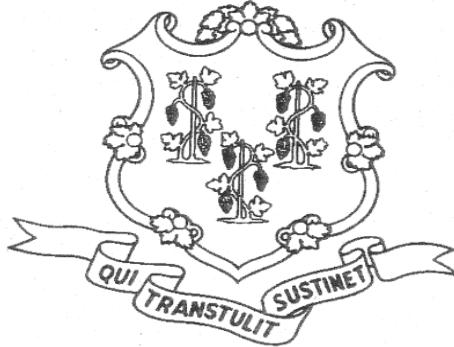


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2019

Name of Facility (as licensed) Healthcare Visions, Inc. d/b/a Beechwood	
Address (No. & Street, City, State, Zip Code) 31 Vauxhall Street, New London, CT 06320	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2018	Report for Year Ending 9/30/2019

License Numbers:	CCNH 2077-C	RHNS	(Specify)	Medicare Provider 07-5335
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Medicaid Provider Numbers:	CCNH 6221	RHNS	ICF-IID
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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) Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019	Page 1	of 37
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Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR 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 Healthcare Visions, Inc. d/b/a Beechwood [facility name], for the cost report period beginning October 1, 2018 and ending September 30, 2019, and that to the best of my knowledge and belief, it is a true, correct, and complete statement prepared from the books and records of the provider(s) in accordance with applicable instructions.

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

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

Signed (Administrator)	Date	Signed (Owner)	Date
Printed Name (Administrator) William E. White		Printed Name (Owner)	
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public			

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	Period Covered:		From 10/1/2018	To 9/30/2019
Address of Facility 31 Vauxhall Street, New London, CT 06320				
Report Prepared By Marcum LLP	Phone Number 203-781-9600	Date 1/18/2020		
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 860-442-4363	Report for Year Ended 9/30/2019	Page 2
Name of Facility (as shown on license) Healthcare Visions, Inc. d/b/a Beechwood		Address (No. & Street, City, State, Zip) 31 Vauxhall Street, New London, CT 06320	
License Numbers:	CCNH 2077-C	RHNS	(Specify)
Medicare Provider No. 07-5335			
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" 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 William E. White		Nursing Home Administrator's License No.:	1539
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name N/A			License No.:

General Information and Questionnaire Partners/Members

General Information and Questionnaire
Corporate Owners

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019	Page of 3A 37
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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	
Healthcare Visions, Inc. d/b/a Beechwood	31 Vauxhall Street, New London, CT 06320	CT	
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
William G. White	31 Vauxhall Street, New London, CT 06320	CEO	100
Diane H. White	31 Vauxhall Street, New London, CT 06320	Secretary	
William E. White	31 Vauxhall Street, New London, CT 06320	President	
Names of Stockholders Owning at Least 10% of Shares			
William G. White	31 Vauxhall Street, New London, CT 06320	CEO	100

**General Information and Questionnaire
Individual Proprietorship**

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019	Page 3B	of 37
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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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input checked="" type="radio"/> Yes <input type="radio"/> 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?				<input checked="" type="radio"/> Yes <input type="radio"/> 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	%**				
Victorian Management, Inc.	31 Vauxhall Street, New London, CT 06320	<input type="radio"/>	<input checked="" type="radio"/>		Rental of Building	Page 22 / Line 9	365,839	249,417
Diane H. White	31 Vauxhall Street, New London, CT 06320	<input type="radio"/>	<input checked="" type="radio"/>		Rental of Parking Lot	Page 22 / Line 9	11,400	11,400
Victorian Management, Inc.	31 Vauxhall Street, New London, CT 06320	<input type="radio"/>	<input checked="" type="radio"/>		Building Depreciation	Page 22 / Line 7b	168,521	168,521
		<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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

