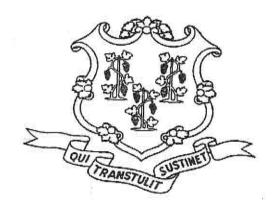
# **State of Connecticut**



# Annual Report of Long-Term Care Facility Cost Year 2020

Name of Facility (as	licensed)						
301 Rope Ferry Road	l, LLC d/b/a Ba	yview Health	Care Center				
Address (No. & Stree 301 Rope Ferry Rd, V							
Type of Facility	Too to a south all the state of						
Chronic and C ✓ Nursing Home (CCNH)			Rest Home with N Supervision only (RHNS)	Jursing	□ (Sp	ecify)	
Report for Year Begi 10/1/2019	nning		Report for Year E 9/30/2020	nding			
License Numbers:		CCNH 2318	RHNS	(	(Specify)	Me	dicare Provider 07-5324
Medicaid Provider N	umbers:	CC	CNH	RHI	NS	IC	F-IID
		2318					
For Department Use							
Sequence Number Assigned	Signed and Notarized	Date Received	Sequence Nun Assigned	ıber	Signed and l	Notarized	Date Received

#### **General Information**

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
301 Rope Ferry Road, LLC d/b/a Bayview Health Care	2318	9/30/2020	1	37

#### Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISIONMENT 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 301 Rope Ferry Road, LLC d/b/a Bayview Health Care Center [facility name], for the cost report period beginning October 1, 2019 and ending September 30, 2020, 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
hirelely (aubor		2112/2021		2112/2021
Printed Name (Administrator) Kimberly Carlson		N.	Printed Name (Owner) Lawrence Santilli	40000
Subscribed and Sworn	State of	Date	Signed (Notary Public)	Comm. Expires
to before me: Montagra	Connecticul	3/12/2021	Land Montegan	413012022
Address of Notary Public	Ruela Ori	36		
Nau	gatuck CT	06770	1904 - 1905 - WATER OF THE RESERVE O	

(Notary Seal)

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# State of Connecticut Department of Social Services

55 Farmington Avenue, Hartford, Connecticut 06105

Data Required for Real Wage Adjus	tm	ent		Page 1A	of 37
Name of Facility		Period Cov	ered:	From	То
301 Rope Ferry Road, LLC d/b/a Bayview Health Care Center				10/1/2019	9/30/2020
Address of Facility					
301 Rope Ferry Rd, Waterford, CT 06385					
Report Prepared By		Phone Nur		Date	
Athena Health Care Associates, Inc		(860) 751-	3900	2/15/2021	
Item  1. Dietary wages paid	\$	Total	CCNH	RHNS	(Specify)
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

			ne No. of Fac -444-1175	cility	Report for Ye 9/30/2020	ar Ended	Page 2	of 37
Name of Facility (as shown on license)	-	300		o. & S	Street, City, Sto	ate, Zip)		
301 Rope Ferry Road, LLC d/b/a Bayview	Health Care C	ente	Fig. 1 Sept. March 1 and 1 Sept. Community of Sept.		프랑 아름아 시아의 경우는 이번 10 아이를 맞는다 이 시작은		5	
License Numbers:	CCNH 2318		RHNS		(Specify)		Medicare ) 07-5324	Provider No
Type of Facility (Check appropriate box(es								
Chronic and Convalescent Nursing Home only (CCNH)			t Home with pervision only			(Specify	)	
Type of Ownership (Check appropriate box	<b>(</b> )							
O Proprietorship  O LLC O	Partnership	0	Profit Corp.	0	Non-Profit Co	гр. О	Government	O Trust
If this facility opened or closed during repo	rt year provide	a:		Date	e Opened	Date Clo	sed	
Has there been any change in ownership	-							
or operation during this report year?		0	Yes	•	No	If "Yes,"	explain ful	ly.
Administrator								
Name of Administrator					Nursing H	Manual School	2222	
Kimberly Carlson					Administra License	1000	2318	
Other Operators/Owners who are assistant	administrators	(ful	l or part time	) of t				
Name Not Applicable					License	No.:		
		_				_		

### General Information and Questionnaire Partners/Members

Name of Facility		License No.	Report for Y	ear Ended	Page of
301 Rope Ferry Road, LLC d/b	o/a Bayview Health Care	2318	9/30/2020		3 37
Legal Name of Part			Business Address State(s) and/or Which Reg		
301 Rope Ferry Road, LLC		301 Rope Ferry Waterford, CT 0		СТ	
Name of Partners/Members	Business Ac	ldress	3	Title	% Owned
Lawrence G Santilli	135 South Road Farmin 06032	ngton, CT	Managing M	1ember	0.6666
Lawrence G Santilli & Janice (	135 South Road Farmin 06032	ngton, CT	Member		0.3334
					l l

## General Information and Questionnaire Corporate Owners

Name of Facility	License No.	Report for Year	Ended	Page of
301 Rope Ferry Road, LLC d/b/a Bayview H	2318	9/30/2020	11111	3A 37
If this facility is owned or operated as a corpo		the following info	mation:	
Legal Name of Corporation		iess Address		ch Incorporated
	= =	9 = = = = = = = = = = = = = = = = = = =		=
Name of Directors, Officers	Busir	ness Address	Title	No. Shares Held by Each
		333		
Names of Stockholders Owning at Least 10% of Shares				
		(H)		

# General Information and Questionnaire Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page of
301 Rope Ferry Road, LLC d/b/a Bayview Health		9/30/2020	3B 37
If this facility is owned or operated as an individua		provide the following informat	tion:
	ner(s) of Facility		
0990309039			
	-		
,			

State of Connecticut
Annual Report of Long-Term Care Facility
CSP-4 Rev. 10/2005

# General Information and Questionnaire Related Parties\*

Name of Facility 301 Rope Ferry Road, L.	ne of Facility Rope Ferry Road, LLC d/b/a Bayview Health Care	License No.	No. 2318		Report for Year Ended 9/30/2020		Page 4	of 37
Are any individuals rece	Are any individuals receiving compensation from the facility related through	cility rela	ted thro	ngh		If "Yes," provide the Name/Address and	e Name/Ado	iress and
marriage, ability to conti	marriage, ability to control, ownership, family or business association?	ss associa	tion?	0	O Yes O No	complete the information on Page 11 of the report.	nation on Pa	ge 11 of the report.
Are any individuals or c	Are any individuals or companies which provide goods or services,	or service	Š,					
including the rental of prelated through family as	including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business	o this fac control,	ility, or busir	ess	O Yes O No			
association to any of the	association to any of the owners, operators, or officials of this facility?	of this fac	ility?			If "Yes," provide the following information:	e following	information:
				Ì				
		Also I	Provides	ss		Indicate Where		
		Goods/	Goods/Services to	s to		Costs are Included		
Name of Related	Business	Non-Related Parties	ated Pa	rrties	Description of Goods/Services	in Annual Report	Cost	Actual Cost to the
Individual or Company	Address	Yes	No	**%	Provided	Page # / Line #	Reported	Related Party
Procare LTC	1492 Highland Ave, Cheshire, CT 06410	0	0	%05>	Рһатпасу	Pg 20, 5a2	307,486	307,486
Miscellaneous Facilities	Various	0	0	%86<	Interfacility Loans	Pg 33, A2		
Laurel Ridge Health Care	642 Danbury Road, Ridgefield, CT 06877	0	0	%86>	Bank Fees	Pg 16, m13	4,872	4,872
Athena Health Care Systems 06032	135 South Rd, Farmington, CT 06032	0	0	%0\$>	Participates in Health Insurance Plan	Pg 15, 1ae	921,054	921,054
Bayview Health Care Landlord	135 South Rd, Farmington, CT 06032	0	•		Lease of Facility	Pg 22, L9 and 10b, pg.	828,771	828,771
Athena Health Care Systems 06032	135 South Rd, Farmington, CT 06032	0	0	<20%	See attached			
Athena Captive LLC	135 South Rd, Farmington, CT 06032	0	•		Worker's Compensation Captive	Pg 15 1a1	451,906	451,906
Athena Health Care Systems 06032	135 South Rd, Farmington, CT 06032	0	0		Facility participates in a multi-facility 401K			- ;
		0	•					

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Provide the percentage amount of revenue received from non-related parties.

Cost year 2020

Bayview RELATED PARTIES QUESTIONNAIRE PAGE 4

FACILITY	ADDRESS	Also Provided Goods/Services to Non-Related Parties Yes No %**	Description of Goods/Services Provided	Indicate Where Gosts are included in Annual Report Page # / Line #	Casts Reported	Actual Cost to the Related Party
mena Health Care Associates	135 South Road Farmington, CT 06032	X × × ×	Management Fees Business Promotion Postage	Pg 15, 1g, Pg 16, m13 Pg 16, m7	\$672,312 \$455 \$776	\$282,202 \$455 \$776
			Payroll Processing	Pg 16, m13	25,53 26,63	\$5,194
			Employee Maniloring	Pg 16, m13	\$6,256	\$6,256
			Maintenance & Repairs	Pg 22, Sa	\$5,435	\$5,435
			Nursing	Pg. 20, 5c	\$2,778	\$2,778

### General Information and Questionnaire Basis for Allocation of Costs

Name of Facility	License No	•	Report for Year Ended	Page	of		
301 Rope Ferry Road, LLC d/b/a Bayview Hea	2318		9/30/2020	5	37		
If the facility is licensed as CDH and/or RCH or must be allocated to CCNH and RHNS as follow		IDS or TE	I services with special Medi	caid rates, c	costs		
Item			Method of Allocation	on			
Dietary		Number o	f meals served to residents				
Laundry		Number o	f pounds processed				
Housekeeping			f square feet serviced				
The state of the s			f hours of routine care provide	led by EAC	H		
Nursing		employee	classification, i.e., Director ( I Nurses, Licensed Practical	or Charge N	Vurse),		
		Attendant		, , , , , , , , , , , , , , , , , , , ,			
Direct Resident Care Consultants		Number o	f hours of resident care provi	ded by EAG	CH		
1			(See listing page 13)				
Maintenance and operation of plant		Square fee					
Property costs (depreciation)		Square fee					
Employee health and welfare		Gross salaries Appropriate cost center involved					
Management services							
All other General Administrative expenses Total of Direct and Allocated Costs  The preparar of this report must answer the following questions applicable to the cost information provided.							
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 O Yes O No If "No," explain fully why such allocation was					tion was		
costs allocated as required? not made.							
Not Applicable							
3 金							
<ol><li>Explain the allocation of related company ex</li></ol>	penses and	attach cop	y of appropriate supporting of	lata.			
Not Applicable							
3. Did the Facility appropriately allocate and se				home cost	centers?		
(e.g., Assisted Living, Home Health, Outpati	ent Services	s, Adult Da	ny Care Services, etc.)				
	O Yes	⊙ No	If "No," explain fully why not made.	such allocat	tion was		
Not Applicable							
WODERSTON (金)							

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.

SHOULD HOLDE HIGHAGE III HIESE AHOUMS.							
Name of Facility			License No.	Report for Year Ended	ear Ended		Page of
301 Rope Ferry Road, LLC d/b/a Bayview Health Care Cen	lealth Ca	are Cen	2318	9/30/2020			6 37
	Related * to	d * to					
	Owners,	lers,					
	Operators,	ators,				Annual	
	Offi	Officers		Date of	Term of	Amount	Amount
Name and Address of Lessor	Yes	No	Description of Items Leased	Lease**	Lease	of Lease	Claimed
Pitney Bowes Credit - P.O.Box 856460, Louisville, KY	0	0	Postage Meter	12/28/10	66 months	1,211	1,211
Leaf 1720A Crest St Moberly Mo 65270	0	0	Copier	03/01/17	50 months	11,894	11,894
CSC Leasing Company, 6806 Paragon Place, Suite 170, Richmond, VA 23230	0	0	Nurse Call System	02/02/15	60 months	7,263	7,263
CSC Leasing Company, 6806 Paragon Place, Suite 170, Richmond, VA 23230	0	0	Telephone System	03/02/15	60 months	13,528	13,528
Leaf 1720A Crest St Moberly Mo 65270	0	0	Xerox Copier	81/55/18	39 months	<i>261</i>	795
Wells Fargo Financial Leasing, Inc - P.O.Box 10306 Des Moines, IA 50306-0306	0	0	Kyocera Printer and Toshiba Copier	06/01/20	60 months	4,390	4,390
	0	0					
Sec	0	0					
	0	0					
	0	0					

Is a Mileage Log Book Maintained for All Leased Vehicles?

\* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.

Total \*\*\*

% 0

O Yes

\*\*\* Amount should agree to Page 22, Line 6e.

<sup>\*\*</sup> Attach copies of newly acquired leases.

# General Information and Questionnaire Accounting Basis

Name of Facility License No.	Report for Year Ended		Page	of
301 Rope Ferry Road, LLC d/b/a B 2318	9/30/2020		7	37
The records of this facility for the period covered by this	report were maintained on the following basis:			
Accrual O Cash O Modified Cash				
s the accounting basis for this	W689970 7M 03 3			
period the same as for the O Yes	If "No," explain.			
previous period? O No			-	
		= :	= =	
Independent Accounting Firm				
Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)			
Dworkin, Hillman, Lamorte & Stercza	4 Corporate Dr., Suite 488, Shelton, CT 06			
2 Marcum LLP	555 Long Wharf Drive, New Haven, CT 0	6511		
3 HFG				
1				
Services Provided by This Firm (describe fully)				
Audit & Tax Return Fees 2019		\$	10,100	
! Medicare Cost Report	200	<u> </u>	2,700	
Line of Credit Audit: Disallowed		\$	3,275	
And the second s		\$	7777	
		Charge for S	ervices Pr	ovided
		\$	16,075	
Are These Charges Reflected in the Expenditure Portion of This Rep	ort? If Yes, Specify Expense Classification and Line No.			
O Yes O No Pg 15, Line 1d				
Legal Services Information		Talankana N	Termelean	
Name of Legal Firm or Independent Attorney		Telephone N 301-760-760		
Midcap Financial Services		203-899-890		
2 Goldman, Gruder & Woods 3 Murtha Cullina		203-899-890 203-772 <b>-7</b> 70		
Pilicy & Ryan, PC		860-444-117		
Treasurer, State of CT		860-443-712		
Address (No. & Street, City, State, Zip Code)		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
7255 Woodmont Ave, Bethesda, MD				
2 200 Connecticut Ave, Norwalk, CT 06854				
3 265 Church St, New Haven, CT 06510				
365 Main St. PO Box 760, Watertown, CT 06795				
5 181 State St, Room 2m PO Box 148 New London, C	CT 06320			
Services Provided by This Firm (describe fully)				
Banking fees-Disallowed		S	3,172	
Collections - Disallowed	44 C	\$	16,128	
General matters - Disallowed		\$	792	
Collections - Disallowed/Conservatorship-Disallowed		\$	1,103	
Conservatorship-Disallowed		S	1,039	0 & W
		Charge for S	Services Pr	ovided
		\$	22,234	
Are These Charges Reflected in the Expenditure Portion of This Rep	ort? If Yes, Specify Expense Classification and Line No.			
O 103 O 110				

State of Connecticut Annual Report of Long-Term Care Facility CSP-8 Rev. 9/2002

# Schedule of Resident Statistics

Name of Facility			License No.	Jo.			Renort fo	Report for Year Ended	Pe		Page	of
301 Rope Ferry Road, LLC d/b/a Bayview Health Care Center	are Center		2	2318			9/30/2020	)			8	37
	D- 18					Period 10/1 Thru 6/30	1 Thru 6/	30	8 18	Period 7/	Period 7/1 Thru 9/30	0
	Total All	Total CCNH	Total RHNS	Total								
	Levels	Level	Level	(Specify)	Total	CCNH	RHINS	(Specify)	Total	CCNH	RHINS	(Specify)
1. Certified Bed Capacity												
<ul> <li>A. On last day of PREVIOUS report period</li> </ul>	127	127			127	127						
B. On last day of THIS report period	127	127							127	127		
2. Number of Residents												
<ul> <li>A. As of midnight of PREVIOUS report period</li> </ul>	119	119			119	119						
B. As of midnight of THIS report period	120	120							120	120		
3. Total Number of Days Care Provided During Period												
A. Medicare	4,311	4,311			3,484	3,484			827	827		
B. Medicaid (Conn.)	29,915	29,915			22,499	22,499			7,416	7,416		
C. Medicaid (other states)												
D. Private Pay	3,989	3,989			2,881	2,881		100.004	1,108	1,108		
E. State SSI for RCH												
F. Other (Specify) Managed Care Other	2,077	2,077			1,609	1,609			468	468		
G. Total Care Days During Period (3A thru F)	40,292	40,292			30,473	30,473			618'6	9,819		
Total Number of Days Not Included in Figures in 3G												.+===
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	09	99	, - co 1 co 2		52	52			80	00		
5. Total Resident Days (3G + 4A + 4B)	40,352	40,352			30,525	30,525			9,827	9,827		

Schedule of Resident Statistics (Cont'd)

A. Were there any changes in the certified bed capacity during the report year?   O Yes	Name of Fac	ility			Licer	nse No.				Report	t for Year	Ended		Page	of
If "YES", provide the following information:   Place of Change	301 Rope Fe	rry Road	, LLC d/	b/a Bayview He		2318					9/30/202	0		9	37
Place of Change			157			ipacity di	iring t	the rep	ort yea	ar?	0	Yes	0	No	
Date of CNH RHNS   (Specify)		1				Cl	nange	in Bec	İs		Car	pacity Afte	r Change		
Change	Date of	CCNH					B-			d	-				
Contemps	3000 B	100		(openity)		Dost	ı -			_	1				
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  CCNH  RHNS  (Specify)  Second Condition  CCNH  RHNS  CCNH  RHNS  CCNH  RHNS  CCNH  RHNS  CCNH  RHNS  COHER State Assisted  CCNH  RHNS  COHER State Assisted  CCNH  RHNS  COHER State Assisted  CCNH  RHNS  CCNH  RHN	Change	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	Reason f	or Change
RESIDENT DAYS for 90 days following the change.   CCNH RHNS (Specify)		1							\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \						
RESIDENT DAYS for 90 days following the change.   CCNH   RHNS   (Specify)															
RESIDENT DAYS for 90 days following the change.   CCNH   RHNS   (Specify)															
RESIDENT DAYS for 90 days following the change.   CCNH RHNS (Specify)															
Change in Resident Days		The state of the s	Control of the Contro				the r	report y	/ear (a	s repor	ted in iter	n 4 above)	provide the nu	mber of	
Second Content				7:	V	1982					CC	NIH	RHNS	(Sne	ecify)
2nd change   3rd change   4th change   5th	1st char	nge		Change in re	calder	it Days							Idiito	(op.	
3rd change   4th change   6. Number of Residents and Rates on September 30 of Cost Year															
Ath change									= -76						
Medicare   Medicaid   Self-Pay   Other State Assisted	4th char	nge											2 - 4 - 4 - 4		
Item	6. Number	of Resid	dents and		ember			ar							
No. of Residents   10   95   12   3   3     Per Diem Rate   a. One bed rm.   638.00   250.79   535.00   496.66   5     b. Two bed rms.   638.00   250.79   525.00   496.66   5     c. Three or more bed rms.   TOTAL   CCNH   RHNS   (Specify)     7. Total Number of Physical Therapy Treatments   A. Medicare - Part B   4,539   4,539     B. Medicaid (Exclusive of Part B)   1. Maintenance Treatments   745   745     2. Restorative Treatments   2,2   2,2   2,2     D. Total Physical Therapy Treatments   14,604   14,604     8. Total Number of Speech Therapy Treatments   14,604   14,604     8. Total Number of Speech Therapy Treatments   14,604   14,604     8. Medicaid (Exclusive of Part B)   1. Maintenance Treatments   131   131     2. Restorative Treatments   131   131     2. Restorative Treatments   902   902			-	Medicare		Medi	caid				Se	lf-Pay		Other Sta	te Assisted
No. of Residents   10   95   12   3   3     Per Diem Rate   a. One bed rm.   638.00   250.79   535.00   496.66   5     b. Two bed rms.   638.00   250.79   525.00   496.66   5     c. Three or more bed rms.   TOTAL   CCNH   RHNS   (Specify)     7. Total Number of Physical Therapy Treatments   A. Medicare - Part B   4,539   4,539     B. Medicaid (Exclusive of Part B)   1. Maintenance Treatments   745   745     2. Restorative Treatments   2,2   2,2   2,2     D. Total Physical Therapy Treatments   14,604   14,604     8. Total Number of Speech Therapy Treatments   14,604   14,604     8. Total Number of Speech Therapy Treatments   14,604   14,604     8. Medicaid (Exclusive of Part B)   1. Maintenance Treatments   131   131     2. Restorative Treatments   131   131     2. Restorative Treatments   902   902															
No. of Residents   10   95   12   3   3     Per Diem Rate   a. One bed rm.   638.00   250.79   535.00   496.66   5     b. Two bed rms.   638.00   250.79   525.00   496.66   5     c. Three or more bed rms.   TOTAL   CCNH   RHNS   (Specify)     7. Total Number of Physical Therapy Treatments   A. Medicare - Part B   4,539   4,539     B. Medicaid (Exclusive of Part B)   1. Maintenance Treatments   745   745     2. Restorative Treatments   2,2   2,2   2,2     D. Total Physical Therapy Treatments   14,604   14,604     8. Total Number of Speech Therapy Treatments   14,604   14,604     8. Total Number of Speech Therapy Treatments   14,604   14,604     8. Medicaid (Exclusive of Part B)   1. Maintenance Treatments   131   131     2. Restorative Treatments   131   131     2. Restorative Treatments   902   902				5539000900000	80		2000		10000	35000000	795910	G999723	Q-000000000000000000000000000000000000	1201100000	B950520000A30
Per Diem Rate					C			HNS	C			INS	(Specify)	R.C.H.	ICF-MR
A. One bed rm.   638.00   250.79   535.00   496.66     b. Two bed rms.   638.00   250.79   525.00   496.66     c. Three or more bed rms.   TOTAL   CCNH   RHNS   (Specify)     7. Total Number of Physical Therapy Treatments   A. Medicare - Part B   4,539   4,539     8. Medicaid (Exclusive of Part B)   1. Maintenance Treatments   745   745     2. Restorative Treatments   745   745     3. Total Physical Therapy Treatments   745   745     4. Total Physical Therapy Treatments   745   745     5. Total Physical Therapy Treatments   746   746     8. Total Number of Speech Therapy Treatments   746   746     8. Medicare - Part B   746   746     8. Medicare - Part B   746   746     9. Medicare Treatments   131   131     1. Maintenance Treatments   131   131     2. Restorative Treatments   902   902	100000000000000000000000000000000000000		S	10	Company of the last	95	VIII-DATE:	S-10450044440	THE COME	12		330000000000000000000000000000000000000	ONE WHO IS NOT STATE		MENNAMED
b. Two bed rms.   638.00   250.79   525.00   496.66     c. Three or more   bed rms.				620.00	DESCRIPTION	250.70	Message	MERSON	(892)	676.00			406.66		
c. Three or more bed rms.       TOTAL       CCNH       RHNS       (Specify)         7. Total Number of Physical Therapy Treatments       4,539       4,539         A. Medicare - Part B       4,539       4,539         B. Medicaid (Exclusive of Part B)       745       745         1. Maintenance Treatments       9,320       9,320         C. Other       9,320       9,320         B. Total Physical Therapy Treatments       14,604       14,604         A. Medicare - Part B       776       776         B. Medicaid (Exclusive of Part B)       1       776         1. Maintenance Treatments       131       131         2. Restorative Treatments       902       902															
TOTAL   CCNH   RHNS   (Specify)				654,00		230,75	0			323.00			170.00		
7. Total Number of Physical Therapy Treatments       TOTAL       CCNH       RHNS       (Specify)         A. Medicare - Part B       4,539       4,539       4,539         B. Medicaid (Exclusive of Part B)       4,539       4,539       4,539         1. Maintenance Treatments       745       745       745         2. Restorative Treatments       9,320       9,320       9,320         D. Total Physical Therapy Treatments       14,604       14,604       14,604         8. Total Number of Speech Therapy Treatments       776       776         B. Medicaid (Exclusive of Part B)       776       776         B. Medicaid (Exclusive of Part B)       131       131         1. Maintenance Treatments       131       131         2. Restorative Treatments       902       902	11 77		۱ ا												
A. Medicare - Part B       4,539       4,539         B. Medicaid (Exclusive of Part B)       745       745         1. Maintenance Treatments       745       745         2. Restorative Treatments       9,320       9,320         D. Total Physical Therapy Treatments       14,604       14,604         8. Total Number of Speech Therapy Treatments       776       776         B. Medicaid (Exclusive of Part B)       776       776         1. Maintenance Treatments       131       131         2. Restorative Treatments       902       902	bcu	11115,			_					•				-1115	
A. Medicare - Part B       4,539       4,539         B. Medicaid (Exclusive of Part B)       745       745         1. Maintenance Treatments       745       745         2. Restorative Treatments       9,320       9,320         D. Total Physical Therapy Treatments       14,604       14,604         8. Total Number of Speech Therapy Treatments       776       776         B. Medicaid (Exclusive of Part B)       776       776         1. Maintenance Treatments       131       131         2. Restorative Treatments       902       902															75.7 Ph. 17
B. Medicaid (Exclusive of Part B)       1. Maintenance Treatments       745       745         2. Restorative Treatments       9,320       9,320         C. Other       9,320       9,320         D. Total Physical Therapy Treatments       14,604       14,604         8. Total Number of Speech Therapy Treatments       776       776         A. Medicare - Part B       776       776         B. Medicaid (Exclusive of Part B)       131       131         1. Maintenance Treatments       131       131         2. Restorative Treatments       902       902	7. Total N	umber of	f Physica	l Therapy Treat	ment	3					ТО	TAL	CCNH	RHNS	(Specify)
1. Maintenance Treatments       745       745         2. Restorative Treatments       9,320       9,320         C. Other       9,320       9,320         D. Total Physical Therapy Treatments       14,604       14,604         8. Total Number of Speech Therapy Treatments       776       776         A. Medicare - Part B       776       776         B. Medicaid (Exclusive of Part B)       131       131         1. Maintenance Treatments       131       131         2. Restorative Treatments       902       902						*						4,539	4,539		
2. Restorative Treatments       9,320       9,320         C. Other       9,320       9,320         D. Total Physical Therapy Treatments       14,604       14,604         8. Total Number of Speech Therapy Treatments       776       776         A. Medicare - Part B       776       776         B. Medicaid (Exclusive of Part B)       131       131         1. Maintenance Treatments       131       131         2. Restorative Treatments       902       902	В										EI (488/19)	\$ 108AUG/118			ALL ENGINEERS
C. Other       9,320       9,320         D. Total Physical Therapy Treatments       14,604       14,604         8. Total Number of Speech Therapy Treatments       776       776         A. Medicare - Part B       776       776         B. Medicaid (Exclusive of Part B)       131       131         1. Maintenance Treatments       131       131         2. Restorative Treatments       902       902												745	745		
D. Total Physical Therapy Treatments			torative '	reatments							_		0.000		
8. Total Number of Speech Therapy Treatments       6       1			Dhueloal '	Thanana Taaata	u au do						-				Tr. 100 - 10
A. Medicare - Part B 776 776  B. Medicaid (Exclusive of Part B) 131 131  2. Restorative Treatments 902 902								_	_		ORAL INSULATION	14,004	14,004		SHARK THE PARTY OF THE
B. Medicaid (Exclusive of Part B)       131       131         1. Maintenance Treatments       131       131         2. Restorative Treatments       902       902					icins						CICTOR STREET	776	776	AND DESCRIPTIONS	MATERIAL POR
1. Maintenance Treatments       131       131       131         2. Restorative Treatments       200											TENESTA IN				O STATE OF THE STATE OF
2. Restorative Treatments         902           C. Other         902												131	131		
												902			
D. Total Speech Therapy Treatments 1,809 1,809												1,809	1,809		
9. Total Number of Occupational Therapy Treatments					Treati	nents					SUPERIOR OF		(网络)特别加美洲山门包第四		SEPTEMBER ST
A. Medicare - Part B 5,137 5,137												5,137	5,137		
B. Medicaid (Exclusive of Part B)  1. Maintenance Treatments  857  857	В											967	067	uniertesynkmä (	Service Carlo Carlo III
1. Maintenance Treatments 857 857  2. Restorative Treatments									-		+	637	83/		
C. Other 9,216 9,216			winive 1	reauments				-				9.216	9.216		
D. Total Occupational Therapy Treatments 15,210 15,210			Occupatio	onal Therapy T	reatn	nents									

