State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2017

Name of Facility (as licensed)							
4 Hazel Avenue Operations LLC, d/b/a/ Glendale center							
Address (No. & Street, City, State, Zip Code)							
4 Hazel Ave., Naugatuck, CT 06770							
Type of Facility							
☑ Chronic and Convalescent Nursing Home only (CCNH)		Rest Home with Nursing Supervision only (RHNS)	□ (Specify)				
Report for Year Beginning		Report for Year Ending					
10/1/2016		9/30/2017					

License Numbers:	CCNH 2371	RHNS	(Specify)	Medicare Provider 07-5240
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Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	000010975		

For Department Use Only

Sequence Number Assigned	Signed and Notarized	Date Received	Sequence Number Assigned	Signed and Notarized	Date Received
			<u> </u>		

Table of Contents

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

State of Connecticut Annual Report of Long-Term Care Facility CSP-1 Rev.9/2002

Ge	eneral Info	rmation			
Name of Facility (as licensed)	License No.	Report for Year End			
Hazel Avenue Operations LLC, d/b/a/ Glendale cer	nt 237	9/30/2017	1 37		
Administr MISREPRESENTATION OR FALSIFIC COST REPORT MAY BE PUNISHABLI FEDERAL LAW.	ATION OF AI				
I HEREBY CERTIFY that I have read the Cost Report and supporting schedules prep center [facility name], for the cost report p 2017, and that to the best of my knowledg prepared from the books and records of th	pared for 4 Ha period beginnir ge and belief, it	zel Avenue Operations LLC, d/b/a/ C ng October 1, 2016 and ending Septe is a true, correct, and complete state	ilendale nber 30, ment		
I hereby certify that I have directed the prepar Schedule of Resident Statistics, Statements of Balance Sheet of this Facility in accordance w year ended as specified above.	f Reported Expe	nditures, Statements of Revenues and th	e related		
I have read this Report and hereby certify my knowledge under the penalty of perjury presented in this Report as a basis for secu residents were incurred to provide resident recorded have been retained as required by request.	y. I also certif uring reimburse t care in this Fa	y that all salary and non-salary experement for Title XIX and/or other Stat acility. All supporting records for the	ses e assisted e expenses		
Signed (Administrator)	Date	Signed (Owner)	Date 11/6 /2017		
rinted Name (Administrator) Ieather Rodriguez		Printed Name (Owner) Keith Davis, V.P. of Reimb., Genesis Healthcare			
before me: Gretchen A. Jeannette PA	Date 11-6-17 <	Signed (Notary Public) Artelen A. Jeannette	Comm. Expires		
Address of Notary Public $101 E. State$	la Cha	+ /			

(Notary Seal)

COMMONWEALTH OF PENNSYLVANIA NOTARIAL SEAL Gretchen A. Jeannette, Notary Public Kennett Square Boro, Chester County My Commission Expires Sept. 23, 2021 MEMBER, PENNSYLVANIAASSOCIATION OF NOTARIES

State of Connecticut Department of Social Services 25 Sigourney Street, Hartford, Connecticut 06106

Data Required for Real Wage Adjus	Page	of		
			1Å	37
Name of Facility	ered:	From	То	
4 Hazel Avenue Operations LLC, d/b/a/ Glendale center			10/1/2016	9/30/2017
Address of Facility				
4 Hazel Ave., Naugatuck, CT 06770	T		T	
Report Prepared By	Phone Num		Date	
Thomas Farnan	978-247-50	29	12/20/2017	
Item	Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	\$ 283,895	283,895		
2. Laundry wages paid	\$			
3. Housekeeping wages paid	\$			
4. Nursing wages paid	\$ 3,824,813	3,824,813		
5. All other wages paid	\$ 565,634	565,634		
6. Total Wages Paid	\$ 4,674,342	4,674,342		
7. Total salaries paid	\$ 265,057	265,057		
8. <i>Total Wages and Salaries Paid</i> (As per page 10 of Report)	\$ 4,939,399	4,939,399		

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

			ne No. of Fac -723-1456	cility	Report for Yea 9/30/2017	r Ended	Page 2		of 37
Name of Facility (as shown on license)	203		- E (Street, City, Stat	a Zin)	2		51	
4 Hazel Avenue Operations LLC, d/b/a/ Gle	ndale center				ugatuck, CT 06				
	CCNH		RHNS	., 1 (0	(Specify)	110	Medicare F	rovic	ler No.
License Numbers:	2371				(Speeng)		07-5240	10,10	
Type of Facility (Check appropriate box(es)									
☑ Chronic and Convalescent Nursing Home only (CCNH)			t Home with ervision only			Specify))		
Type of Ownership (Check appropriate box)	1								
O Proprietorship O LLC O H	Partnership	0	Profit Corp.	0	Non-Profit Corp	o. O	Government	0	Trust
If this facility opened or closed during repor	t year provid	e:		Date	e Opened I	Date Clo	sed		
Has there been any change in ownership									
or operation during this report year?		0	Yes	\odot	No I	f "Yes,"	explain full	у.	
Administrator					I				
Name of Administrator					Nursing Hor				
Heather Rodriguez					Administrato		1691		
Other Operators/Owners who are assistant a	dministrators	(ful	l or part time	ofth	License N	0.:			
Name	ummistrators	(Iui) 01 U	License N	0.			
					License iv	0			

General Information and Questionnaire Partners/Members

Name of Facility 4 Hazel Avenue Operations LL		License No. 2371	Report for Y 9/30/2017	ear Ended	Page 3	of 37
4 Hazel Avenue Operations LLC, d/b/a/ Glendale cent Legal Name of Partnership/LLC		Business A		State(s) and		(s) in
Name of Partners/Members	Business Ac	ldress	,	Title	% Ov	vned

General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year I	Ended	Page of
4 Hazel Avenue Operations LLC, d/b/a/ Glen	2371		3A 37	
If this facility is owned or operated as a corpo	ration, provide the	following information	ation:	
Legal Name of Corporation	Busines	ss Address	State(s) in Whi	ch Incorporated
4 Hazel Avenue Operations	101 East State Str	eet, Kennett	PA	
LLC, d/b/a/ Glendale center	Square, PA 1934	8		
Name of Directors, Officers	Busines	ss Address	Title	No. Shares Held by Each
See Attached				
Names of Stockholders Owning at Least 10% of Shares				
See Attached				

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						
4 Hazel Avenue Operations LLC, d/b/a/ Glendale of		9/30/2017	3B 37						
If this facility is owned or operated as an individual proprietorship, provide the following information:									
Ow	ner(s) of Facility								

General Information and Questionnaire Related Parties*

Name of Facility		License			Report for Year Ended		Page	of
4 Hazel Avenue Operati	ons LLC, d/b/a/ Glendale cente		2371		9/30/2017		4	37
Are ony individuals read	eiving compensation from the fa	aility re	latad th	rough			NT / A 1	1 1
	0 1			U		If "Yes," provide th		
marriage, ability to cont	rol, ownership, family or busine	ess asso	ciation?	0	Yes O No	complete the inform	nation on Pa	ge 11 of the report.
Are any individuals or c	ompanies which provide goods	or servi	ices,					
including the rental of p	roperty or the loaning of funds t	to this fa	acility,					
related through family a	ssociation, common ownership,	control	l, or bus	iness	⊙ Yes O No			
association to any of the	owners, operators, or officials	of this f	acility?			If "Yes," provide th	e following	information:
	*							
		Als	so Provi	des		Indicate Where		
		Good	ls/Servi	ces to		Costs are Included		
Name of Related	Business		Related 1		Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes	No	%**	Provided	Page # / Line #	Reported	Related Party
	101 East State Street, Kennett	•						
Genesis Health Ventures	Square, PA 19348	U	0		Home Office	Pg 16/m12	523,027	523,027
Genesis ElderCare	101 East State Street, Kennett	\odot	0					
Rehabilitation Services	Square, PA 19348	•	•	63%	PT/OT/ST- Direct and Indirect Cost	Pg 13/B5, 9,10	1,253,312	1,253,312
Genesis ElderCare Staffing Services	101 East State Street, Kennett Square, PA 19348	0	\odot		Staffing Pool	Pg 10/A12	9,299	9.299
	101 East State Street, Kennett				Statting Fool	rg 10/A12	9,299	9,299
Services	Square, PA 19348	\odot	0	83%	Medical Director /NP	Pg 13/B8, Pg 10/A12	42,283	42,283
	101 East State Street, Kennett	\odot	0			0 , 0	,	
Career Staffing	Square, PA 19348	0	0	60%	Outside Agency	Pg 13/B11 a,b,c		
Respiratory Health Services	515 Fairmount Ave, 6th Floor, Suite	\odot	0	4.4.0/	Descriptory Thereasy	$D_{2} = 12/D_{12} = D_{2} = 20/C5E^{2}$	72,729	72 720
Respiratory nearth services	101 East State Street, Kennett			44%	Respiratory Therapy	Pg 13/B12, Pg 20/C5E	12,129	72,729
Liberty Health (Insurance)	Square, PA 19348	\odot	0		Insurance	Pg 27/14	198,001	198,001
Genesis Healthcare Corp.	101 East State Street, Kennett Square, PA 19348	۲	0		Capital Interest	Page 17, page 26-12A	40,999	40,999
Control realized corp.		0	0			1 ugo 17, pugo 20-12/1	+0,777	

* 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	License No.		Report for Year Ended	Page	of						
4 Hazel Avenue Operations LLC, d/b/a/ Glendal	2371		9/30/2017	5	37						
If the facility is licensed as CDH and/or RCH or	provides AII	OS or TBI	services with special Medicaid 1	rates, costs	3						
must be allocated to CCNH and RHNS as follow	-		•								
Item			Method of Allocation								
Dietary	1	Number of meals served to residents									
Laundry	I	Number of pounds processed									
Housekeeping	I	Number of	square feet serviced								
	I	Number of	hours of routine care provided	by EACH							
Nursing	e	employee c	classification, i.e., Director (or C	Charge Nur	rse),						
]	Registered	Nurses, Licensed Practical Nurs	ses, Aides	and						
	1	Attendants									
Direct Resident Care Consultants	I	Number of	hours of resident care provided	by EACH	[
	S	specialist ((See listing page 13)								
Maintenance and operation of plant	(Square feet	t								
Property costs (depreciation)		Square feet									
Employee health and welfare	(Gross salar	ries								
Management services		* *	e cost center involved								
All other General Administrative expenses	r	Total of Direct and Allocated Costs									
The preparer of this report must answer the follo	wing questio	ns applical	ble to the cost information provi	ded.							
1. In the preparation of this Report, were all	• Yes	O No	If "No," explain fully why such	1 allocation	n was not						
costs allocated as required?	0 165		made.								
2. Explain the allocation of related company exp	penses and at	tach copy o	of appropriate supporting data.								
3. Did the Facility appropriately allocate and sel	f-disallow di	rect and in	direct costs to non-nursing hom	e cost cent	ters?						
(e.g., Assisted Living, Home Health, Outpatie	ent Services,	Adult Day	Care Services, etc.)								
	• Yes	O No	If "No," explain fully why such made.	1 allocatior	n was not						

