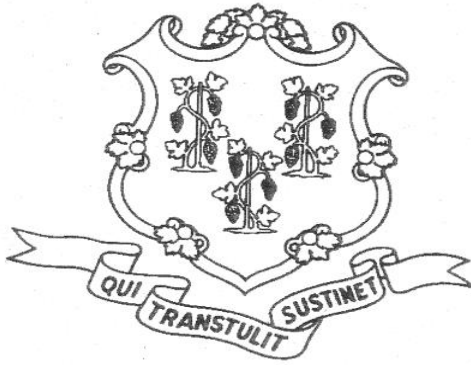


State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2016

Name of Facility (as licensed) Gladeview Health Care Center, LLC	
Address (No. & Street, City, State, Zip Code) 60 Boston Post Road, Old Saybrook, CT 06477	
Type of Facility <input type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS) <input type="checkbox"/> (Specify)	
Report for Year Beginning 10/1/2015	Report for Year Ending 9/30/2016

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

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General Information

Name of Facility (as licensed) Gladeview Health Care Center, LLC	License No. 2024C	Report for Year Ended 9/30/2016	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 Gladeview Health Care Center, LLC [facility name], for the cost report period beginning October 1, 2015 and ending September 30, 2016, 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) Paul Knutsen			Printed Name (Owner) Linda Silberstein		
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /	
Address of Notary Public					

(Notary Seal)

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 Gladeview Health Care Center, LLC		Period Covered:	From 10/1/2015	To 9/30/2016
Address of Facility 60 Boston Post Road, Old Saybrook, CT 06477				
Report Prepared By Gladeview Health Care Center		Phone Number 860-388-6696	Date 2/13/2017	
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 860-388-6696		Report for Year Ended 9/30/2016		Page 2	of 37
Name of Facility (as shown on license) Gladeview Health Care Center, LLC			Address (No. & Street, City, State, Zip) 60 Boston Post Road, Old Saybrook, CT 06477		
License Numbers:		CCNH 2024C	RHNS	(Specify)	Medicare Provider No. 07-5313
Type of Facility (Check appropriate box(es))					
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)		<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)		<input type="checkbox"/> (Specify)	
Type of Ownership (Check appropriate box)					
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust					
If this facility opened or closed during report year provide:			Date Opened	Date Closed	
Has there been any change in ownership or operation during this report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "Yes," explain fully.					
Administrator					
Name of Administrator Paul Knutsen			Nursing Home Administrator's License No.:	001500	
Other Operators/Owners who are assistant administrators (full or part time) of this facility.					
Name Linda Silberstein			License No.:	None	

General Information and Questionnaire
Corporate Owners

Name of Facility Gladeview Health Care Center, LLC	License No. 2024C	Report for Year Ended 9/30/2016	Page 3A	of 37
If this facility is owned or operated as a corporation, provide the following information:				
Legal Name of Corporation	Business Address	State(s) in Which Incorporated		
Gladeview Health Care Center	60 Boston Post Road Old Saybrook, CT 06475	CT		
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each	
Linda Silberstein	60 Boston Post Road Old Saybrook, CT 06475	President	100	
Names of Stockholders Owning at Least 10% of Shares				
Same as above				

**General Information and Questionnaire
Individual Proprietorship**

Name of Facility Gladeview Health Care Center, LLC	License No. 2024C	Report for Year Ended 9/30/2016	Page 3B	of 37
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility

N/A

General Information and Questionnaire
Related Parties*

Name of Facility Gladeview Health Care Center, LLC	License No. 2024C	Report for Year Ended 9/30/2016	Page 4	of 37
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? Yes No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Gladeview LLC	60 Boston Post Road Old Saybrook, CT 06475	<input type="radio"/>	<input checked="" type="radio"/>		Lease of real property	Pg 22, Line 9	1,560,000	1,560,000
Linda Silberstein	60 Boston Post Road Old Saybrook, CT 06475	<input type="radio"/>	<input checked="" type="radio"/>		Salaries and Benefits	Pg 10, line A3,Pge 15,1	132,642	132,642
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input type="radio"/>					
		<input type="radio"/>	<input 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 Gladeview Health Care Center, LLC	License No. 2024C	Report for Year Ended 9/30/2016	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

N/A

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

N/A

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

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

N/A

General Information and Questionnaire Leases (Excluding Real Property)

Operating Leases - Include all long-term leases for motor vehicles and equipment that have not been capitalized. Short-term leases or as needed rentals should not be included in these amounts.

