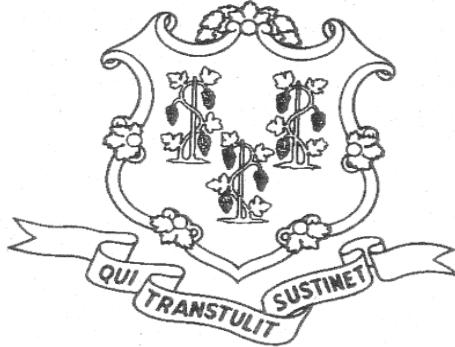


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2019

Name of Facility (as licensed) Yale New Haven Care Continuum d/b/a Grimes Center	
Address (No. & Street, City, State, Zip Code) 1354 Chapel Street, New Haven, CT 06511	
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 2027-C	RHNS	(Specify)	Medicare Provider 07-5275
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Medicaid Provider Numbers:	CCNH 20272	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) Yale New Haven Care Continuum d/b/a Grimes Center	License No. 2027-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 Yale New Haven Care Continuum d/b/a Grimes 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.

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) Carol Work			Printed Name (Owner) Vincent Tammaro	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Yale New Haven Care Continuum d/b/a Grimes Center	Period Covered:		From 10/1/2018	To 9/30/2019
Address of Facility 1354 Chapel Street, New Haven, CT 06511				
Report Prepared By Marcum LLP	Phone Number 203-781-9600	Date 12/3/2019		
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$			
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$			
5. All other wages paid	\$			
6. Total Wages Paid	\$			
7. Total salaries paid	\$			
8. Total Wages and Salaries Paid (As per page 10 of Report)	\$			

Wages - Compensation computed on an hourly wage rate.

Salaries - Compensation computed on a weekly or other basis which does not generally vary, based on the number of hours worked.

DO NOT include Fringe Benefit Costs.

General Information and Questionnaire
Type of Facility - Organization Structure

	Phone No. of Facility 203-867-8300	Report for Year Ended 9/30/2019	Page 2
		of 37	
Name of Facility (as shown on license) Yale New Haven Care Continuum d/b/a Grimes Center		Address (No. & Street, City, State, Zip) 1354 Chapel Street, New Haven, CT 06511	
License Numbers:	CCNH 2027-C	RHNS	(Specify)
Medicare Provider No. 07-5275			
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 type="radio"/> Profit Corp. <input checked="" 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 Carol Work		Nursing Home Administrator's License No.:	001494
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	License No.	Report for Year Ended	Page	of
Yale New Haven Care Continuum d/b/a Grim	2027-C	9/30/2019	3A	37

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

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-3B Rev. 10/2005

General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
Yale New Haven Care Continuum d/b/a Grimes Ce	2027-C	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 Yale New Haven Care Continuum d/b/a Grimes Center		License No. 2027-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 type="radio"/> Yes <input checked="" 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	%**				
Bridgeport Hospital	267 Grant street, Bridgeport, CT 06610	<input type="radio"/>	<input checked="" type="radio"/>		Various	Page 31 / Line A8	3,500	3,500
Yale New Haven Hospital	20 York Street, New Haven, CT 06510	<input type="radio"/>	<input checked="" type="radio"/>		Various	Page 34 / Line B3	11,799,072	11,799,072
Medical Center Pharmacy and Home Care Center, Inc.	50 York Street, New Haven, CT 06511	<input type="radio"/>	<input checked="" type="radio"/>		Pharmacy	Page 34 / Line B3	551,536	551,536
Northeast Medical Group	99 Hawley Lane, 1st floor, Stratford CT 06614	<input type="radio"/>	<input checked="" type="radio"/>		Various	Page 34 / Line B3	419	419
Corporate Professional Business Services	789 Howard Ave, New Haven, CT 06519	<input type="radio"/>	<input checked="" type="radio"/>		Various	Page 34 / Line B3	655	655
Yale New Haven Health Services Corporation	789 Howard Ave, New Haven, CT 06519	<input type="radio"/>	<input checked="" type="radio"/>		Various	Page 34 / Line B3	457,736	457,736
Yale New Haven Hospital	20 York Street, New Haven, CT 06510	<input type="radio"/>	<input checked="" type="radio"/>		Pastor	Page 16 / Line m11	39,492	39,492
Yale New Haven Hospital	20 York Street, New Haven, CT 06510	<input type="radio"/>	<input checked="" type="radio"/>		Bookkeeper	Page 16 / Line m11	94,085	94,085
		<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 Yale New Haven Care Continuum d/b/a Grimes	License No. 2027-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.