State of Connecticut Annual Report of Long-Term Care Facility CSP-6 Rev. 9/2002

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 Y	ear Ended		Page	of
4 Hazel Avenue Operations LLC, d/b/a/ Gle	ndale ce	nter	2371	9/30/2017			6	37
	Relate	ed * to						
	Own	ners,						
	-	ators,				Annual		
		cers		Date of	Term of	Amount		ount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	of Lease	Clai	med
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
	0	0						
Is a Mileage Log Book Maintained for All L	eased V	ehicles	? O Yes	0	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

4 Hazel Avenue Operations LLC, d[2371 9/30/2017 7 37 The records of this facility for the period covered by this report were maintained on the following basis:	4 Hazel Avenue Operations LLC, d 2371 9:00:2017 7 37 The records of this facility for the period covered by this report were maintained on the following basis: 0	Name of Facility	License No.	Report for Year Ended	Page of
The records of this facility for the period covered by this report were maintained on the following basis: Ø Accrual O Cash O Modified Cash Is the accounting basis for this Ø Yes If "No," explain. period the same as for the Ø Yes If "No," explain. providues period? O No Name of Accounting Firm Address (No. & Street, City, State, Zip Code) 1 KPMC Pear Marwick 1600 Market Street, Philadelphia, PA 19103 1600 Market Street, Philadelphia, PA 19103 2 1 Services Provided by This Firm (describe fully) 1 Services Provided by This Firm (describe fully) 1 Verse S S 2 3 S S S 4 Services Information S 2 And the second market and in the Expenditure Parties of This Report? If Yes, Specify Expense Classification and Line No. Charge for Services Provided Second Sec	The records of this facility for the period covered by this report were maintained on the following basis: Ø Accrual O Cash O Modified Cash Is the accounting basis for this Ø Yes If "No," explain. period the same as for the Ø Yes If "No," explain. providues period? O No Name of Accounting Firm Address (No. & Street, City, State, Zip Code) 1 KPMC Pear Marwick 1600 Market Street, Philadelphia, PA 19103 1600 Market Street, Philadelphia, PA 19103 2 1 Services Provided by This Firm (describe fully) 1 Services Provided by This Firm (describe fully) 1 Verse S S 2 3 S S S 4 Services Information S 2 And the second market and in the Expenditure Parties of This Report? If Yes, Specify Expense Classification and Line No. Charge for Services Provided Second Sec				
Ø Accrual O Cash O Modified Cash The the accounting basis for this period the same as for the Ø Yes If "No," explain. periods period? O No If "No," explain. Independent Accounting Firm Address (No. & Street, City, State, Zip Code) Independent Accounting Firm Name of Accounting Firm Address (No. & Street, City, State, Zip Code) Isomore (Accounting Firm) Name of Accounting Firm Isomore (Accounting Firm) Address (No. & Street, City, State, Zip Code) 1 KPMG Peat Marwick S 2 S S 3 S S 4 S Charge for Services Provided by This Firm (describe fully) 1 Year end financial andit S 2 S S 3 S S 4 S Charge for Services Provided by This Firm (describe fully) 1 State of Connecticut - Court of Probate 203-720-7046 2 Bloom & Witkin G17-456-0500 3 S S 2 S S 3 S S 3 S S	Ø Accrual O Cash O Modified Cash The the accounting basis for this period the same as for the Ø Yes If "No," explain. periods period? O No If "No," explain. Independent Accounting Firm Address (No. & Street, City, State, Zip Code) Independent Accounting Firm Name of Accounting Firm Address (No. & Street, City, State, Zip Code) Isomore (Accounting Firm) Name of Accounting Firm Isomore (Accounting Firm) Address (No. & Street, City, State, Zip Code) 1 KPMG Peat Marwick S 2 S S 3 S S 4 S Charge for Services Provided by This Firm (describe fully) 1 Year end financial andit S 2 S S 3 S S 4 S Charge for Services Provided by This Firm (describe fully) 1 State of Connecticut - Court of Probate 203-720-7046 2 Bloom & Witkin G17-456-0500 3 S S 2 S S 3 S S 3 S S				1 51
Is the accounting basis for this period the same as for the O Yes If "No," explain. Previous period? O No Independent Accounting Firm Name of Accounting Firm Name of Accounting Firm Name of Accounting Firm I Address (No. & Street, City, State, Zip Code) I 600 Market Street, Philadelphia, PA 19103 Services Provided by This Firm (<i>describe fully</i>) I Year end financial and S Independent Accounting Firm I Ver end financial and S Independent Accounting Firm I Ver end financial and S Independent Accounting Firm I Ver end financial and S Independent Accounting Firm I Ver end financial and S Independent Accounting Firm I Ver end financial and S Independent Accounting Firm I Ver end financial and I Ver	Is the accounting basis for this period the same as for the O Yes If "No," explain. Previous period? O No Independent Accounting Firm Name of Accounting Firm Name of Accounting Firm Name of Accounting Firm I Address (No. & Street, City, State, Zip Code) I 600 Market Street, Philadelphia, PA 19103 Services Provided by This Firm (<i>describe fully</i>) I Year end financial and S Independent Accounting Firm I Ver end financial and S Independent Accounting Firm I Ver end financial and S Independent Accounting Firm I Ver end financial and S Independent Accounting Firm I Ver end financial and S Independent Accounting Firm I Ver end financial and S Independent Accounting Firm I Ver end financial and I Ver	The records of this facility for the	period covered by this report	were maintained on the following basis.	
period the same as for the O Yes If "No," explain. previous period? O No Independent Accounting Firm Name of Accounting Firm I KFMG Peat Marwick I 600 Market Street, City, State, Zip Code) I 600 Market Street, Philadelphia, PA 19103 Services Provided by This Firm (describe fally) I veare of financial audit S Charge for Services Provided S Are These Charges Reflected in the Expenditure Potion of This Report? If Yes, Specify Expense Classification and Line No. C Yes O No C Yes O No C Yes O Independent Attorney Services Provided Prime I file Expenditure Parties of Charge I Provide S Services Provided Prime I Probate Connecticut - Court of Probate Services Provided Prime I Pri	period the same as for the O Yes If "No," explain. previous period? O No Independent Accounting Firm Name of Accounting Firm I KPMG Peat Marwick I 600 Market Street, City, State, Zip Code) I 600 Market Street, Philadelphia, PA 19103 Services Provided by This Firm (describe fally) Services Provided by This Firm (describe fally) Yes end financial audi S I Yes end financial audi S I Charge for Services Provided S And These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. Yes O No I fuel connecticut - Court of Probate S Sources Provided by This Firm (describe fally) I State of Connecticut - Court of Probate S Sources Provided by This Firm (describe fally) I State of Connecticut - Court of Probate S Sources Provided by This Firm (describe fally) I State of Connecticut - Court of Probate S Sources Provided by This Firm (describe fally) I State of Connecticut - Court of Probate S Sources Provided by This Firm (describe fally) I State of Connecticut - Court of Probate S Sources Provided by This Firm (describe fally) I State of Connecticut - Court of Probate S Sources Provided by This Firm (describe fally) I State of Connecticut - Court of Probate S Sources Provided by This Firm (describe fally) I State Cannecticut - Court of Probate S Sources Provided by This Firm (describe fally) I Probate Cannecticut - Court of Probate S Sources Provided by This Firm (describe fally) I Probate Cannecticut - S S Sources Provided by This Firm (describe fally) I Probate Cannecticut - S S Sources Provided by This Firm (describe fally) I Probate Conservatorelip S Sources Provided by This Firm (describe fally) I Probate Cannecticut - S S Sources Provided by This Firm (describe fally) I Probate Cannecticut - S S Sources Provided by This Firm (describe fally) I Probate Cannecticut - S Sources Sources Provided by This Firm (describe fally) I Probate Cannecticut - S Sources Sources Provided by This Firm (describe fally) Sources Provided by This Firm (describe fally) Sources Provi	● Accrual O Cash O	Modified Cash		
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2 Reduction in R.E tax assessment \$ 4,085 3 \$ \$ 4 \$ \$ 5 \$ \$ Charge for Services Provided \$ 4,395 Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. Legal Fees pg. 15 1-e	2 Reduction in R.E tax assessment \$ 4,085 3 \$ \$ 4 \$ \$ 5 \$ \$ Charge for Services Provided \$ 4,395 Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. Legal Fees pg. 15	1 Probate Court Fee for Conservatorshi	in		\$ 310
3 \$ 4 \$ 5 \$ Charge for Services Provided \$ 4.395 Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. Legal Fees pg. 15 1-e	3 \$ 4 \$ 5 \$ Charge for Services Provided \$ 4.395 Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. Legal Fees pg. 15 1-e		-P		
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Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. Legal Fees pg. 15 1-e	Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. Legal Fees pg. 15 1-e				
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Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. Legal Fees pg. 15 1-e	Are These Charges Reflected in the Expenditure Portion of This Report? If Yes, Specify Expense Classification and Line No. Legal Fees pg. 15 1-e				-
Legal Fees pg. 15 1-e	Legal Fees pg. 15 1-e				\$ 4,395
Legal rees pg. 13 1-e	• Yes O No	Are These Charges Reflected in the Expen-	•	es, Specify Expense Classification and Line No.	
• Yes O No		• Yes • No	Legal rees pg. 15 1-e		