#### Annual Report of Long-Term Care Facility

CSP-10 Rev. 9/2002

Report of Expenditures - Salaries & Wages

Name of Facility 301 Rope Ferry Road, LLC d/b/a Bayview Health Care Cer	License No.		Report for Yes 9/30/2020	ar Ended	Page 10	of   37
Are time records maintained by all individuals receiving co	3 ( ) - 1 ( ) sances - 1 ( )		Yes	0	No	
41e time records manitamed by an individuals receiving co	inpensacion:		NEXTAGE.	9%7.	110	
AND AND AND SOURCE EVEN WHILE SEREN AS THAT OF A			Total Cost	and Hours		
			01 02 WX	222	NSG 64604N	939
Item A. Salaries and Wages*	CCNH	Hours	RHNS	Hours	(Specify)	Hours
Salaries and Wages*     Operators/Owners (Complete also Sec. I     of Schedule A1)						
2. Administrator(s) (Complete also Sec. III	ESAMBLE DO					
of Schedule A1)	157,959	2,179				
3. Assistant Administrator (Complete also Sec. IV	NAME OF STREET		THE THE REST		REVERSE	MINE THE
of Schedule A1)						
4. Other Administrative Salaries (telephone		Total Control	TO STREET			Marie Strong
operator, clerks, receptionists, etc.)	283,503	10,927				
5. Dietary Service					E (B) (1) (B) (B) (1) (B)	SSA BUREZAS
a. Head Dietitian		Designation of the second				711
b. Food Service Supervisor	43,562	1,478				
<ul> <li>c. Dietary Workers</li> </ul>	534,740	28,717				
<ol><li>Housekeeping Service</li></ol>		METERS IN				
a. Head Housekeeper	64,221	2,241				
b. Other Housekeeping Workers	319,382	18,615				
<ol><li>Repairs &amp; Maintenance Services</li></ol>			ME WERE		The sall grant	
Engineer or Chief of Maintenance	69,823	2,222				
b. Other Maintenance Workers	63,801	2,499		A A STATE OF THE S	VINNEW INVESTIGATION	
8. Laundry Service						
a, Supervisor	106.545	5.016	-			-
b. Other Laundry Workers	106,545	5,816				
Barber and Beautician Services						
10. Protective Services	Manhada Literaria Mila	ALCOHOL: USA	company and a second		STOREST CONTRACTOR	Stational Co.
11. Accounting Services a. Head Accountant		CHARLES WEEK		A COLUMN TO SERVICE A SERV	DEGRAMMARIE EN PROPERTOR	MONTH PROPERTY
b. Other Accountants						
12. Professional Care of Residents				SUBDRUGERA	MARKETAN	NO EXCENSION
a. Directors and Assistant Director of Nurses	229,677	4,068				AND DESCRIPTION OF THE PERSON NAMED IN COLUMN
	229,011	4,000	STATE OF STREET	- Control of the Control		CONTRACTOR OF COMME
b. RN 1. Direct Care	761,419	17,352	AND DESCRIPTION OF THE PARTY OF	Contract State of the last of	STATE OF STREET	AND DESIGNATION OF THE PERSON NAMED IN
2. Administrative**	449,928	15,477				
c. LPN	147,728			DESCRIPTION OF THE PARTY OF THE	SEDELLO DE LOS DELOS DE LOS DELOS DE LOS DELOS DE LOS DELOS DE LOS DE LOS DELOS DE LOS DELOS DE LOS DELOS DE LOS DELOS DELOS DELOS DE LOS DELOS	MANINE
Direct Care	1,170,269	34,949		Management ave	ATTENNACTOR SHOWING	-
2. Administrative**	1,170,207	01,212				
d. Aides and Attendants	2,122,974	101,904				35
e. Physical Therapists	583,419	15,827				
f. Speech Therapists	93,208	1,986				
g. Occupational Therapists	318,222	7,984				
h. Recreation Workers	199,057	8,832				
i. Physicians				R COURTE DE LA	DESCRIPTION OF THE PARTY OF	MALE TO S
Medical Director					-1	
Utilization Review						
3. Resident Care***						
4. Other (Specify)		1000 = 101		ENERGE E		WESSIVES!
j. Dentists						
k. Pharmacists						
Podiatrists						
m. Social Workers/Case Management	276,745	9,230				-
n. Marketing					The state of the s	C Company of the Comp
o. Other (Specify)	Total Control of the Party of t	A-1/12 1/5/2			MES ASSESSMEN	ON THE PERSON
See Attached Schedule  A-13. Total Salary Expenditures	7,848,454	292,303				

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

<sup>\*\*\*</sup> This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

#### Schedule of Other Salaries and Wages (Page 10)

		CCNH	R	HNS	(Spe	cify)
Position	S	Hours	S	Hours	S	Hours
						Month of the Control
				STATE OF THE PARTY		7 10 2
Total	s		s -		\$ -	

#### Schedule of Other Fees (Page 13)

		CCNH	RI	INS	(Spe	cify)
Service	S	Hours	\$	Hours	S	Hours
					Activity at	
					d d	
Γotal	\$	-   -	\$ -	-	\$ -	

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.	9	Renort for	Report for Year Ended		Page	of
									205	5
301 Rope Ferry Road, LLC d/b/a Bayview Health Care Center	Sayview He	salth Care C	enter	2318		9/30/2020			=	37
		Salary Paid	-							
				Fringe Benefits and/or Other Payments	Full Description of	Total Hours	Line Where Claimed on	Name and Address of All	Total Hours	Compensation
Name	CCNH	RHINS	(Specify)	(describe fully)	Services Rendered	Worked	Page 10	Other Employment**	Worked	Received
Section I - Operators/Owners										
Not Applicable							- 5			
ord										
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).										
Not Applicable										223
2- 3)	- 5-55-7		0114 = ===							
										77

<sup>\*</sup> No allowance for salaries will be considered unless full information is provided. Use additional sheets if required.

<sup>\*\*</sup> Include all employment worked during the cost year.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

Schedule A1 - Salary Information for Operators/Owners; Administrators,

Assistant Administrators and Other Related Parties\*

	_	_											
	Jo	37			Compensation Received		1	* 11			140		8
	Page	12		Total	Hours Worked								
				!!	Name and Address of All Other Employment**								
I altics.	ear Ended			Line Where	Claimed on Page 10		A2						
Nelaleu	Report for Year Ended	9/30/2020		Total	Hours Worked		2,179 A2						
Assistant Auministrators and Ouici Neigicu Fallies					Full Description of Services Rendered		Day to day operations of the nursing home facility.						
שוואווווואר	License No.	2318		Fringe Benefits and/or Other	Payments (describe fully)		Health & life insurances, Payroll Taxes					v	
essistant		enter	1		(Specify)								
L		alth Care C	Salary Paid		RHNS								
		ayview He			CCNH		157,959			i,		2 144-	=
	Name of Facility (as licensed)	301 Rope Ferry Road, LLC d/b/a Bayview Health Care Center	E 45-1		Name	Section III - Administrators***	Kimberly Carlson (10/1/19- 9/30/20)	-22 20 - 2-1	Section IV - Assistant Administrators				

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

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

<sup>\*\*\*</sup> If more than one Administrator is reported, include dates of employment for each.