Name of Facility			License No.	Report for Year Ended			Page	of
Gladeview Health Care Center, LLC			2024C	9/30/2016			6	37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed	
	Yes	No						
Connecticut Business Systems, 50 Rockwell Road, Newington, CT 06111	<input type="radio"/>	<input checked="" type="radio"/>	Copier	11/28/13	month to month	Various	2,479	
Wells Fargo Leasing, P.O. Box 6434, Carol Stream, IL 60197	<input type="radio"/>	<input type="radio"/>	Copier	02/01/13	48 Months	21,563	15,242	
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
	<input type="radio"/>	<input type="radio"/>						
Is a Mileage Log Book Maintained for All Leased Vehicles ?							<input type="radio"/> Yes	<input type="radio"/> No
Total ***							17,721	

* 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 Gladeview Health Care Center, LLC	License No. 2024C	Report for Year Ended 9/30/2016	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.

Independent Accounting Firm

Name of Accounting Firm 1 Simione Macca and Larrow 2 Craig J Lubiski and Company 3 4	Address (No. & Street, City, State, Zip Code) 4130 Whitney Ave, Hamden, CT 06518
--	---

Services Provided by This Firm (*describe fully*)

1 401k audit, tax return	\$ 8,975
2 Medicare Cost Report	\$ 4,575
3	\$
4	\$
Charge for Services Provided	
\$ 13,550	

Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No.
 Yes No Pg 15 Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 Shipman & Goodwin 2 Litler Mendelson PC 3 4 5	Telephone Number 860-251-1919 203-974-8700
---	--

Address (*No. & Street, City, State, Zip Code*)
 1 One Constitution Plaza, Hartford, CT 06103
 2 265 Church St, Suite 300, New Haven, CT 06510
 3
 4
 5

Services Provided by This Firm (*describe fully*)

1 Employee related issues	\$ 237
2 Employee related issues	\$ 4,069
3	\$
4	\$
5	\$
Charge for Services Provided	
\$ 4,306	

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

Schedule of Resident Statistics

Name of Facility Gladeview Health Care Center, LLC			License No. 2024C			Report for Year Ended 9/30/2016				Page 8	of 37	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	132	132			132	132			132	132		
B. On last day of THIS report period	132	132			132	132			132	132		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	119	119			119	119			128	128		
B. As of midnight of THIS report period	125	125			128	128			125	125		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,212	4,212			2,959	2,959			1,253	1,253		
B. Medicaid (Conn.)	31,010	31,010			23,336	23,336			7,674	7,674		
C. Medicaid (other states)												
D. Private Pay	4,440	4,440			3,230	3,230			1,210	1,210		
E. State SSI for RCH												
F. Other (Specify) Managed care	5,137	5,137			3,961	3,961			1,176	1,176		
G. Total Care Days During Period (3A thru F)	44,799	44,799			33,486	33,486			11,313	11,313		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	323	323			240	240			83	83		
B. Other Bed Reserve Days	4	4			4	4						
5. Total Resident Days (3G + 4A + 4B)	45,126	45,126			33,730	33,730			11,396	11,396		

Schedule of Resident Statistics (Cont'd)

Name of Facility Gladeview Health Care Center, LLC			License No. 2024C			Report for Year Ended 9/30/2016			Page 9		of 37		
4. Were there any changes in the certified bed capacity during the report year? <input type="radio"/> Yes <input checked="" type="radio"/> No If "YES", provide the following information:													
Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained			CCNH	RHNS	(Specify)	
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)				
5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.													
Change in Resident Days								CCNH	RHNS	(Specify)			
1st change													
2nd change													
3rd change													
4th change													
6. Number of Residents and Rates on September 30 of Cost Year													
Item	Medicare		Medicaid		Self-Pay			Other State Assisted					
	CCNH	RHNS	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR				
No. of Residents	10		88		27								
Per Diem Rate													
a. One bed rm.	var		246.00		381.00								
b. Two bed rms.	var		246.00		361.00								
c. Three or more bed rms.													
7. Total Number of Physical Therapy Treatments								TOTAL	CCNH	RHNS	(Specify)		
A. Medicare - Part B								1,509	1,509				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								282	282				
2. Restorative Treatments													
C. Other								9,129	9,129				
D. Total Physical Therapy Treatments								10,920	10,920				
8. Total Number of Speech Therapy Treatments													
A. Medicare - Part B								269	269				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								24	24				
2. Restorative Treatments													
C. Other								1,019	1,019				
D. Total Speech Therapy Treatments								1,312	1,312				
9. Total Number of Occupational Therapy Treatments													
A. Medicare - Part B								1,318	1,318				
B. Medicaid (Exclusive of Part B)													
1. Maintenance Treatments								185	185				
2. Restorative Treatments													
C. Other								9,003	9,003				
D. Total Occupational Therapy Treatments								10,506	10,506				