Item	Method of Allocation
Dietary	Number of meals served to residents
Laundry	Number of pounds processed
Housekeeping	Number of square feet serviced
Nursing	Number of hours of routine care provided by EACH employee classification, i.e., Director (or Charge Nurse), Registered Nurses, Licensed Practical Nurses, Aides and Attendants
Direct Resident Care Consultants	Number of hours of resident care provided by EACH specialist (<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 9/30/2019			Page of 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					
Accelerated Care Plus (ACP), 13828 Collections Center Drive, Chicago, IL 60693	<input type="radio"/>	<input checked="" type="radio"/>	Rehab Equipment	06/10/09	Open Ended	8,853	8,853
Accelerated Care Plus (ACP), 13828 Collections Center Drive, Chicago, IL 60693	<input type="radio"/>	<input checked="" type="radio"/>	Rehab Equipment	05/22/19	Open Ended	2,249	2,249
Aztec, 31 Vauxhall St, New London, CT 06320	<input type="radio"/>	<input checked="" type="radio"/>	Copiers	06/26/18	60 Months	8,353	8,353
	<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"/>					
	<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 ***	19,455

* 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 Healthcare Visions, Inc. d/b/a Beec	License No. 2077-C	Report for Year Ended 9/30/2019	Page 7	of 37
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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.

N/A

Independent Accounting Firm

Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1 Marcum LLP	555 Long Wharf Drive, 8th Floor, New Haven, CT 06511
2 Laura Daniels	7 Fencove Ct, Old Saybrook, CT 06475
3 Whittlesey & Hadley, P.C.	1 Hamden Center, 2319 Whitney Ave, Suite 2a, Hamden, CT
4	

Services Provided by This Firm (*describe fully*)

1	Preparation of Medicaid and Medicare Cost Reports	\$ 8,022
2	Month End Closings	\$ 4,675
3	Review of Financial Statements and Preparation of Tax Returns	\$ 24,884
4		\$
		Charge for Services Provided
		\$ 37,581

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

Yes No | Page 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Murtha Cullina	860-240-6000
2 Archbold Law Firm	941-960-8825
3 Messier Massad & Burdick	860-443-7014
4	
5	

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

1 PO Box 150435, Hartford, CT 06115
2 2389 Ringling Blvd, Suite A, Sarasota, FL 34237
3 21 Huntington St # 1, New London, CT 06320
4
5

Services Provided by This Firm (*describe fully*)

1	General Employee / Resident Services	\$	3,744
2	General Legal Services	\$	3,280
3	General Resident Legal Services	\$	317
4		\$	
5		\$	
		Charge for Services Provided	
		\$	7,341

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

Page 15, Line 1e

Schedule of Resident Statistics

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood			License No. 2077-C				Report for Year Ended 9/30/2019				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					60	60			60	60		
A. On last day of PREVIOUS report period	60	60			60	60			60	60		
B. On last day of THIS report period	60	60			60	60			60	60		
2. Number of Residents					59	59			51	51		
A. As of midnight of PREVIOUS report period	59	59			59	59			51	51		
B. As of midnight of THIS report period	57	57			51	51			57	57		
3. Total Number of Days Care Provided During Period					2,522	2,522			757	757		
A. Medicare	3,279	3,279			2,522	2,522			757	757		
B. Medicaid (Conn.)	11,716	11,716			8,596	8,596			3,120	3,120		
C. Medicaid (other states)												
D. Private Pay	4,192	4,192			3,055	3,055			1,137	1,137		
E. State SSI for RCH												
F. Other (Specify) Hospice / Managed Care	1,144	1,144			949	949			195	195		
G. Total Care Days During Period (3A thru F)	20,331	20,331			15,122	15,122			5,209	5,209		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	20,331	20,331			15,122	15,122			5,209	5,209		

Schedule of Resident Statistics (Cont'd)

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?

 Yes No

If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change	
	CCNH (1)	RHNS (2)	(Specify) (3)	Lost			Gained			CCNH	RHNS	(Specify)		
				(1)	(2)	(3)	(1)	(2)	(3)					
N/A														

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.