#### Annual Report of Long-Term Care Facility

CSP-13 Rev. 9/2002

B. Report of Expenditures - Professional Fees

Name of Facility 301 Rope Ferry Road, LLC d/b/a Bayview Health C	License No. 231	8	Report for Y 9/30/2020	ear Ended	Page 13	of   37
Sor Rope Ferry Road, EDE Grova Bayview Health C	251		Total Cost	and Hours		
	Politica Valuations	250	Alles (Section Sections)		1202 1001000	150
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	44,871	997				
2. Dentist	12,852	20				
3. Pharmacist	12,527	12				
4. Podiatrist						
Physical Therapy     a. Resident Care						
b. Other		1,20,000				
6. Social Worker						
7. Recreation Worker						
8. Physicians	STIME NEW					
<ul> <li>a. Medical Director (entire facility)</li> </ul>	91,500	228				
b. Utilization Review	ASSIDADA NO DE		nes a local	Walnings		
(Title 18 and 19 only) monthly meeting						1
c. Resident Care**						
d. Administrative Services facility  1. Infection Control Committee (Quarterly meetings)						
Pharmaceutical Committee     (Quarterly meetings)						
Staff Development Committee     (Once annually)						
e. Other (Specify)	MUNISPERNINI		G OF SALES			
9. Speech Therapist					NEW SEASON	Box I more like
a. Resident Care						
b. Other						
10. Occupational Therapist						TEMPONEN.
a. Resident Care						OT PARTY
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN	E SERVE	ALIEN STATE				
1. Direct Care				Rest S		
2. Administrative***						
c. Aides						
d. Other						A DITA MARKET
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	161,750	1,257	===			

<sup>\*</sup> 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.

<sup>\*\*</sup> 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.

<sup>\*\*\*</sup> 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. Health Care ( 2318		Report for 3 9/30/2020	Year Ended	Page 14	of 37
301 Rope Ferry Road, LLC d/b/a Bayview l	Health Care Q 2318	Delated*	* to Owners,		14	31
Name & Address of Individual	Full Explanation of Service		ors, Officers		nation of Rel	ationship
7), control (1980), 350 (V. control (1990), 304 (1990), 304 (1990), 305 (1990), 307 (1990), 307 (1990), 307 (1		Yes	No			
Joseph Allessandro, 63 Canterbury Road, Brooklyn, CT 06234	Medical Director	0	0			
Andrea Gutierrez, D.O., 272 Allen Hill Rd., Brooklyn, CT 06234	Assistant Medical Director	0	0			
Kathleen LaBella, 12 Wadsworth Lane, Waterford, CT 06385	Dietician	0	0			
Procare, LTC, 111 Executive Blvd., Farmingdale, NY 11735	Pharmacy Services	0	0	Common Own	ers; Minority In	terest
Healthdrive Dental And Medical Group, 25 Needham St, Newtown, Ct	Dentist /Podiatry	0	0			
	THE TOTAL	0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
		0	0			
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		0	0			
		0	0			
		0	0			
		0	•			
		0	0			
		0	0			

<sup>\*</sup> Use additional sheets if necessary.

<sup>\*\*</sup> Refer to Page 4 for definition of related.

# C. Expenditures Other Than Salaries - Administrative and General

Name of Facility License No. 301 Rope Ferry Road, LLC d/b/a Bayview Healt 2318	 Report for Ye	ar Ended	Page 15	of 37
of Rope Ferry Road, Ede divid Day view Heard	7/30/2020			
Item	Total	CCNH	RHNS	(Specify)
. Administrative and General				
a. Employee Health & Welfare Benefits				
<ol> <li>Workmen's Compensation</li> </ol>	\$ 451,906	451,906		
2. Disability Insurance	\$			
Unemployment Insurance	\$ 79,735	79,735		
4. Social Security (F.I.C.A.)	\$ 558,124	558,124		
5. Health Insurance	\$ 819,490	819,490		
Life Insurance (employees only)				
(not-owners and not-operators)	\$			
7. Pensions (Non-Discriminatory)	\$ 38,467	38,467		
(not-owners and not-operators)				<b>不够到了</b>
8. Uniform Allowance	\$ 			4
9. Other (Specify)	\$		See	
See Attached Schedule			(english plant	
b. Personal Retirement Plans, Pensions, and	\$			
Profit Sharing Plans for Owners and				
Operators (Discriminatory)*				
c. Bad Debts*	\$ 61,089	61,089		SAMPLEY IN APPLE
d. Accounting and Auditing	\$ 16,075	16,075		
e. Legal (Services should be fully described on Page 7)	\$ 22,234	22,234		
f. Insurance on Lives of Owners and	\$			
Operators (Specify)*				
g. Office Supplies	\$ 45,517	45,517		
h. Telephone and Cellular Phones				
1. Telephone & Pagers	\$ 19,958	19,958		
2. Cellular Phones	\$ 1,923	1,923		
i. Appraisal (Specify purpose and	\$			
attach copy)*				
j. Corporation Business Taxes (franchise tax)	\$	and the state of t		A SHAPE SECULORATE
k. Other Taxes (Not related to property - See Page 22)				
1. Income*	\$ 14,153	14,153		
2. Other (Specify)	\$			
See Attached Schedule				
<ol><li>Resident Day User Fee</li></ol>	\$ 720,145	720,145		
ubtotal	\$ 2,848,816	2,848,816		

<sup>\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

Attachment Page 15

#### Schedule of Other Employee Benefits

Description	CCN	H RHNS	(Specify)
<b>Fotal</b>	\$	- \$	- \$ -

#### Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
	얼마닷컴(() 12월 일 7일 등 12일 등 12일		
Total	\$ -	\$ -	\$ -

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

Name of Facility License No.		Report for Y	ear Ended	Page	of
301 Rope Ferry Road, LLC d/b/a Bayview Health Care 2318		9/30/2020		16	37
Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Fo.	rward:	2,848,816	2,848,816		
l. Travel and Entertainment					
Resident Travel and Entertainment	\$			7 5	
2. Holiday Parties for Staff	\$	3,120	3,120		
3. Gifts to Staff and Residents	\$	25,815	25,815		
4. Employee Travel	\$	2,442	2,442	50,75	
<ol><li>Education Expenses Related to Seminars and Conventions</li></ol>	\$	4,617	4,617		
6. Automobile Expense (not purchase or depreciation)	\$				
7. Other (Specify)	\$				
See Attached Schedule	***				TO SELECT OF THE
m. Other Administrative and General Expenses					<b>建筑的高级</b>
Advertising Help Wanted (all such expenses )	\$	29,992	29,992		
2. Advertising Telephone Directory (all such expenses )***	\$	262	262		
3. Advertising Other (Specify)***	\$	12,031	12,031		
See Attached Schedule					
4. Fund-Raising***	\$				
5. Medical Records	\$	777			
6. Barber and Beauty Supplies (if this service is supplied	\$				
directly and not by contract or fee for service)***					
7. Postage	\$	4,523	4,523		
* 8. Dues and Membership Fees to Professional	\$	8,166	8,166		
Associations (Specify)					
See Attached Schedule					A PERCEAS
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.**	** \$				
9. Subscriptions	\$	1,250	1,250		
10. Contributions***	\$		~~~		
See Attached Schedule					
11. Services Provided by Contract (Specify and Complete	\$				
Schedule C-2, Page 21 for each firm or individual)					
12. Administrative Management Services**	\$	454,877	454,877		
13. Other (Specify)	\$	163,017	163,017		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	\$	3,558,928	3,558,928		

<sup>\*</sup> Do not include Subscriptions, which should go in item 9.

<sup>\*\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 28 of the Cost Report.

#### Schedule of Other Travel and Entertainment

Description	CCNI	1	RHNS	5	(Speci	fy)
						43
		-			N - 201	
				100		
					97 (111)	
Total Other Travel and Entertainment	s	-	S	- 3	s	

#### Schedule of Other Advertising

Description		CNH	RH	NS	(Spec	cify)
Promotional	s	12,031		VG EV	N+-#	1677
			Later Con-	-		-
Total Other Advertising	s	12,031	s		s	

#### Schedule of Dues

Description		CNH	RI	INS	(Spe	cify)
CT Assoc of Health Care Facilities	S	8,166				
		WE B			1	
				(Mali)		
				2011		Sir
Total Dues	\$	8,166	S		S	

#### Schedule of Contributions

Description	C	CNH	R	HNS	(Sp	ecify)
Total Contributions	S		S	V. 1	S	12

#### Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Licenses	\$ 3,380		
Bank Charges	S 48,520		
Payroll Processing Fees	S 23,009		
Employee Physicals & Background Checks	\$ 10,424	87/64/	li i pace
Energy Audit	\$ 16,720		
Data Processing	\$ 60,964		
Total Other Administrative and General	\$ 163,017	s -	s -

# Schedule C-1 - Management Services\*

Name of Facility 301 Rope Ferry Road, LLC d/b/a Bayviev	License No. 2318	Report for Year Ended 9/30/2020	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 #
Athena Health Care Assoc., Inc 135 South Road, Farmington, CT 06032	639,516	Contract Attached to a Prior Year	See Below
Allocation of Above	422,081	Admin/Gen 66%	Pg 16 Line 12
	102,323	Indirect 16%	Pg 18 Line 2c
	115,112	Direct 18%	Pg 20 Line 5j
Athena Health Care Assoc., Inc 135 South Road, Farmington, CT 06032	32,796	Admin/Gen- Other Expense	Pg 16, Line m12

<sup>\*</sup> 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)

Nan	ne of Facility		Licens			Report fo	г Үе	ar Ended	Page	of
301 Rope Ferry Road, LLC d/b/a Bayview Health		Car	5	231	8	9/30/2	020		18	37
	Item			38	Total	CCNI	I	RHNS	(S	pecify)
2.	Dietary a. In-House Preparation & Service 1. Raw Food			B	292,199	292,	199			
	2. Non-Food Supplies	3-00-		5	29,324	29,3			1 27 2	
	Other (Specify)  Dishes & Utensils			S .	3,347	3,3	347			
	b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)		\$	S						
	c. Other (Specify)  Management Services Temp Staffing				103,307	103,	307			
2D.	Total Dietary Expenditures (2a + b + c + d)			S	428,177	428,	177			
2E.	Dietary Questionnaire				Total	CCNI	I	RHNS	(S	pecify)
F.	Resident Meals: Total no. of meals served pe	r da	y:*		330		330			
G.	Is cost of employee meals included in 2D?	0	Yes		0	No				
H.	Did you receive revenue from employees?	0	Yes		0	No		If yes, specify amt.		\$1,858
I.	Where is the revenue received reported in the	Co	st Repo	rt? (P	age/Line	Item)			18,2.a.	1
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	0	Yes		0	No		If yes, specify cost.		\$64
K.	Is any revenue collected from these people?	0	Yes		•	No		If yes, specify amt.		
L.	Where is the revenue received reported in the	Co	st Repo	rt? (P	age/Line	Item)				
М.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	0	Yes		•	No		If yes, specify cost.		
N.	Is any revenue collected from employees?	0	Yes		0	No		If yes, specify amt.		
Ο.	Where is the revenue received reported in the	Co	et Reno	rt2 (D	age/Line	Item)		The second secon		

<sup>\*</sup> Count each tray served to a resident at meal time, but do not count liquids or other "between meal" snacks.

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

Name of Facility 301 Rope Ferry Road, LLC d/b/a Bayview Health Care (		License	No. 2318	Report for Y 9/30/2020	ear Ended	Page of 19   37
301	Rope Ferry Road, LLC d/b/a Bayview Health Care C	-	2318	9/30/2020		19   37
	Item		Total	CCNH	RHNS	(Specify)
3.	Laundry a. In-House Processing* 1. Bed linens, cubicle curtains, draperies,	Lbs.				¥
	gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$				
	<ol><li>Employee items including uniforms, gowns, etc. washed, ironed and/or</li></ol>	Lbs.				
	processed.***	Amt. \$				
	3. Personal clothing of residents	Lbs.				
	washed, ironed, and/or processed.***	Amt. \$				
	4. Repair and/or purchase of linens.***	Lbs.	··.			
	b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	Amt. \$	22,591	22,591		
	c. Other (Specify ) Supplies	\$	7,585	7,585		
3D.	Total Laundry Expenditures (3a + b + c)	\$	30,176	30,176		
3E. F.	Laundry Questionnaire  Is cost of employee laundry included in 3D? O	Yes	•	No	If yes, specify cost.	
G.	Did you receive revenue from employees?	Yes	0	No	If yes, specify amt.	
H.	Where is the revenue received reported in the Cost	Report?		(Page/Line		
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	Yes	•	No	If yes, specify cost.	
J.	Did you receive revenue from these people?	Yes	0	No	If yes, specify amt.	
K.	Where is the revenue received reported in the Cost	Report?		(Page/Line	(Item)	

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

All allocations should add to total recorded in 3D.