Report of Expenditures - Salaries & Wages

Name of Facility Gladeview Health Care Center, LLC	License No. 2024C	Report for Year Ended 9/30/2016	Page 10	of 37		
Are time records maintained by all individuals receiving compensation? <input checked="" type="radio"/> Yes <input type="radio"/> No						
	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	196,507	2,200				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	143,608	2,760				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	318,771	12,212				
5. Dietary Service						
a. Head Dietitian	56,854	1,662				
b. Food Service Supervisor						
c. Dietary Workers	446,969	29,718				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers						
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	73,718	2,400				
b. Other Maintenance Workers	28,608	1,597				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	277,444	4,648				
b. RN						
1. Direct Care	1,085,799	25,526				
2. Administrative**	329,580	6,938				
c. LPN						
1. Direct Care	492,452	17,731				
2. Administrative**						
d. Aides and Attendants	1,770,655	99,923				
e. Physical Therapists	345,314	6,983				
f. Speech Therapists	66,578	1,449				
g. Occupational Therapists	187,022	4,498				
h. Recreation Workers	145,802	7,998				
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	181,716	5,734				
n. Marketing						
o. Other (Specify) See Attached Schedule						
<i>A-13. Total Salary Expenditures</i>	6,147,397	233,977				

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

Name of Facility				License No.	Report for Year Ended			Page	of	
Gladeview Health Care Center, LLC				2024C	9/30/2016			11	37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										

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

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

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

Name of Facility (as licensed)				License No.	Report for Year Ended				Page	of
Gladeview Health Care Center, LLC				2024C	9/30/2016				12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Paul Knutsen	196,507			Health & Life insurance. Payroll taxes	Day to day operations of the nursing home	2,200	A2			
Section IV - Assistant Administrators										
Linda Silberstein	132,642			Health & Life insurance. Payroll taxes	Day to day operations of the nursing home	2,180	A3			
Matthew McCormick	10,966				Day to day operations of the nursing home	580	A3			

*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		
Gladeview Health Care Center, LLC	2024C	9/30/2016	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	5,016	55				
3. Pharmacist						
4. Podiatrist	176	3				
5. Physical Therapy						
a. Resident Care						
b. Other						
6. Social Worker	3,000	24				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	37,700	845				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	30,213	81				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	2,880	25				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	66,974	1,634				
2. Administrative***						
c. Aides	189,161	6,781				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	335,120	9,448				

* 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 Gladeview Health Care Center, LLC		License No. 2024C		Report for Year Ended 9/30/2016	Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
William H. Johnson MSW, Inc. PO Box 1354, Belchertown, MA 01007	Social Worker	<input type="radio"/>	<input checked="" type="radio"/>			
Prakash Huded MS, 28 Marlboro, Rd., Portland CT	Medical Director, Physician Services	<input type="radio"/>	<input checked="" type="radio"/>			
Med Options, PO Box 5023, New Britain, CT 06050	Physician Services	<input type="radio"/>	<input checked="" type="radio"/>			
SDX Swallowing Diagnostics, PO Box 484, Avon, CT 06001	Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>			
HealthDrive Dental Group, One Prestige Dr., Suite 107, Meriden, CT 06450	Dental Services	<input type="radio"/>	<input checked="" type="radio"/>			
The Nurse Network, PO Box 982, Southington, CT 06489	Nursing Pool	<input type="radio"/>	<input checked="" type="radio"/>			
Dr. Mukerjee, 71 Quail Run, Madison, CT 06443	Cardiac Services	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input type="radio"/>			
		<input type="radio"/>	<input 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
Gladeview Health Care Center, LLC	2024C	9/30/2016		15	37
Item	Total	CCNH	RHNS	(Specify)	
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$ 217,107	217,107			
2. Disability Insurance	\$				
3. Unemployment Insurance	\$ 137,606	137,606			
4. Social Security (F.I.C.A.)	\$ 439,707	439,707			
5. Health Insurance	\$ 420,599	420,599			
6. Life Insurance (employees only) (not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$ 22,055	22,055			
8. Uniform Allowance	\$				
9. Other (<i>Specify</i>) See Attached Schedule	\$				
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$ 110,000	110,000			
d. Accounting and Auditing	\$ 13,550	13,550			
e. Legal (<i>Services should be fully described on Page 7</i>)	\$ 4,306	4,306			
f. Insurance on Lives of Owners and Operators (<i>Specify</i>)*	\$				
g. Office Supplies	\$ 68,722	68,722			
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$ 18,845	18,845			
2. Cellular Phones	\$ 10,733	10,733			
i. Appraisal (<i>Specify purpose and attach copy</i>)*	\$				
j. Corporation Business Taxes (<i>franchise tax</i>)	\$ 360	360			
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>) See Attached Schedule	\$				
3. Resident Day User Fee	\$ 819,507	819,507			
Subtotal	\$ 2,283,097	2,283,097			

