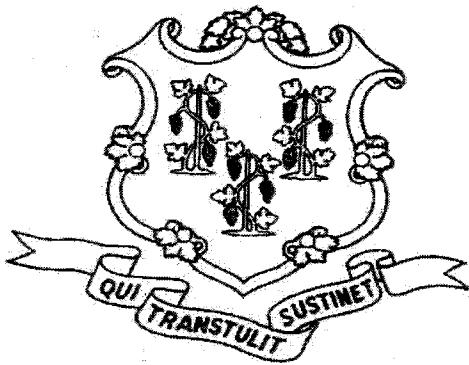


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2019

Name of Facility (as licensed)

Parkside Rehabilitation and Healthcare Center, LLC of New Britain, CT d/b/a Grandview Rehabilitation and Healthcare

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

55 Grand Street, New Britain, CT 06052

Type of Facility

Chronic and Convalescent

Rest Home with Nursing

Nursing Home only
(CCNH)

Supervision only
(RHNS)

(Specify)

Report for Year Beginning

10/1/2018

Report for Year Ending

9/30/2019

License Numbers:	CCNH 2428	RHNS	(Specify)	Medicare Provider 07-5182
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Medicaid Provider Numbers:	CCNH '000010439	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) Parkside Rehabilitation and Healthcare Center, LLC of	License No. 2428	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 Parkside Rehabilitation and Healthcare Center, LLC of New Britain, CT d/b/a Grandview Rehabilitation and Healthcare Center [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. (1)

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.

(1) Subject to Desk Review Audit

Signed (Administrator)	Date	Signed (Owner)	Date
Printed Name (Administrator) Donna Stango		Printed Name (Owner) David Blumenkrantz	
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 Parkside Rehabilitation and Healthcare Center, LLC of New Britain, CT d/b/a Grandview Rel	Period Covered: From 10/1/2018	To 9/30/2019		
Address of Facility 55 Grand Street, New Britain, CT 06052				
Report Prepared By Marcum LLP	Phone Number 203-781-9600	Date 2/8/2020		
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 860-223-3617	Report for Year Ended 9/30/2019	Page 2	of 37
Name of Facility (as shown on license) Parkside Rehabilitation and Healthcare Center, LLC of New B	Address (No. & Street, City, State, Zip) 55 Grand Street, New Britain, CT 06052			
License Numbers: CCNH 2428	RHNS	(Specify)		Medicare Provider No. 07-5182
Type of Facility (Check appropriate box(es))				
<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)				
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 Donna Stango		Nursing Home Administrator's License No.: 949		
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 Parkside Rehabilitation and Healthcare Center	License No. 2428	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 N/A	Business Address	State(s) in Which Incorporated	
Name of Directors, Officers N/A	Business Address	Title	No. Shares Held by Each
Names of Stockholders Owning at Least 10% of Shares N/A			

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Parkside Rehabilitation and Healthcare Center, LL	2428	9/30/2019	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	License No.	Report for Year Ended	Page
Parkside Rehabilitation and Healthcare Center, LLC of	2428	9/30/2019	4

Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No

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?

Ovarian

If "Yes," provide the following information:

- * 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 Parkside Rehabilitation and Healthcare Center,	License No. 2428	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.

Is a Mileage Log Book Maintained for All Leased Vehicles?

* 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 Parkside Rehabilitation and Health	License No. 2428	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 1 Marcum LLP 2 Solomon Hirsch, CPA P.C. 3 4	Address (No. & Street, City, State, Zip Code) 555 Long Wharf Drive, New Haven, CT 06511 14 Joan Lane, Monsey, NY 1052
---	---

Services Provided by This Firm (*describe fully*)

1 Cost report preparation, reimbursement consulting	\$ 5,747
2 Tax Return / Other Accounting	\$ 6,563
3	\$
4	\$
	Charge for Services Provided \$ 12,310

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 1 Apex Global Solutions, LLC 2 Apex Healthcare Partners LLC 3 Berlin Probate Court 4 Goldman, Gruder, & Woods, LLC 5 See Attached	Telephone Number (518) 595-9784 (845) 288-2990 203-899-8900 See Attached
--	--

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

1 400 Rella Blvd Suite 200 Montebello NY 10901
2 21 Robert Pitt Drive Monsey NY 10952
3 One Liberty Square PO Box 400, New Britaain CT 06050-0400
4 200 Connecticut Avenue Norwalk, CT 06854
5 See Attached

Services Provided by This Firm (*describe fully*)

1 Tax and Legal Advisory	\$ 474
2 Tax and Legal Advisory	\$ 408
3 Conservatorship (Disallow)	\$ 120
4 Collections (Disallow)	\$ 1,905
5 See Attached	\$ 32,820
	Charge for Services Provided \$ 35,727

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

Yes No | Page 15, Line 1e

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-7 Rev. 6/95

General Information and Questionnaire
Legal Firm Continued

Name of Facility	License No.	Report for Year Ended	Page	of
Grandview Rehabilitation and Healthcare Center	2428	9/30/2019	7a	37

Legal Services Information

Name of Legal Firm or Independent Attorney	Telephone Number
1 Horizon Aso	(516) 326-2020
2 Kroll, McNamara, Evan, & Delehanty, LLP	(860) 561-7070
3 Law Offices of Dmitry Tayts	(914) 373-6774
4 Murtha Cullina LLP	(860) 240-6000
5 Reid and Reige, P.C.	(860) 278-1150
6 Rosenbaum & Associates	(215) 569-0200
7 Silverman Shin & Byrne PLLC	(212) 779-8600
8 Updike, Kelly & Spellacy, P.C.	(860) 548-2600
9	
10	
11	
12	
13	
14	

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

1 Horizon ASO Agency Brooklyn NY 11203
2 65 Memorial Road West Hartford CT 06107
3 51 Carnoustie Circle Bloomfield CT 06002
4 185 Asylum Street Hartford CT 06103-3469
5 One Financial Plaza Hartford CT 06103
6 4 Canaan Circle South Salem NY 10590
7 88 Pine St 22nd Floor, NY NY 10005
8 100 Pearl Street Hartford CT 06123
9
10
11
12
13
14

Services Provided by This Firm (describe fully)

1 Employment Related	14
2 Bankruptcy Notice (Disallow)	110
3 Collections (Disallow)	150
4 General Litigation	255
5 Bankruptcy Litigation (response to Walnut's trustee) (Disallow)	25,000
6 Legal Advisory	3,000
7 Employment Counseling Retainer, Employment Counseling (Disallow Retainer)	3,523
8 Resident Trust Fund	768
9	
10	
11	
12	
	Charge for Services Provided
	\$ 32,820