Schedule of Resident Statistics

Name of Facility			License N	No.			Report fo	or Year Ende	ed		Page	of
4 Hazel Avenue Operations LLC, d/b/a/ Glendale cer	nter		2	371			9/30/201	7			8	37
						Period 10	/1 Thru 6/	30		Period 7/2	'1 Thru 9/30	
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
 Certified Bed Capacity 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 ResidentsA. As of midnight of PREVIOUS report period	99	99			99	99			96	96		
B. As of midnight of THIS report period	102	102			96	96			102	102		
3. Total Number of Days Care Provided During Period												
A. Medicare	9,062	9,062			7,175	7,175			1,887	1,887		
B. Medicaid (Conn.)	23,034	23,034			17,176	17,176			5,858	5,858		
C. Medicaid (other states)												
D. Private Pay	1,518	1,518			1,002	1,002			516	516		
E. State SSI for RCH												
F. Other (Specify)	4,394	4,394			3,475	3,475			919	919		
G. Total Care Days During Period (3A thru F)	38,008	38,008			28,828	28,828			9,180	9,180		
Total Number of Days Not Included in Figures in 4. 3G for Which Revenue Was Received for Reserved Beds A. Medicaid Bed Reserve Days	19	19			19	19						
B. Other Bed Reserve Days	27	27			19	19			9	9		
5. Total Resident Days (3G + 4A + 4B)	38,054			28,865	28,865			9,189	9,189			

State of Connecticut Annual Report of Long-Term Care Facility CSP-9 Rev. 9/2002

			Scl	ned	ule of	Re	side	nt S	tatis	stics (O	Cont'd)		
Name of Facil	lity			Licer	nse No.				Report	t for Year	Ended		Page	of
4 Hazel Aven	ue Oper	ations L	LC, d/b/a/ Glend	/	2371				-	9/30/201	7		9	37
	•	-		-	pacity du	ring th	ne repoi	rt year	?	0	Yes	۲	No	
	, provid			1011.	CI	nange	in Red	ç.		Ca	pacity Afte	er Change		
Data of	CONIL	RHNS	-			lange			L	Ca	pacity Alte			
Date of	CCNH	KHNS	(specify)		Lost		,	Jaine	a	-				
Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason f	or Change
	(1)	(2)	(3)	(1)	(2)	(5)	(1)	(2)	(5)	corun	Iunio	(speeny)	reason r	or change
	-	-		-		the re	eport ye	ear (as	reporte	ed in item	4 above) p	provide the num	ber of	
			Change in Re	esider	t Days					CC	CNH	RHNS	(Spe	ecify)
1st chang														
2nd chan	0													
3rd chan														
4th chan 6. Number		lents and	l Rates on Septe	mber	30 of Cos	st Yea	r							
0. 110000	or resid	ionts un	Medicare							Se	elf-Pay		Other Sta	te Assisted
											2			
	Item		CCNH	C	CNH	RI	HNS	CO	CNH	RF	INS	(Specify)	R.C.H.	ICF-IID
No. of R	esidents		17		70				15					
Per Dien														
a. One b			LC, d/b/a/ Glen 2371 9 37 n the certified bed capacity during the report year? O Yes O No lowing information: Change in Beds Capacity After Change O No (3) (1) (2) (3) (1) (2) (3) CNH RHNS (Specify) (3) (1) (2) (3) (1) (2) (3) CNH RHNS (Specify) (3) (1) (2) (3) (1) (2) (3) CNH RHNS (Specify) n certified bed capacity during the report year (as reported in item 4 above) provide the number of 0 0 0 0 0 days following the change.											
b. Two l			545.72		207.98				469.07					
c. Three bed r		e												
bed I	ms.													
				dh/a/ Glent 2371 9/30/2017 9 37 he certified bed capacity during the report year? O Yes O No No ing information: Image Change in Beds Capacity After Change O Yes O No (3) (1) (2) (3) (1) (2) (3) CCNH RHNS (Specify) (3) (1) (2) (3) (1) (2) (3) CCNH RHNS (Specify) (3) (1) (2) (3) (1) (2) (3) CCNH RHNS (Specify) (1) (2) (3) (1) (2) (3) CCNH RHNS (Specify) etrified bed capacity during the report year (as reported in item 4 above) provide the number of lays following the change. Image Image										
7. Total Nu	mber of	Physica	al Therapy Treat	ments						ТО	TAL	CCNH	RHNS	(Specify)
A.	Medica	ire - Part	t B								2,719	2,719		
B.			usive of Part B)											
-														
C	2. Res	torative	Treatments											
		Physical	Therapy Treatm	ents										
											50,005	50,005		
		re - Part									625	625		
B.	Medica	uid (Excl	usive of Part B)											
			e Treatments											
		torative	Treatments											
	Other	neech T	horany Treature	nte										
					nents						3,434	3,434		
		re - Part		Team	101113						2.472	2.472		
			usive of Part B)								,=			
			e Treatments											
		torative	Treatments								695	695		
	Other)												
D.	Total C	<i>ccupati</i>	onal Therapy Th	reatm	ents						31,252	31,252		

State of Connecticut Annual Report of Long-Term Care Facility CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Report of Ex		- Salaric	U		_	
Name of Facility	License No.		Report for Yea	r Ended	Page	of
4 Hazel Avenue Operations LLC, d/b/a/ Glendale center	2371		9/30/2017		10	37
Are time records maintained by all individuals receiving cor	npensation?	\odot	Yes	0	No	
			Total Cost a	and Hours		
			Total Cost			
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)	115,992	2,086				
3. Assistant Administrator (Complete also Sec. IV						
of Schedule A1)						
 Other Administrative Salaries (telephone operator, clerks, receptionists, etc.) 	180 520	0.177				
5. Dietary Service	189,529	9,177				
a. Head Dietitian	20,107	670				
b. Food Service Supervisor	34,704	1,286				
c. Dietary Workers	229,085	15,736				
6. Housekeeping Service						
a. Head Housekeeper						
b. Other Housekeeping Workers 7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	69,262	2,195				
b. Other Maintenance Workers	26,606	1,695				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers						
9. Barber and Beautician Services 10. Protective Services						
10. Protective Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	149,065	2,425				
b. RN						
1. Direct Care	1,340,381	37,808				
2. Administrative** c. LPN	214,622	5,727				
c. LPN 1. Direct Care	664,619	21,651				
2. Administrative**	004,017	21,051				
d. Aides and Attendants	1,495,031	88,157				
e. Physical Therapists						
f. Speech Therapists						
g. Occupational Therapists	112.042	5 401				
h. Recreation Workers	113,042	5,491				
i. Physicians 1. Medical Director						
2. Utilization Review						
Resident Care***						
4. Other (Specify)						
j. Dentists	┨────┤					
k. Pharmacists I. Podiatrists	+					
m. Social Workers/Case Management	167,195	6,969				
n. Marketing	107,175	0,707				
o. Other (Specify)						
See Attached Schedule	110,160	5,033				
A-13. Total Salary Expenditures	4,939,399	206,106				

* 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.

4 Hazel Avenue Operations LLC, d/b/a/ Glendale center 9/30/2017

Schedule of Other Salaries and Wages (Page 10)

		CCNH		RH	NS	(Specify)			
Position			\$	Hours	\$	Hours		\$	Hours
Ward Clerks	0	\$	56,393.76	2,487			\$	-	-
Other	0	\$	-	-			\$	-	-
Central Supply	0	\$	25,693.18	1,181			\$	-	-
Medical Records	0	\$	28,072.82	1,365			\$	-	-
0	0	\$	-	-					
0	0	\$	-	-					
0	0	\$	-	-					
0	0	\$	-	-					
0	0		-	-					
0	0	\$	-	-					
0	0	-	-	-					
0	0	<u> </u>	-	-					
0	0	-	-	-					
0	0	-	-	_					
0	0	-	-	_					
0	0	-		_					
0	0	-	-	_					
0	0	φ	-						
		-							
Total		\$	110,159.76	5,033	\$ -	-	\$	-	-

Schedule of Other Fees (Page 13)

.....

		CC	NH	RH	NS	(Spe	cify)
Service		\$	Hours	\$	Hours	\$	Hours
1020620010	Consulting Fees	\$ 480.52	N/A				
3015620020	Purchased Services	\$ 21,001.10	N/A				
3155620020	Purchased Services	\$ (64.47)	N/A				
3155620020	Purchased Services	\$ 31,656.80	N/A				
1020620010	Consulting Fees	\$ 2,905.79	N/A				
0	0	\$ -	-				
0	0	\$ -	-				
0							
0							
0							
Total		\$ 55,980	-	\$-	-	\$ -	-

......

Attachment Page 10/13

.....

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				License No.		1	Year Ended		Page	of
4 Hazel Avenue Operations LLC, d	/b/a/ Glend:	ale center		2371		9/30/2017	Tear Endea		11	37
The operations EDC, d	or ar orienta	Salary Pai	d	2371		JI 30/2011			11	57
Name	CCNH	RHNS	(Specify)	Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
Section 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 Ot	ther Related Parties*
---------------------------------	-----------------------

Name of Facility (as licensed)				License No.		Report for Year Ended				of
4 Hazel Avenue Operations LLC, o	d/b/a/ Glend	ale center		2371		9/30/2017				37
		Salary Pai	d	Fringe Benefits and/or Other Payments	Full Description of	Total Hours		Name and Address of All	Total Hours	Compensation
Name	CCNH	RHNS	(Specify)	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section III - Administrators***										
Heather Rodriguez	115,992				Management of Center	2,086	2			
Section IV - Assistant Administrators										

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

** Include <u>all</u> other employment worked during the cost year.

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

State of Connecticut Annual Report of Long-Term Care Facility CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees Report for Year Ended Name of Facility License No. Page of 4 Hazel Avenue Operations LLC, d/b/a/ Glendale ce 2371 9/30/2017 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 2,807 19 3. Pharmacist 9,523 194 4. Podiatrist 5. Physical Therapy a. Resident Care 1,115,470 15,280 b. Other 6. Social Worker 7. Recreation Worker 8. Physicians a. Medical Director (entire facility) 52.406 277 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 54,693 701 b. Other 10. Occupational Therapist 88,267 a. Resident Care 1,209 b. Other 11. Nurses and aides and attendants a. RN 1. Direct Care 2. Administrative*** b. LPN 1. Direct Care 113 3 2. Administrative*** c. Aides d. Other 12. Other (Specify) See Attached Schedule 55,980 **B-13** Total Fees Paid in Lieu of Salaries 17,684 1,379,258