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

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended	Page	of	
Gladeview Health Care Center, LLC	2024C	9/30/2016	16	37	
Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,283,097	2,283,097		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$	15,882	15,882		
4. Employee Travel	\$	209	209		
5. Education Expenses Related to Seminars and Conventions	\$	7,304	7,304		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	2,144	2,144		
7. Other (<i>Specify</i>)	\$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$				
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$	1,597	1,597		
3. Advertising Other (<i>Specify</i>)***	\$	19,028	19,028		
See Attached Schedule					
4. Fund-Raising***	\$				
5. Medical Records	\$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	\$				
7. Postage	\$	6,354	6,354		
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>)	\$	10,450	10,450		
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	1,564	1,564		
9. Subscriptions	\$				
10. Contributions***	\$	812	812		
See Attached Schedule					
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	182,819	182,819		
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>)	\$	33,406	33,406		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$	2,564,666	2,564,666		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional	\$ 19,028		
Total Other Advertising	\$ 19,028	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
CT Association of Health Care Facilities	\$ 8,984		
CT River Area Health District	\$ 70		
ALTCFM	\$ 120		
CACHF	\$ 315		
CLIA Lab	\$ 150		
State of CT Boilers	\$ 80		
DEA	\$ 731		
Total Dues	\$ 10,450	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Exchange Club	\$ 812		
Total Contributions	\$ 812	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Back ground checks	\$ 2,462		
Bank Charges	\$ 8,359		
Employee physicals	\$ 15,509		
Penalties	\$ 1,100		
Prior year petty cash	\$ 5,976		
Total Other Administrative and General	\$ 33,406	\$ -	\$ -

Schedule C-1 - Management Services*

Name of Facility Gladeview Health Care Center, LLC	License No. 2024C	Report for Year Ended 9/30/2016	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 Gladeview Health Care Center, LLC		License No. 2024C	Report for Year Ended 9/30/2016	Page 18	of 37
Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1.	Raw Food	\$ 282,327	282,327		
2.	Non-Food Supplies	\$ 116,757	116,757		
3.	Other (Specify) _____ Supplements	\$ 172	172		
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$			
c. Management Services**		\$			
d. Other (Specify) _____		\$			
2E. Total Dietary Expenditures (2a + b + c + d)		\$ 399,256	399,256		
2F. Dietary Questionnaire		Total	CCNH	RHNS	(Specify)
G. Resident Meals: Total no. of meals served per day:*		396	396		
H. Is cost of employee meals included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No					
I. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
J. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
K. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
L. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
M. Where is the revenue received reported in the Cost Report? (Page/Line Item)					
N. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2E? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify cost.					
O. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, specify amt.					
P. Where is the revenue received reported in the Cost Report? (Page/Line Item)					

* Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.
 ** Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

Name of Facility Gladeview Health Care Center, LLC		License No. 2024C	Report for Year Ended 9/30/2016	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 (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$	87,096	87,096	
c.	Management Services**	\$	49,929	49,929	
d.	Other (Specify)	\$			
3E. Total Laundry Expenditures (3a + b + c + d)		\$	137,025	137,025	
3F. Laundry Questionnaire					
G.	Is cost of employee laundry included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
H.	Did you receive revenue from employees?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
I.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			
J.	Is Cost of laundry provided to persons other than employees or residents included in 3E?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify cost.	
K.	Did you receive revenue from these people?	<input type="radio"/> Yes	<input checked="" type="radio"/> No	If yes, specify amt.	
L.	Where is the revenue received reported in the Cost Report?	(Page/Line Item)			

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.

All allocations should add to total recorded in 3E.

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

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

**C. Expenditures Other Than Salaries (cont'd) - Housekeeping and Resident Care
 Basis for Allocation of Costs (See Note on Page 5)**

Name of Facility		License No.	Report for Year Ended		Page	of
Gladeview Health Care Center, LLC		2024C	9/30/2016		20	37
Item			Total	CCNH	RHNS	(Specify)
4.	Housekeeping	Sq. Ft. Serviced by Personnel				
a.	In-House Care					
	1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)	Amt. \$	18,756	18,756		
b.	Purchased Services (<i>by contract other than through Management Services</i>) (<i>Complete Schedule C-2 att. Page 21</i>)	Sq. Ft. Serviced by Personnel				
		Amt. \$	330,844	330,844		
c.	Management Services*	\$				
d.	Other (<i>Specify</i>)	\$				
4E.	Total Housekeeping Expenditures (4a + b + c + d)	\$	349,600	349,600		
5.	Resident Care (Supplies)**					
a.	Prescription Drugs***					
	1. Own Pharmacy	\$				
	2. Purchased from Partners Pharmacy	\$	339,577	339,577		
b.	Medicine Cabinet Drugs	\$				
c.	Medical and Therapeutic Supplies	\$	234,312	234,312		
d.	Ambulance/Limousine***	\$	13,560	13,560		
e.	Oxygen					
	1. For Emergency Use	\$				
	2. Other***	\$	39,223	39,223		
f.	X-rays and Related Radiological Procedures***	\$	10,120	10,120		
g.	Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h.	Laboratory***	\$	51,869	51,869		
i.	Recreation	\$	18,381	18,381		
j.	Other (Specify)**** See Attached Schedule	\$	80,786	80,786		
5K.	Total Resident Care Expenditures (5a - 5j)	\$	787,828	787,828		