Schedule of Resident Statistics

Name of Facility Parkside Rehabilitation and Healthcare Center, LLC of New Britain, CT		License No. 2428		Report for Year Ended 9/30/2019				Report for Year Ended 9/30/2018			
				Period 10/1 Thru 6/30		Period 7/1 Thru 9/30		Period 10/1 Thru 6/30		Period 7/1 Thru 9/30	
		Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Total	CCNH	RHNS (Specify)	Total	CCNH	RHNS (Specify)
1. Certified Bed Capacity											
A. On last day of PREVIOUS report period	160	160				160	160			160	160
B. On last day of THIS report period	160	160				160	160			160	160
2. Number of Residents											
A. As of midnight of PREVIOUS report period	123	123				123	123			137	137
B. As of midnight of THIS report period	142	142				137	137			142	142
3. Total Number of Days Care Provided During Period											
A. Medicare	4,484	4,484				3,340	3,340			1,144	1,144
B. Medicaid (Conn.)	40,696	40,696				29,603	29,603			11,093	11,093
C. Medicaid (other states)											
D. Private Pay	2,695	2,695				2,125	2,125			570	570
E. State SSI for RCH											
F. Other (Specify) Hospice / HMO & Private Insur	507	507				289	289			218	218
G. Total Care Days During Period (3A thru F)	48,382	48,382				35,357	35,357			13,025	13,025
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)	48,382	48,382				35,357	35,357			13,025	13,025

Schedule of Resident Statistics (Cont'd)

Name of Facility Parkside Rehabilitation and Healthcare Center	License No. 2428	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	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)		
				(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.

1st change	Change in Resident Days			CCNH	RHNS	(Specify)
	CCNH	RHNS	(Specify)	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	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	13		118		11				
Per Diem Rate									
a. One bed rm.	Various		218.03		500.00				
b. Two bed rms.	Various		218.03		250.00				
c. Three or more bed rms.	Various		218.03		225.00				

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B

TOTAL CCNH RHNS (Specify)

14,650 14,650

B. Medicaid (Exclusive of Part B)

3,447 3,447

1. Maintenance Treatments

2. Restorative Treatments

C. Other

3,350 3,350

D. **Total Physical Therapy Treatments**

21,447 21,447

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B

1,897 1,897

B. Medicaid (Exclusive of Part B)

303 303

1. Maintenance Treatments

2. Restorative Treatments

C. Other

321 321

D. **Total Speech Therapy Treatments**

2,521 2,521

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B

14,128 14,128

B. Medicaid (Exclusive of Part B)

2,700 2,700

1. Maintenance Treatments

2. Restorative Treatments

C. Other

3,281 3,281

D. **Total Occupational Therapy Treatments**

20,109 20,109

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*					Hours
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	137,846	2,291			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	201,727	14,897			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor	49,543	2,083			
c. Dietary Workers	331,294	24,126			
6. Housekeeping Service					
a. Head Housekeeper	106,788	2,089			
b. Other Housekeeping Workers	186,491	22,757			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	70,498	2,193			
b. Other Maintenance Workers	68,696	4,221			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	75,316	5,803			
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	231,446	4,400			
b. RN					
1. Direct Care	787,866	14,028			
2. Administrative**	215,006	4,734			
c. LPN					
1. Direct Care	1,252,967	47,981			
2. Administrative**					
d. Aides and Attendants	1,441,438	99,021			
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	114,470	5,895			
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	183,916	3,337			
n. Marketing					
o. Other (Specify)					
See Attached Schedule					
<i>A-13. Total Salary Expenditures</i>	5,455,308	259,856			

* 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)

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

* 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	
				2428				9/30/2019				12 37	
Name		CCNH	RHNS	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		
Section III - Administrators***													
Donna Stango	137,846				Non Discriminatory	Administrator	2,291	A2	N/A				
Section IV - Assistant Administrators													

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2019		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	55,207	1,005			
2. Dentist	7,200	191			
3. Pharmacist	30,126	336			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	414,400	5,268			
b. Other					
6. Social Worker	2,566	51			
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	36,000	323			
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) Physicians	5,600	Disallowed			
9. Speech Therapist					
a. Resident Care	104,329	1,414			
b. Other					
10. Occupational Therapist					
a. Resident Care	391,304	5,013			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	54,802	891			
2. Administrative***	28,611	194			
b. LPN					
1. Direct Care	55,490	1,226			
2. Administrative***					
c. Aides	126,405	6,328			
d. Other					
12. Other (Specify) See Attached Schedule	150	3			
B-13 Total Fees Paid in Lieu of Salaries	1,312,190	22,243			

* 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*

* 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	\$ 268,364	268,364			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 128,665	128,665			
4. Social Security (F.I.C.A.)	\$ 398,282	398,282			
5. Health Insurance	\$ 268,482	268,482			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 2,095	2,095			
8. Uniform Allowance	\$				
9. Other (Specify)	\$ 12,918	12,918			
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 124,676	124,676			
d. Accounting and Auditing	\$ 12,310	12,310			
e. Legal (Services should be fully described on Page 7)	\$ 35,727	35,727			
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$ 26,641	26,641			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 29,073	29,073			
2. Cellular Phones	\$ 2,994	2,994			
i. Appraisal (Specify purpose and attach copy)*	\$				
j. Corporation Business Taxes (franchise tax)	\$ 303	303			
k. Other Taxes (Not related to property - See Page 22)					
1. Income*	\$				
2. Other (Specify)	\$				
See Attached Schedule					
3. Resident Day User Fee	\$ 923,093	923,093			
Subtotal	\$ 2,233,623	2,233,623			

* 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

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
	0		
Total	\$ -	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2019		16	37
Item		Total	CCNH	RHNS	(Specify)
	<i>Subtotals Brought Forward:</i>	2,233,623	2,233,623		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$ 9,800	9,800			
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$ 8,034	8,034			
5. Education Expenses Related to Seminars and Conventions	\$ 2,127	2,127			
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>)	\$ 15,530	15,530			
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$ 18,707	18,707			
4. Fund-Raising***	\$				
5. Medical Records	\$ 464	464			
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$ 47	47			
7. Postage	\$ 4,716	4,716			
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$ 350	350			
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$ 325	325			
9. Subscriptions	\$ 95	95			
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>)	\$ 617,181	617,181			
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$ 20,733	20,733			
C-14 Total Administrative & General Expenditures	\$ 2,931,732	2,931,732			