1st change	Change in Resident Days			CCNH	RHNS	(Specify)
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	5	33		19				
Per Diem Rate								
a. One bed rm.	Various	240.29		415.00				
b. Two bed rms.	Various	240.29		395.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	1,518	1,518	(Specify)
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	231	231	
2. Restorative Treatments			
C. Other	11,585	11,585	
D. Total Physical Therapy Treatments	13,334	13,334	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	167	167	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments			
C. Other	1,235	1,235	
D. Total Speech Therapy Treatments	1,402	1,402	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	1,526	1,526	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	184	184	
2. Restorative Treatments			
C. Other	12,987	12,987	
D. Total Occupational Therapy Treatments	14,697	14,697	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2019		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)
A. Salaries and Wages*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)	92,695	Disallowed			
2. Administrator(s) (Complete also Sec. III of Schedule A1)	98,119	2,080			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	287,814	11,042			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor					
c. Dietary Workers	275,869	16,735			
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers	169,206	11,139			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance					
b. Other Maintenance Workers	102,675	4,808			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	30,394	2,117			
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	99,075	1,968			
b. RN					
1. Direct Care	555,140	14,145			
2. Administrative**	212,648	6,389			
c. LPN					
1. Direct Care	556,054	19,552			
2. Administrative**					
d. Aides and Attendants	1,045,379	60,052			
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	59,242	3,191			
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	64,017	2,068			
n. Marketing					
o. Other (Specify)					
See Attached Schedule					
A-13. Total Salary Expenditures	3,648,327	155,286			

* 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)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood				License No. 2077-C		Report for Year Ended 9/30/2019			Page 11	of 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										
William G. White (Disallowed)	92,695			See Page 28	Rental Office, CEO/President	N/A	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.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

**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
Healthcare Visions, Inc. d/b/a Beechwood				2077-C		9/30/2019			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***										
William E. White	98,119			Group Benefits	Administrator	2,080	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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019		Page 13	of 37
Item	Total Cost and Hours				
	CCNH	Hours	RHNS	Hours	(Specify)
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)					
1. Dietitian	27,325	459			
2. Dentist	4,536	Monthly			
3. Pharmacist	6,240	96			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	238,887	3,666			
b. Other					
6. Social Worker	1,935	5			
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	47,000	188			
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) Physiatrist	15,413	103			
9. Speech Therapist					
a. Resident Care	25,118	354			
b. Other					
10. Occupational Therapist					
a. Resident Care	263,305	3,678			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	4,940	75			
2. Administrative***					
b. LPN					
1. Direct Care	3,765	74			
2. Administrative***					
c. Aides					
d. Other					
12. Other (Specify) See Attached Schedule	480	30			
B-13 Total Fees Paid in Lieu of Salaries	638,944	8,728			

* 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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship	
		Yes	No		
Access Capital, 405 Park Ave-NY	Contract RNs / LPNs	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
All American, 494 Broad St-Newark NJ	Contract RNs	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Ready Nurse, PO Box 3010756-Dallas TX	Contract LPNs	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
CareerStaff Unlimited, PO Box 3010756-Dallas TX	Contract LPNs	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Ellen Smith, 9 Sunrise Lane, Madison, CT 06443	Dietician	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Partners Pharmacy, 50 Lawrence Road, Springfield Township, New Jersey 07081	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
IPC Hospitalists, PO Box 844929, Los Angeles, CA 90084-4929	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Yale NewHaven Health, PO Box 9403, New Haven, CT 06534	Physiatrist	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
HealthPro Management Services, LLC 307 International Circle, Suite 100,Hunt Valley	Physical, Occupational and Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Nutmeg Behavioral Health, 103 Myron Street, Suite A, West Springfield, MA 011089	Contract Social Worker	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Healthdrive Dental Group, 888 Worcester Street, Ste 130, Wellesley, MA 02482	Dentist	<input type="radio"/>	<input checked="" type="radio"/>	N/A	
Procaire, PO Box 801, Tolland, CT 06084	Respiratory Therapist	<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"/>		
		<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.

** 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
		9/30/2019		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 115,654	115,654			
2. Disability Insurance	\$ 6,927	6,927			
3. Unemployment Insurance	\$ 78,752	78,752			
4. Social Security (F.I.C.A.)	\$ 270,149	270,149			
5. Health Insurance	\$ 290,733	290,733			
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 3,346	3,346			
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$				
8. Uniform Allowance	\$ (1,408)	(1,408)			
9. Other (Specify) See Attached Schedule	\$ 17,645	17,645			
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 92,617	92,617			
d. Accounting and Auditing	\$ 37,581	37,581			
e. Legal (Services should be fully described on Page 7)	\$ 7,341	7,341			
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$ 99,825	99,825			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 6,159	6,159			
2. Cellular Phones	\$ 1,721	1,721			
i. Appraisal (Specify purpose and attach copy)*	\$				
j. Corporation Business Taxes (franchise tax)	\$ 129	129			
k. Other Taxes (Not related to property - See Page 22)					
1. Income*	\$				
2. Other (Specify) See Attached Schedule	\$ 959	959			
3. Resident Day User Fee	\$ 334,575	334,575			
Subtotal	\$ 1,362,705	1,362,705			