<sup>\*\*\*</sup> 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)

	ne of Facility		Repor	rt for Year Er	nded	Page	of
301	Rope Ferry Road, LLC d/b/a Bayview Hea	2318		9/30/2020		20	37
	Item		L3-1#0******34***	Total	CCNH	RHNS	(Specify)
4.	Housekeeping a. In-House Care	Sq. Ft. Serviced by Personnel					
	<ol> <li>Supplies - Cleaning (Mops, pails, brooms, etc.)</li> </ol>	Amt.	\$	47,482	47,482		
	b. Purchased Services (by contract other than through Management Services)	Sq. Ft. Serviced by Personnel					
	(Complete Schedule C-2 att. Page 21)	Amt.	\$				
	C. Other (Specify)		\$				
4D.	Total Housekeeping Expenditures (4a +	b+c)	\$	47,482	47,482		
i.	Resident Care (Supplies)**						
	a. Prescription Drugs***						<b>新聞的學術局</b>
	Own Pharmacy     Purchased from	= 9	\$ \$	260 419	260.419		
	Purchased from     Procare, LTC		20	269,418	269,418		
	b. Medicine Cabinet Drugs		\$	23,755	23,755		
-	c. Medical and Therapeutic Supplies		\$	319,614	319,614		
-	d. Ambulance/Limousine***		\$	15,908	15,908		
-	e. Oxygen						10000000000000000000000000000000000000
	1. For Emergency Use		\$				
_	2. Other***		\$	14,550	14,550		
	f. X-rays and Related Radiological Procedures***		\$	17,689	17,689		
	g. Dental (Not dentists who should be inc salaries or fees)	luded under	\$				
	h. Laboratory***		\$	13,470	13,470		
	i. Recreation		\$	10,158	10,158		
	j. Direct Management Services*		\$				
	k. Indirect Management Services*		\$				
	1. Other (Specify)****		\$	194,353	194,353	ula Nickel (American September 1997)	
	See Attached Schedule			POR SERVER			
M.	Total Resident Care Expenditures (5a - 5	j)	\$	878,915	878,915		

<sup>\*</sup> Schedule C-1, Page 17 must be fully completed or this expenditure will not be allowed.

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

<sup>\*\*\*</sup> Facility should self-disallow the expense on Page 29 of the Cost Report.

<sup>\*\*\*\*</sup> ICFMR's should provide a detailed schedule of all Day Program Costs.

#### Schedule of Other Resident Care

Description		CCNH	RHNS	(Specify)
Management Fee Direct	\$	115,112		
Medical Equip Rentals-Medicaid	\$	23,923		
Physical Therapy Supplies	\$	7,938		
OT Supplies	<b>*</b>	285		
Oxygen Concentrator Rentals	\$	17,876		
Cable TV Fees	\$	21,116		
Medical Equip Rentals-Other	\$	7,743		
Speech Therapy Supplies	\$	360		
Total Other Resident Care	\$	194,353	\$ -	\$ -

State of Connecticut Annual Report of Long-Term Care Facility CSP-21 Rev. 10/2001

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

Name of Facility		7		License No.	Report for Year Ended				Page	Jo
301 Rope Ferry Road, LLC d/b/a Bayview Health Care Center	/b/a Bayview Health C	are Center		2318	9/30/2020				21	37
The Control of the Co										
		Related ** to Owners,	to Owners,							
		Operators, Officers	Officers				Total Cost	Total Cost/Page Ref. ***	_	T
Name of Individual or				Explanation of	Full Explanation of					
Company	Address	Yes	No	Relationship	Service Provided*	CCNH	RHINS	(Specify)	Pg	Line
ADP	100 Corporate Drive, South Windsor, CT	0	0		Payroll Processing	17,815			91	16 m13
CWPM	415, Plainville, CT 06062	0	0	3	Rubbish Removal	22 386			22 6f	Į,
Allied Snow Removal	42 Washington St, Mystic, CT 06355	0	0		Snow Removal	18,080			22	191
Procare LTC	111 Executive Blvd, Farminedale, NY 11735	0	C	Common Owners; Primary Interest	Pharmacv	307 486			16	16 m13
Winterberry Group	2070 West St, Southington, CT 06489		0		Groundskeeping	23,813			22	91
PointClickCare	P.O. Box 674802, Detroit, MI 48267	0	0		Data Processing	26,357			16	16 m13
7		0	0							
		0	0				e vene			
		0	0							
		0	0						######################################	
		0	0							
		0	0						1	
		0	0							
		0	0	\						

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

<sup>\*\*</sup> Refer to Page 4 for definition of related.

<sup>\*\*\*</sup> 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

	License No.	Report for Ye	ar Ended		Page	of
301 Rope Ferry Road, LLC d/b/a Bayview He	2318	9/30/2020			22	37
Item		Total	CCNH	RHNS	(Spe	ecify)
6. Maintenance & Operation of Plant						38 %
a. Repairs & Maintenance	\$	74,821	74,821			
b. Heat	\$	157,047	157,047			
c. Light & Power	\$	116,378	116,378			
d. Water	\$	31,341	31,341			
e. Equipment Lease (Provide detail on pa	ge 6) \$	39,081	39,081			
f. Other (itemize)	\$	81,119	81,119			
See Attached Schedule		TO DESCRIPTION				
6g. Total Maint. & Operating Expense (6a - 6	5f) \$	499,787	499,787			
7. Depreciation (complete schedule page 23*	)					
a. Land Improvements	\$	584	584			
b. Building & Building Improvements	\$	29,669	29,669			
c. Non-Movable Equipment	\$	5,693	5,693			
d. Movable Equipment	\$	42,994	42,994			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	78,940	78,940			
Amortization (Complete att. Schedule Page     a. Organization Expense	e 24*) \$					
b. Mortgage Expense	\$	1,651	1,651			
c. Leasehold Improvements	\$	34,798	34,798			
d. Other (Specify)	\$				4	
*8e. Total Amortization Costs (8a + b + c + d)	\$	36,449	36,449			
<ol> <li>Rental payments on leased real property les real estate taxes included in item 10b</li> </ol>	ss \$	647,977	647,977			
10. Property Taxes						
a. Real estate taxes paid by owner	\$					
b. Real estate taxes paid by lessor	\$	114,454	114,454			
c. Personal property taxes	\$	17,482	17,482			
11. Total Property Expenses (7e + 8e + 9 + 10		895,302	895,302			

<sup>\*</sup> 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	CCI	H	RHNS	(Spec	ify)
Groundskeeping	\$ 2	25,349			
Rubbish Removal	\$ 2	25,754			
Snow Removal	\$ 1	18,080			
Supplies	\$	11,936			
					211
					TE (N
			H RICHVIA		
		1970 16			
Total Other Repairs and Maintenance	\$ \$	81,119	\$ -	\$	¥

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

Name of Facility										
201 Rone Ferry Road 11 C d/h/s Raymism Health Care Center	Health Care	ontor	License No.	0.		Report for Year Ended	Snded		Page	of 3.7
sor respectively road, the did naylier i	Icain Car	- CITICI	7	010		3/30/2020		9	67	37
			Historical	Tago		Accumulated	Mathodof			
			Exclusive of	~	Cost to Be	Beginning of	Computing	Useful	Depreciation	
Property Item			Land		Depreciated	Year's Operations		Life	for This Year	Totals
A. Land Improvements							_		Name	
<ol> <li>Acquired prior to this report period</li> </ol>			47,027	7	47,027	44,720	S/L	5 years	584	
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	ach schedule)									
A-4. Subtotal							20年以後後			584
B. Building and Building Improvements									Mile	And the state of t
1. Acquired prior to this report period			837,227	1	837,227	664,087	S/L	Various	29,669	
2. Disposals (attach schedule)									arante	
3. Acquired during this report period (attach schedule)	ach schedule)									
B-4. Subtotal			TX SX Institute	Marie Control			· · · · · · · · · · · · · · · · · · ·			29,669
C. Non-Movable Equipment										
1. Acquired prior to this report period			338,953	3	338,953	307,549	S/L	Various	5,693	
2. Disposals (attach schedule)										
3. Acquired during this report period (attach schedule)	ach schedule)									
C-4. Subtotal				No. of the last of	強いのはは					5,693
	Is a mileage									
2714	logbook	Date of	坦			Accumulated	Makedar			
	maintained:	Acquistion	Т		1	Depreciation to	Memod of			
	Yes No	Month Year	Exclusive of Land	f Salvage Value	Cost to Be Depreciated	Beginning of Year's Operations	Computing Depreciation	Useful Life	Depreciation for This Year	Totals
D. Movable Equipment	STATE OF THE PARTY									
<ol> <li>Motor Vehicles (Specify name, model</li> </ol>										
and year of each vehicle)										
. b.										
.0.								- 4	520(1)	
d.										
2. Movable Equipment						· · · · · · · · · · · · · · · · · · ·				
a. Acquired prior to this report period		9 2	2019 2,071,220	0	2,071,220	1,864,378	S/L	Various	41,553	
b. Disposals (attach schedule)										
c. Acquired during this report period			<b>建</b>	in Seen seed the						
(attach schedule)		9 2	2020 29,038	8	29,038		S/L	Various	1,441	
D-3. Subtotal										42,994
E. Total Depreciation						で 一				78,940

#### Schedule of Land Improvements Acquired during this report period

The state of the s	Description of Item	Cost	Useful Life	Depreciation
Acquisition Date	Description of Item	Cost	Life	Depreciation
Additions:				
The state of the s				
		KNE U SUB BURESTER		
A SERVICE TO LEGISLATION				THE NUMBER OF
Total additions for Land Improv	vements	\$ -		S -
Deletions:				
			and the same of the same	
			HEROSUSHIN	
			LILLY I S	
Total deletions for Land Improv	ements	\$ .		\$ -

<sup>\*</sup>Ties to Page 23, Line A3

#### Schedule of Building Improvements Acquired during this report period

Description of Item	Cost	Useful Life	Depreciatio
rovements	\$ -		\$ -
		1010 108	
rovements	\$ -		s -
	Description of Item  provements	Description of Item Cost  provements S -	Description of Item Cost Life  Cost Life  From the second

<sup>\*</sup>Ties to Page 23, Line B3

#### Schedule of Non-Movable Equipment Acquired during this report period

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

<sup>\*</sup>Ties to Page 23, Line C3

<sup>\*\*</sup>Ties to Page 23, Line A2

<sup>\*\*</sup>Tics to Page 23, Line B2

<sup>\*\*</sup>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:				
11/19/2021	Dishwasher Motor	3,104	10	155
3/20/2021	Thermal Printer	1,057	10	53
5/20/2021	Laptops	1,533	3	256
6/20/2021	Ice and Water Dispenser	5,706	10	285
7/20/2021	Tablets	1,563	5	156
8/20/2021	Washer	16,075	15	536
Total additions for	Movable Equipment	\$ 29,038		\$ 1,441
Deletions:				
Total deletions for	Movable Equipment	\$ -		s -

<sup>\*</sup>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:				
11/19/2021	Fire Service Exit Signage	1,515	5	152
11/19/2021	Handicap Ramps	4,000	8	250
1/20/2021	Boiler Improvements	4,186	15	139
1/20/2021	Outdoor Lamps and Wiring	1,230	10	61
2/20/2021	Boiler Replacement	19,510	20	488
7/20/2021	Garage Door	1,637	10	82
Total additions for	Leasehold Improvement	\$ 32,078		\$ 1,172
Deletions:				
Total deletions for	Leasehold Improvement	s -		S -

<sup>\*</sup>Ties to Page 24, Line C3

<sup>\*\*</sup>Ties to Page 24, Line C2

Annual Report of Long-Term Care Facility CSP-24 Rev. 10/2006 State of Connecticut