* 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)
	0		
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
	0		
Promotional Advertising	\$ 18,707		
Total Other Advertising	\$ 18,707	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
	0		
CAHCF	\$ 350		
Total Dues	\$ 350	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
	0		
Total Contributions	\$ -	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
	0		
Gen Nsg Exp>Licenses	\$ 731		
Dietary Exp>Licenses	\$ 1,621		
Admin Exp>Meals (Disallow)	\$ 5,196		
Admin Exp>Criminal Checks	\$ 1,704		
Admin Exp>Licenses	\$ 6,918		
Admin Exp>Bank Fees (Disallowed \$6,119)	\$ 4,413		
Non-Operating (Inc)/Exp	\$ 150		
Total Other Administrative and General	\$ 20,733	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Parkside Rehabilitation and Healthcare Ce	License No. 2428	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 #

*** 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	License No.	Report for Year Ended	Page	of
Parkside Rehabilitation and Healthcare Center, LLC of	2428	9/30/2019	18	37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 343,354	343,354		
2. Non-Food Supplies	\$ 40,671	40,671		
3. Other (Specify) _____ Other Dietary Supplies	\$ 4,760	4,760		
b. Purchased Services (<i>by contract other than through Management Services</i>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$			
c. Other (Specify) _____	\$			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 388,785	388,785		
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	License No.	Report for Year Ended		Page of
	2428	9/30/2019		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. \$	14,895	14,895	
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>) <i>(Complete Schedule C-2 att. Page 21)</i>	\$	3,144	3,144	
c. Other (Specify) Laundry Supplies	\$	8,555	8,555	
3D. Total Laundry Expenditures (3a + b + c)	\$	26,594	26,594	
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 Parkside Rehabilitation and Healthcare Center,	License No. 2428	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. \$			
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)				
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel			
	Amt. \$			
C. Other (<i>Specify</i>) Housekeeping Supplies	\$	54,271	54,271	
4D. Total Housekeeping Expenditures (4a + b + c)	\$	54,271	54,271	
5. Resident Care (Supplies)**				
a. Prescription Drugs***	\$			
1. Own Pharmacy	\$			
2. Purchased from Pharmacy	\$	272,943	272,943	
b. Medicine Cabinet Drugs	\$	33,780	33,780	
c. Medical and Therapeutic Supplies	\$			
d. Ambulance/Limousine***	\$	11,989	11,989	
e. Oxygen				
1. For Emergency Use	\$			
2. Other***	\$	4,906	4,906	
f. X-rays and Related Radiological Procedures***	\$	7,246	7,246	
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$			
h. Laboratory***	\$	26,962	26,962	
i. Recreation	\$	30,567	30,567	
j. Direct Management Services*	\$			
k. Indirect Management Services*	\$			
l. Other (<i>Specify</i>)**** See Attached Schedule	\$	335,396	335,396	
5M. Total Resident Care Expenditures (5a - 5j)	\$	723,789	723,789	

* 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)
	0		
Gen Nsg Exp>Supplies	\$ 102,711		
Gen Nsg Exp>Equip-Minor	\$ 39,112		
Gen Nsg Exp>Equip-Rental	\$ 39,560		
Gen Nsg Exp>Software Rental	\$ 37,759		
Gen Nsg Exp>Incontinence Supplies	\$ 48,631		
Gen Nsg Exp>House	\$ 21,435		
IV Exp>RX (Disallow)	\$ 8,461		
Physical Therapy Exp>Supplies	\$ 564		
Physical Therapy Exp>Equip-Minor	\$ 130		
PEN Exp>Supplies (Disallow)	\$ 6,310		
Wound Care Exp>Supplies (Disallow)	\$ 13,167		
Wound Care Exp>Equip-Rental (Disallow)	\$ 1,711		
Urological & Ostomy Exp>Supplies (Disallow)	\$ 14,665		
Billable Med Supplies (Disallow)	\$ 475		
Other Ancillary Exp>Physician Technical Charges>Adjustments	\$ 70		
Social Services Exp>Supplies	\$ 635		
Total Other Resident Care	\$ 335,396	\$ -	\$ -

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

Name of Facility	License No.	Report for Year Ended				Page of 21 37				
		Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*		CCNH	RHNS	(Specify)	Pg
Name of Individual or Company	Address	Yes	No							Total Cost/Page Ref.***
Apex Global Solutions, LLC	200 Montebello NY 10901	○	○	N/A	Payroll Services	258,546				16 m11
Advanced Health Inc.	2 Mc Leod Terrace New City NY 10956	○	○	N/A	Management Consulting Services	243,000				16 m11
Pharmscript, LLC	150 Pierce St Somerset NJ 08873	○	○	N/A	Pharmacy Services	144,007				20 Var
Delta Elevator LLC	132 Fitzgerald Drive, East Hartford, CT 06118	○	○	N/A	Contracted Maintenance Expense	10,035				22 6f
Silver Key Medicaid	Howell Township, NJ 07731	○	○	N/A	General Nursing Expenses	10,000				20 5j
AccessRN	Street Maumee OH 43537	○	○	N/A	Contracted Maintenance Expense	12,195				20 Var
On-Time IT Solutions, Inc.	154 Spring St Monroe NY 10950	○	○	N/A	IT	29,908				16 m11
Horizon Aso	Horizon ASO Agency Brooklyn NY 11203	○	○	N/A	Payroll Services	27,097				16 m11
US Laboratories	PO Box 845127 Boston MA 02284	○	○	N/A	Lab Expenses	27,056				20 5h
Frontier 3005	PO Box 20550 Rochester NY 14602-0550	○	○	N/A	Telephone Expenses	21,507				16 m11
SMG Landscaping	15 Louis Rd, Middlefield, CT 06455	○	○	N/A	Landscaping	18,750				22 6f
Northwest Refuse Service, LLC	2001 Windsor Ave, Baltimore, MD 21217	○	○	N/A	Sanitation & Incineration	15,300				22 6f
BDB Payroll Service	768 Bedford Ave, Brooklyn, NY 11205	○	○	N/A	Payroll Services	15,123				16 m11
See Attached	See Attached	○	○	○	See Attached	87,360				

* 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).