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

** Do not include any fees to professional staff, these should be reported on Page 13, or, if paid on salary basis, on Page 10.

*** Facility should self-disallow the expense on Page 29 of the Cost Report.

**** ICFMR's should provide a detailed schedule of all Day Program Costs.

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
Cable TV	\$ 22,312		
Therapy Equipment rental	\$ 22,305		
Speech Therapy supplies	\$ 1,585		
Oxygen rental	\$ 13,213		
OT - Supplies	\$ 833		
Medical Equipment	\$ 20,538		
Total Other Resident Care	\$ 80,786	\$ -	\$ -

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

Name of Facility Gladeview Health Care Center, LLC			License No. 2024C		Report for Year Ended 9/30/2016			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
Partners Pharmacy	PO Box 9689, Uniondale, NY 11555	<input type="radio"/>	<input checked="" type="radio"/>		Pharmacy supplies and service	320,369			20	5a2
PointClickCare	Suite 4, Mississauga, ON L5N 8E9	<input type="radio"/>	<input checked="" type="radio"/>		Computer services	33,904			16	M11
Peoples Payroll	850 Main Street, Bridgeport, CT 06604	<input type="radio"/>	<input checked="" type="radio"/>		Payroll processing	35,831			16	M11
CT Waste Processing	PO Box 99, Plainville, CT 06062	<input type="radio"/>	<input checked="" type="radio"/>		Rubbish removal	26,375			22	6f
Sullivan Lawn Service	8 Piney Branch Road, Ivorytown, CT	<input type="radio"/>	<input checked="" type="radio"/>		Groundskeeping	48,794			22	6f
Controlled Air	21 Thompson Rd, Branford, CT 06405	<input type="radio"/>	<input checked="" type="radio"/>		Maintenance	14,008			22	6a
Heritage Health Care Services	1009 Reservoir Ave., Cranston, RI 02910	<input type="radio"/>	<input checked="" type="radio"/>		Housekeeping and Laundry	500,025			19,20	3b,4b
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input type="radio"/>							
		<input type="radio"/>	<input 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
Gladeview Health Care Center, LLC	2024C	9/30/2016			22	37
Item	Total	CCNH	RHNS	(Specify)		
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$ 91,912	91,912				
b. Heat	\$ 29,677	29,677				
c. Light & Power	\$ 126,968	126,968				
d. Water	\$ 42,298	42,298				
e. Equipment Lease (<i>Provide detail on page 6</i>)	\$ 17,721	17,721				
f. Other (<i>itemize</i>)	\$ 94,257	94,257				
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$ 402,833	402,833				
7. Depreciation (<i>complete schedule page 23*</i>)						
a. Land Improvements	\$					
b. Building & Building Improvements	\$					
c. Non-Movable Equipment	\$ 13,599	13,599				
d. Movable Equipment	\$ 41,970	41,970				
*7e. Total Depreciation Costs (7a + b + c + d)	\$ 55,569	55,569				
8. Amortization (<i>Complete att. Schedule Page 24*</i>)						
a. Organization Expense	\$					
b. Mortgage Expense	\$ 10,202	10,202				
c. Leasehold Improvements	\$ 25,748	25,748				
d. Other (<i>Specify</i>)	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$ 35,950	35,950				
9. Rental payments on leased real property less real estate taxes included in item 10b	\$ 1,584,209	1,584,209				
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$ 678	678				
11. Total Property Expenses (7e + 8e + 9 + 10)	\$ 1,676,406	1,676,406				

* Amounts entered in these items must agree with detail on Schedule for Depreciation and Amortization Page 23 and Page 24.