* 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	License No.		Report for Y	Year Ended	Page	of
4 Hazel Avenue Operations LLC, d/b/a/ Glo	endale center 2371		9/30/2017		14	37
Name & Address of Individual	Full Explanation of Service	Operato	* to Owners, rs, Officers		nation of R	elationship
		Yes	No			
		•	0			
Genesis Eldercare Rehabilitation Services, 101 East State Street, Kennett Square, PA 19348	Physical, Occupational, and Speech Therapy	۲	0	Common Own		
Genesis Eldercare Physician Services, 101 East State Street, Kennett Square, PA 19348	Medical Director	۲	0	Common Own	-	
Genesis Eldercare Staffing Services, 101 East State Street, Kennett Square, PA 19348	Nursing Pool	۲	0	Common Own	ership	
Respiratory Health Services, 515 Fairmount Ave, 6th Floor, Suite 600, Towson, MD 21286	Respiratory and Oxygen Supplies	۲	0	Common Own	ership	
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			

* 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 Ye	ear Ended	Page	of
4 Hazel Avenue Operations LLC, d/b/a/ Glendale 2371		9/30/2017		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	213,526	213,526		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	68,756	68,756		
4. Social Security (F.I.C.A.)	\$	361,688	361,688		
5. Health Insurance	\$	410,764	410,764		
6. Life Insurance (employees only)					
(not-owners and not-operators)	\$				
7. Pensions (Non-Discriminatory)	\$				
(not-owners and not-operators)					
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*	\$	164,710	164,710		
d. Accounting and Auditing	\$				
e. Legal (Services should be fully described on Page 7)	\$	4,395	4,395		
f. Insurance on Lives of Owners and	\$				
Operators (Specify)*					
g. Office Supplies	\$	39,843	39,843		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	34,652	34,652		
2. Cellular Phones	\$	844	844		
i. Appraisal (Specify purpose and	\$				
attach copy)*					
j. Corporation Business Taxes (<i>franchise tax</i>)	\$				
k. Other Taxes (<i>Not related to property - See Page 22</i>)					
1. Income*	\$				
2. Other (<i>Specify</i>)	\$	612	612		
See Attached Schedule	Ť	012	012		
3. Resident Day User Fee	\$	543,149	543,149		
Subtotal	\$	1,842,939	1,842,939		

* 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

4 Hazel Avenue Operations LLC, d/b/a/ Glendale center 9/30/2017

Attachment Page 15

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

Description		CCNH	RHNS	()	Specify)
1020640110	Sales Tax	\$ 331	\$ -	\$	-
1020640110	Sales Tax	\$ 281	\$ -	\$	-
0	0	\$ -	\$ -	\$	-
0	0	\$ -	\$ -	\$	-
	0	\$ -	\$ -	\$	-
Total		\$ 612	\$ -	\$	-

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

Name of Facility License No.		Report for Y	ear Ended	Page	of
4 Hazel Avenue Operations LLC, d/b/a/ Glendale cen 2371		9/30/2017		16	37
Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forwa	ard:	1,842,939	1,842,939		•
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$	3,126	3,126		
5. Education Expenses Related to Seminars and Conventions	\$	275	275		
6. Automobile Expense (not purchase or depreciation)	\$				
7. Other (<i>Specify</i>)	\$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (all such expenses)	\$				
2. Advertising Telephone Directory (all such expenses)***	\$				
3. Advertising Other (Specify)***	\$	11,965	11,965		
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	\$	1,623	1,623		
* 8. Dues and Membership Fees to Professional	\$	10,585	10,585		
Associations (Specify)					
See Attached Schedule					
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$	616	616		
9. Subscriptions	\$	217	217		
10. Contributions***	\$	1,525	1,525		
See Attached Schedule					
11. Services Provided by Contract (Specify and Complete	\$	4,126	4,126		
Schedule C-2, Page 21 for each firm or individual)					
12. Administrative Management Services**	\$	523,305	523,305		
13. Other (<i>Specify</i>)	\$	33,069	33,069		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$	2,433,369	2,433,369		

* 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.

4 Hazel Avenue Operations LLC, d/b/a/ Glendale center Attachment Page 16 9/30/2017

Schedule of Other Travel and Entertainment

Description	CCNH	RHNS	(Specify)
			0
			0
			0
			0
			0
			0
Total Other Travel and Entertainment	\$ -	\$ -	\$ -

.------

Schedule of Other Advertising

Description		CCNH	RHNS	(Specify)
1020630020	Advertising	\$ 1,058	0	0
1020630020	Advertising	\$ 1,401	0	0
1020630330	Marketing Expense	\$ 5,755	0	0
1020630330	Marketing Expense	\$ 31	0	0
1020630330	Marketing Expense	\$ 71	0	0
3165630330	Marketing Expense	\$ 249	0	0
1020630331	Marketing Exp- Corpo	\$ 3	0	0
1020630331	Marketing Exp- Corpo	\$ 457	0	0
1020630331	Marketing Exp- Corpo	\$ 2,939		
0	0	\$ -		
Total Other Advertis	ing	\$ 11,965	\$ -	\$ -

Schedule of Dues

Description		CCNH	RHNS	(Specify)
0	0	0	0.00	0.00
0	0	0	0.00	0.00
	0	0	0.00	0.00
1020630310	Licenses & Certification	11,201	0.00	0.00
1020630310	Dues to Chamber of C	(616)	0.00	0.00
1020630310	0	0	0.00	0.00
1020630310	0	0	0.00	0.00
1020630310	0	0	0.00	0.00
1020630310	0	0	0.00	0.00
1020630310	0	0	0.00	0.00
1020630310	0	0	0.00	0.00
1020630310	0	0	0.00	0.00
1020630310	0	0	0.00	0.00
1020630310	0	0	0.00	0.00

1020630310	0	0	0.00	0.00
1020630310	0	0	0.00	0.00
Total Dues		\$ 10,585	\$ -	\$ -

Schedule of Contributions

Description		CCNH	RHNS	(Specify)
1020630135	Political Contributions	1524.68	0	0
0	0	0	0	0
0	0	0	0	0
Total Contributions		\$ 1,525	\$-	\$-

Schedule of Other Administrative and General

Description		CCNH	RHNS	(Specify)
1020630060	Bank Service Charges	4562.45	0	0
1020630120	Collection Fees	9164.61	disallowed	0
1020630120	Collection Fees	115.36	disallowed	0
1020630140	Education Expense	109.7	0	
1020630140	Education Expense	18.1	0	0
1020630180	Employee Physicals	12630.55	0	0
1020630200	Employee Relations	2583.19	0	0
1020630380	Printing	158.43	0	0
1020630610	Training Expense	261.05	0	0
1020630610	Training Expense	544.06	0	0
1020640090	Miscellaneous	-47.58	0	0
1020640090	Miscellaneous	-4.02	0	0
1020660080	Rental Expense	11.12	0	0
1020660990	Accrued Expense Estin	2941.78	disallowed	0
1020720070	State Tax Annual Rep	20	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
			0	0
0	0	0	0	0
0	0	0	0	0
0	0	0	0	0
Total Other Adminis	trative and General	\$ 33,069	\$ -	\$ -

Name of Facility	License No.	Report for Year Ended	Page of
4 Hazel Avenue Operations LLC, d/b/a/ C		9/30/2017	17 37
Name & Address of Individual or	Cost of	En11 Description of Monte Comises	Indicate Where Costs
Name & Address of Individual or	Management Service	Full Description of Mgmt. Service Provided	are Included in Annual
Company Supplying Service Genesis Health Ventures, 101 East St.,	523,027	Mgmt Services, Property Mgmt	Report Page #/Line # pg 16 m-12
Kennett Square, PA 19348	525,027	Assisting, MIS, Personnel,	pg 10 m-12
Remett Square, 111 19546		Compliance	
		Comphanee	
Genesis Health Ventures, 101 East St.,	40,999	Capital Interest	pg 26 12-A-1
Kennett Square, PA 19348	+0,777	Suprai morosi	ro -0 12 11 1

Schedule C-1 - Management Services*

* 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)

		N	ote or	n Page 5)			
	ne of Facility		License	e No.	Report for Y	ear Ended	Page of
4 H	azel Avenue Operations LLC, d/b/a/ Glendale c	cente	2	2371	9/30/2017		18 37
	Item			Total	CCNH	RHNS	(Specify)
2.	Dietary						
	a. In-House Preparation & Service						
	1. Raw Food		\$	165,429	165,429		
	2. Non-Food Supplies		\$	22,636	22,636		
	3. Other (<i>Specify</i>)		\$	(1,715)	(1,715)		
	b. Purchased Services (by contract other		\$	182,486	182,486		
	than through Management Services)						
	(Complete Schedule C-2 att. Page 21)						
	c. Management Services**		\$				
	d. Other (<i>Specify</i>)		\$				
25							
2E.	<i>Total Dietary Expenditures</i> (2a + b + c + d)		\$	368,837	368,837		
2F.	Dietary Questionnaire			Total	CCNH	RHNS	(Specify)
G.	Resident Meals: Total no. of meals served per	day	y:*				
H.	Is cost of employee meals included in 2E?	0	Yes	\odot	No		
I.	Did you receive revenue from employees?	0	Yes	\odot	No	If yes, specify amt.	
J.	Where is the revenue received reported in the	Cos	st Repor	? (Page/Line	Item)		
	Is cost of meals provided to persons other		*			10 10	
K.	than employees or residents (i.e., Board	0	Yes	\odot	No	If yes, specify	
	Members, Guests) included in 2E?					cost.	
L.	Is any revenue collected from these people?	0	Yes	۲	No	If yes, specify	
г.	is any revenue concered from these people.	Ŭ	105	0	110	amt.	
M.	Where is the revenue received reported in the	Cos	st Repor	? (Page/Line]	Item)		
	Is cost of food (other than meals, e.g.,						
N	snacks at monthly staff meetings, board	\circ	Yes	0	No	If yes, specify	
N.	meetings) provided to employees included	0	105	•	INU	cost.	
	in 2E?						
0	Is any revenue collected from complements?		Yes	•	No	If yes, specify	
О.	Is any revenue collected from employees?	0	168	0	No	amt.	
P.	Where is the revenue received reported in the	Cos	st Repor	? (Page/Line)	[tem)		
- •		200	1.1.00		,		