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

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

Name of Facility Parkside Rehabilitation and Healthcare Center	License No. 2428	Report for Year Ended 9/30/2019			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	54,419	54,419			
b. Heat	\$	40,390	40,390			
c. Light & Power	\$	109,999	109,999			
d. Water	\$	68,096	68,096			
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$	37,812	37,812			
f. Other (<i>itemize</i>)	\$	98,175	98,175			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	408,891	408,891			
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$	2,979	2,979			
d. Movable Equipment	\$	8,956	8,956			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	11,935	11,935			
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$	30,462	30,462			
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$	30,462	30,462			
9. Rental payments on leased real property less real estate taxes included in item 10b	\$	840,000	840,000			
10. Property Taxes						
a. Real estate taxes paid by owner	\$	180,167	180,167			
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$	22,568	22,568			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	1,085,132	1,085,132			

* 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

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

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
2/18/2019	Sign Installation	\$ 4,404	10 Years	\$ 440
5/23/2019	Convection Steamer	\$ 8,692	10 Years	\$ 869
Total additions for Non-Movable Equipment		\$ 13,096		\$ 1,309 *
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:				
12/4/2018	Network Equipment	\$ 3,000	5	\$ 600
3/29/2019	Heavy- Duty Power Lift	\$ 3,170	5	\$ 632
Total additions for Movable Equipment		\$ 6,170		\$ 1,232
Deletions:				
Total deletions for Movable Equipment		\$ -		\$ -

*Ties to Page 23, Line D2c

****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/1/2018	Electrical work	\$ 6,977	20	\$ 349
10/1/2018	Elevator Repair	\$ 3,350	20	\$ 168
10/1/2018	Flooring for common areas	\$ 53,285	20	\$ 2,664
2/18/2019	Sink Repair	\$ 2,596	20	\$ 130
3/1/2019	Sliding Door control updates	\$ 2,972	20	\$ 149
4/1/2019	Installation of doors	\$ 5,483	20	\$ 274
6/13/2019	Paving Sidewalk	\$ 3,517	20	\$ 176
6/20/2019	Elevator Repair	\$ 2,725	20	\$ 136
Total additions for Leasehold Improvement		\$ 80,905		\$ 4,046
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ -

***Ties to Page 24, Line C3**

****Ties to Page 24, Line C2**

GRANDVIEW REHABILITATION AND HEALTHCARE CENTER
FIXED ASSET / DEPRECIATION SCHEDULE

System No.	Description	Date In Service	Method	Life	Historical Cost	Deprec.	2017 A/D	2018 A/D	2019 A/D	Deprec.	2019 A/D	NBV
NON-MOVABLE EQUIPMENT												
Supply & install service sink		3/1/2016	S/L	10	3,935	394	788	394	1,182	394	1,576	2,359
AC startup		4/1/2016	S/L	10	3,404	340	680	340	1,020	340	1,360	2,044
Repair to roof fans		7/1/2016	S/L	10	3,582	358	716	358	1,074	358	1,432	2,150
InSinkErator garbage disposal		2/1/2017	S/L	5	2,889	578	578	578	1,156	578	1,734	1,155
Sign Installation		2/18/2019	S/L	10	4,404	-	-	-	-	440	440	3,964
Convection Steamer		5/23/2019	S/L	10	8,692	-	-	-	-	869	869	7,823
TOTAL NON-MOVABLE EQUIPMENT					26,906	26,906	1,670	2,762	1,670	4,432	2,979	7,411
MOVABLE EQUIPMENT												
4 low beds w/ rails		3/1/2016	S/L	15	3,689	246	492	246	738	246	984	2,705
2 floor burnishers		4/1/2016	S/L	15	2,716	181	362	181	543	181	724	1,992
5 low beds with rails		4/1/2016	S/L	15	4,735	316	632	316	948	316	1,264	3,471
IT equipment		9/1/2016	S/L	3	6,932	2,311	4,622	2,310	6,932	-	6,932	-
Lenovo think pads		9/1/2016	S/L	3	5,174	1,725	3,450	1,724	5,174	-	5,174	-
Laptops, monitors, & desktops		11/1/2016	S/L	3	4,786	1,595	1,595	1,595	3,190	1,595	4,785	1
3 beds & 5 mattresses		2/1/2017	S/L	15	4,705	314	314	314	628	314	942	3,763
HP server		5/1/2017	S/L	5	10,369	2,074	2,074	2,074	4,146	2,074	6,220	4,149
Network equipment		6/1/2017	S/L	5	3,201	640	640	640	1,280	640	1,920	1,281
2018 Additions												
Website Design		8/1/2018	S/L	5	5,925	-	-	1,185	1,185	1,185	2,370	3,555
Laptops & software		11/5/2017	S/L	5	5,867	-	-	1,173	1,173	1,173	2,346	3,521
2019 Additions												
Network Equipment		12/4/2018	S/L	5	3,000	-	-	-	-	600	600	2,400
Heavy-Duty Power Lift		3/29/2019	S/L	5	3,170	-	-	-	-	634	634	2,536
TOTAL MOVABLE EQUIPMENT					64,269	64,269	9,402	14,181	11,758	25,937	8,958	34,895
LEASEHOLD IMPROVEMENTS												
Wiring for repairs to roof fan		3/1/2016	S/L	27	2,741	102	204	102	306	102	408	2,333
Elevator work		3/1/2016	S/L	20	3,658	183	366	183	549	183	732	2,926
Install piston packing/clean		3/1/2016	S/L	20	6,029	301	602	301	903	301	1,204	4,825
Fire stopping system		3/1/2016	S/L	25	30,000	1,200	2,400	1,200	3,600	1,200	4,800	25,200
Generator work		3/1/2016	S/L	5	11,964	2,393	4,786	2,393	7,179	2,393	9,572	2,392
Wiring		4/1/2016	S/L	27	3,641	135	270	135	405	135	540	3,101
Door equipment		5/1/2016	S/L	15	3,302	220	440	220	660	220	880	2,422
Tracing and installing new phone lines		6/1/2016	S/L	10	2,718	272	544	272	816	272	1,088	1,630
Installed sinks		7/1/2016	S/L	20	7,518	376	752	376	1,128	376	1,504	6,014
Fire coughting		11/1/2016	S/L	20	23,000	1,150	1,150	1,150	2,300	1,150	3,450	19,550
Elevator repairs & parts		11/1/2016	S/L	20	13,800	690	690	690	1,380	690	2,070	11,730
Repaired walls of the bldg		12/1/2016	S/L	20	9,040	452	452	452	904	452	1,336	7,684
Resident room, bathroom repair		12/1/2016	S/L	20	6,350	318	318	318	636	318	954	5,396