# Amortization Schedule\*

Nan	Name of Facility			License No.		Report for Year Ended	ır Ended		Page	Jo
301	301 Rope Ferry Road, LLC d/b/a Bayview Health Care Cente	alth Care	Cente	2318	8	9/30/2020			24	37
						Accumulated				
		Date of	Jo:			Amort. to				
		Acquisition	ition			Beginning of	Basis for			
				Length of	Cost to Be	Year's	Computing	Rate	Rate Amortization	
	Item	Month	Year	Amortization	Amortized	Operations	Amortization**	%	for This Year	Totals
Ą.	Organization Expense									
	1								Darries C	
	2.									
	3.	S								
A-4	A-4. Subtotal								THE RESERVE OF THE PARTY OF THE	
B.	Mortgage Expense									
									account.	
	2. Deferred Finance Fees-Refinance/ H Var		Var	5	286,028	231,697			1,651	
	3,									
B-4.	. Subtotal								A STATE OF THE PARTY OF THE PAR	1,651
J.	Leasehold Improvements and Other									
	1. Acquired prior to this report period		2019	2019 Various	3,555,188	65,834	S/L		33,626	
	2. Disposals (attach schedule)									
	3. Acquired during this report period									
	(attach schedule)		2020	2020 Various	32,078				1,172	
C-4	. Subtotal		THE PARTY NAMED IN							34,798
D.	Total Amortization							STATE		36,449
350	* Straight-line method must be used									

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

me of Facility License N 1 Rope Ferry Road, LLC d/b/a Bayy 2	lo. 2318	Report for Year En 9/30/2020	ded		Page 25	of   37
Property Questionnaire		272072020		10000		
Part A						
Is the property either owned by the Facility	0	Yes	0	No	If "Yes," compl	lete Part l
or leased from a Related Party?*	O	res	· ·	NO	If "No," comple	ete Part C
*If any owner or operator of this facility is relate						
business association to any person or organizati	ion from whom	n buildings are leased, th	en it is considered			
a related party transaction.  Description		Total				
Date Land Purchased		1000				
2. Date Structure Completed		11.0				
3. If NOT Original Owner, Date of Purcha	ase	07/12/06				
4. Date of Initial Licensure		06/09/86				
<ol><li>Total Licensed Bed Capacity</li></ol>		127				
Square Footage						
7. Acquisition Cost					2017年 建化	
a. Land		217,747				
b. Building		5,032,701				
Part B - Owner and Related Parties		1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mor	tgage
1. Financing		III ID W D h	ERINGENE COMMENT			
a. Type of Financing (e.g., fixed, varial     b. Date Mortgage Obtained	bie)	HUD/KeyBank 03/29/12				
c. Interest Rate for the Cost Year		3.22%/6.91%				
d. Term of Mortgage (number of years)	<b>Y</b>	35				
e. Amount of Principal Borrowed		9,944,000				
f. Principal balance outstanding as of		8,459,270				
Complete if Mortgage was Refinance	d					
During Current Cost Year						
g. Type of Financing (e.g., fixed, varial	ble)		recommendation of the second			
h. Date of Refinancing						
i. New Interest Rate						
<ol> <li>j. Term of Mortgage (number of years)</li> </ol>	)					
k. Amount of Principal Borrowed						1
Principal Outstanding on Note Paid-	Marie Control					
Part C - Arms-Length Leases for Rea				m er	I A I A	. CT
Name and Address of Lessor	Pro	operty Leased	Date of Lease	Term of Lease	Annual Amou	nt of Lea
				ľ		
	1					
			-			
		-				

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 Yo	ear Ended		Page of
301 Rope Ferry Road, LLC d/b/a Bay 2318		9/30/2020			26   37
Item		Total	CCNH	RHNS	(Specify)
12. Interest					
A. Building, Land Improvement & Non-Movable Equipment					
First Mortgage	\$				
Name of Lender	Rate				
Address of Lender					
2. Second Mortgage	\$			A STOREGUE AND A STOREGUE	
Name of Lender	Rate				
Address of Lender					
3. Third Mortgage	\$	(CONSTRUCTION OF THE SE		LIOCUSTING STUBS	
Name of Lender	Rate				
Address of Lender					
4. Fourth Mortgage	\$	SUBSCINETE SUBSCIENCE	EN CHIANGEN CHIANGE AN ARCHEO		
Name of Lender	Rate				
Address of Lender					
B. CHEFA Loan Information					
1. Original Loan Amount	\$				
2. Loan Origination Date				E CONTRACTOR	
3. Interest Rate %					
4. Term					
5. CHEFA Interest Expense			DGW CUI PHOLO		
12 B7. Total Building Interest Expense (A1 - A4 + B5)	\$				
		(Cor	ry Subtotals	forward to r	next nage)

(Carry Subtotals forward to next page)

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

Name of Facility License 301 Rope Ferry Road, LLC d/b/a B	No. 2318		Report for Ye 9/30/2020	ear Ended		Page of 27   37
Item			Total	CCNH	RHNS	(Specify)
B Call Control	btotals Brou	ight Forward:	5.5 (111) (11.74)			
12. C. Movable Equipment						
Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender	** = *					
Address of Lender		<u> </u>				
B. Item	Rate	Amount				
Lender	-					
Address of Lender						
<ol> <li>C. 3. Total Movable Equipment Int Expense (C1 + 2)</li> </ol>	erest	\$	AND SECURITION OF THE PARTY OF			
12. D. Other Interest Expense (Specify)		\$		25,206		
Vendor Interest						
13. Total All Interest Expense (12B7 + 1	2C3 + 12D	) \$	25,206	25,206		
<ol> <li>Insurance         <ul> <li>a. Insurance on Property (buildings)</li> </ul> </li> </ol>	only)	\$	74,233	74,233		
b. Insurance on Automobiles	Olliy)	\$		74,233		
c. Insurance other than Property (as	specified a					
<ol> <li>Umbrella (Blanket Coverage)</li> </ol>		\$		11-2		
<ol><li>Fire and Extended Coverage</li></ol>		\$				
3. Other (Specify)		\$			<b>斯學學</b> (1741)	
14d. Total Insurance Expenditures (14a -	+b+c)	\$	74,233	74,233		WHITE LANGE PARTY AND A STATE OF
15. Total All Expenditures (A-13 thru C		\$		14,448,410		

## D. Adjustments to Statement of Expenditures

	e of Fa Rope F		Road, LLC d/b/a Bayview Health Care Center	Lic	ense No. 2318	Report for Yea 9/30/2020	r Ended	Page of 28   37
No.	Page No.	No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
Page	10 - 5	Salari	es and Wages				THE REAL PROPERTY.	
1.			Outpatient Service Costs	\$				
2.			Salaries not related to Resident Care	\$				
3.	10	A12g	Occupational Therapy	\$	318,222	318,222		
4.			Other - See attached Schedule	\$	114,466	114,466		
	13 - 1	rofes	sional Fees				TOTAL BASE	
5.			Resident Care Physicians **	\$				
6.			Occupational Therapy	\$				
7.			Other - See attached Schedule	\$				
Page.	s 15 &	2 16 -	Administrative and General					
8.			Discriminatory Benefits	\$				
9.	15	1c	Bad Debts	\$	61,089	61,089		
10.	15	1d	Accounting	\$	3,275	3,275		
10a.			Legal	\$	22,234	22,234		
11.			Telephone	\$				
12.	15	1h2	Cellular Telephone	\$	1,563	1,563		
13.			Life insurance premiums on the life				RESIDENCE OF	
201001			of Owners, Partners, Operators	\$				Comment of the commen
14.	16	13	Gifts, flowers and coffee shops	\$	25,815	25,815		
15.			Education expenditures to colleges or universities for tuition and related costs					
			for owners and employees	\$				
16.			Travel for purposes of attending				DATE OF THE PARTY	2回约10回形版和
4874960			conferences or seminars outside the					
			continental U.S. Other out-of-state					
			travel in excess of one representative	\$	Marie Constitution of the		Philippin and Charles and Charles	
17.			Automobile Expense (e.g. personal use)	\$				
18.	16	m2&3	Unallowable Advertising *	\$	12,293	12,293	-	
19.	15		Income Tax / Corporate Business Tax	\$	14,153	14,153		
20.		.,	Fund Raising / Contributions	\$				
21.			Unallowable Management Fees	\$	257,472	257,472		
22.			Barber and Beauty	\$				
23.			Other - See attached Schedule	\$	48,520	48,520		
1000 00000	18 - 1	Dietar	y Expenditures		SOLA MARKETONIA	<b>原</b> 學無理	071117218 2200	
24.			Meals to employees, guests and others					
	10		who are not residents	\$	64	64		
Page	19 - 1	aund	ry Expenditures	-		Sales Contraction		EFE METERS
25.	17-1		Laundry services to employees, guests		NO LEGICAL	ONE BASIL MARKO		REPORT OF THE PARTY OF
20,			and others who are not residents	\$	NINE STATE OF THE			American Wally College
Page	20 - 1	Touse	keeping Expenditures	-			And West Land	
26.	20-1	Louise	Housekeeping services to employees, guests					
20.			and others who are not residents	\$	NAME OF TAXABLE PARTY.			
_			Subtotal (Items 1 - 26)		879,166	879,166		
	-		Subtotal (Items 1 - 20)	φ ,		arry Subtotal fo		

<sup>\*</sup> All except "Help Wanted".

<sup>(</sup>Carry Subtotal forward to next page)

<sup>\*\*</sup> 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	RH	NS	(Specify)
10	12M	Community Coordinator & Marketing Salaries and Benefits	\$ 114,466			
						Sin_2   1811
6.07.380						
			 111.166	ф.		d
Total Othe	r Salaries	Adjustment	\$ 114,466	\$	- 1	\$ -

## Schedule of Fees Adjustments

Page Ref	Line Ref	Description	 CCNH	RHNS	(Specify)
X LIX					
	70.10				
					308000
Total Othe	r Fees Adj	ıstments	\$ -	\$ -	\$ -

## Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M13	Bank Charges	\$ 48,520		
		ETAIL DE TOTAL SEN EM TERROLENNES EN ENERGE			
Total Othe	r A&G Ad	justments	\$ 48,520	\$ -	\$ -

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

Nam	e of Fa	acility	D. Adjustments to Statemen	_	ense No.	Report for Y	AND DESCRIPTION OF THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED	Page	of
			Road, LLC d/b/a Bayview Health Care Cente		2318	9/30/2020		29	37
					Total				
Item	Page	Line			Amount of				
	No.		Item Description		Decrease	CCNH	RHNS	(Sp	ecify)
			Subtotals Brought Forward	\$	879,166	879,166		3300	
Page	20 - I	Reside	nt Care Supplies***			KENEWEN BU			THE REAL PROPERTY.
27.			Prescription Drugs	\$	269,418	269,418			
28.		5d	Ambulance/Limousine	\$	15,908	15,908			
29.		5f	X-rays, etc	\$	17,689	17,689			
30.	20	5h	Laboratory	\$	13,470	13,470			
31.	20	5c	Medical Supplies	\$	19,194	19,194			
32.	20	500	Oxygen (non emergency)	\$	14,550	14,550			
33.	20	5j	Occupational Therapy	\$	285	285			
34.			Other - See Attached Schedule	\$	22,014	22,014			
Page	22 - N	Mainte	enance and Property						
35.			Excess Movable Equipment Depreciation			This sold sold			
			See Attached Schedule	\$	8,195	8,195			
36.			Depreciation on Unallowable						
Samoon			Motor Vehicles	\$					
37.			Unallowable Property and Real		HS-107 BS-661 GVID				Will be seen
			Estate Taxes	\$					
38.			Rental of Building Space or Rooms	\$					
39.			Other - See Attached Schedule	\$					
Page	27 - I	nsura	nce			S COUNTY OF SERVI			
40.			Mortgage Insurance	\$					Kina and America
41.	75.42		Property Insurance	\$					
Othe	r - Mis	scellar	neous						
42.			Other - Indirect	\$	17,516	17,516			
43.			Interest Income on Account Rec.	\$					
44.			Other - Miscellaneous Administrative	\$					
45.			Management Fees Direct	\$	70,220	70,220			
46.			Management Fees Indirect	\$	62,418	62,418			
47.			Other - Direct	\$					
Not I	For Pr	ofit P	roviders Only			NO PURE DE LA			
48.			Building/Non Movable Eq. Depreciation						
			Unallowable Building Interest -						
			See Attached Schedule	\$					
49.	Total	Amoi	unt of Decrease (Items 1 - 48)	\$	1,410,043	1,410,043			

<sup>\*\*\*</sup> Items billed directly to Department of Social Services and/or Health Services in CT, or other states, Medicare, and private-pay residents. Identify separately by category as indicated on Page 20.