* 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	License	e No.	Report for Y	Year Ended	Page of
4 Hazel Avenue Operations LLC, d/b/a/ Glendale center	er	2371	9/30/2017		19 37
Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies,					
gowns and other resident care items	Amt. \$	4,858	4,858		
washed, ironed, and/or processed.***					
2. Employee items including uniforms,	Lbs.				
gowns, etc. washed, ironed and/or					
processed.***	Amt. \$				
3. Personal clothing of residents	Lbs.				
washed, ironed, and/or processed.***					
wushed, ironed, and/or processed.	Amt. \$				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. \$	1,766	1,766		
b. Purchased Services (by contract other	\$				
than through Management Services)			,		
(Complete Schedule C-2 att. Page 21)					
c. Management Services**	\$				
d. Other (Specify)	\$				
3E. <i>Total Laundry Expenditures</i> (3a + b + c + d)	\$	145,008	145,008		
3F. Laundry Questionnaire					
G. Is cost of employee laundry included in 3E? C) Yes	\odot	No	If yes,	
				specify cost. If yes,	
H. Did you receive revenue from employees? C) Yes	\odot	No	specify amt.	
I. Where is the revenue received reported in the Cos	t Report?		(Page/Line	1 7	
Is Cost of laundry provided to persons other		~	N	If yes,	
J. than employees or residents included in 3E?) Yes	\odot	No	specify cost.	
K. Did you receive revenue from these people? C) Yes		No	If yes,	
				specify amt.	
L. Where is the revenue received reported in the Cos	t Report?		(Page/Line	e 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.	Rep	ort for Year E	nded	Page	of
4 Hazel Avenue Operations LLC, d/b/a/ Glenda	2371		9/30/2017		20	37
Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced					
a. In-House Care	by Personnel					
1. Supplies - Cleaning (Mops,	Amt.	\$	14,331	14,331		
pails, brooms, etc.)						
b. Purchased Services (by contract other	Sq. Ft. Serviced					
than through Management Services)	by Personnel					
(Complete Schedule C-2 att.	Amt.	\$	207,789	207,789		
Page 21)						
c. Management Services*		\$				
d. Other (<i>Specify</i>)		\$				
4E. Total Housekeeping Expenditures (4a +	b + c + d)	\$	222,120	222,120		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		\$				
2. Purchased from		\$	482,983	482,983		
b. Medicine Cabinet Drugs		\$	32,331	32,331		
c. Medical and Therapeutic Supplies		\$	112,561	112,561		
d. Ambulance/Limousine***		\$	13,290	13,290		
e. Oxygen						
1. For Emergency Use		\$				
2. Other***		\$	16,192	16,192		
f. X-rays and Related Radiological		\$	36,022	36,022		
Procedures***						
g. Dental (Not dentists who should be inc	luded under	\$				
salaries or fees)						
h. Laboratory***		\$	67,623	67,623		
i. Recreation		\$	35,203	35,203		
j. Other (Specify)****		\$	105,049	105,049		
See Attached Schedule						
5K. Total Resident Care Expenditures (5a - 5	5j)	\$	901,253	901,253		

* 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.

4 Hazel Avenue Operations LLC, d/b/a/ Glendale center 9/30/2017

Schedule of Other Resident Care

Description		CCNH	RHNS	(Specify)
3060610160	Incontinency	\$ 46,984	0	0
3060610161	Incontinency - Rebate	\$ (6,989)	0	0
3080630030	Advertising-Help War	\$ 204	0	0
3080630030	Advertising-Help War	\$ 280	0	0
3080630030	Advertising-Help War	\$ 474	0	0
3080630080	Books, Dues & Subsc	\$ 344	0	0
3080630140	Education Expense	\$ 1,265	0	0
3080630140	Education Expense	\$ 676	0	0
3015630530	Supplies	\$ 30	0	0
3120630530	Supplies	\$ 3,376	0	0
3155630530	Supplies	\$ 14,701	0	0
3155630530	Supplies	\$ 7,483	0	0
3090630535	Office Supplies	\$ 321	0	0
3080630550	T&E-Lodging/Transp	\$ 178	0	0
3120660080	Rental Expense	\$ 1,511	0	0
3155660080	Rental Expense	\$ 72	0	0
3155660080	Rental Expense	\$ 17,572	0	0
3010610300	Consolidated Billing	\$ 16,570	0	0
0	0	\$ -	0	0
0	0	\$ _	0	0
0	0	\$ -	0	0
0	0	\$ -	0	0
0	0	\$ -	0	0
Total Other Resident Care		\$ 105,049	\$ -	\$ -

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

				License No.	Report for Year Ende	d			Page	
4 Hazel Avenue Operations I	LLC, d/b/a/ Glendale c	enter		2371	9/30/2017				21	37
		Related ** Operators	,				Total Cost	/Page Ref.**	*	
Name of Individual or Company	Address	Yes	No	Explanation of Relationship	Full Explanation of Service Provided*	CCNH	RHNS	(Specify)	Pg	Line
Healthcare Services Group	Drive, Bensalem, PA 19020	0	o	Vendor Contracted	Laundry Purchased Services	138,384				3b
Healthcare Services Group	Drive, Bensalem, PA 19020 Drive, Bensalem, PA	0	۲	Vendor Contracted	Housekeeping Purchased Services	207,789			20	4b
Healthcare Services Group	Drive, Bensalem, PA 19020	0	۲	Vendor Contracted	Dietary Purchased Services	182,486			18	2b
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0							
		0	0 0							
		0	0							
		0	0							
		0	0							

* 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 L	icense No.	Report for Ye	ear Ended		Page of
4 Hazel Avenue Operations LLC, d/b/a/ Glend	2371	9/30/2017			22 37
Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant		Total	CCIVII	KIIND	(Speerry)
a. Repairs & Maintenance	\$	112,123	112,123		
b. Heat	\$	51,307	51,307		
c. Light & Power	\$	148,632	148,632		
d. Water	\$	44,420	44,420		
e. Equipment Lease (<i>Provide detail on pag</i>		11,120	11,120		
f. Other (<i>itemize</i>)	<u>\$</u>				
See Attached Schedule	Ψ				
6g. Total Maint. & Operating Expense (6a - 6	f) \$	356,482	356,482		
7. Depreciation (<i>complete schedule page 23*</i>)			,		
a. Land Improvements	\$	726	726		
b. Building & Building Improvements	\$	450,537	450,537		
c. Non-Movable Equipment	\$	5,433	5,433		
d. Movable Equipment	\$	86,452	86,452		
*7e. <i>Total Depreciation Costs</i> (7a + b + c + d)	\$	543,148	543,148		
8. Amortization (Complete att. Schedule Page	24*)				
a. Organization Expense	\$				
b. Mortgage Expense	\$				
c. Leasehold Improvements	\$				
d. Other (<i>Specify</i>)	\$				
*8e. <i>Total Amortization Costs</i> (8a + b + c + d)	\$				
9. Rental payments on leased real property les	S				
real estate taxes included in item 10b	\$	1,996,406	1,996,406		
10. Property Taxes					
a. Real estate taxes paid by owner	\$				
b. Real estate taxes paid by lessor	\$	213,169	213,169		
c. Personal property taxes	\$				
11. Total Property Expenses (7e + 8e + 9 + 10) \$	2,752,723	2,752,723		

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

4 Hazel Avenue Operations LLC, d/b/a/ Glendale center 9/30/2017

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
Total Other Repairs and Maintenance	\$ -	\$ -	\$ -
^			

State of Connecticut Annual Report of Long-Term Care Facility CSP-23 Rev. 10/2006

					Deprec	iation Sc	hedule					
			License No.			Report for Year E	nded		Page	of		
4 Hazel Avenue Operations LLC, d/b/a/ Glendale center			237	1		9/30/2017			23	37		
Property Item					Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
· · ·	A. Land Improvements		Land	value	Depreciated	Operations	Depreciation	LIIC	for this real	Totals		
1. Acquired prior to this report period					7,756		7,756	1,706	S/I	Various	467	
2. Disposals (attach schedule)					7,730		7,750	1,700	5/L	various	407	
3. Acquired during this report period (attac	h schod	lula)			15,500		15,500				258	
A-4. Subtotal	II SCHOU	iuic)			15,500		15,500				238	725
B. Building and Building Improvements												125
1. Acquired prior to this report period					13,361,168		13,361,168	2,079,791	S/I	Various	449,942	
2. Disposals (attach schedule)					13,301,100		15,501,100	2,079,791	D/L	various	++9,9+2	
3. Acquired during this report period (attac	h sched	hule)			43,840		43,840				595	
B-4. Subtotal	ii seneu	uic)			45,040		43,040				575	450,537
C. Non-Movable Equipment												450,557
1. Acquired prior to this report period		49,997		49,997	26,380	S/I	Various	5,306				
2. Disposals (attach schedule)			49,997		47,777	20,300	5/1	v arrous	5,500			
3. Acquired during this report period (attac	h sched	lule)			1,520		1,520				127	
C-4. Subtotal	ii seneu	iuic)			1,520		1,520				127	5,433
	Is a mi logb mainta Yes	ook	Date of A Month	cquisition Year	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
 D. Movable Equipment Motor Vehicles (Specify name, model and year of each vehicle) a. b. c. d. 2. Movable Equipment Acquired prior to this report period 					776,505		776,505	468,503	S/L S/L	Various	86,452	
b. Disposals (attach schedule) c. Acquired during this report period (attach schedule) D-3. Subtotal												86,452
E. Total Depreciation												543,147
L. Ioun Deprecumon												545,147

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4 Hazel Avenue Operations LLC, d/b/a/ Glendale center 9/30/2017

Schedule of Land Improvements Acquired during this report period

Schedule of Land I	inprovements Acquired during th	is report period		
			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
7/31/2017	Pavilion 16'x24'	15500	10	258
Total additions for	Land Improvements	15500		258
Deletions:				
Total deletions for	Land Improvements	\$ -		\$ -
*Ties to Page 23.	Line A3			

Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

Schedule of Buildin	ng Improvements Acquired during th	lis report period	ı Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
6/30/2017	Architectural Services	45,864.50	20.00	573.31
9/30/2017	Jeron Provider 680+ Nurse Call Syste	500.00	20.00	-
11/30/2016	Permiy drawings for pavillion	515.00	20.00	21.46
10/1/2017	Reserved the Sep 16 Accruals	(3,040.00)		-
Total additions for	Building Improvement:	\$ 43,840		\$ 595
Deletions:				

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			Ī
Total deletions for Building Improvement	\$ -	\$ -	**
*Ties to Page 23, Line B3			•

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report perio

			Useful	
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
11/30/2016	Compressor RTU #4 1st install	1,520.00	10.00	126.67
Total additions for	Non-Movable Equipmen	\$ 1,520		\$ 127
Deletions:				
Detetions.				
		¢		¢
1 otal deletions for	Non-Movable Equipmen	\$ -		\$ -
*Ties to Page 23,	Line C3			

ries to Page 23, Line C3

**Ties to Page 23, Line C2 _____

Schedule of Movable Equipment Acquired during this report perio

Acquisition Date	Description of Item	Cost	Life	Depreciation	
Additions:	_				
				-	
				_	
				-	
				-	
				-	
				-	
				-	
Total additions for	Movable Equipment	\$ -		\$ -	
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 perio