GRANDVIEW REHABILITATION AND HEALTHCARE CENTER
FIXED ASSET / DEPRECIATION SCHEDULE

System No.	Description	Date In Service	Method	Life	Historical Cost	Deprec.	2017 A/D	2018 A/D	2018 Deprec.	2019 A/D	2019 Deprec.	NBV
Resident room, bathroom repair		1/1/2017	\$L	20	3,000	150	150	100	100	300	150	450
Floor 1 PT closet		2/1/2017	\$L	20	2,000	100	100	200	200	300	100	1,700
Floor 2 south wing shower room		2/1/2017	\$L	20	2,500	125	125	250	250	375	125	2,125
Plumbing - pipe repair		2/1/2017	\$L	25	3,069	123	123	246	246	123	369	2,700
Door replacement		4/1/2017	\$L	20	2,769	138	138	276	276	138	414	2,355
Hot-water pump		5/1/2017	\$L	10	3,146	315	315	630	630	315	945	2,201
Roofing		7/1/2017	\$L	27	9,800	363	363	726	726	363	1,089	8,711
Flooring		7/1/2017	\$L	20	16,331	817	817	1,634	1,634	817	2,451	13,880
Lock System		7/1/2017	\$L	20	11,757	588	588	1,176	1,176	588	1,764	9,993
2018 Additions												
Replace railing		10/1/2017	\$L	15	5,956	-	-	397	397	397	794	5,162
Doors project-part 1/2		10/10/2017	\$L	20	7,875	-	-	394	394	394	788	7,087
installed boiler room pump 1/2		10/18/2017	\$L	20	3,146	-	-	157	157	157	314	2,832
plumbing repair		10/18/2017	\$L	25	6,370	-	-	255	255	255	510	5,860
Doors project-part 2/2		11/9/2017	\$L	20	7,875	-	-	394	394	394	788	7,087
installed boiler room pump 2/2		11/1/2017	\$L	20	3,146	-	-	157	157	157	314	2,832
Outlets installation 1/2		11/30/2017	\$L	20	1,436	-	-	72	72	72	144	1,292
Outlets installation 2/2		11/30/2017	\$L	20	1,107	-	-	55	55	55	110	997
Generator electric wiring 1/2		12/1/2017	\$L	20	6,711	-	-	336	336	336	672	6,039
air duct cleaning-1/3		12/8/2017	\$L	20	38,710	-	-	1,936	1,936	1,936	3,872	34,838
Boiler room piping 1/2		12/18/2017	\$L	20	2,364	-	-	118	118	118	236	2,128
boiler leak 1/2		12/15/2017	\$L	20	1,633	-	-	82	82	82	164	1,469
boiler leak 2/2		12/17/2017	\$L	20	1,106	-	-	55	55	55	110	996
Generator Electric wiring 2/2		1/3/2018	\$L	20	6,711	-	-	336	336	336	672	6,039
Boiler room piping 2/2		1/1/2018	\$L	20	2,364	-	-	118	118	118	236	2,128
boiler mixing valve piping		1/1/2018	\$L	20	3,999	-	-	200	200	200	400	3,599
installed boiler room pump 2/2		1/1/2018	\$L	20	3,146	-	-	157	157	157	314	2,832
sign installation		1/3/2018	\$L	10	4,139	-	-	414	414	414	828	3,311
flooring project		2/6/2018	\$L	20	78,545	-	-	3,927	3,927	3,927	7,834	70,691
stairwell door replacement full		2/20/2018	\$L	20	3,789	-	-	189	189	189	378	3,411
additional bathroom exhaust		2/1/2018	\$L	20	3,031	-	-	152	152	152	304	2,727
replaced motor in dishmachine		2/20/2018	\$L	10	3,150	-	-	315	315	315	630	2,520
generator ATS purchase		4/2/2018	\$L	5	7,019	-	-	1,404	1,404	1,404	2,808	4,211
flooring project		5/2/2018	\$L	20	6,067	-	-	303	303	303	606	5,461
fire wall & door installation		5/1/2018	\$L	20	7,200	-	-	360	360	360	720	6,480
pavement strip		7/11/2018	\$L	20	32,690	-	-	1,634	1,634	1,634	3,268	29,422
replaced flooring		9/1/2018	\$L	20	2,867	-	-	143	143	143	286	2,581
test wire and connect cameras		9/1/2018	\$L	5	9,225	-	-	1,845	1,845	1,845	3,690	5,535
2019 Additions												
Electrical Work		10/1/2018	\$L	20	6,977	-	-	-	-	-	349	349
Elevator repair		10/1/2018	\$L	20	3,350	-	-	-	-	-	168	168
Flooring for common areas		10/1/2018	\$L	20	53,285	-	-	-	-	-	2,664	50,621
Sink Repair		2/18/2019	\$L	20	2,596	-	-	-	-	-	130	130
Sliding door control updates		3/1/2019	\$L	20	2,972	-	-	-	-	-	149	149
Installation of doors		4/1/2019	\$L	20	5,483	-	-	-	-	-	274	274

GRANDVIEW REHABILITATION AND HEALTHCARE CENTER
FIXED ASSET /DEPRECIATION SCHEDULE

System No.	Description	Date In Service	Method	Life	Historical Cost	Deprec.	2017 A/D	2018 A/D	2019 A/D	NBV
	Paving Sidewalk	6/13/2019	S/L	20	3,517	-	-	-	176	176
	Elevator repair	6/20/2019	S/L	20	2,725	-	-	-	136	136
TOTAL LEASEHOLD IMPROVEMENTS										
			520,414		10,511	15,693	26,416	42,109	30,462	72,571
										447,843
TOTAL ASSETS PER C/R SCHEDULE										
			611,589		21,583	32,636	39,844	72,478	42,397	114,877
			611,589						36,190	84,084
			(0)		21,583	32,636	39,844	72,478	6,207	30,793
										(30,793)

F/S vs C/R NBV - Page 31, Line B9

F/S vs C/R NBV - Page 36, Line F1

30,793

(6,207)

Amortization Schedule*

Name of Facility			License No.			Report for Year Ended			Page		of	
			2428			9/30/2019			24		37	
			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		
Item	Month	Year	Month	Year	Amortization							
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			439,509	42,109	S/L	Var	26,416		
2. Disposals (attach schedule)												
3. Acquired during this report period (attach schedule)	Var	Var	Various			80,905		S/L	Var	4,046		
C-4. Subtotal												
D. Total Amortization												

* Straight-line method must be used.

** Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

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

Name of Facility Parkside Rehabilitation and Healthcare	License No. 2428	Report for Year Ended 9/30/2019	Page 25	of 37	
11. Property Questionnaire					
Part A					
Is the property either owned by the Facility or leased from a Related Party?*		<input type="radio"/> Yes	<input checked="" 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					
6. Square Footage					
7. Acquisition Cost					
a. Land					
b. Building					
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variable)					
b. Date Mortgage Obtained					
c. Interest Rate for the Cost Year					
d. Term of Mortgage (number of years)					
e. Amount of Principal Borrowed					
f. Principal balance outstanding as of					
Complete if Mortgage was Refinanced During Current Cost Year					
g. Type of Financing (e.g., fixed, variable)					
h. Date of Refinancing					
i. New Interest Rate					
j. Term of Mortgage (number of years)					
k. Amount of Principal Borrowed					
l. Principal Outstanding on Note Paid-Off					
Part C - Arms-Length Leases for Real Property Improvements Only					
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease	
Grand Street Real Estate, LLC, 2071 Flatbush Avenue Suite 22, Brooklyn, NY 11234	Building, real/personal property, equipment	03/01/16	3 Years	840,000	

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			Page	of
		9/30/2019			27	37
Item		Total	CCNH	RHNS	(Specify)	
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$				
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$				
14. Insurance						
a. Insurance on Property (buildings only)		\$ 23,473	23,473			
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$ 63,092	63,092			
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$ 2,525	2,525			
Crime Insurance, Surety Bond						
14d. Total Insurance Expenditures (14a + b + c)		\$ 89,090	89,090			
15. Total All Expenditures (A-13 thru C-14)		\$ 12,475,782	12,475,782			

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of
Item No.	Page No.	Line No.	2428	9/30/2019		28 37
			Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages						
1.			Outpatient Service Costs	\$		
2.			Salaries not related to Resident Care	\$		
3.			Occupational Therapy	\$		
4.			Other - See attached Schedule	\$		
Page 13 - Professional Fees						
5.			Resident Care Physicians **	\$		
6.	13	B10a	Occupational Therapy	\$	391,304	391,304
7.			Other - See attached Schedule	\$	5,750	5,750
Pages 15 & 16 - Administrative and General						
8.			Discriminatory Benefits	\$		
9.	15	1c	Bad Debts	\$	124,676	124,676
10.			Accounting	\$		
10a.	15	1e	Legal	\$	30,285	30,285
11.			Telephone	\$		
12.	15	1h2	Cellular Telephone	\$	1,554	1,554
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$		
14.			Gifts, flowers and coffee shops	\$		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$		
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$		
17.			Automobile Expense (e.g. personal use)	\$		
18.	16	m2/3	Unallowable Advertising *	\$	18,707	18,707
19.			Income Tax / Corporate Business Tax	\$		
20.			Fund Raising / Contributions	\$		
21.			Unallowable Management Fees	\$		
22.			Barber and Beauty	\$		
23.			Other - See attached Schedule	\$	11,885	11,885
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)			\$	584,161	584,161	

* 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

Schedule of Fees Adjustments

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Admin Exp>Meals	\$ 5,196		
16	m13	Admin Exp>Bank Fees (Disallowed \$6,119)	\$ 6,119		
16	m8a	Chamber of Commerce Dues	\$ 325		
16	m13	Non-Operating (Inc)/Exp	\$ 150		
16	m9	Credit Card Fees	\$ 95		
Total Other A&G Adjustments			\$ 11,885	\$ -	\$ -

**Grandview Rehabilitation and Healthcare Center
Disallowance Schedule for Cell Phones
September 30, 2019**

Pg. 28b

	<u>Amount</u>
Total Cell Phone Expense	2,994 TB Linked
Cell Phone Allowed Based on Bed Capacity	4
Monthly Allowable amount per Cell Phone	\$ 30
Months in Cost Report Year	<u>12</u>
Total Allowable Cost	<u>\$ 1,440</u>
Full Year Cost Report (365 out of 365 Days)	<u>100%</u>
Revised Allowable Cost	<u>\$ 1,440</u>
 Disallowed Cell Phone (Page 28, Line 12)	 <u><u>\$ 1,554</u></u>

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-29 Rev. 9/2018

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

Name of Facility				License No.	Report for Year Ended		Page	of
Parkside Rehabilitation and Healthcare Center, LLC of New				2428	9/30/2019		29	37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)	
Subtotals Brought Forward				\$ 584,161	584,161			
Page 20 - Resident Care Supplies***								
27.	20	5a2	Prescription Drugs	\$ 272,943	272,943			
28.	20	5d	Ambulance/Limousine	\$ 11,989	11,989			
29.	20	5f	X-rays, etc	\$ 7,246	7,246			
30.	20	5h	Laboratory	\$ 26,962	26,962			
31.			Medical Supplies	\$				
32.	20	5e2	Oxygen (non emergency)	\$ 4,906	4,906			
33.			Occupational Therapy	\$				
34.			Other - See Attached Schedule	\$ 59,394	59,394			
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$				
36.			Depreciation on Unallowable Motor Vehicles	\$				
37.			Unallowable Property and Real Estate Taxes	\$				
38.			Rental of Building Space or Rooms	\$				
39.			Other - See Attached Schedule	\$				
Page 27 - Insurance								
40.			Mortgage Insurance	\$				
41.			Property Insurance	\$				
Other - Miscellaneous								
42.			Other - Indirect	\$				
43.	30	IV 5	Interest Income on Account Rec.	\$ 51	51			
44.			Other - Miscellaneous Administrative	\$ 327	327			
45.			Management Fees Direct	\$				
46.			Management Fees Indirect	\$				
47.			Other - Direct	\$				
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)				\$ 967,979	967,979			

*** 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	5i	Cable Television Disallowance (See Attached)	\$ 14,605		
20	5i	IV Exp>RX (Disallow)	\$ 8,461		
20	5i	PEN Exp>Supplies (Disallow)	\$ 6,310		
20	5i	Wound Care Exp>Supplies (Disallow)	\$ 13,167		
20	5i	Wound Care Exp>Equip-Rental (Disallow)	\$ 1,711		
20	5i	Urological & Ostomy Exp>Supplies (Disallow)	\$ 14,665		
20	5i	Billable Med Supplies (Disallow)	\$ 475		
Total Other Ancillary Costs			\$ 59,394	\$ -	\$ -

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

Total Other Adjustments \$ - \$ - \$ -

Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref Line Ref Description CCNH RHNS (Specify)

Schedule of Other - Direct Adjustments

Attachment Page 29

Schedule of Unallowable Building Interest

Grandview Rehabilitation and Healthcare Center
Disallowance Schedule for Cable TV
September 30, 2019

Pg. 29b

	<u>Amount</u>
Total Cable TV Expense acct # 8510-087-00	\$ 18,205 TB Linked

	<u>Amount</u>
Monthly Allowable amount	\$ 300
Months in Cost Report Year	<u>12</u>
Total Allowable Cost	\$ 3,600
Full Year Cost Report (365 out of 365 Days)	<u>100%</u>
Revised Allowable Cost	\$ 3,600

Disallowed Cable TV	<u><u>\$ 14,605</u></u>
----------------------------	-------------------------