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Maintenance Supplies	\$ 25,909		
Groundskeeping	\$ 41,973		
Rubish Removal	\$ 26,375		
Total Other Repairs and Maintenance	\$ 94,257	\$ -	\$ -

Gladeview Health Care Center, LLC
9/30/2016

Schedule of Land Improvements Acquired during this report period

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

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

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

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

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

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
8/30/2016	Laptop and networking equipment	\$ 3,947	3 Yrs	\$ 658
11/10/2015	Electric beds	\$ 15,706	5 Yrs	\$ 1,571
6/29/2016	Convection oven	\$ 10,549	5 Yrs	\$ 1,054
Total additions for Movable Equipment		\$ 30,202		\$ 3,283 *
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:				
4/1/2016	Doors	\$ 5,474	10 yr	\$ 274
8/16/2016	Doors	\$ 2,291	10 yr	\$ 115
5/31/2016	Paving	\$ 7,726	10 yr	\$ 386
4/8/2016	Flooring	\$ 1,928	10 yr	\$ 96
9/28/2016	Outdoor patio	\$ 20,000	10 yr	\$ -
Total additions for Leasehold Improvement		\$ 37,419		\$ 871 *
Deletions:				
Total deletions for Leasehold Improvement		\$ -		\$ - **

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility

Amortization Schedule*

Name of Facility Gladeview Health Care Center, LLC			License No. 2024C		Report for Year Ended 9/30/2016			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. Mortgage cost	12	2011	10	269,173	238,257	SL		10,202	
2.									
3.									
B-4. Subtotal									10,202
C. Leasehold Improvements and Other									
1. Acquired prior to this report period	9	2015		934,333	781,391	SL		24,877	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)				37,419				871	
C-4. Subtotal									25,748
D. Total Amortization									35,950

* 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 Gladeview Health Care Center, LLC	License No. 2024C	Report for Year Ended 9/30/2016	Page 25	of 37
11. Property Questionnaire				
Part A				
Is the property either owned by the Facility or leased from a Related Party?*		<input checked="" type="radio"/> Yes	<input type="radio"/> No	If "Yes," complete Part B. If "No," complete Part C.
*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.				
Description	Total			
1. Date Land Purchased	01/01/85			
2. Date Structure Completed				
3. If NOT Original Owner, Date of Purchase				
4. Date of Initial Licensure	11/20/87			
5. Total Licensed Bed Capacity	132			
6. Square Footage				
7. Acquisition Cost				
a. Land	450,000			
b. Building	7,222,138			
Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	12/27/14			
c. Interest Rate for the Cost Year	372.00%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	9,670,400			
f. Principal balance outstanding as of 9/30/16				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				
Part C - Arms-Length Leases for Real Property Improvements Only				
Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility		License No.	Report for Year Ended		Page	of
Gladeview Health Care Center, LLC		2024C	9/30/2016		26	37
Item			Total	CCNH	RHNS	(Specify)
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
2. Second Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
3. Third Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
4. Fourth Mortgage			\$			
Name of Lender		Rate				
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount			\$			
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)			\$			

(Carry Subtotals forward to next page)

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

Name of Facility		License No.		Report for Year Ended		Page	of
Gladeview Health Care Center, LLC		2024C		9/30/2016		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)				\$	5,941	5,941	
13. Total All Interest Expense (12B7 + 12C3 + 12D)				\$	5,941	5,941	
14. Insurance							
a. Insurance on Property (buildings only)				\$	29,639	29,639	
b. Insurance on Automobiles				\$			
c. Insurance other than Property (as specified above)							
1. Umbrella (Blanket Coverage)				\$			
2. Fire and Extended Coverage				\$			
3. Other (Specify)				\$			
14d. Total Insurance Expenditures (14a + b + c)				\$	29,639	29,639	
15. Total All Expenditures (A-13 thru C-14)				\$	12,835,711	12,835,711	

D. Adjustments to Statement of Expenditures

Name of Facility				License No.	Report for Year Ended	Page	of
Gladeview Health Care Center, LLC				2024C	9/30/2016	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	\$ 187,022	187,022		
4.			Other - See attached Schedule	\$			
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians **	\$ 30,213	30,213		
6.			Occupational Therapy	\$			
7.			Other - See attached Schedule	\$			
Pages 15 & 16 - Administrative and General							
8.	15	1a5	Discriminatory Benefits	\$ 6,526	6,526		
9.	15	1c	Bad Debts	\$ 110,000	110,000		
10.			Accounting & Legal	\$			
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$ 9,653	9,653		
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.	16	L3	Gifts, flowers and coffee shops	\$ 15,882	15,882		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.	16	L6	Automobile Expense (e.g. personal use)	\$ 2,144	2,144		
18.	16	M2&	Unallowable Advertising *	\$ 20,625	20,625		
19.			Income Tax / Corporate Business Tax	\$			
20.	16	M10	Fund Raising / Contributions	\$ 812	812		
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$			
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)				\$ 382,877	382,877		

* All except "Help Wanted".