			Useful		
Acquisition Date	Description of Item	Cost	Life	Depreciation	
Additions:					Ι
					1
					1
					Î
					Ì
					1
Total additions for	Leasehold Improvemen	\$ -		\$ -	*
Deletions:					
					Ì
					Ì.
					1
					1
Total deletions for	Leasehold Improvemen	\$ -		\$ -	**
*Ties to Page 24, I	Line C3				-

**Ties to Page 24, Line C2

Amortization Schedule*

Nam	e of Facility			License No.		Report for Yea	r Ended		Page	of
4 Ha	zel Avenue Operations LLC, d/b/a/ Gleno	dale cent	er	23	71	9/30/2017			24	37
		Date Acqui				Accumulated Amort. to Beginning of	Basis for			
	_			Length of	Cost to Be	Year's	Computing		Amortization	
	Item	Month	Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
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									
	2. Disposals (attach schedule)									
	3. Acquired during this report period									
	(attach schedule)									
C-4.	Subtotal									
D.	Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

A. Minimum of 5 years or 60 months.

B. Life of mortgage; OR

C. Remaining Life of Lease; OR

D. Actual Life if owned by Related Party.

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

Name of FacilityLicense No4 Hazel Avenue Operations LLC, d/b/a22	o. 371	Report for Year En 9/30/2017	ded		Page of 25 37
11. Property Questionnaire		·			·
Part A					
Is the property either owned by the Facility	0	Yes	۲	No	If "Yes," complete Part B.
or leased from a Related Party?*	Ŭ	103	Ũ	110	If "No," complete Part C.
*If any owner or operator of this facility is related business association to any person or organization					
related party transaction.		Jununigs are leased, me	i it is considered a		
Description		Total			
1. Date Land Purchased					
2. Date Structure Completed					
3. If NOT Original Owner, Date of Purchas 4. Date of Initial Licensure	se				
5. Total Licensed Bed Capacity		120			
6. Square Footage		120	•		
7. Acquisition Cost					
a. Land					
b. Building				-	
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing					
a. Type of Financing (e.g., fixed, variab	ole)				
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	l				
During Current Cost Year					
g. Type of Financing (e.g., fixed, variab	ole)				
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-0	Off				
Part C - Arms-Length Leases for Real			7		
Name and Address of Lessor	1	perty Leased		Term of Lease	Annual Amount of Lease
Well Tower /Healthcare REIT, Inc		d Equipment	04/01/11		1,996,406
Address: One Seagate Suite 1500					
Toledo, OH 43603-1475					

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 Yea	ar Ended		Page of
4 Hazel Avenue Operations LLC, d/b/ 2371		9/30/2017			26 37
Item		Total	CCNH	RHNS	(Specify)
12. Interest					· · · · · ·
A. Building, Land Improvement & Non-Movable					
Equipment	¢	40.000	10.000		
1. First Mortgage Name of Lender	\$ Rate	40,999	40,999		
Name of Lender	Kale				
Address of Lender					
2. Second Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
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	ф.				
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)	\$	40,999	40,999		

(Carry Subtotals forward to next page)

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

Name of Facility License N			Report for Ye	ear Ended		Page of
4 Hazel Avenue Operations LLC, d/ 23	371		9/30/2017		[27 37
Item			Total	CCNH	RHNS	(Specify)
Sub	ototals Bro	ught Forward:	40,999	40,999		
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender		I				
Address of Lender						
2. Other (<i>Specify</i>)		\$				
A. Item	Rate	Amount				
Lender	<u> </u>	<u> </u>				
Address of Lender						
B. Item	Rate	Amount				
Lender		I				
Address of Lender						
12. C. 3. Total Movable Equipment Interes	est					
Expense $(C1 + 2)$		\$				
12. D. Other Interest Expense (<i>Specify</i>)		\$				
	72 · 10D)	¢	40.000	40,000		
13. Total All Interest Expense (12B7 + 120	-3 + 12D)	\$	40,999	40,999		
14. Insurance	111	\$	2 0 2 2	2 0 2 2		
a. Insurance on Property (buildings or	lly)	+	3,932	3,932		
b. Insurance on Automobiles c. Insurance other than Property (as sp	pacified ab	\$				
1. Umbrella (<i>Blanket Coverage</i>)	194,069	194,069				
2. Fire and Extended Coverage	194,009	194,009				
3. Other (Specify)						
14d. Total Insurance Expenditures (14a + b	(+c)	\$	198,001	198,001		
15. Total All Expenditures (A-13 thru C-14	,	\$	13,737,451	13,737,451		

D. Adjustments to Statement of Expenditures

	e of Fa zel Av		Dperations LLC, d/b/a/ Glendale center	Li	cense No. 2371	Report for Year 9/30/2017	r Ended	Page of 28 37
	Page No.		Item Description		Total Amount of Decrease	ССИН	RHNS	(Specify)
Page	10 - S	alarie	s and Wages					
1.			Outpatient Service Costs	\$				
2.			Salaries not related to Resident Care	\$				
3.			Occupational Therapy	\$				
4.			Other - See attached Schedule	\$	21,551	21,551		
Page	13 - P		sional Fees					
5.	13	8-c	Resident Care Physicians **	\$				
6.			Occupational Therapy	\$				
7.			Other - See attached Schedule	\$	1,311,023	1,311,023		
Page	s 15 &	16 -	Administrative and General					
8.			Discriminatory Benefits	\$				
9.	15	1-c	Bad Debts	\$	164,710	164,710		
10.			Accounting & Legal	\$	(32,007)	(32,007)		
11.			Telephone	\$				
12.			Cellular Telephone	\$				
13.			Life insurance premiums on the life					
			of Owners, Partners, Operators	\$				
14.			Gifts, flowers and coffee shops	\$				
15.			Education expenditures to colleges or					
			universities for tuition and related costs					
			for owners and employees	\$				
16.			Travel for purposes of attending					
			conferences or seminars outside the					
			continental U.S. Other out-of-state					
			travel in excess of one representative	\$				
17.			Automobile Expense (e.g. personal use)	\$				
18.	16	m-2 8	Unallowable Advertising *	\$	11,965	11,965		
19.			Income Tax / Corporate Business Tax	\$				
20.			Fund Raising / Contributions	\$	1,525	1,525		
21.			Unallowable Management Fees	\$	564,304	564,304		
22.			Barber and Beauty	\$				
23.			Other - See attached Schedule	\$	(19,170)	(19,170)		
Page	18 - L	Dietary	Expenditures					
24.			Meals to employees, guests and others					
			who are not residents	\$				
Page	19 - L	aund	ry Expenditures	ŕ				
25.			Laundry services to employees, guests					
			and others who are not residents	\$				
Page	20 - H	louse	keeping Expenditures	7				
26.			Housekeeping services to employees, guests					
201			and others who are not residents	\$				
	l	l	Subtotal (Items 1 - 26			2,023,901		

* 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.

4 Hazel Avenue Operations LLC, d/b/a/ Glendale center 9/30/2017

Schedule of Other Salaries Adjustment

Page Ref	Line Ref		Description	CCNH	RHNS	(5	Specify)
10	2	Administrator's salary disallowed	0	\$ 21,551	\$ -	\$	-
0	0	0	0	\$ -	\$ -	\$	-
0	0	0	0	\$ -	\$ -	\$	-
0	0	0	0	\$ -	\$ -	\$	-
0	0	0	0	\$ -	\$ -	\$	-
0	0	0	0	\$ -	\$ -	\$	-
Total Othe	r Salaries A	djustment		\$ 21,551	\$ -	\$	-

Schedule of Fees Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
13	5	Rehabilitation Services	3120620020	\$ 93,931	0	0
13	5	Rehabilitation Services	3195620020	\$ 1,021,539	0	0
13	9	Speech Therapist	3170620020	\$ 54,693	0	0
13	10	Occupational Therapist	3105620020	\$ 88,267	0	0
13	12	Other	3010620020	\$ -	0	0
13	12	Other	3015620020	\$ 21,001	0	0
13	12	Respiratory Purchased Servies	3155620020	\$ 31,592	0	0
					0	0
					0	0
					0	0
					0	0
					0	0
Total Other	r Fees Adju	stments		\$ 1,311,023	\$ -	\$-

Schedule of Other A&G Adjustments

Page Ref	Line Ref		Description	CCNH	RHNS	(Specify)
16	m-13	Collection Fees	1020630120	\$ 9,280	0	0
16	m-8a	Dues	Chamber of Commerce	\$ 616	0	0
16	m-13	Estimated Accrual	1020660990	\$ 2,942	0	0
16	m-13	Non-recurring Charges	7010800030	\$ -	0	0
16	m-13	Fines and Penalty	1020640080	\$ -	0	0
15	1-a-1	adj workers comp	0	\$ (32,007)	0	0
0	0	0	0	\$ -	0	0
0	0	0	0	\$ -	0	0
0	0	0	0	\$ -	0	0
Total Othe	r A&G Adj	ustments		\$ (19,170)	\$ -	\$ -

	D. Adjustments to Statement of Expenditures (cont'd) Name of Facility License No. Report for Year Ended Page of											
Name	e of Fa	cility		Lice	ense No.	Report for Y	ear Ended	Page	of			
4 Haz	zel Av	enue (Operations LLC, d/b/a/ Glendale center		2371	9/30/2017		29	37			
					Total							
Item	Page	Line			Amount of							
No.	No.	No.	Item Description		Decrease	CCNH	RHNS	(Sp	becify)			
			Subtotals Brought Forward	\$	2,023,901	2,023,901			-			
Page	20 - R	eside	nt Care Supplies***									
27.	20	5-a-2	Prescription Drugs	\$	482,983	482,983						
28.	20	5-d	Ambulance/Limousine	\$	13,290	13,290						
29.	20	5-f	X-rays, etc	\$	36,022	36,022						
30.	20	5-h	Laboratory	\$	67,623	67,623						
31.			Medical Supplies	\$								
32.	20	5-e-2	Oxygen (non emergency)	\$	16,192	16,192						
33.			Occupational Therapy	\$								
34.			Other - See Attached Schedule	\$	77,198	77,198						
Page	22 - N	<i>lainte</i>	nance and Property									
35.			Excess Movable Equipment Depreciation									
			See Attached Schedule	\$								
36.			Depreciation on Unallowable									
			Motor Vehicles	\$								
37.			Unallowable Property and Real									
			Estate Taxes	\$								
38.			Rental of Building Space or Rooms	\$								
39.			Other - See Attached Schedule	\$								
Page	27 - I	nsura	nce									
40.			Mortgage Insurance	\$								
41.			Property Insurance	\$								
Othe	r - Mis	cellar	neous									
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	\$	110,566	110,566						
Not 1	For Pr	ofit P	roviders Only									
50.			Building/Non Movable Eq. Depreciation									
			Unallowable Building Interest -									
			See Attached Schedule	\$								
51.	Total	Amot	unt of Decrease (Items 1 - 50)	\$	2,827,775	2,827,775						