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>)		\$ 33,139,823	33,139,823			
b. Medicaid Room and Board Contractual Allowance **		\$ (24,426,432)	(24,426,432)			
2. a. Medicaid (<i>All other states</i>)		\$				
b. Other States Room and Board Contractual Allowance **		\$				
3. a. Medicare Residents (<i>all inclusive</i>)		\$ 2,877,557	2,877,557			
b. Medicare Room and Board Contractual Allowance **		\$ (830,381)	(830,381)			
4. a. Private-Pay Residents and Other		\$ 2,806,890	2,806,890			
b. Private-Pay Room and Board Contractual Allowance **		\$ (1,580,435)	(1,580,435)			
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare		\$ 239,975	239,975			
b. Prescription Drugs - Medicare Contractual Allowance **		\$ (239,975)	(239,975)			
c. Prescription Drugs - Non-Medicare		\$ 33,405	33,405			
d. Prescription Drugs - Non-Medicare Contractual Allowance **		\$ (33,405)	(33,405)			
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		\$ 432,456	432,456			
b. Physical Therapy - Medicare Contractual Allowance **		\$ (208,790)	(208,790)			
c. Physical Therapy - Non-Medicare		\$ 210,575	210,575			
d. Physical Therapy - Non-Medicare Contractual Allowance **		\$ (184,949)	(184,949)			
4. a. Speech Therapy - Medicare		\$ 164,841	164,841			
b. Speech Therapy - Medicare Contractual Allowance **		\$ (113,562)	(113,562)			
c. Speech Therapy - Non-Medicare		\$ 57,052	57,052			
d. Speech Therapy - Non-Medicare Contractual Allowance **		\$ (51,114)	(51,114)			
5. a. Occupational Therapy - Medicare		\$ 423,619	423,619			
b. Occupational Therapy - Medicare Contractual Allowance **		\$ (226,527)	(226,527)			
c. Occupational Therapy - Non-Medicare		\$ 188,414	188,414			
d. Occupational Therapy - Non-Medicare Contractual Allowance **		\$ (171,240)	(171,240)			
6. a. Other (<i>Specify</i>) - Medicare		\$ 2,251	2,251			
b. Other (<i>Specify</i>) - Non-Medicare		\$ (42,494)	(42,494)			
III. Total Resident Revenue (Section I. thru Section II.)		\$ 12,467,554	12,467,554			
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>)		\$ 51	51			
6. Private Duty Nurses' Fees		\$				
7. Barber, Coffee, Beauty and Gift shops		\$				
8. Other (<i>Specify</i>)		\$ 295,885	295,885			
V. Total Other Revenue (1 thru 8)		\$ 295,936	295,936			
VI. Total All Revenue (III +V)		\$ 12,763,490	12,763,490			

* 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	Vaccine Rev>Medicare B	0		
		\$ 2,251		
Total Other Resident Revenue - Medicare		\$ 2,251	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
30 II 6B	Vaccine Rev>Medicaid	0		
30 II 6B	Vaccine Rev>Medicaid>C/A	\$ (98)		
30 II 6B	Other Rev>Write-offs-Sequester	\$ 98		
		\$ (42,494)		
Total Other Resident Revenue		\$ (42,494)	\$ -	\$ -

Interest Income**Account**

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
30 IV 5	Interest(Inc)/Exp>Income	N/A	0		
			\$ 51		
Total Interest Income			\$ 51	\$ -	\$ -

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV 8	Non-Operating (Inc)/Exp>Prior Year (No current year associated expense)	0		
30 IV 8	Misc. Income (Disallow)	\$ 295,558		
		\$ 327		
Total Other Revenue		\$ 295,885	\$ -	\$ -

G. Balance Sheet

Name of Facility Parkside Rehabilitation and Healthcare	License No. 2428	Report for Year Ended 9/30/2019	Page 31	of 37
Account		Amount		
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)		\$ 478,615		
2. Resident Accounts Receivable (Less Allowance for Bad Debts)		\$ 2,271,054		
3. Other Accounts Receivable (Excluding Owners or Related Parties)		\$ 1,117,508		
4. Inventories		\$		
5. Prepaid Expenses		\$ 213,214		
a. _____				
b. _____				
c. _____				
d. See Schedule		213,214		
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)		\$ 4,080,391		
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 520,414	Accum. Depreciation 72,571 Net	\$ 447,843	
5. Non-Movable Equipment	*Historical Cost 26,906	Accum. Depreciation 7,411 Net	\$ 19,495	
6. Movable Equipment	*Historical Cost 64,269	Accum. Depreciation 34,895 Net	\$ 29,374	
7. Motor Vehicles	*Historical Cost _____	Accum. Depreciation _____ Net	\$	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)		\$ 30,793		
F/S v/s C/R NBV		30,793		
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)		\$ 527,505		

* 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

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

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

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

Schedule of Other Assets Page 32 Line D7

Schedule of Notes Payable (Itemize) Page 33 Line A2

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

Page Ref	Line Ref	Description	
33	A12	Other Current Payable>Resident Funds	\$ 54,222
33	A12	AK Related Payables>Write-offs>sequester	\$ (15,128)
33	A12	Accrued Wages & Related>Retirement WH	\$ 12,820
33	A12	Other Accrued	\$ 2,672,742
33	A12	Other Accrued>Accounting Fees	\$ 7,850
33	A12	Other Accrued>Provider Tax	\$ -483
33	A12	Other Accrued>Insurance	\$ 60194
33	A12	Other Accrued>Working Capital	\$ 1525000
Total Other Current Liabilities (Itemized)			\$ 4,317,217

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

G. Balance Sheet (cont'd)

Name of Facility Parkside Rehabilitation and Healthcare	License No. 2428	Report for Year Ended 9/30/2019	Page 32	of 37
Account		Amount		
		Total Brought Forward:		\$ 4,607,896
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>)			\$	
Name and Address	Amount	Loan Date		
7. Other Assets (<i>itemize</i>)			\$	10,180
Other Assets>Deposits	10,180			
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	10,180
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	4,618,076

* 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 Parkside Rehabilitation and Healthcare Cen	License No. 2428	Report for Year Ended 9/30/2019	Page 34	of 37
Account				Amount
Total Brought Forward:				5,983,993
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>)				\$ 1,302,299
Due to Liability				1,302,299
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$ 1,302,299
C. Total All Liabilities (Lines A-13 + B-5)				\$ 7,286,292

G. Balance Sheet (cont'd)

Reserves and Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Parkside Rehabilitation and Healthcar	2428	9/30/2019	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				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ (2,962,131)
6. Gain or Loss for Period		10/1/2018	thru	9/30/2019
				\$ 293,915
7. Total Net Worth				\$ (2,668,216)
C. Total Reserves and Net Worth				\$ (2,668,216)
D. Total Liabilities, Reserves, and Net Worth				\$ 4,618,076