Is a Mileage Log Book Maintained for All Leased Vehicles ?

Yes

⊕ No

Total ***

* 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 Yale New Haven Care Continuum	License No. 2027-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, New Haven, CT 06511
2 KPMG LLP	P.O. Box 120522, Dallas, TX 75312-0522
3	
4	

Services Provided by This Firm (*describe fully*)

1	Medicaid Cost Report and Reimbursement Advisory Services	\$	8,331
2	Tax compliance and consulting service	\$	5,663
3		\$	
4		\$	
		Charge for Services Provided	
		\$	13,994

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 N/A	
2	
3	
4	
5	

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

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
5	\$

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 Yale New Haven Care Continuum d/b/a Grimes Center			License No. 2027-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					120	120			120	120		
A. On last day of PREVIOUS report period	120	120			120	120			120	120		
B. On last day of THIS report period	120	120			120	120			120	120		
2. Number of Residents					104	104			102	102		
A. As of midnight of PREVIOUS report period	104	104			104	104			102	102		
B. As of midnight of THIS report period	107	107			102	102			107	107		
3. Total Number of Days Care Provided During Period					6,827	6,827			2,568	2,568		
A. Medicare	9,395	9,395			6,827	6,827			2,568	2,568		
B. Medicaid (Conn.)	18,851	18,851			14,442	14,442			4,409	4,409		
C. Medicaid (other states)												
D. Private Pay	9,466	9,466			7,238	7,238			2,228	2,228		
E. State SSI for RCH												
F. Other (Specify)												
G. Total Care Days During Period (3A thru F)	37,712	37,712			28,507	28,507			9,205	9,205		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds					393	393			228	228		
A. Medicaid Bed Reserve Days	621	621			393	393			228	228		
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	38,333	38,333			28,900	28,900			9,433	9,433		

Schedule of Resident Statistics (Cont'd)

Name of Facility Yale New Haven Care Continuum d/b/a Grim	License No. 2027-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	RHNS	(Specify)	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	23	61		23				
Per Diem Rate								
a. One bed rm.	Various	274.61		500.00				
b. Two bed rms.	Various	274.61		470.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

A. Medicare - Part B	1,797	1,797	(Specify)
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments	8,851	8,851	
C. Other	34,380	34,380	
D. Total Physical Therapy Treatments	45,028	45,028	

8. Total Number of Speech Therapy Treatments

A. Medicare - Part B	245	245	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments	653	653	
C. Other	2,463	2,463	
D. Total Speech Therapy Treatments	3,361	3,361	

9. Total Number of Occupational Therapy Treatments

A. Medicare - Part B	894	894	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments			
2. Restorative Treatments	7,313	7,313	
C. Other	30,902	30,902	
D. Total Occupational Therapy Treatments	39,109	39,109	

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*					
1. Operators/Owners (Complete also Sec. I of Schedule A1)					
2. Administrator(s) (Complete also Sec. III of Schedule A1)	164,358	2,080			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	126,178	4,905			
5. Dietary Service					
a. Head Dietitian	58,978	1,248			
b. Food Service Supervisor	53,428	2,080			
c. Dietary Workers	490,502	25,229			
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers	315,380	17,414			
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance	74,725	2,080			
b. Other Maintenance Workers	51,540	2,300			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers	107,661	6,507			
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	217,939	4,160			
b. RN					
1. Direct Care	1,490,447	33,559			
2. Administrative**	708,754	15,605			
c. LPN					
1. Direct Care	1,018,972	33,246			
2. Administrative**					
d. Aides and Attendants	1,729,642	91,384			
e. Physical Therapists	819,894	20,176			
f. Speech Therapists	86,885	2,085			
g. Occupational Therapists	660,944	14,143			
h. Recreation Workers	70,835	3,293			
i. Physicians					
1. Medical Director					
2. Utilization Review					
3. Resident Care***	72,766	2,080			
4. Other (Specify)					
j. Dentists					
k. Pharmacists					
l. Podiatrists					
m. Social Workers/Case Management	156,208	4,160			
n. Marketing					
o. Other (Specify)					
See Attached Schedule	201,325	9,027			
A-13. Total Salary Expenditures	8,677,361	296,761			