## Schedule of Other Ancillary Costs

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Medical Equipment Rental -Other	\$ 7,743		
20	52b	E-Box	\$ 14,27		
105, 13					
Total Othe	r Ancillary	Costs	\$ 22,014	s -	\$ -

## Schedule of Excess Movable Equipment Depreciation

Line Ref	Description	CCNH	RHNS	(Specify)
7d	Moveable Equipment Dep carryforward	\$ 8,195		
es Movable	Equipment Depreciation	\$ 8195	s -	\$ -
	7d	Line Ref Description  7d Moveable Equipment Dep carryforward  8 September 1	7d Moveable Equipment Dep carryforward \$ 8,195	7d Moveable Equipment Dep carryforward \$ 8,195

## Schedule of Other Property Adjustments

Page Ref	Line Ref	Description	C	CNH	RHNS	(Spe	cify)
W							
							Yaran
				3			
Total Othe	r Property	Adjustments	5		\$ -	S	

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Radio and Television Revenue	\$ 17,516		
	132				
100//20-					
Total Othe	r Adjustm	ents	\$ 17,516	\$ -	\$ -

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
					0
I otal Othe	r Adjustm	nts		3 -	3 -

Schedule of Other - Direct Adjustments

Page Ref	Line Ref	Description	 CCNH	RHNS	(Sp	ecify)
					181	
m need						
Total Othe	r Adjustme	nts	\$ -	\$ -	\$	100

Schedule of Unallowable Building Interest

Page Ref	Line Ref	Description	C	CNH	RHNS	(S	pecify)
No. of Street,							
				Tanty			
	4						
				10.50			
				Jarie			
Total Una	llowable Bu	ilding Interest	\$		\$	- \$	

## F. Statement of Revenue

Name of Facility License No. 301 Rope Ferry Road, LLC d/b/a Bayviev 2318	Report for Y 9/30/2020	ear Ended		Page 30	of 37
Item	Total	CCNH	RHNS	(Spe	cify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (CT only)	\$ 15,525,985	15,525,985	THE PERSON NAMED IN COLUMN	Name of the last	
b. Medicaid Room and Board Contractual Allowance **	\$ (7,899,689)	(7,899,689)			
2. a. Medicaid (All other states)	\$				
b. Other States Room and Board Contractual Allowance **	\$				
3. a. Medicare Residents (all inclusive)	\$ 2,239,865	2,239,865			
b. Medicare Room and Board Contractual Allowance **	\$ 482,243	482,243			
4. a. Private-Pay Residents and Other	\$ 3,194,125	3,194,125			
b. Private-Pay Room and Board Contractual Allowance **	\$ (217,864)	(217,864)			
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	\$ 205,846	205,846			
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (205,846)	(205,846)			
c. Prescription Drugs - Non-Medicare	\$	152,294			
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (152,194)	(152,194)			
2. a. Medical Supplies - Medicare	\$ 7,568	7,568	V255		
b. Medical Supplies - Medicare Contractual Allowance **	\$ (906)	(906)			
c. Medical Supplies - Non-Medicare	\$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	\$		W-0		
3. a. Physical Therapy - Medicare	\$ 600,955	600,955			
b. Physical Therapy - Medicare Contractual Allowance **	\$ (331,850)	(331,850)			
c. Physical Therapy - Non-Medicare	\$ 252,390	252,390			
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (252,390)	(252,390)			
4. a. Speech Therapy - Medicare	\$ 157,930	157,930			
b. Speech Therapy - Medicare Contractual Allowance **	\$ (67,595)	(67,595)			
c. Speech Therapy - Non-Medicare	\$ 72,140	72,140			
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$	(72,140)			
5. a. Occupational Therapy - Medicare	\$ 630,310	630,310			
<ul> <li>b. Occupational Therapy - Medicare Contractual Allowance **</li> </ul>	\$ (343,500)	(343,500)			
c. Occupational Therapy - Non-Medicare	\$	242,250			
<ul> <li>d. Occupational Therapy - Non-Medicare Contractual Allowance **</li> </ul>	\$ (242,250)	(242,250)			
6. a. Other (Specify) - Medicare	\$				
b. Other (Specify) - Non-Medicare	\$ 173,142	173,142			
III. Total Resident Revenue (Section I. thru Section II.)	\$ 14,150,819	14,150,819			
IV. Other Revenue*		9.			
Meals sold to guests, employees & others	\$				
2. Rental of rooms to non-residents	\$ J. =				
3. Telephone	\$				
Rental of Television and Cable Services	\$				
5. Interest Income (Specify)	\$	483			
6. Private Duty Nurses' Fees	\$				
7. Barber, Coffee, Beauty and Gift shops	\$ The state of the s				
8. Other (Specify)	\$ 	10,848			
V. Total Other Revenue (1 thru 8)	\$ 11,331	11,331			
VI. Total All Revenue (III +V)	\$ 14,162,150	14,162,150			

<sup>\*</sup> Facility should off-set the appropriate expense on Page 28 or Page 29 of the Cost Report.

<sup>\*\*</sup> Facility should report all contractual allowances and/or payer discounts.

## Schedule of Other Resident Revenue - Medicare

#### Related Exp

Page Ref	Description	CCNE	RH	NS (S	Specify)
			Spirit II		No.
					11/2
Total Oth	er Resident Revenue - Medicare	S	- \$	- \$	

#### Schedule of Other Non-Medicare Resident Revenue

## Related Exp

Page Ref	Description	CCNH	RHNS	(Specify)
pg 31, a3	Misc Revenue from CRF Funds	\$ 172,641		
	OXYGEN-PRIVATE SNF	\$ 501		
Total Oth	er Resident Revenue	\$ 173,142	s -	s -

## Interest Income

## Account

Page Ref Account	Balance	C	CNH	RHNS	(S	pecify)
pg 31, LA2 Interest on A/R	N/A	\$	483			
			) WESHO			
						100
Total Interest Income		S	483	\$ -	\$	

## Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
NA	Bad Debt Recoveries	\$ 6,93	)	
NA	Nursing Supplies Rebate	\$ 3,91	3	
	Manager and other and plant and an entire early			
Total Oth	er Revenue	\$ 10,84	8 \$ -	\$ -

## G. Balance Sheet

Name of Facility		PATE AND SOLVEN STATE OF THE SECOND STATE OF THE SECOND SE	License No.	Report for Year Ended	Page	
301	Rop	e Ferry Road, LLC d/b/a Bay	vi 2318	9/30/2020	31	37
			Account			Amount
Asse	ets					
A.	Cu	irrent Assets			1000	
	1.	Cash (on hand and in banks	<del></del>		\$	552,635
	2.	Resident Accounts Receivab		The state of the s	\$	1,012,376
	3.	Other Accounts Receivable	(Excluding Owners o	r Related Parties)	\$	(849,762)
	4	Inventories			\$	21,138
	5.	Prepaid Expenses			\$	134,234
		a. Prepaid Insurance		121,837		
		b. Prepaid Expense/Lease, N	Medical Director and	Ac 4,953		
		c. Prepaid Interest		7,444		
		d. See Schedule		A Constitution of the Cons	NOVEN COLUM	
	6.	Interest Receivable			\$	
	7.	Medicare Final Settlement R	leceivable		\$	(529,140)
	8.	Other Current Assets (itemiz	e)	72 X VEVEN	\$	33,500
		Medicaid Cost settlement  Due From Related Party		10,550 22,950		
		Due From Related Party		22,930		
		See Schedule			<b>外北海州市安徽</b>	
A-9.	To	tal Current Assets (Lines Al	thru 8)		\$	374,981
В.	Fiz	ked Assets				
	1.	Land	//		\$	
	2.	Land Improvements	*Historical Cost	47,027	\$	1,723
			Accum. Depreciat	ion 45,304 Net		-1501
	3.	Buildings	*Historical Cost	837,227	\$	143,472
	10000	Chapterial and Victorial	Accum. Depreciat	ion 693,755 Net		
	4.	Leasehold Improvements	*Historical Cost	398,563	\$	297,932
			Accum, Depreciat	ion 100,631 Net		
	5.	Non-Movable Equipment	*Historical Cost	338,953	\$	25,711
		** *	Accum. Depreciat	ion 313,242 Net		
	6.	Movable Equipment	*Historical Cost	2,085,843	\$	179,872
		137 W	Accum. Depreciat	ion 1,905,971 Net		
	7.	Motor Vehicles	*Historical Cost		\$	
			Accum. Depreciat	ion Net		
	8.	Minor Equipment-Not Depre	eciable		\$	
	9.	Other Fixed Assets (itemize	)		\$	(1,533)
		Excluded Movable Equip	ment Carryforward	14,416		
		See Schedule		(15,949)		
B-10	).	Total Fixed Assets (Lines B	31 thru 9)		\$	647,177

<sup>\*</sup> Historical Costs must agree with Historical Cost reported in Schedules on (Carry Total forward to next page) Depreciation and Amortization (Pages 23 and 24).

## Bayview Prepaid Expenses Act #1580

DESCRIPTION	BALANCE
Software	140.28
Software	353.50
Software	1,329.42
Software	3,025.14
Software	104.15
100000 (100000 00000 000000 000000 000000 000000	3
	4,952.49

\$ 76,974

	2018 TV's cost report	\$ 12,051 \$ 5		\$ 1.205 \$ 1.205 \$ 2.410 \$ 5.026 \$ 1.206 \$ 1.206
	2017 TV's cost report	\$23,935 \$55	<u>- 1</u>	\$ 2,384 \$ 21,542 \$ 4,787 \$ 4,787 \$ 4,787 \$ 2,394 \$ 2,394
	2016 TV's cost report	\$ 810 \$ 5		, 243 5 5 5 6 7 29 8 1 1 1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2
	2015 TV's cost report	\$ 827 \$ 5		\$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$ \$
	TV's 2015 2016 2017 2014 cost TV's cost TV's cost report report report report	\$ 2,406 \$ 5		\$ 241 \$ 5 166 \$ 5 1,204 \$ 5 1,204 \$ 5 2,42 \$ 5 2,42 \$ 5 2,42 \$ 5 2,42 \$ 5 2,42
Bayview Moveable Equipment Carryforward Schedule   Amount		\$ 2,471		\$ 2,348 \$ 3,348 \$ 2,348 \$ 3,348 \$ 3,488 \$ 3,48
arryforwar	2008 2008 Herliage Herilage	381		2
ulpment C	2007 Heritage	\$11,267	\$ 376 \$10,882	\$ 10,141 \$ 1
oveable Eq	2007 2007 Herilage Heritage	\$ 11,974	\$ 698 \$ 11,376	\$ 100,000
Bayylew Mc Amount Amount	2007 Harilage	\$ 2,225 \$ 5 5	w w	445 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5
B Amount	2001 Adj 2001 Adj #1 #2	\$ (1,206) \$ (4,708) \$ 2,225 \$ 5 \$ 10 \$ 5 NDD BACHADD BACK	\$ (235) \$ (4,473) \$ (4,473) \$ (4,022) \$ (3,671) \$ (3,060) \$ (3,060) \$ (3,060) \$ (4,71) \$ (4,7	4711 4711 5 (471) 5 (235) 5 (235) 6 (471) 7 (235) 7 (471) 7 (235)
Amount	2001 Adj #1	\$ (1,206) \$ (4,708) \$ 5 \$ 10 ADD BACHADD BACK	\$ (121) \$ (1,088) \$ (241) \$ (241) \$ (241) \$ (241) \$ (121) \$ (121)	
Amount	1999 Bed Addillon Adj	\$ 10,906 \$ 10	\$ 1,091 \$ 1,091	\$ 1.001 -
Amount Amount	1998 Adj 2000 Adj	5 68 5 5	**************************************	
Amount	1998 Adj	\$ 3,567	\$ 357 \$ 2,863 \$ 2,497 \$ 2,140 \$ 2,140 \$ 2,140 \$ 3,57 \$ 1,070 \$ 3,57 \$ 3,	
		Cost	Deprac Book Velue Book Velue Deprac Book Value	Deprec Book Value Deprec Book Value
osi Year			1998 1998 1999 2000 2001 2001 2002 2002 2003 2003 2004 2004 2005 2005 2005 2006 2006 2007	2008 2009 2009 2010 2010 2011 2011 2013 2013 2014 2014 2015 2016 2016 2016 2016 2018 2018 2018 2018 2018 2018 2018 2018