(Carry Subtotal forward to next page)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

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

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

Name of Facility			License No.	Report for Year Ended	Page	of	
Gladeview Health Care Center, LLC			2024C	9/30/2016	29	37	
Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Subtotals Brought Forward				\$ 382,877	382,877		
Page 20 - Resident Care Supplies***							
27.	20	5a2	Prescription Drugs	\$ 339,577	339,577		
28.	20	5d	Ambulance/Limousine	\$ 13,560	13,560		
29.	20	5f	X-rays, etc	\$ 10,120	10,120		
30.	20	5h	Laboratory	\$ 51,869	51,869		
31.	20	5c	Medical Supplies	\$ 11,716	11,716		
32.	20	5e2	Oxygen (non emergency)	\$ 39,223	39,223		
33.	20	5j	Occupational Therapy	\$ 2,418	2,418		
34.			Other - See Attached Schedule	\$			
Page 22 - Maintenance and Property							
35.			Excess Movable Equipment Depreciation See Attached Schedule	\$			
36.			Depreciation on Unallowable Motor Vehicles	\$			
37.	22	10c	Unallowable Property and Real Estate Taxes	\$ 199	199		
38.			Rental of Building Space or Rooms	\$			
39.			Other - See Attached Schedule	\$			
Page 27 - Insurance							
40.			Mortgage Insurance	\$			
41.	27	14b	Property Insurance	\$			
Other - Miscellaneous							
42.			Research or Experimental Activities	\$			
43.			Radio and Television Revenue	\$			
44.			Vending Machine Revenue	\$			
45.			Purchase Discounts and Allowances	\$			
46.			Duplications of functions or services	\$			
47.			Expenditures made for the protection, enhancement or promotion of the providers interest	\$			
48.			Interest Income on Accounts Rec	\$			
49.			Other (include personnel and other costs unrelated to resident care) - See Attached Schedule	\$ 39,164	39,164		
Not For Profit Providers Only							
50.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	\$			
51.	Total Amount of Decrease (Items 1 - 50)			\$ 890,723	890,723		

*** 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.

Gladeview Health Care Center, LLC
9/30/2016

Schedule of Other Ancillary Costs

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

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
Total Excess Movable Equipment Depreciation			\$ -	\$ -	\$ -

Schedule of Other Property Adjustments

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Cable TV	\$ 22,312		
30	IV8	Misc income	\$ 16,852		
Total Other Adjustments			\$ 39,164	\$ -	\$ -

Schedule of Unallowable Building Interest

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

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended			Page	of
Gladeview Health Care Center, LLC	2024C	9/30/2016			30	37
Item	Total	CCNH	RHNS	(Specify)		
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 11,458,556	11,458,556				
b. Medicaid Room and Board Contractual Allowance **	\$ (3,970,446)	(3,970,446)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 1,614,125	1,614,125				
b. Medicare Room and Board Contractual Allowance **	\$ 306,082	306,082				
4. a. Private-Pay Residents and Other	\$ 3,417,157	3,417,157				
b. Private-Pay Room and Board Contractual Allowance **	\$					
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	\$ 15,448	15,448				
b. Medical Supplies - Medicare Contractual Allowance **	\$					
c. Medical Supplies - Non-Medicare	\$					
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$					
3. a. Physical Therapy - Medicare	\$ 474,142	474,142				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (425,399)	(425,399)				
c. Physical Therapy - Non-Medicare	\$ 265,440	265,440				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (265,440)	(265,440)				
4. a. Speech Therapy - Medicare	\$ 129,825	129,825				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (110,853)	(110,853)				
c. Speech Therapy - Non-Medicare	\$ 66,103	66,103				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (66,103)	(66,103)				
5. a. Occupational Therapy - Medicare	\$ 486,063	486,063				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (442,177)	(442,177)				
c. Occupational Therapy - Non-Medicare	\$ 249,728	249,728				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (249,728)	(249,728)				
6. a. Other (<i>Specify</i>) - Medicare	\$					
b. Other (<i>Specify</i>) - Non-Medicare	\$					
III. Total Resident Revenue (Section I. thru Section II.)	\$ 12,952,523	12,952,523				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 16,853	16,853				
V. Total Other Revenue (1 thru 8)	\$ 16,853	16,853				
VI. Total All Revenue (III +V)	\$ 12,969,376	12,969,376				

* Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

** Facility should report all contractual allowances and/or payer discounts.

Schedule of Other Resident Revenue - Medicare

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue - Medicare		\$ -	\$ -	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
Total Other Resident Revenue		\$ -	\$ -	\$ -