* 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 Yale New Haven Care Continuum d/b/a Grimes Center				License No. 2027-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										
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
Yale New Haven Care Continuum d/b/a Grimes Center				2027-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***										
Carol Work	164,358			Non Discrim	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	License No.	Report for Year Ended		Page	of
	2027-C	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					
2. Dentist	6,589	Monthly Fee			
3. Pharmacist					
4. Podiatrist					
5. Physical Therapy					
a. Resident Care					
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)					
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**					
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify)					
9. Speech Therapist					
a. Resident Care	12,408	177			
b. Other					
10. Occupational Therapist					
a. Resident Care					
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care					
2. Administrative***	20,565	Contracted			
b. LPN					
1. Direct Care	811,188	19,645			
2. Administrative***					
c. Aides	269,129	10,821			
d. Other					
12. Other (Specify)					
See Attached Schedule	673				
B-13 Total Fees Paid in Lieu of Salaries	1,120,552	30,643			

* 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 Yale New Haven Care Continuum d/b/a Grimes Center	License No. 2027-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		
AAA Nursing Care LLC	3303 Main Street, Stratford, CT 06614	<input type="radio"/>	<input checked="" type="radio"/>	Contract LPN / CNAs	
Maxim Staffing Solutions	12588 Collections Center Drive, Chicago, IL 60693	<input type="radio"/>	<input checked="" type="radio"/>	Contract LPN / CNAs	
Favorite Healthcare Staffing	P.O. Box 803356, Kansas City, MO 64180-3356	<input type="radio"/>	<input checked="" type="radio"/>	Contract LPN / CNAs	
Harborside Rehabilitation LP	P.O. Box 301076, Dallas, TX 75303-1076	<input type="radio"/>	<input checked="" type="radio"/>	Contract LPN / CNAs	
Nursefinders Inc	2735 Collection Center Drive, Chicago, IL 60693-2735	<input type="radio"/>	<input checked="" type="radio"/>	Contract LPN / CNAs	
The Nurse Network LLC	653 Main Street, Plantsville, CT 06479	<input type="radio"/>	<input checked="" type="radio"/>	Contract LPN / CNAs	
Healthdrive Dental Group	888 Worcester Street, Wellesley, MA 02482-3744	<input type="radio"/>	<input checked="" type="radio"/>	Dentist	
Healthdrive Eye Care Group	888 Worcester Street, Wellesley, MA 02482-3744	<input type="radio"/>	<input checked="" type="radio"/>	Eye Care	
Foremost Rehab of CT, LLC	1157 Highland Avenue, Suite 101, Cheshire, CT 06410	<input type="radio"/>	<input checked="" type="radio"/>	Contract ST	
Celtic Consulting	507 East Main Street, Suite 308, Torrington, CT 06790	<input type="radio"/>	<input checked="" type="radio"/>	MDS Consulting	
Robert Badrigan DDS PC	5 South Main Street, Suite 515, Branford, CT 06405	<input type="radio"/>	<input checked="" type="radio"/>	Dentist	
		<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
Yale New Haven Care Continuum d/b/a Grimes	2027-C	9/30/2019	15	37
Item	Total	CCNH	RHNS	(Specify)
1. Administrative and General				
a. Employee Health & Welfare Benefits				
1. Workmen's Compensation	\$ 71,380	71,380		
2. Disability Insurance	\$ 16,899	16,899		
3. Unemployment Insurance	\$ 12,046	12,046		
4. Social Security (F.I.C.A.)	\$ 639,246	639,246		
5. Health Insurance	\$ 1,516,781	1,516,781		
6. Life Insurance (employees only) (not-owners and not-operators)	\$ 2,984	2,984		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$			
8. Uniform Allowance	\$ 18,565	18,565		
9. Other (Specify) See Attached Schedule	\$ 14,429	14,429		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$			
c. Bad Debts*	\$ 1,180,082	1,180,082		
d. Accounting and Auditing	\$ 13,994	13,994		
e. Legal (Services should be fully described on Page 7)	\$			
f. Insurance on Lives of Owners and Operators (Specify)*	\$			
g. Office Supplies	\$ 84,067	84,067		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 6,837	6,837		
2. Cellular Phones	\$			
i. Appraisal (Specify purpose and attach copy)*	\$			
j. Corporation Business Taxes (franchise tax)	\$			
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$			
2. Other (Specify) See Attached Schedule	\$			
3. Resident Day User Fee	\$ 608,848	608,848		
Subtotal	\$ 4,186,158	4,186,158		