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page of
		9/30/2019	36 37
Account			Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2018			\$ (2,964,191)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$ 12,763,490
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$ 12,469,575
D. Net Income or Deficit			\$ 293,915
E. Balance			\$ (2,670,276)
F. Additions			
1. Additional Capital Contributed (<i>itemize</i>)			
Expenses Per Page 27		\$12,475,782	
F/S vs C/R Depreciation		(\$6,207)	
Expenses Per F/S		\$12,398,474	
2. Other (<i>itemize</i>)			
Prior Period Adjustment		2,060	
F-3. Total Additions			\$ 2,060
G. Deductions			
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$
Name and Address (No., City, State, Zip)		Title	Amount
2. Other Withdrawings (<i>Specify</i>)			\$
Purpose		Amount	
3. Total Deductions			\$
H. Balance at End of Period		09/30/19	\$ (2,668,216)

I. Preparer's/Reviewer's Certification

Name of Facility Parkside Rehabilitation and Healthcare	License No. 2428	Report for Year Ended 9/30/2019	Page of 37 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 <i>Matthew S Bavolack</i>	Title Principal	Date Signed 02/13/20
Printed Name of Preparer Matthew S. Bavolack		
Address Address 555 Long Wharf Drive, New Haven, CT 06511		Phone Number 203-781-9600
Contacted Person Regarding Additional Information Needed Regarding This Report Shlomo Brisk		Phone Number 845-746-5074
Contact Email Address Sbrisk@axgsolutions.com		

ACCOUNTANTS' CONSULTING REPORT

Management is responsible for the accompanying Annual Report of Long-Term Care Facility (the "Cost Report") for Parkside Rehabilitation and Healthcare Center, LLC of New Britain, CT d/b/a Grandview Rehabilitation and Healthcare Center for the year ended September 30, 2019, included in the accompanying prescribed form. We have prepared the Cost Report in accordance with the American Institute of Certified Public Accountants' Statements on Standards for Consulting Services. The Cost Report was prepared in conformity with regulations prescribed by The State of CT Department of Social Services (DSS) from data provided to us by the management of Parkside Rehabilitation and Healthcare Center, LLC of New Britain, CT d/b/a Grandview Rehabilitation and Healthcare Center. We did not audit or review the Cost Report included in the accompanying prescribed form, nor were we required to perform any procedures to verify the accuracy or completeness of the information provided by management. Accordingly, we do not express an opinion, a conclusion, nor provide any form of assurance on the Cost Report included in the accompanying prescribed form.

Management is responsible for maintaining its records in accordance with accounting principles generally accepted in the United States of America and in accordance with reimbursement regulations set forth by DSS. Management is also responsible for designing, implementing, and maintaining internal control relevant to the preparation and fair presentation of the financial data and supplemental information included in the Cost Report.

This report is intended solely for the information and use of the management of Parkside Rehabilitation and Healthcare Center, LLC of New Britain, CT d/b/a Grandview Rehabilitation and Healthcare Center and DSS and is not intended to be, and should not be, used by anyone other than these specified parties.

MARCUM LLP

New Haven, CT
February 8, 2020

Annual Report of Long-Term Care Facility Cost Year 2019 Checklist

This checklist is not required to be submitted with the Annual Report

Facility Name Parkside Rehabilitation and Healthcare Center, LLC of New Britain, CT d/b/a Grandview Rehabilitation and Healthcare Center

Complete the following check list. **Provide an explanation for any “No” answers.** Attach additional sheets to explain further, if necessary.

Yes No

1. Have all related parties been properly disclosed on Pages 4, 11, 12, 14, 17 and 21?

Explanation: _____

Yes No

2. Are the methods of allocating costs consistent with prior year? If not, explain the reporting change.

Explanation: _____

Yes No

3. Are costs allocated based on the methods prescribed on Page 5 of the Annual Report? If not, provide the basis of your allocation.

Explanation: _____

Yes No

4. Do equipment leases listed on Page 6 agree with equipment leases reported on Page 22, Line 6e? If not, state where these costs are included in the Annual Report.

Explanation: _____

Yes No

5. Do accounting and legal fees reported on Page 7 agree with Page 15, Lines 1d and 1e, respectively?

Explanation: _____

Yes No

6. During cost year, did you report all certified bed changes on Page 9? Do the bed change dates agree to the license issued by the Department of Health?

Explanation: _____

Yes No

7. If there has been a change in Administrators, have the dates of employment and applicable hours for each Administrator been reported on Page 12?

Explanation: _____

Yes No

8. Have hours been reported for all expenses claimed on Page 13? Hours must be actual rather than estimated.

Explanation: _____

Yes No

9. Has resident day user fee expense been properly reported on Page 15, Line 1k3?

Explanation: _____

Yes No

10. Have purchased services greater than \$10,000 reported on Pages 16, 18, 19, 20 and 22 been detailed on Page 21?

Explanation: _____

Yes No

11. Have the dietary and laundry questionnaires on Pages 18 and 19 been completed?

Explanation: _____

Yes No

12. Has the personal use portion of automobile expense been disallowed, including, depreciation, lease payments, insurance and taxes?

Explanation: _____

Yes No

13. Does historical cost and accumulated depreciation of all assets reported on Pages 23 and 24 roll forward from the prior cost year?

Explanation: _____

Yes No

14. Does the net book value of all assets reported on Pages 23 and 24 agree with the net book value reported on Pages 31 and 32?

Explanation: _____

Yes No

15. Has asset useful life been reported in accordance with the 2013 edition of the American Hospital Association guidelines?

Explanation: _____

Yes No

16. Have all assets been categorized between movable and fixed in accordance with the 2013 edition of the American Hospital Association guidelines?

Explanation: _____

Yes No

17. Have all contractual allowances been properly reported on Page 30?

Explanation: _____

Yes No

Were all discrepancies on the Error Page addressed?

Yes No

19. Have Pages 1 and 37 been signed? ***Cost reports without a signed Page 1 and 37 will not be accepted.***

Explanation: _____

Yes No

20. Have detailed schedules been provided for all "other" line items, fixed asset and movable equipment additions? ***If detail is not provided, appropriate disallowances will be made.***

Explanation: _____

Yes No

21. Have all costs associated with non-nursing home businesses (i.e., Adult Daycare, Meals on Wheels, Outpatient Therapy Services, etc.) been disallowed on Pages 28 and/or 29 of the Annual Report?

Explanation: _____

Yes No

22. Has all required documentation been submitted to the Annual Report review and audit contractor?

Explanation: _____