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

*** 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.

4 Hazel Avenue Operations LLC, d/b/a/ Glendale center 9/30/2017

Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Spe	cify)
20	5-j	Consolidated Billing	\$ 16,569.95	\$ -	\$	-
20	5-ј	Respiratory Supplies	\$ 22,183.50	\$ -	\$	-
20	5-j	Respiratory Rental	\$ 17,643.65	\$ -	\$	-
20	5-i	Cable TV	\$ 20,801.20	\$ -	allow \$	3600
			\$ -	\$ -	\$	-
			\$ -	\$ -	\$	-
			\$ -	\$ -	\$	-
			\$ -	\$ -	\$	-
			\$ -	\$ -	\$	-
			\$ -	\$ -	\$	-
Total Other	r Ancillary	Costs	\$ 77,198	\$ -	\$	-

Schedule of Excess Movable Equipment Depreciation

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Exces	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Exces	s Movable	Equipment Depreciation	\$ -	\$-	\$ -

Schedule of Other Property Adjustments

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

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
27	14 c1	General liability Insurance Adjust	110,566	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Othe	r Adjustme	nts	\$ 110,566	\$ -	\$ -

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
0	0-Jan	0	0	0	0
Total Unall	lowable Bui	lding Interest	\$-	\$ -	\$ -

State of Connecticut Annual Report of Long-Term Care Facility CSP-30 Rev.10/2005

F. Statement of Revenue

F. Statement of Ke Name of Facility License No.		ear Ended		Page of
4 Hazel Avenue Operations LLC, d/b/a/ C 2371	9/30/2017	Report for Year Ended 9/30/2017		
				30 37
Item	Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue				
1. a. Medicaid Residents (CT only)	\$ 10,041,363	10,041,363		
b. Medicaid Room and Board Contractual Allowance **	\$ (5,334,495)	(5,334,495)		
2. a. Medicaid (All other states)	\$			
b. Other States Room and Board Contractual Allowance **	\$			
3. a. Medicare Residents (all inclusive)	\$ 4,748,646	4,748,646		
b. Medicare Room and Board Contractual Allowance **	\$ (1,656,631)	(1,656,631)		
4. a. Private-Pay Residents and Other	\$ 3,146,133	3,146,133		
b. Private-Pay Room and Board Contractual Allowance **	\$ (1,150,167)	(1,150,167)		
II. Other Resident Revenue				
1. a. Prescription Drugs - Medicare	\$ 336,324	336,324		
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (117,331)	(117,331)		
c. Prescription Drugs - Non-Medicare	\$ 177,522	177,522		
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (67,071)	(67,071)		
2. a. Medical Supplies - Medicare	\$ 1,895	1,895		
b. Medical Supplies - Medicare Contractual Allowance **	\$ (661)	(661)		
c. Medical Supplies - Non-Medicare	\$ 247	247		
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$ (120)	(120)		
3. a. Physical Therapy - Medicare	\$ 1,164,463	1,164,463		
b. Physical Therapy - Medicare Contractual Allowance **	\$ (406,239)	(406,239)		
c. Physical Therapy - Non-Medicare	\$ 437,539	437,539		
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (166,425)	(166,425)		
4. a. Speech Therapy - Medicare	\$ 291,810	291,810		
b. Speech Therapy - Medicare Contractual Allowance **	\$ (101,802)	(101,802)		
c. Speech Therapy - Non-Medicare	\$ 81,139	81,139		
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (30,325)	(30,325)		
5. a. Occupational Therapy - Medicare	\$ 1,243,882	1,243,882		
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (433,946)	(433,946)		
c. Occupational Therapy - Non-Medicare	\$ 509,421	509,421		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (192,770)	(192,770)		
6. a. Other (<i>Specify</i>) - Medicare	\$ 73,149	73,149		
b. Other (Specify) - Non-Medicare	\$ 31,203	31,203		
III. Total Resident Revenue (Section I. thru Section II.)	\$ 12,626,753	12,626,753		
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>)	\$ 401	401		
6. Private Duty Nurses' Fees	\$			ļ
7. Barber, Coffee, Beauty and Gift shops	\$ 23,515	23,515		
8. Other (<i>Specify</i>)	\$ 1,442	1,442		ļ
V. Total Other Revenue (1 thru 8)	\$ 25,358	25,358		L
VI. Total All Revenue (III +V)	\$ 12,652,111	12,652,111		
	-2,002,111	.2,022,111		I

* 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)
II-6-a	Medicare Part A	X-Ray	29,681.37	-	-
II-6-a	Medicare Part A	Laboratory	49,265.62	-	-
II-6-a	Medicare Part A	Respiratory Therapy & Supplie	26,759.32	-	-
II-6-a	Medicare Part A	Nursing Treatment Supplies	-	-	-
II-6-a	Medicare Part A	Audiology	-	-	-
II-6-a	Medicare Part A	Incontinency	-	-	-
II-6-a	Medicare Part A	Oxygen & Supplies	-	-	-
II-6-a	Medicare Part A	Physician Visit	-	-	-
II-6-a	Medicare Part A	Ambulance	-	-	-
II-6-a	Medicare Part A	Flu Shot	6,635.00	-	-
II-6-a	Contractuals-Medicare	X-Ray	(10,354.76)	-	-
II-6-a	Contractuals-Medicare	Laboratory	(17,187.00)	-	-
II-6-a	Contractuals-Medicare	Respiratory Therapy & Supplie	(9,335.36)	-	-
II-6-a	Contractuals-Medicare	Nursing Treatment Supplies	-	-	-
II-6-a	Contractuals-Medicare	Audiology	-	-	-
II-6-a	Contractuals-Medicare	Incontinency	-	-	-
II-6-a	Contractuals-Medicare	Oxygen & Supplies	-	-	-
II-6-a	Contractuals-Medicare	Physician Visit	-	-	-
II-6-a	Contractuals-Medicare	Ambulance	-	-	-
II-6-a	Contractuals-Medicare	Flu Shot	(2,314.71)	-	-
0	0	0	-	-	-
Total Oth	er Resident Revenue - Med	icare	\$ 73,149	\$-	\$ -

Schedule of Other Non-Medicare Resident Revenue

Related Exp

Page Ref	Description		CCNH	RHNS	(Specify)
II-6-b	Medicaid	X-Ray	-	-	-
II-6-b	Medicaid	Laboratory	76.24	-	-
II-6-b	Medicaid	Respiratory Therapy & Supplie	4,748.15	-	-
II-6-b	Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Medicaid	Audiology	-	-	-
II-6-b	Medicaid	Incontinency	-	-	-
II-6-b	Medicaid	Oxygen & Supplies	-	-	-
II-6-b	Medicaid	Physician Visit	-	-	-
II-6-b	Medicaid	Ambulance	-	-	-
II-6-b	Medicaid	Flu Shot	-	-	-
II-6-b	Contractuals-Medicaid	X-Ray	-	-	-
II-6-b	Contractuals-Medicaid	Laboratory	(40.50)	-	-
II-6-b	Contractuals-Medicaid	Respiratory Therapy & Supplie	(2,522.46)	-	-
II-6-b	Contractuals-Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Contractuals-Medicaid	Audiology	-	-	-
II-6-b	Contractuals-Medicaid	Incontinency	-	-	-
II-6-b	Contractuals-Medicaid	Oxygen & Supplies	-	-	-
II-6-b	Contractuals-Medicaid	Physician Visit	-	-	_
II-6-b	Contractuals-Medicaid	Ambulance	-	_	-
II-6-b	Contractuals-Medicaid	Flu Shot	-	-	-

II-6-b	Non-Medicaid	X-Ray	12,496.92	_	-
II-6-b	Non-Medicaid	Laboratory	16,237.53	-	-
II-6-b	Non-Medicaid	Respiratory Therapy & Supplie	16,241.10	-	-
II-6-b	Non-Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Non-Medicaid	Audiology	-	-	-
II-6-b	Non-Medicaid	Incontinency	-	-	-
II-6-b	Non-Medicaid	Oxygen & Supplies	-	-	-
II-6-b	Non-Medicaid	Physician Visit	-	-	-
II-6-b	Non-Medicaid	Ambulance	-	-	-
II-6-b	Non-Medicaid	Flu Shot	643.00	-	-
II-6-b	Contractuals-Non-Medicaid	X-Ray	(4,568.64)	-	-
II-6-b	Contractuals-Non-Medicaid	Laboratory	(5,936.14)	-	-
II-6-b	Contractuals-Non-Medicaid	Respiratory Therapy & Supplie	(5,937.44)	-	-
II-6-b	Contractuals-Non-Medicaid	Nursing Treatment Supplies	-	-	-
II-6-b	Contractuals-Non-Medicaid	Audiology	-	-	-
II-6-b	Contractuals-Non-Medicaid	Incontinency	-	-	-
II-6-b	Contractuals-Non-Medicaid	Oxygen & Supplies	-	-	-
II-6-b	Contractuals-Non-Medicaid	Physician Visit	-	-	-
II-6-b	Contractuals-Non-Medicaid	Ambulance	-	-	-
II-6-b	Contractuals-Non-Medicaid	Flu Shot	(235.07)	-	-
0	0	0	-	-	-
0	0	0	-	-	-
Total Othe	er Resident Revenue		\$ 31,203	\$-	\$ -

Interest Income

Account

Page Ref	Account	Balance	CCNH	RHNS	(Specify)
IV-5	Interest On Overdue Accou	Other Non-Operating	400.69	-	-
IV-5	0	0	-	-	-
0	0	0	-	-	-
0	0	0	-	-	-
Total Inter	rest Income		\$ 401	\$-	\$ -