* 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)
	-		
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>	4,186,158	4,186,158		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	12,864	12,864		
5. Education Expenses Related to Seminars and Conventions	\$	1,170	1,170		
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>)	\$	4,645	4,645		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$				
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	1,200	1,200		
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)***	\$	4,161	4,161		
7. Postage	\$	365	365		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	16,688	16,688		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$				
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	408,155	408,155		
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$	191,368	191,368		
C-14 Total Administrative & General Expenditures	\$	4,826,774	4,826,774		

* 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)
Marketing and Promotional	\$ 1,200		
Total Other Advertising	\$ 1,200	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Leading Age Dues	\$ 10,204		
CHEFA Dues	6,484		
Total Dues	\$ 16,688	\$ -	\$ -

Schedule of Contributions

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

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Assessments and fees	\$ 2,720		
Miscellaneous Expense	2,178		
Billing Solutions	1,582		
Courier Service	2,194		
Employee Survey	10,074		
Accrual for PIP Payout	165,948		
Employee Assistance Program	4,626		
Treasurer State of CT Fees	954		
Florist	506		
Medicare Enrollment Fee	586		
Total Other Administrative and General	\$ 191,368	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Yale New Haven Care Continuum d/b/a C	License No. 2027-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	License No.	Report for Year Ended		Page of
	2027-C	9/30/2019		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 438,679	438,679		
2. Non-Food Supplies	\$			
3. Other (Specify) _____	\$			
b. Purchased Services (by contract other than through Management Services) <i>(Complete Schedule C-2 att. Page 21)</i>	\$ 700	700		
c. Other (Specify) _____	\$			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 439,379	439,379		
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)				
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)				
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 Yale New Haven Care Continuum d/b/a Grimes Center	License No. 2027-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. \$			
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)	\$	63,463	63,463	
c. Other (Specify)	\$			
3D. Total Laundry Expenditures (3a + b + c)	\$	63,463	63,463	
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	License No.	Report for Year Ended		Page	of
		9/30/2019		20	37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced				
a. In-House Care	by Personnel				
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	46	46		
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. \$	43,745	43,745		
C. Other (Specify)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	43,791	43,791		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$	935,464	935,464		
2. Purchased from	\$				
b. Medicine Cabinet Drugs	\$	539,308	539,308		
c. Medical and Therapeutic Supplies	\$				
d. Ambulance/Limousine***	\$	156,858	156,858		
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	156,216	156,216		
f. X-rays and Related Radiological Procedures***	\$				
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	94	94		
i. Recreation	\$	20,538	20,538		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)**** See Attached Schedule	\$	30,921	30,921		
5M. Total Resident Care Expenditures (5a - 5j)	\$	1,839,399	1,839,399		

* 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)
Med Elect Parts	\$ -		
Solutions & IV	13,400		
Wound Care Supplies	439		
Purchased Service - Medical Waste	4,310		
Physical Therapy Equipment	9,654		
Prosthetics	3,000		
Total Other Resident Care	\$ 30,921	\$ -	\$ -