* 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**

Attachment Page 15

Schedule of Other Employee Benefits

Description	CCNH	RHNS	(Specify)
Employee Benefits (Uniforms / Retirement Plan)	\$ 4,869		
CEO Benefits (Disallowed on Pg 28a)	4,710		
Employee Relations (Disallowed on Pg 28a)	7,182		
Employee Assistance Program	884		
Total	\$ 17,645	\$ -	\$ -

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Sales Tax	\$ 229		
Motor Vehicle Tax (Disallowed on Pg 28a)	730		
Total	\$ 959	\$ -	\$ -

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

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		1,362,705	1,362,705		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$	8,372	8,372		
3. Gifts to Staff and Residents	\$	8,204	8,204		
4. Employee Travel	\$	3,426	3,426		
5. Education Expenses Related to Seminars and Conventions	\$	7,115	7,115		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	6,076	6,076		
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	2,326	2,326		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	14,945	14,945		
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	\$				
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	4,879	4,879		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$	4,157	4,157		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	43,200	43,200		
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$	40,156	40,156		
<i>C-14 Total Administrative & General Expenditures</i>	\$	1,505,561	1,505,561		

* 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)
	-		
Various Advertising (Disallowed on Pg 28)	\$ 14,945		
Total Other Advertising	\$ 14,945	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	-		
CATRD Dues	\$ 40		
CAHCF Dues	4,444		
ALTCFM Dues	85		
American College of Healthcare Dues	310		
Total Dues	\$ 4,879	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
	-		
Donations (Disallowed on Pg 28)	\$ 4,007		
Sponsorships (Disallowed on Pg 28)	150		
Total Contributions	\$ 4,157	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	-		
Pre Employment Expenses	4,854		
Licensing Fees	687		
Equipment Rental	318		
Employee Physicals	65		
Bank Charges	15,124		
Collection Fee (Disallowed on Pg 28)	56		
Fines (Disallowed on Pg 28)	17,345		
Admissions Event (Disallowed on Pg 28)	70		
Non Deductible Penalty (Disallowed on Pg 28)	1,637		
Total Other Administrative and General	\$ 40,156	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019	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 #
N/A			

*** In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.**

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

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019		Page 18 of 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 151,768	151,768		
2. Non-Food Supplies	\$ 14,486	14,486		
3. Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) <i>(Complete Schedule C-2 att. Page 21)</i>	\$			
c. Other (Specify) _____	\$			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 166,254	166,254		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
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 meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.
K. Is any revenue collected 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)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
O. 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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019		Page 19	of 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. \$	3,557	3,557		
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 (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$				
c. Other (Specify) Other Laundry Supplies	\$	6,872	6,872		
3D. Total Laundry Expenditures (3a + b + c)	\$	10,429	10,429		
3E. Laundry Questionnaire					
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
G. Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
H. Where is the revenue received reported in the Cost Report?	(Page/Line Item)				
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.		
J. Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.		
K. 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 3D.

*** 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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019	Page 20	of 37
Item		Total	CCNH	RHNS (Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel			
a. In-House Care	Amt.	\$ 30,448	30,448	
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)				
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.	\$		
C. Other (<i>Specify</i>)		\$ 194	194	
Other Housekeeping Supplies				
4D. Total Housekeeping Expenditures (4a + b + c)		\$ 30,642	30,642	
5. Resident Care (Supplies)**				
a. Prescription Drugs***				
1. Own Pharmacy	\$			
2. Purchased from Partners Pharmacy	\$	166,276	166,276	
b. Medicine Cabinet Drugs	\$	42,082	42,082	
c. Medical and Therapeutic Supplies	\$	102,909	102,909	
d. Ambulance/Limousine***	\$	6,540	6,540	
e. Oxygen				
1. For Emergency Use	\$			
2. Other***	\$	7,614	7,614	
f. X-rays and Related Radiological Procedures***	\$	8,935	8,935	
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$			
h. Laboratory***	\$	4,279	4,279	
i. Recreation	\$	21,226	21,226	
j. Direct Management Services*	\$			
k. Indirect Management Services*	\$			
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	22,471	22,471	
5M. Total Resident Care Expenditures (5a - 5j)		\$ 382,332	382,332	