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30IV8	Fee Income	\$ 1		
30IV8	Miscellaneous income	\$ 16,852		
Total Other Revenue		\$ 16,853	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center, LLC	2024C	9/30/2016	31	37
Account			Amount	
Assets				
A. Current Assets				
1. Cash (<i>on hand and in banks</i>)			\$	319,098
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$	1,645,912
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$	(137,978)
4. Inventories			\$	24,951
5. Prepaid Expenses			\$	122,827
a. Insurance	83,707			
b. Other	6,056			
c. Deposits	33,064			
d.				
6. Interest Receivable			\$	
7. Medicare Final Settlement Receivable			\$	
8. Other Current Assets (<i>itemize</i>)			\$	

A-9. Total Current Assets (Lines A1 thru 8)			\$	1,974,810
B. Fixed Assets				
1. Land			\$	
2. Land Improvements	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
3. Buildings	*Historical Cost _____		\$	
	Accum. Depreciation _____	Net		
4. Leasehold Improvements	*Historical Cost <u>971,752</u>		\$	164,613
	Accum. Depreciation <u>807,139</u>	Net		
5. Non-Movable Equipment	*Historical Cost <u>259,602</u>		\$	96,169
	Accum. Depreciation <u>163,433</u>	Net		
6. Movable Equipment	*Historical Cost <u>653,049</u>		\$	203,784
	Accum. Depreciation <u>449,265</u>	Net		
7. Motor Vehicles	*Historical Cost <u>4,900</u>		\$	
	Accum. Depreciation <u>4,900</u>	Net		
8. Minor Equipment-Not Depreciable			\$	
9. Other Fixed Assets (<i>itemize</i>)			\$	

B-10. Total Fixed Assets (Lines B1 thru 9)			\$	464,566

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center, LLC	2024C	9/30/2016	32	37
Account			Amount	
Total Brought Forward:			\$	2,439,376
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>)			\$	57,675
	Deffered financing fee	57,675		

D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$	57,675
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$	2,497,051

* 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 Gladeview Health Care Center, LLC		License No. 2024C	Report for Year Ended 9/30/2016	Page 33	of 37
Account				Amount	
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable				\$	613,592
2. Notes Payable (<i>itemize</i>)				\$	

3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$	
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$	356,324
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$	
6. Accrued Payroll Taxes Payable				\$	5,953
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>)				\$	242,071
Accounting		15,100	Provider fee	201,139	
Property taxes		7,749	Other	82	
Refunds		16,795			
Pension		1,206			
A-13. Total Current Liabilities (Lines A1 thru 12)				\$	1,217,940

* 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 Gladeview Health Care Center, LLC	License No. 2024C	Report for Year Ended 9/30/2016	Page 34	of 37
Account				Amount
Total Brought Forward:				1,217,940
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>)				\$
B-5. Total Long-Term Liabilities (Lines B1 thru 4)				\$
C. Total All Liabilities (Lines A-13 + B-5)				\$ 1,217,940

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

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center, LLC	2024C	9/30/2016	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			\$	1,000
3. Paid-in Surplus			\$	
4. Treasury Stock			\$	
5. Cumulated Earnings			\$	1,144,446
6. Gain or Loss for Period	10/1/2015	thru 9/30/2016	\$	133,665
7. Total Net Worth			\$	1,279,111
C. Total Reserves and Net Worth			\$	1,279,111
D. Total Liabilities, Reserves, and Net Worth			\$	2,497,051

H. Changes in Total Net Worth

Name of Facility Gladeview Health Care Center, LLC	License No. 2024C	Report for Year Ended 9/30/2016	Page 36	of 37
Account			Amount	
A. Balance at End of Prior Period as shown on Report of 09/30/2015			\$	1,145,446
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)			\$	12,969,376
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)			\$	12,835,711
D. Net Income or Deficit			\$	133,665
E. Balance			\$	1,279,111
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions			\$	
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)			\$	
Name and Address (<i>No., City, State, Zip</i>)		Title	Amount	
2. Other Withdrawings (<i>Specify</i>)			\$	
Purpose		Amount		
3. Total Deductions			\$	
H. Balance at End of Period			\$	1,279,111
				09/30/16

I. Preparer's/Reviewer's Certification

Name of Facility Gladeview Health Care Center, LLC	License No. 2024C	Report for Year Ended 9/30/2016	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		
Preparer/Reviewer Certification				
<p>I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. I have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.</p>				
Signature of Preparer	Title	Date Signed		
Printed Name of Preparer				
Gladeview Health Care Center				
Address Address			Phone Number	
60 Boston Post Road, Old Saybrook, CT 06475			860-388-6696	

Error Check

Level	Item	Reported as		
CCH	Page 29 - Total Adjustments to Expense	#REF!	is inconsistent with balance of	#REF!
RHNS	Page 29 - Total Adjustments to Expense	#REF!	is inconsistent with balance of	#REF!
Other	Page 29 - Total Adjustments to Expense	#REF!	is inconsistent with balance of	#REF!