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

Name of Facility Yale New Haven Care Continuum d/b/a Grimes Center				License No. 2027-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
American Medical Response	Atlanta, GA 30384-0296	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Patient transport	156,858			20	5d
Wescom Solutions, DBA Pointclickcare	P.O. Box 674802, Detroit, MI 48267-4801	<input type="radio"/>	<input checked="" type="radio"/>	N/A	AR System Support	42,356			16	m11
Technical Gas Products	Industrial Road, 1B Suite 1, Wallingford, CT	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Oxygen Provider	49,190			20	5e2
Feury Image Group, Inc.	85 Avenue K, Newark, NJ 07105	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Uniforms	15,799			15	1a8
O2 Safe Respiratory	Industrial Road, 1B Suite 1, Wallingford, CT	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Oxygen Provider	107,026			20	5e2
Press Ganey Associates Inc.	Milwaukee, WI 53288-0335	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Employee survey	10,074			16	m13
Comcast Corporation	P.O. Box 70219, Philadelphia, PA 19176	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Cable TV Service	12,018			20	5i
Cross charge of a portion of pastor's time from YNHH to YNHCC	20 York Street, New Haven, CT 06510	<input checked="" type="radio"/>	<input type="radio"/>	Employee	Salary and Fringe	39,492			16	m11
Cross charge of bookkeeper's (DD) time from parent company to	20 York Street, New Haven, CT 06510	<input checked="" type="radio"/>	<input type="radio"/>	Employee	Salary and Fringe	94,085			16	m11
Unitex Textile Rental Inc.	565 Taxter Rd Suite 620, Elmsford, NY 10523	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Linen rentals	63,463			19	3b
Reitman Personnel Services	163 Cedar Street, Branford, CT 06405	<input type="radio"/>	<input checked="" type="radio"/>	N/A	Contracted Housekeeping	43,745			20	4b
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							
		<input type="radio"/>	<input checked="" type="radio"/>							

* List all contracted services over \$10,000. Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended		Page of
		9/30/2019		22 37
Item	Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant				
a. Repairs & Maintenance	\$ 511,884	511,884		
b. Heat	\$			
c. Light & Power	\$ 248,524	248,524		
d. Water	\$ 45,264	45,264		
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$			
f. Other (<i>itemize</i>)	\$ 5,133	5,133		
See Attached Schedule				
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 810,805	810,805		
7. Depreciation (<i>complete schedule page 23*</i>)				
a. Land Improvements	\$			
b. Building & Building Improvements	\$ 432,199	432,199		
c. Non-Movable Equipment	\$			
d. Movable Equipment	\$ 36,339	36,339		
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 468,538	468,538		
8. Amortization (<i>Complete att. Schedule Page 24*</i>)				
a. Organization Expense	\$			
b. Mortgage Expense	\$			
c. Leasehold Improvements	\$ 7,686	7,686		
d. Other (<i>Specify</i>)	\$			
*8e. Total Amortization Costs (8a + b + c + d)	\$ 7,686	7,686		
9. Rental payments on leased real property less real estate taxes included in item 10b	\$			
10. Property Taxes				
a. Real estate taxes paid by owner	\$			
b. Real estate taxes paid by lessor	\$			
c. Personal property taxes	\$			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 476,224	476,224		

* 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

***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:				
12/1/2018	Medline - 10 Hospital Beds	\$ 19,365	10	\$ 1,936
Total additions for Movable Equipment		\$ 19,365		\$ 1,936
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

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Yale New Haven Care Continuum d/b/a Grimes Center			License No. 2027-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		72,467	40,762	S/L	Var	7,686	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									7,686
D. Total Amortization									7,686

* 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 Yale New Haven Care Continuum d/b/	License No. 2027-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	09/12/12			
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase	09/12/12			
4. Date of Initial Licensure				
5. Total Licensed Bed Capacity	120			
6. Square Footage				
7. Acquisition Cost				
a. Land	1,580,000			
b. Building	2,127,000			

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

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)		\$				
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$				
14. Insurance						
a. Insurance on Property (buildings only)		\$ 17,991	17,991			
b. Insurance on Automobiles		\$				
c. Insurance other than Property (as specified above)						
1. Umbrella (Blanket Coverage)		\$				
2. Fire and Extended Coverage		\$				
3. Other (Specify)		\$ 66,382	66,382			
Malpractice Insurance						
14d. Total Insurance Expenditures (14a + b + c)		\$ 84,373	84,373			
15. Total All Expenditures (A-13 thru C-14)		\$ 18,382,121	18,382,121			