* 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)
Equipment Rental Nursing (Disallowed on Pg 29a)	\$ -		
Oxygen Rental-MRA (Disallowed on Pg 29a)	3,180		
Medical Rental--Med A (Disallowed on Pg 29a)	2,627		
Oxygen Rental--Managed Care (Disallowed on Pg 29a)	823		
Medical Rental- Managed Care (Disallowed on Pg 29a)	72		
Oxygen Rental--House (Disallowed on Pg 29a)	1,537		
T19 Medical Rental	125		
Supplies - Rehab	4,053		
ADL Supplies	3,280		
Splint/Brace Supplies (Disallowed on Pg 29a)	39		
W/C - Parts	252		
W/C Cushions	383		
Walking Devices (Disallowed on Pg 29a)	40		
Total Other Resident Care	\$ 22,471	\$ -	\$ -

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

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood				License No. 2077-C	Report for Year Ended 9/30/2019				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
Strategic Health Care Solutions	2-8 Forest Glen Circle, Middletown CT 06457	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Insurance Contractor	20,472			16	m11
ProCaire, LLC	PO Box 801 Tolland, CT 06084	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Oxygen Company	15,781			22	5E2 /
Partners Pharmacy of CT	Uniondale, NY 11555- 9689	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Pharmacy	166,276			20	5A2
Complete Payroll Solutions	One Carando Drive Springfield, MA 01104	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Payroll	18,182			16	m11
American Health Tech	PO Box 936171 Atlanta GA 31193	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Electronic Health Records	41,662			15	1g
		<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"/>							
		<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"/>							

* 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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019			Page 22 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	\$ 41,051	41,051			
b. Heat	\$ 35,291	35,291			
c. Light & Power	\$ 74,885	74,885			
d. Water	\$ 29,510	29,510			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 19,455	19,455			
f. Other (<i>itemize</i>)	\$ 14,681	14,681			
See Attached Schedule					
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 214,873	214,873			
7. Depreciation (<i>complete schedule page 23*</i>)					
a. Land Improvements	\$				
b. Building & Building Improvements	\$ 168,521	168,521			
c. Non-Movable Equipment	\$				
d. Movable Equipment	\$ 42,327	42,327			
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 210,848	210,848			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)					
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$ 3,783	3,783			
d. Other (<i>Specify</i>)	\$				
*8e. Total Amortization Costs (8a + b + c + d)	\$ 3,783	3,783			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 377,239	377,239			
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$ 99,059	99,059			
c. Personal property taxes	\$				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 690,929	690,929			

* 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)
Contract Labor	-		
Waste Disposal	\$ 190	14,491	
Total Other Repairs and Maintenance	\$ 14,681	\$ -	\$ -

Depreciation Schedule

Schedule of Land Improvements Acquired during this report period

*Ties to Page 23, Line A3

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

Schedule of Building Improvements Acquired during this report period

***Ties to Page 23, Line B3**

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

***Ties to Page 23, Line C3**

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

*Ties to Page 23, Line D2c

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood			License No. 2077-C		Report for Year Ended 9/30/2019			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	74,015	60,538	S/L			
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									3,783
D. Total Amortization									3,783

* 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 Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019	Page 25	of 37
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11. Property Questionnaire

Part A

Is the property either owned by the Facility
or leased from a Related Party?*

Yes

No

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

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

Description	Total			
1. Date Land Purchased	01/01/55			
2. Date Structure Completed	01/01/55			
3. If NOT Original Owner, Date of Purchase	03/08/93			
4. Date of Initial Licensure	04/01/91			
5. Total Licensed Bed Capacity	60			
6. Square Footage	47,000			
7. Acquisition Cost				
a. Land	10,466			
b. Building	17,785			