\$ 3,210 \$ 1,468 \$ 1,168 \$ 1,268 \$ 1,268 \$ 1,268 \$ 2,710 \$ 2,750 \$ 3,75

#### Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Rei	Description	myrelly an	711/	
	Tel Vi				
				No.	
Wast.					1
otal Pren	aid Expens		2		-

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

age Ref	Line Ref	Description	
otal Othe	r Current	Assets (Itemize)	s -

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

Page Ref	Line Ref	Description	-757 - 75 - 1757   1757 - 1757 - 1757
		Fixed Asset Difference to Books	\$ (15,949)
Total Othe	r Other Fi	sed Assets (Itemize)	\$ (15,949)

#### Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description		
a Figure 1 to Ohill		Deposits-Security Deposits Leased Equip	S	6,930
-525		Project Development	S	40,065
		Deferred Finance Fees net of amort	S	84,144
	O HE LET			1000000
D/AHA				
				100
				101 100
Total Other	er Assets		3	131,139

#### Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
		Notes Payable; Related Party	\$ (856,880)
		Line of Credit	\$ (3,481,001)
Total Note	s Payable		\$ (4,337,881)

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

Page Ref	Line Ref	Description	
		Acc'd Expenses Sales Tax	5 912
		Acc'd Health Insurance	\$ (2,035)
	30/19	Acc'd Operating Expenses	\$ 74,160
manual E		Provider Taxes Due	520245
	de la constitución de la constit	Acc'd Expense Property Taxes	-253
Total Othe	er Current	Liabilities (Itemize)	\$ 593,029

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

Line Ref Description	
Due to Related Landlord	S (1,175,078)
Due to Affiliates	\$ 3,326
Notes Pay-Mckesson	\$ (61,848)
Current Liabilities (Itemize)	\$ (1.233.600)
	Due to Related Landlord Due to Affiliates

## Bayview ACCRUED OPERATING EXP - 2170 September 30, 2020

DESCRIPTION	BALANCE
SJE	\$14,926.80
Health Insurance	\$13,686.80
Lease	(\$1,732.51)
X-Ray	\$1,276.75
LAB	\$1,301.45
Ambulance	(\$739.28)
Lease Credit	(\$2,404.00)
Wellness	(\$5,164.62)
401K	(\$5,470.38)
Record Storage	\$631.56
Deposits	\$7,727.00
Promotion	\$510.47
Electricity	\$1,736.49
Supplies	\$3,442.00
Cable	(\$1,785.97)
Supplies Void	(\$586.88)
Insurance Credit	(\$1,149.35)
Engagement Letter	\$10,100.00
Management Fee	\$37,854.11
- W	\$74,160.44

# G. Balance Sheet (cont'd)

		Facility	License No.	Report for Year	Ended		Page 32	of   37
301	Kop	e Ferry Road, LLC d/b/a Bay		9/30/2020		<u> </u>		
-			Account	maral massal	. Dammandi	ф	Am	ount
_	Y	1 11 19	1 1 C D '- D	Total Brough	it Forward:	Ф		1,022,158
Ċ.		asehold or like property recor	ded for Equity Purpose	S.		\$		390,340
	_	Land	*Historical Cost			ф		390,340
	۷.	Land Improvements	Accum. Depreciation		Net	\$		
	2	Buildings	*Historical Cost	7,019,660	INCL	Φ		
	٥.	Dullulligs	Accum. Depreciation		Net	\$		4,562,779
_	1	Non-Movable Equipment	*Historical Cost	2,450,661	INCL	Ψ		4,502,775
	٦.	Non-Movable Equipment	Accum. Depreciation		Net	\$		
	5.	Movable Equipment	*Historical Cost	1	1401	Ψ		
	٥.	Movable Equipment	Accum. Depreciation	•	Net	\$		
	6.	Motor Vehicles	*Historical Cost		1101	Ψ		
	О.	Wiotor Vemeres	Accum. Depreciation	,	Net	\$		
	7	Minor Equipment-Not Depr			1100	\$		<del></del>
C-8						\$		4,953,119
D.		vestment and Other Assets	(01)			-		.,,
	15/5010000	Deferred Deposits				\$		
	_	Escrow Deposits				\$		
		Organization Expense	*Historical Cost					
	(B)		Accum. Depreciation	n	Net	\$		
	4.	Goodwill (Purchased Only)				\$		3,360,483
	5.		dent Care (itemize)			\$		
	6.	Loans to Owners or Related	Parties (itemize)			\$		(3,802,307
		Name and Address	Amount	Loan D	ate			SE E SE SE SE SE
		Related Party	(3,802,307)	3/29/12		4		
	7.	Other Assets (itemize)				\$		131,139
				101 100				
	<i>p</i> = 1	See Schedule	. (C) 151 (1 - 6)	131,139		d'	SEP COLUMN	(210.000
D-8.		tal Investments and Other A		)		\$		(310,685
D-9.	10	tal All Assets (Lines A9 + B	10 + C8 + D8)			\$		5,664,592

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

# G. Balance Sheet (cont'd)

Name of Facility			License No.	Report for Year	Ended	Page	
301 Rope Fe	rry R	oad, LLC d/b/a Bayview He	2318	9/30/2020		33	37
		Α	ccount				Amount
Liabilities							
A.	Cu	rrent Liabilities				œ	064.047
	2.	Trade Accounts Payable Notes Payable (itemize)				\$	964,047
	۷.	Notes Payable (ttemize)				9	(4,337,861)
				and the second	- 4-13		
		See Schedule		(4,337,88	1)		
	3.	Loans Payable for Equipment	nt (Current portio	n) (itemize)		\$	
		Name of Lender	Purpose	Amount	Date Due		
		1					
						TEXT DESCRIPTION	
				1			
-	4.	Accrued Payroll (Exclusive				\$	278,814
	5.	Accrued Payroll (Owners ar		s only)		\$	
	6.	Accrued Payroll Taxes Paya				\$	257,223
	7.	Medicare Final Settlement F	ayable			\$	
	8.	Medicare Current Financing	Payable			\$	
	9.	Mortgage Payable (Current	Portion)			\$	
	10.	Interest Payable (Exclusive of	of Owner and/or I	Related Parties)		\$	
	11.	Accrued Income Taxes*		V -		\$	
	12.	Other Current Liabilities (ite	emize)			\$	593,029
				See Schedule	593,029		
A-13	To	tal Current Liabilities (Lines	s A1 thru 12)			\$	(2,244,768

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

# G. Balance Sheet (cont'd)

Name of Facility	License No. Report for Year Ended		Ended	Page	of
301 Rope Ferry Road, LLC d/b/a Bayview	2318	9/30/2020		34	37
· ·	Account			An	nount
		Total Broug	ht Forward:		(2,244,768)
Liabilities (cont'd)					
<ul> <li>B. Long-Term Liabilities</li> </ul>					
<ol> <li>Loans Payable-Equipment</li> </ol>	(itemize )		\$		
Name of Lender	Purpose	Amount	Date Due		
Mortgages Payable	1000		\$	III DIEMERALISMONE	573,952
Loans from Owners or Rel	ated Parties (itemiz	ze)	\$		
Name and Address of Lender	Amount	Loan I		SECTION AND	和 新
. 141110 4114 1 1 1 1 1 1 1 1 1 1 1 1 1 1	8-018070-72				
			3		
			ille		
			100		
4. Other Long-Term Liabilitie	o (itamina)	1	\$	ENTRES INCOMES	(1,233,600)
4. Other Long-Term Liabilitie	os (ttemtze)		4	KIND SECTION	(1,233,000)
4.306.75					
See Schedule		(1,233,600	)		
B-5. Total Long-Term Liabilities (	Lines B1 thru 4)	(1,20,000	\$		(659,648)
C. Total All Liabilities (Lines A-	13 + B-5)		\$		(2,904,416)

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

ASI/#U/S9140A	ne of Facility  Rope Ferry Road, LLC d/b/a Bayy  License No.  Report for Year Ended 9/30/2020	Page 35	of   37
301	Rope Ferry Road, LLC d/b/a Bayy 2318 9/30/2020 Account		Amount
A.	Reserves		
	Reserve for value of leased land	\$	390,340
	Reserve for depreciation value of leased buildings and appurtenances to be amortized	\$	4,562,779
	3. Reserve for depreciation value of leased personal property (Equity)	\$	
	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	\$	4,953,119
В.	Net Worth 1. Owner's Capital	\$	
	2. Capital Stock	\$	
	3. Paid-in Surplus	\$	(1,571,468)
	4. Treasury Stock	\$	
	5. Cumulated Earnings	\$	5,473,617
	6. Gain or Loss for Period 10/1/2019 thru 9/30/2020	\$	(286,260)
	7. Total Net Worth	\$	3,615,889
C.	Total Reserves and Net Worth	\$	8,569,008
D.	Total Liabilities, Reserves, and Net Worth	\$	5,664,592

# H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year	Ended	Page	of
301 Rope Ferry Road, LLC d/b/a Bayvie	2318	9/30/2020		36	37
	Account			Amount	
A. Balance at End of Prior Period as sl	nown on Report o	f 09/30/2019	9	3	4,098,032
B. Total Revenue (From Statement of	Total Revenue (From Statement of Revenue Page 30)			3	14,162,150
Total Expenditures (From Statement of Expenditures Page 27)				S	14,448,410
D. Net Income or Deficit			15	S	(286,260)
E. Balance			[5	3	3,811,772
F. Additions					
1. Additional Capital Contributed	(itemize)				
Heatlh Insurance Expense		(155,630)			
2019 State Income Taxes		(39,900)			
Lease Expense		(353)			信服器等情報
20					
2. Other (itemize)					
2000 NOT DESCRIPTION OF STREET					
			Ü		Chief Laborate
			l l		
F-3. Total Additions			5	\$	(195,883)
G. Deductions	Deductions				
<ol> <li>Drawings of Owners/Operators.</li> </ol>	Drawings of Owners/Operators/Partners (Specify)			\$	
Name and Address (No., City,	State, Zip)	Title	Amount		
2. Other Withdrawings (Specify)				\$	
Purpose			unt	STATE OF	MARIE SERVICE AND
1 31,000					
			ĺ		
			1		
Total Deductions				\$	
				\$	3,615,889
H. Balance at End of Period	09/30	JI 40		ν	3,013,003

## I. Preparer's/Reviewer's Certification

Name of Facility	#1550/909 MACAN (#1590) 0.00 M ■2.		Page of		
301 Rope Ferry Road, LLC d/b/a Bayy		9/30/2020	37 37		
	Check appropriate category	T			
Chronic and Convalescent Nurs Home only (CCNH)	Rest Home with Nursing Supervision only (RHNS)				
	Preparer/Reviewer Certifica	ation			
I have read the most recent Fed appropriate personnel as to the applicable regulations. All non automatically removed in the S performed by me are properly r	d this report and am familiar with the applicate and State issued field audit reports for the possible inclusion in this report of expenses varieties are reimbursable expenses of which I am aware tate rate computation system) as a result of resported as such in this report on Pages 28 and a contained in this report is in agreement with	e Facility and have inquired of which are not reimbursable under (except those expenses known to ading reports, inquiry or other se d 29 (adjustments to statement of	the be rvices		
Signature of Preparer	Fitle	Date Signed	<b>)</b>		
Printed Name of Preparer					
Athena Health Care Associates, Inc					
Addres Address	Phone Number	Phone Number			
135 South Road, Farmington CT 0603	860-751-3900	860-751-3900			
Contacted Person Regarding Additiona	t Phone Number	Phone Number			
Paulina Myslinski	860-751-3900	860-751-3900			
Contact Email Address					
Pmyslinski@Athenahealthcare.com					