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended		Page of
Yale New Haven Care Continuum d/b/a Grimes Center				2027-C	9/30/2019		28 37
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs	\$			
2.			Salaries not related to Resident Care	\$			
3.	10	A12g	Occupational Therapy	\$ 660,944	660,944		
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.			Resident Care Physicians **	\$			
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$ 673	673		
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$ 1,180,082	1,180,082		
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.			Cellular Telephone	\$			
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.	15	1a9	Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$ 14,429	14,429		
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	\$ 5,374	5,374		
17.			Automobile Expense (e.g. personal use)	\$			
18.	16	m2/3	Unallowable Advertising *	\$ 1,200	1,200		
19.			Income Tax / Corporate Business Tax	\$			
20.			Fund Raising / Contributions	\$			
21.			Unallowable Management Fees	\$			
22.	16	m6	Barber and Beauty	\$ 4,161	4,161		
23.			Other - See attached Schedule	\$ 211,437	211,437		
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)				\$ 2,078,300	2,078,300		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

** Physicians who provide services to Title 19 residents are required to bill the Department of Social Services directly for each individual resident.

Schedule of Other Salaries Adjustment

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Salaries Adjustment			\$ -	\$ -	\$ -

Schedule of Fees Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
13	12o	Eyecare Specialist	\$ 673		
Total Other Fees Adjustments			\$ 673	\$ -	\$ -

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	m13	Non Routine Bank Charges	\$ 482		
16	m11	Purchased Service - Pastor	39,492		
16	m13	Accrual for PIP Payout	165,948		
16	m13	Florist	506		
16	m13	Medicare Enrollment Fee	586		
16	m11	Catering Service (Dept Meetings)	2,245		
16	m13	Misc Expenses	2,178		
Total Other A&G Adjustments			\$ 211,437	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

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

Name of Facility			License No.	Report for Year Ended		Page of	
Yale New Haven Care Continuum d/b/a Grimes Center			2027-C	9/30/2019		29 37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	\$ 2,078,300	2,078,300		
Page 20 - Resident Care Supplies***							
27.	20	5a1	Prescription Drugs	\$ 935,464	935,464		
28.	20	5d	Ambulance/Limousine	\$ 156,858	156,858		
29.			X-rays, etc	\$			
30.	20	5h	Laboratory	\$ 94	94		
31.			Medical Supplies	\$			
32.	20	5e2	Oxygen (non emergency)	\$ 156,216	156,216		
33.			Occupational Therapy	\$			
34.			Other - See Attached Schedule	\$ 24,818	24,818		
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	\$ 303	303		
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.			Property Insurance	\$			
Other - Miscellaneous							
42.			Other - Indirect	\$			
43.			Interest Income on Account Rec.	\$			
44.			Other - Miscellaneous Administrative	\$			
45.			Management Fees Direct	\$			
46.			Management Fees Indirect	\$			
47.			Other - Direct	\$ 3,091	3,091		
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)				\$ 3,355,144	3,355,144		

*** 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

Schedule of Excess Movable Equipment Depreciation

Schedule of Other Property Adjustments

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Other Adjustments			\$ -	\$ -	\$ -

Schedule of Other - Direct Adjustments

Attachment Page 29

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>)	\$	10,013,894	10,013,894			
b. Medicaid Room and Board Contractual Allowance **	\$	(4,789,161)	(4,789,161)			
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents(<i>all inclusive</i>)	\$	6,192,277	6,192,277			
b. Medicare Room and Board Contractual Allowance **	\$	(1,833,866)	(1,833,866)			
4. a. Private-Pay Residents and Other	\$	4,844,922	4,844,922			
b. Private-Pay Room and Board Contractual Allowance **	\$	(1,156,262)	(1,156,262)			
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$					
b. Prescription Drugs - Medicare Contractual Allowance **	\$					
c. Prescription Drugs - Non-Medicare	\$					
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$					
2. a. Medical Supplies - Medicare	\$					
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$					
b. Physical Therapy - Medicare Contractual Allowance **	\$					
c. Physical Therapy - Non-Medicare	\$					
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$					
4. a. Speech Therapy - Medicare	\$					
b. Speech Therapy - Medicare Contractual Allowance **	\$					
c. Speech Therapy - Non-Medicare	\$					
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$					
5. a. Occupational Therapy - Medicare	\$					
b. Occupational Therapy - Medicare Contractual Allowance **	\$					
c. Occupational Therapy - Non-Medicare	\$					
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$					
6. a. Other (<i>Specify</i>) - Medicare	\$	732,346	732,346			
b. Other (<i>Specify</i>) - Non-Medicare	\$	807,374	807,374			
III. Total Resident Revenue (Section I. thru Section II.)		\$ 14,811,524	14,811,524			
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$	4,387	4,387			
8. Other (<i>Specify</i>)	\$	3,361	3,361			
V. Total Other Revenue (1 thru 8)		\$ 7,748	7,748			
VI. Total All Revenue (III +V)		\$ 14,819,272	14,819,272			