Part B - Owner and Related Parties

	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	04/21/16			
c. Interest Rate for the Cost Year	3.83%			
d. Term of Mortgage (number of years)	18			
e. Amount of Principal Borrowed	3,659,568			
f. Principal balance outstanding as of 9/30/19	3,172,926			

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 9/30/2019			Page 26	of 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 9/30/2019			Page 27	of 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)		\$	25,088	25,088		
Loan / Auto Loan Interest						
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$	25,088	25,088		
14. Insurance						
a. Insurance on Property (buildings only)		\$	17,882	17,882		
b. Insurance on Automobiles		\$	14,177	14,177		
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$				
2. Fire and Extended Coverage		\$	31,970	31,970		
3. Other (Specify)		\$	22,486	22,486		
Liability Insurance						
14d. Total Insurance Expenditures (14a + b + c)		\$	86,515	86,515		
15. Total All Expenditures (A-13 thru C-14)		\$	7,399,894	7,399,894		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		2077-C	9/30/2019	28 37	
Item Description				Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$	92,695	92,695	
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$	263,305	263,305	
7.			Other - See attached Schedule	\$	480	480	
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$	92,617	92,617	
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$	641	641	
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	L3	Gifts, flowers and coffee shops	\$	8,204	8,204	
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	\$	2,070	2,070	
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m2/3	Unallowable Advertising *	\$	14,945	14,945	
19.			Income Tax / Corporate Business Tax	\$			
20.	16	m10	Fund Raising / Contributions	\$	4,157	4,157	
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$	61,159	61,159	
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)				\$	540,273	540,273	

* 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)
10	A1	Bill White's Salary	\$ 92,695		
Total Other Salaries Adjustment			\$ 92,695	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	B12o	Respiratory Therapist	\$ 480		
Total Other Fees Adjustments			\$ 480	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Collection Fee	\$ 56		
15	Var	Owner Benefits	9,788		
15	1a9	Employee Relations	7,182		
15	1g	Office Supplies	13,565		
16	m13	Fines	17,345		
16	m13	Non Deductible Penalty	1,637		
16	m13	Admissions Events	70		
15	1k2	Motor Vehicle Taxes	730		
16	L6	Automobile Expense	6076		
15	1a9	Other Benefits Relating to CEO	4710		
Total Other A&G Adjustments			\$ 61,159	\$ -	\$ -

State of Connecticut

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

Name of Facility				License No.	Report for Year Ended		Page of
Healthcare Visions, Inc. d/b/a Beechwood				2077-C	9/30/2019		29 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 540,273	540,273		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 166,276	166,276		
28.	20	5d	Ambulance/Limousine	\$ 6,540	6,540		
29.	20	5f	X-rays, etc	\$ 8,935	8,935		
30.	20	5h	Laboratory	\$ 4,279	4,279		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 7,614	7,614		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 27,678	27,678		
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	\$ 14,177	14,177		
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.	27	14C3	Property Insurance	\$ 18,190	18,190		
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	\$ 29,398	29,398		
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)				\$ 823,360	823,360		

*** 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.

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	51	Equipment Rental Nursing	\$ 6,060		
20	51	Oxygen Rental-MRA	3,180		
20	51	Medical Rental--Med A	2,627		
20	51	Oxygen Rental--Managed Care	823		
20	51	Medical Rental- Managed Care	72		
20	51	Oxygen Rental--House	1,537		
20	51	Splint/Brace Supplies	39		
20	51	Walking Devices	40		
20	5i	Cable Television Disallowance (See Attached)	13,300		
Total Other Ancillary Costs			\$ 27,678	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Total Other Adjustments	\$ -	\$ -	\$ -
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Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Attachment Page 29

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
30	IV 8	Recovery of Bad Debt	\$ (580)		
30	IV 8	Optum Incentive Bonus	8,529		
30	IV 8	Workers Comp Audit Rebate	20,620		
30	IV 5	Interest Income	704		
22	6G	Outpatient - Overhead (See Attached)	81		
22	10b	Outpatient - Taxes (See Attached)	37		
27	14a	Outpatient - Property Insurance (See Attached)	7		
Total Other Adjustments			\$ 29,398	\$ -	\$ -

