount	Loan Date	
Due From 169 Davenport Realty		194,580		
7. Other Assets (<i>itemize</i>)			\$	

See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	194,580
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	7,753,459

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

G. Balance Sheet (cont'd)

Name of Facility		License No.	Report for Year Ended	Page	of
Advanced Center for Nursing & Rehabilitation		2434	9/30/2018	33	37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	3,720,986
2. Notes Payable (<i>itemize</i>)				\$	912,775
Note Payable		912,775			
See Schedule					
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	557,762
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	111,353
7. Medicare Final Settlement Payable				\$	
8. Medicare Current Financing Payable				\$	
9. Mortgage Payable (<i>Current Portion</i>)				\$	
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$	
11. Accrued Income Taxes*				\$	
12. Other Current Liabilities (<i>itemize</i>)				\$	1,110,470
Ascentium Loan		373,389			
Ascentium Loan #2		675,850			
Resident Trust		61,231			
See Schedule					
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	6,413,346

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

(Carry Total forward to next page)

Annual Report of Long-Term Care Facility

CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility Advanced Center for Nursing & Rehabilitat		License No. 2434	Report for Year Ended 9/30/2018	Page 34	of 37
Account				Amount	
Total Brought Forward:				6,413,346	
Liabilities (cont'd)					
B. Long-Term Liabilities					
1. Loans Payable-Equipment (<i>itemize</i>)					\$
Name of Lender	Purpose	Amount	Date Due		
2. Mortgages Payable					\$
3. Loans from Owners or Related Parties (<i>itemize</i>)					\$
Name and Address of Lender	Amount	Loan Date			
4. Other Long-Term Liabilities (<i>itemize</i>)					\$

See Schedule					
B-5. Total Long-Term Liabilities (Lines B1 thru 4)					\$
C. Total All Liabilities (Lines A-13 + B-5)					\$ 6,413,346

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

Name of Facility	License No.	Report for Year Ended	Page	of
Advanced Center for Nursing & Rehabil	2434	9/30/2018	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 (<i>Equity</i>)			\$	
4. Reserve for leasehold real properties on which fair rental value is based			\$	
5. Reserve for funds set aside as donor restricted			\$	
6. Total Reserves			\$	
B. Net Worth				
1. Owner's Capital			\$	
2. Capital Stock			\$	
3. Paid-in Surplus			\$	243,083
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	(1,084,153)
6. Gain or Loss for Period			\$	2,181,183
	10/1/2017	thru	9/30/2018	
7. Total Net Worth			\$	1,340,113
C. Total Reserves and Net Worth			\$	1,340,113
D. Total Liabilities, Reserves, and Net Worth			\$	7,753,459

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Advanced Center for Nursing & Rehabil	2434	9/30/2018	36	37
Account			Amount	
A.	Balance at End of Prior Period as shown on Report of 09/30/2017		\$	290,848
B.	Total Revenue (<i>From Statement of Revenue Page 30</i>)		\$	25,377,792
C.	Total Expenditures (<i>From Statement of Expenditures Page 27</i>)		\$	23,196,609
D.	Net Income or Deficit		\$	2,181,183
E.	Balance		\$	2,472,031
F.	Additions			
	1. Additional Capital Contributed (<i>itemize</i>)			
	Expenses Per Page 27	\$23,614,637		
	F/S vs C/R Depreciation	(418,028)		
	Expenses Per F/S	\$23,196,609		
	2. Other (<i>itemize</i>)			
	Contributions	243,083		
F-3.	Total Additions		\$	243,083
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (<i>Specify</i>)		\$	
	Name and Address (<i>No., City, State, Zip</i>)	Title	Amount	
	2. Other Withdrawings (<i>Specify</i>)		\$	1,375,000
	Purpose	Amount		
	Distributions	1,375,000		
	3. Total Deductions		\$	1,375,000
H.	Balance at End of Period	09/30/18	\$	1,340,114

I. Preparer's/Reviewer's Certification

Name of Facility Advanced Center for Nursing &	License No. 2434	Report for Year Ended 9/30/2018	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>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.</p>				
Signature of Preparer		Title		Date Signed
Printed Name of Preparer				
Matthew S. Bovolack				
Address Address			Phone Number	
555 Long Wharf Drive, New Haven, CT 06511			203-781-9600	
Annual Report Contact			Phone Number	
Mark Salamon			718-882-6400;217	
Annual Report Contact Email Address				
Msalamon@goldcrestcc.com				

Subject to the attached accountants' consulting report