* 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	Lab Revenue	\$ 586,003		
30 II 6a	X-Ray Revenue	224,021		
30 II 6a	Cont Adj - Lab Revenue	(259,365)		
30 II 6a	Cont Adj - X-Ray Revenue	(7,347)		
30 II 6a	Cont Allow Med B	(9,237)		
30 II 6a	DME Revenue	361		
30 II 6a	Revenue Med B	110,764		
30 II 6a	Revenue Med A	87,146		
Total Other Resident Revenue - Medicare		\$ 732,346	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
30 II 6b	Revenue HMO	\$ 807,374		
Total Other Resident Revenue		\$ 807,374	\$ -	\$ -

Interest Income**Account**

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 IV 8	Other operating income	\$ 135		
30 IV 8	Medical Records Revenue	1,374		
30 IV 8	Vending machine revenue	1,473		
30 IV 8	LMH Paramedic sys billable calls	109		
30 IV 8	Audiologist Credit with no current year expenses	270		
Total Other Revenue		\$ 3,361	\$ -	\$ -

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>)			\$	46,701
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	2,345,810
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	
4. Inventories			\$	
5. Prepaid Expenses			\$	5,300
a. Prepaid Expenses - Other		5,100		
b. Prepaid Insurance		200		
c. _____				
d. See Schedule				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	3,500
Intercompany Receivables - Bridgeport Hospital		3,500		
See Schedule				
A-9. Total Current Assets (Lines A1 thru 8)			\$	2,401,311
B. Fixed Assets				
1. Land			\$	1,580,000
2. Land Improvements	*Historical Cost	231,484	\$	
	Accum. Depreciation	231,484	Net	
3. Buildings	*Historical Cost	10,855,883	\$	1,177,275
	Accum. Depreciation	9,678,608	Net	
4. Leasehold Improvements	*Historical Cost	72,467	\$	24,019
	Accum. Depreciation	48,448	Net	
5. Non-Movable Equipment	*Historical Cost	837,294	\$	
	Accum. Depreciation	837,294	Net	
6. Movable Equipment	*Historical Cost	1,529,194	\$	90,968
	Accum. Depreciation	1,438,226	Net	
7. Motor Vehicles	*Historical Cost		\$	
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	675,240
F/S vs C/R NBV		675,240		
See Schedule				
B-10. Total Fixed Assets (Lines B1 thru 9)			\$	3,547,502

* 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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			\$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			\$ -

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

Page Ref	Line Ref	Description	
	33 A12	Accrued Taxes / State Taxes	\$ 144,089
	33 A12	Other accrued expenses	624,559
	33 A12	Flex dependent care / Spending Medical	1,013
	33 A12	Garnishments	2,688
	33 A12	Gift Shop PR Reduction	301
	33 A12	TSA Fidelity	8,416
	33 A12	Union Dues / United Way	534
	33 A12	Third Party Liability Insurance	397,062
	33 A12	Patient Trust Fund	25,003
Total Other Current Liabilities (Itemize)			\$ 1,203,665