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2019			Page 30	of 37
		Item	Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 4,333,295	4,333,295				
b. Medicaid Room and Board Contractual Allowance **	\$ (1,449,386)	(1,449,386)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents(<i>all inclusive</i>)	\$ 1,261,985	1,261,985				
b. Medicare Room and Board Contractual Allowance **	\$ 709,919	709,919				
4. a. Private-Pay Residents and Other	\$ 1,967,030	1,967,030				
b. Private-Pay Room and Board Contractual Allowance **	\$ (14,663)	(14,663)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 141,692	141,692				
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$ 30,440	30,440				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$ 451	451				
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 430,019	430,019				
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$ 72,562	72,562				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$ 52,978	52,978				
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$ 9,312	9,312				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$ 509,813	509,813				
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$ 71,259	71,259				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$ (1,046,219)	(1,046,219)				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 83,430	83,430				
III. Total Resident Revenue (Section I. thru Section II.)		\$ 7,163,917	7,163,917			
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>)	\$ 704	704				
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 39,420	39,420				
V. Total Other Revenue (1 thru 8)		\$ 40,124	40,124			
VI. Total All Revenue (III +V)		\$ 7,204,041	7,204,041			

* 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	Laboratory-Med A	\$ 4,074		
30 II 6a	Equipment Rental-Med A	6,293		
30 II 6a	Other Services-MCR	1,314		
30 II 6a	Contract Allow-Ancillary-MCR	(1,038,659)		
30 II 6a	Radiology-MCR	8,212		
30 II 6a	Contract All Ancillarie-Med B	(25,717)		
30 II 6a	Med B C/A 2% Sequestration	(1,736)		
30 II 6a	Clinic Income			
Total Other Resident Revenue - Medicare		\$ (1,046,219)	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue**Related Exp**

Page Ref	Description	CCNH	RHNS	(Specify)
30 II 6b	Oxygen Sup & rentals- Private	\$ 106		
30 II 6b	Oxygen Sup & Rental-Title XIX	5,620		
30 II 6b	Equipment Rental-MCD	180		
30 II 6b	Contract Allow-MCD Ancillary	(3,375)		
30 II 6b	Oxygen Supplies& Rentals-Med A	265		
30 II 6b	Equip Rental-MGD	113		
30 II 6b	Laboratory-MGD	710		
30 II 6b	Contact Allowance-Ancillary-MG	(13,560)		
30 II 6b	Radiology-MGD	444		
30 II 6b	Managed Medicare Part B	42,097		
30 II 6b	Managed Medicare B Contract Al	(390)		
30 II 6b	Our Patient Therapy	52,373		
30 II 6b	Cont. Adjustment Outpatient Th	(1,117)		
30 II 6b	Outpt 2% C/A	(36)		
Total Other Resident Revenue		\$ 83,430	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30 IV 5	Interest on Accounts Receivable	\$ 994,270	\$ 42		
30 IV 5	Interest Income	231,474	662		
Total Interest Income		\$ 704	\$ -	\$ -	

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV 8	Recovery of Bad Debt (Disallowed on Pg 29a)	\$ 580		
30 IV 8	Credit for Prior Period AR expense	6,714		
30 IV 8	Flu Vaccine Revenue	648		
30 IV 8	Optum Incentive Bonus (Disallowed on Pg 29a)	8,529		
30 IV 8	Class Action Settlement (No current year expense)	306		
30 IV 8	Workers Comp Audit Rebate (Disallowed on Pg 29a)	20,620		
30 IV 8	Medical Records Revenue from 2016 (No Current Year Expense)	69		
30 IV 8	Credit for Reversal of Late Fees (No Current Year Expense)	\$ 1,954		
Total Other Revenue		\$ 39,420	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2019	31	37
		Account	Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	231,474
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	994,270
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	6,937
4. Inventories			\$	
5. Prepaid Expenses			\$	8,834
a. <u>Prepaid Utilities</u>		8,834		
b. _____				
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	(7,159)
Patient Refunds		(7,159)		
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	1,234,356
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	74,015	\$	9,694
	Accum. Depreciation	64,321	Net	
5. Non-Movable Equipment	*Historical Cost		\$	
	Accum. Depreciation	Net		
6. Movable Equipment	*Historical Cost	199,544	\$	44,819
	Accum. Depreciation	154,725	Net	
7. Motor Vehicles	*Historical Cost	124,015	\$	29,679
	Accum. Depreciation	94,336	Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	677
F/S vs C/R NBV		679		
See Schedule		(2)		
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	84,869