Schedule of Other Revenue

Page Ref	Description		CCNH	RHNS	(Specify)
IV-8	Medical Record	0	1,228.26	-	-
IV-8	Donation	0	100.00	-	-
IV-8	T&E-Mileage/Parking/Tolls	0	113.65	-	-
0	0	0	-	-	-
0	0	0	-	-	-
0	0	0	-	-	-
0	0	0	-	-	-
0	0	0	-	-	-
0	0	0	-	-	-
0	0	0	-	-	-
0	0	0	-	-	-
0	0	0	-	-	-
Total Othe	Total Other Revenue			\$-	\$ -

State of Connecticut Annual Report of Long-Term Care Facility CSP-31 Rev. 6/95

G. Balance Sheet

	License No.	Report for Year Ended	Page	
Hazel Avenue Operations LLC, d/b	o/a/ 2371	9/30/2017	31	37
	Account			Amount
Assets				
A. Current Assets			+	
1. Cash (on hand and in banks			\$	11,207
2. Resident Accounts Receiva	``````````````````````````````````````	/	\$	1,268,118
3. Other Accounts Receivable	(Excluding Owners	or Related Parties)	\$	(96,572
4 Inventories			\$	54,260
5. Prepaid Expenses			\$	57,484
a. Prepaid Expenses			_	
b. Prepaid Prop Taxes		51,646	_	
c. Prepaid Escrow Real Est			_	
d. Prepaid Personal Propert	ty Tax	5,838		
6. Interest Receivable			\$	
7. Medicare Final Settlement	Receivable		\$	
8. Other Current Assets (itemi	ze)		\$	
A-9. Total Current Assets (Lines A	1 thru 8)		\$	1,294,497
B. Fixed Assets				
1. Land			\$	2,780,000
2. Land Improvements	*Historical Cost	23,256	\$	20,823
1	Accum. Deprecia			,
3. Buildings	*Historical Cost	13,405,007	\$	10,874,679
	Accum. Deprecia	· · ·	Ŧ	,,,
4. Leasehold Improvements	*Historical Cost		\$	
1. Deusenoid improvements	Accum. Deprecia	tion Net	Ψ	
	<u>^</u>		\$	10.702
5 Non-Moyable Equipment	THISTOPICAL COST	51517		19/0
5. Non-Movable Equipment	*Historical Cost	51,517 tion 31.814 Net	Ψ	19,703
	Accum. Deprecia	tion 31,814 Net		
 5. Non-Movable Equipment 6. Movable Equipment 	Accum. Deprecia *Historical Cost	tion 31,814 Net 776,505	\$	
6. Movable Equipment	Accum. Deprecia *Historical Cost Accum. Deprecia	tion 31,814 Net 776,505	\$	
	Accum. Deprecia *Historical Cost Accum. Deprecia *Historical Cost	tion 31,814 Net 776,505 tion 554,955 Net		
6. Movable Equipment7. Motor Vehicles	Accum. Deprecia *Historical Cost Accum. Deprecia *Historical Cost Accum. Deprecia	tion 31,814 Net 776,505 tion 554,955 Net	\$	
6. Movable Equipment	Accum. Deprecia *Historical Cost Accum. Deprecia *Historical Cost Accum. Deprecia	tion 31,814 Net 776,505 tion 554,955 Net	\$	
 Movable Equipment Motor Vehicles Minor Equipment-Not Depresent 	Accum. Deprecia *Historical Cost Accum. Deprecia *Historical Cost Accum. Deprecia reciable	tion 31,814 Net 776,505 tion 554,955 Net	\$	
6. Movable Equipment7. Motor Vehicles	Accum. Deprecia *Historical Cost Accum. Deprecia *Historical Cost Accum. Deprecia reciable	tion 31,814 Net 776,505 tion 554,955 Net	\$ \$ \$	
 Movable Equipment Motor Vehicles Minor Equipment-Not Depresent 	Accum. Deprecia *Historical Cost Accum. Deprecia *Historical Cost Accum. Deprecia reciable	tion 31,814 Net 776,505 tion 554,955 Net	\$ \$ \$	19,703 221,550

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

(Carry Total forward to next page)

State of Connecticut Annual Report of Long-Term Care Facility CSP-32 Rev. 6/95

G. Balance Sheet (cont'd)

Nam	e of	Facility	License No.	Report for Year Ended	 Page		of
4 Ha	zel .	Avenue Operations LLC, d/b/a/	2371	9/30/2017	32		37
			Account		Ar	nount	
				Total Brought Forward:	\$	15,21	1,254
C.	Le	asehold or like property recorde	d for Equity Purposes	5.			
	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	\$		
		Minor Equipment-Not Deprec			\$		
C-8		tal Leasehold or Like Propertie	es (C1 thru 7)		\$		
D.	Inv	vestment and Other Assets					
		Deferred Deposits			\$		
	2.	Escrow Deposits			\$		
	3.	Organization Expense	*Historical Cost				
			Accum. Depreciation	Net	\$		
		Goodwill (Purchased Only)			\$		
	5.	Investments Related to Reside	nt Care (<i>temize</i>)		\$		
	6.	Loans to Owners or Related Pa	· /		\$ 		
		Name and Address	Amount	Loan Date			
<u> </u>	7.	Other Assets (<i>itemize</i>)			\$	1.04	1,935
		I/C Due to/Due From GHV		1,041,935		,	
				, ,			
D-8.	То	tal Investments and Other Asso	ets (Lines D1 thru 7)		\$	1,04	1,935
D-9.	То	tal All Assets (Lines A9 + B10	+ C8 + D8)		\$	16,25	3,189

* 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 E	nded	Page	of	
4 Hazel Ave	enue C	perations LLC, d/b/a/ Glend	2371	9/30/2017		33	37
Account					Amount		
Liabilities							
А.	Cu	rrent Liabilities					
	1.	Trade Accounts Payable			9	5	498,643
	2.	Notes Payable (itemize)			\$	5	
	3.	Loans Payable for Equipme	-	itemize)	1	5	
		Name of Lender	Purpose	Amount	Date Due		
	4.	Accrued Payroll(Exclusive	of Owners and/or Sto	ckholders only)	9	5	136,178
	5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)					5	
	6.	Accrued Payroll Taxes Pay		<i>,</i> ,	9		40
7. Medicare Final Settlement Payable					9		
8. Medicare Current Financing Payable					9		
9. Mortgage Payable (<i>Current Portion</i>)					9	5	
	10. Interest Payable (Exclusive of Owner and/or Related Parties)					5	
11. Accrued Income Taxes*				9	5		
		Other Current Liabilities (it	emize)		9		233,838
		Accrued Provider/Bed Tax		Deferred Revenue	2,113		
		Accr Exp Water and Sewer	1,988	A/R Credit Gross Up Li			
		Accr Exp Gas and Electricity	5,699	Accr Exp Other	3,974		
		Accr Sales and Use Tax - FY17	64	Accr Exp Suspense	(2,470)		
A-13	. To	tal Current Liabilities (Line	s A1 thru 12)		9	5	868,699

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

(Carry Total forward to next page)

State of Connecticut Annual Report of Long-Term Care Facility CSP-34 Rev. 6/95

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year	Ended	Page		of
4 Hazel Avenue Operations LLC, d/b/a/ G		9/30/2017		34		37
	Account			A	mount	
Total Brought Forward:					86	58,699
Liabilities (cont'd)						
B. Long-Term Liabilities	· /• · · · ·		\$			
Name of Lender	Purpose	Amount	Date Due			
2. Mortgages Payable			\$			
3. Loans from Owners or Re	elated Parties (itemize)	\$			
Name and Address of Lender	Amount	Loan D	ate			
4. Other Long-Term Liabili	ties (itemize)		\$		10 33	34,989
4. Other Long-Term Liabilities (<i>temize</i>) 19,334,989					17,5.	л т ,707
B-5. Total Long-Term Liabilities (Lines B1 thru 4)					19,33	34,989
C. Total All Liabilities (Lines A-13 + B-5)					20,20)3,688

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

	ne of Facility License No. Report for Year Ended	Pag	
4 Ha	azel Avenue Operations LLC, d/b/a 2371 9/30/2017 Account	35	Amount 37
A.	Reserves		Amount
	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	\$	(12,129)
	4. Treasury Stock	\$	
	5. Cumulated Earnings	\$	(2,853,029)
	6. Gain or Loss for Period 10/1/2016 thru 9/30/2017	\$	(1,085,341)
	7. Total Net Worth	\$	(3,950,499)
C.	Total Reserves and Net Worth	\$	(3,950,499)
D.	Total Liabilities, Reserves, and Net Worth	\$	16,253,189

State of Connecticut Annual Report of Long-Term Care Facility CSP-36 Rev. 6/95

H. Changes in Total Net Worth

Name of Fa	cility	License No.	Report for Year	Ended	Page	of	
	enue Operations LLC, d/b/a/	2371	9/30/2017		36	37	
Account					Amount		
A. Balance at End of Prior Period as shown on Report of 09/30/2016					5	(2,865,158)	
B. Total	Revenue (From Statement of	Revenue Page 30)		S	5	12,652,111	
C. Total	Expenditures (From Statemen	nt of Expenditures F	Page 27)	S		13,737,452	
D. Net Ir	come or Deficit			5		(1,085,341)	
E. Balan				5	5	(3,950,499)	
	ions dditional Capital Contributed ther (<i>itemize</i>)	(įtemize)					
F-3. Total Additions G. Deductions					6		
1. D	rawings of Owners/Operators	/Partners (Specify)		5	5		
	Name and Address (No., City,		Title	Amount			
					h		
2. Other Withdrawings(Specify) Purpose Amount					Þ		
	Purpose		Amo				
3. Total Deductions			5		(2.050.400)		
H. Balan	Balance at End of Period09/30/17			5	(3,950,499)		

State of Connecticut Annual Report of Long-Term Care Facility CSP-37 Rev. 9/2002

I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page of				
4 Hazel Avenue Operations LLC, d/b/a/	2371	9/30/2017	37 37				
Check appropriate category							
Image: Chronic and Convalescent Nursing Home only (CCNH) Rest Home with Nursing Supervision only (RHNS) Image: Chronic and Convalescent Nursing Supervision only (RHNS)							
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					
Thom Farmer Sr. O'scitor of Rein butsement 12/19/2017							
Printed Name of Preparer							
Thomas Farnan - Director of Reimbursement							
Addres Address		Phone Number					
200 Brickstone Square, Andover, MA 0181	0	978-247-5029					