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

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

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:	\$ 5,948,813
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				\$
2. Land Improvements	*Historical Cost	Accum. Depreciation	Net	\$
3. Buildings	*Historical Cost	Accum. Depreciation	Net	\$
4. Non-Movable Equipment	*Historical Cost	Accum. Depreciation	Net	\$
5. Movable Equipment	*Historical Cost	Accum. Depreciation	Net	\$
6. Motor Vehicles	*Historical Cost	Accum. Depreciation	Net	\$
7. Minor Equipment-Not Depreciable				\$
C-8 Total Leasehold or Like Properties (C1 thru 7)				\$
D. Investment and Other Assets				
1. Deferred Deposits				\$
2. Escrow Deposits				\$
3. Organization Expense	*Historical Cost	Accum. Depreciation	Net	\$
4. Goodwill (Purchased Only)				\$
5. Investments Related to Resident Care (itemize)				\$
6. Loans to Owners or Related Parties (itemize)				\$
Name and Address	Amount	Loan Date		
7. Other Assets (itemize)				\$ 700,999
Intangible Assets	701,000			
Rounding	(1)			
See Schedule				
D-8. Total Investments and Other Assets (Lines D1 thru 7)				\$ 700,999
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)				\$ 6,649,812

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of								
Yale New Haven Care Continuum d/b/a Grimes	2027-C	9/30/2019	33 37								
Account			Amount								
Liabilities											
A. Current Liabilities											
1. Trade Accounts Payable			\$								
2. Notes Payable (<i>itemize</i>)			\$								
See Schedule											
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)			\$								
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left; padding: 2px;">Name of Lender</th> <th style="text-align: left; padding: 2px;">Purpose</th> <th style="text-align: left; padding: 2px;">Amount</th> <th style="text-align: left; padding: 2px;">Date Due</th> </tr> </thead> <tbody> <tr><td style="height: 150px;"></td><td></td><td></td><td></td></tr> </tbody> </table>				Name of Lender	Purpose	Amount	Date Due				
Name of Lender	Purpose	Amount	Date Due								
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)			\$ 800,249								
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)			\$								
6. Accrued Payroll Taxes Payable			\$ 56,981								
7. Medicare Final Settlement Payable			\$								
8. Medicare Current Financing Payable			\$								
9. Mortgage Payable (<i>Current Portion</i>)			\$								
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)			\$								
11. Accrued Income Taxes*			\$								
12. Other Current Liabilities (<i>itemize</i>)			\$ 1,203,665								
See Schedule			1,203,665								
A-13. Total Current Liabilities (Lines A1 thru 12)			\$ 2,060,895								

* 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 Yale New Haven Care Continuum d/b/a Grif	License No. 2027-C	Report for Year Ended 9/30/2019	Page 34	of 37
Account			Amount	
Total Brought Forward:			2,060,895	
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>)			\$	12,809,418
Name and Address of Lender	Amount	Loan Date		
YNHH/MCP/NMG/CPBS/ YNHHS	12,809,418			
4. Other Long-Term Liabilities (<i>itemize</i>)			\$	4,000,000
Long Term Liability due to YNH	4,000,000			
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	16,809,418
C. Total All Liabilities (Lines A-13 + B-5)			\$	18,870,313

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

Name of Facility	License No.	Report for Year Ended	Page	of
		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			\$	(8,967,035)
6. Gain or Loss for Period	10/1/2018	thru	9/30/2019	\$ (3,253,466)
7. Total Net Worth			\$	(12,220,501)
C. Total Reserves and Net Worth				\$ (12,220,501)
D. Total Liabilities, Reserves, and Net Worth				\$ 6,649,812

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of		
Yale New Haven Care Continuum d/b/a	2027-C	9/30/2019	36	37		
Account				Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2018				\$ (8,967,034)		
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 14,819,272		
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 18,072,738		
D. Net Income or Deficit				\$ (3,253,466)		
E. Balance				\$ (12,220,500)		
F. Additions						
1. Additional Capital Contributed (<i>itemize</i>)						
Expenses Per Page 27				\$ 18,382,121		
(Less) F/S vs C/R Depreciation				(309,383)		
Total Expenses per F/S				\$ 18,072,738		
Rounding				(1)		
2. Other (<i>itemize</i>)						
F-3. Total Additions				\$ (1)		
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				\$ (12,220,501)		

I. Preparer's/Reviewer's Certification

Name of Facility Yale New Haven Care Continuum d/b/a	License No. 2027-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
Debbie Bielefield		203-688-6140
Contact Email Address		
deborah.bielefield@ynhh.org		