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

(Carry Total forward to next page)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			\$ -

Schedule of Other Current Assets (itemized) Page 31 Line A8

Page Ref	Line Ref	Description	
Total Other Current Assets (Itemize)			\$ -

Schedule of Other Fixed Assets (Itemize) Page 31 Line B9

Schedule of Other Assets Page 32 Line D7

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	\$	
	33 A12	Current Liabilities		\$ (7,530)
	33 A12	Patient Deposits		(4,087)
	33 A12	Patient Rec Fund		2,328
	33 A12	Suspense - Flexible Spending		(12,336)
	33 A12	401(k) Payable		847
	33 A12	HUD Suspense Account		(25,518)
	33 A12	Customer Deposits		15,485
	33 A12	State Sales Tax		(250)
	33 A12	Provider Tax Payable		89,776
	33 A12	Accrued Benefits		3,748
Total Notes Payable				\$ 62,463

Schedule of Other Current Liabilities (Itemize) Page 33 Line A12

Page Ref	Line Ref	Description	
		Total Other Current Liabilities (Itemize)	\$ -

Schedule of Other Long-Term Liabilities (Itemize) Page 34 Line B4

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
		9/30/2019	32	37
Account		Amount		
Total Brought Forward:			\$	1,319,225
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	5,055,638 4,290,801 Net	\$	764,837
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)			\$	764,837
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>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	2,084,062

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

G. Balance Sheet (cont'd)

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019	Page 34	of 37
Account		Amount		
		Total Brought Forward:		549,368
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)			\$ 17,895	
Name of Lender	Purpose	Amount	Date Due	
	Auto Loan	17,895		
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>)			\$ 319,688	
<u>Loan Payable Liberty Bank</u>	319,688			
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$ 337,583	
C. Total All Liabilities (Lines A-13 + B-5)			\$ 886,951	

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

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019	Page 35	of 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		\$ 764,837		
5. Reserve for funds set aside as donor restricted		\$		
6. Total Reserves		\$ 764,837		
B. Net Worth				
1. Owner's Capital		\$		
2. Capital Stock		\$ 1,000		
3. Paid-in Surplus		\$		
4. Treasury Stock		\$		
5. Cumulated Earnings		\$ 458,606		
6. Gain or Loss for Period		10/1/2018	thru	9/30/2019 \$ (27,332)
7. Total Net Worth		\$ 432,274		
C. Total Reserves and Net Worth		\$ 1,197,111		
D. Total Liabilities, Reserves, and Net Worth		\$ 2,084,062		

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Healthcare Visions, Inc. d/b/a Beechwood	2077-C	9/30/2019	36	37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2018				\$ 511,745
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 7,204,041
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 7,231,373
D. Net Income or Deficit				\$ (27,332)
E. Balance				\$ 484,413
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
Expenses Per Pg 27				\$ 7,399,894
F/S vs C/R Depreciation				(168,521)
Expenses Per F/S				\$ 7,231,373
2. Other (<i>itemize</i>)				
Prior Period Adjustment				1,971
F-3. Total Additions				\$ 1,971
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)				\$ 54,110
Name and Address (No., City, State, Zip)				
Distribution to Stockholders				54,110
2. Other Withdrawings (<i>Specify</i>)				\$
Purpose				Amount
3. Total Deductions				\$ 54,110
H. Balance at End of Period				\$ 432,274

I. Preparer's/Reviewer's Certification

Name of Facility Healthcare Visions, Inc. d/b/a Beechwood	License No. 2077-C	Report for Year Ended 9/30/2019	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

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		
Matthew S. Bavolack		
Address	Phone Number	
555 Long Wharf Drive, New Haven, CT 06511	203-781-9600	
Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number	
Bill White	860-442-4363	
Contact Email Address		
Facebook.com/BeechwoodRehav/		