State of Connecticut

Annual Report of Long-Term Care Facility

Cost Year 2020

Name of Facility (as licensed) Gladeview Health Care Center		
Address (No. & Street, City, State, Zip Code) 60 Boston Post RoadOld Saybrook, CT 06475		
Type of Facility ☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)		
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020	

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

Medicaid Provider Numbers:	CCNH	RHNS	ICF-IID
	2024C		

For Department Use Only

Sequence Number Assigned	Signed and Notarized	Date Received	Sequence Number Assigned	Signed and Notarized	Date Received

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General Information

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center	2024C	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 Gladeview 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
Printed Name (Administrator) Paul Knutsen			Printed Name (Owner) Linda Silberstein	
Subscribed and Sworn to before me:	State of	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public				

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Gladeview Health Care Center	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 60 Boston Post RoadOld Saybrook, CT 06475				
Report Prepared By Gladeview Health Care Center	Phone Number 860-388-6696		Date 2/1/2021	

Item		Total	CCNH	RHNS	(Specify)
1. Dietary wages paid	$				
2. Laundry wages paid	$				
3. Housekeeping wages paid	$				
4. Nursing wages paid	$				
5. All other wages paid	$				
6. ***Total Wages Paid***	$				
7. Total salaries paid	$				
8. ***Total Wages and Salaries Paid*** (As per page 10 of Report)	$				

Wages - Compensation computed on an hourly wage rate.

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

DO NOT include Fringe Benefit Costs.

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General Information and Questionnaire

Type of Facility - Organization Structure

Phone No. of Facility	Report for Year Ended	Page	of
860-388-6696	9/30/2020	2	37

Name of Facility (as shown on license)	Address (*No. & Street, City, State, Zip*)
Gladeview Health Care Center	60 Boston Post RoadOld Saybrook, CT 06475

	CCNH	RHNS	(Specify)	Medicare Provider No.
License Numbers:	2024C			07-5313

Type of Facility (Check appropriate box(es))

☑ Chronic and Convalescent Nursing Home only (CCNH) ☐ Rest Home with Nursing Supervision only (RHNS) ☐ (Specify)

Type of Ownership (Check appropriate box)

○ Proprietorship ○ LLC ○ Partnership ◉ Profit Corp. ○ Non-Profit Corp. ○ Government ○ Trust

If this facility opened or closed during report year provide:	Date Opened	Date Closed

Has there been any change in ownership or operation during this report year? ○ Yes ◉ No If "Yes," explain fully.

Administrator

Name of Administrator	Nursing Home Administrator's License No.:
Paul Knutsen	001500

Other Operators/Owners who are assistant administrators (full or part time) of this facility.

Name	License No.:
Linda Silberstein	None

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General Information and Questionnaire
Partners/Members

Name of Facility	License No.	Report for Year Ended	Page	of
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Legal Name of Partnership/LLC	Business Address	State(s) and/or Town(s) in Which Registered
N/A		

Name of Partners/Members	Business Address	Title	% Owned
N/A			

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General Information and Questionnaire
Corporate Owners

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as a corporation, provide the following information:

Legal Name of Corporation	Business Address	State(s) in Which Incorporated
Gladeview Health Care Center	60 Boston Post Road Old Saybrook, CT 06475	CT

Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Linda Silberstein	60 Boston Post Road Old Saybrook, CT 06475	President	100
Names of Stockholders Owning at Least 10% of Shares			
Same as above			

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General Information and Questionnaire
Individual Proprietorship

Name of Facility	License No.	Report for Year Ended	Page	of
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If this facility is owned or operated as an individual proprietorship, provide the following information:

Owner(s) of Facility
N/A

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General Information and Questionnaire
Related Parties*

Name of Facility	License No.	Report for Year Ended	Page	of
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Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association? ⊙ Yes ○ No

If "Yes," provide the Name/Address and complete the information on Page 11 of the report.

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

If "Yes," provide the following information:

Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Description of Goods/Services Provided	Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party
		Yes	No	%**				
Gladeview LLC	60 Boston Post Road Old Saybrook, CT 06475	○	⊙		Lease of Real Property	Pg 22, Line 9	1,200,000	1,200,000
Linda Silberstein	60 Boston Post Road Old Saybrook, CT 06475	○	⊙		Salaries and Benefits	Pg 10, line A3Pg 15, lir	202,364	202,364
Dawn Ra Corp	225 Boston Post Road Orange, CT 06477	○	⊙		Shared Salaries and Benefits (reduced from	Pg 10, line A3Pg 15, lir		53,850
Cori Knutsen	172 Route 6, Columbia, CT 06237	○	⊙		Salaries and Benefits	Pg 10, line A4Pg 15, lir	16,181	16,181
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					
		○	⊙					

* Use additional sheets if necessary.

** Provide the percentage amount of revenue received from non-related parties.

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General Information and Questionnaire
Basis for Allocation of Costs

Name of Facility	License No.	Report for Year Ended	Page	of
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

N/A

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

N/A

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

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

N/A

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General Information and Questionnaire
Leases (Excluding Real Property)

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

Name of Facility	License No.	Report for Year Ended	Page	of
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Name and Address of Lessor	Related * to Owners, Operators, Officers Yes	Related * to Owners, Operators, Officers No	Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
Wells Fargo Leasing, PO Box 6434, Carol Stream, IL 60197	○	⊙	Copier	10/04/16	48 months	18,300	18,300
Neopost, PO Box 6813, Carol Stream, IL 60197-6813	○	⊙	Postage machine	04/25/19	39 Months	1,100	1,100
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					
	○	⊙					

Is a Mileage Log Book Maintained for All Leased Vehicles ? ○ Yes ⊙ No **Total** *** 19,400

* Refer to Page 4 for definition of related. If "Yes," transaction should be reported on Page 4 also.
** Attach copies of newly acquired leases.
*** Amount should agree to Page 22, Line 6e.

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General Information and Questionnaire
Accounting Basis

Name of Facility	License No.	Report for Year Ended	Page	of
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The records of this facility for the period covered by this report were maintained on the following basis:

⊙ Accrual ○ Cash ○ Modified Cash

Is the accounting basis for this period the same as for the previous period? ⊙ Yes ○ No — If "No," explain.

Independent Accounting Firm

	Name of Accounting Firm	Address (No. & Street, City, State, Zip Code)
1	Simione, Macca and Larrow	4130 Whitney Ave, Hamden, CT 06518
2	Craig J Lubiski and Company	225 Pitkin St, East Hartford, CT 06108
3		
4		

Services Provided by This Firm (*describe fully*)

1	401k Audit, tax return	$	24,425
2	Medicare Cost report	$	2,300
3		$	
4		$	
		Charge for Services Provided	
		$	26,725

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

⊙ Yes ○ No — PG 15 Line 1d

Legal Services Information

	Name of Legal Firm or Independent Attorney	Telephone Number
1	Shipman & Goodwin	860-251-5000
2	Murtha Cullina	203-772-7700
3	Littler Mendelson PC	
4		
5		

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

1 One Constitution Plaza, Hartford, CT 06103
2 265 Church St.New Haven, CT 06510
3 125 South Wacker Dr 12th Fl, Chicago, IL 60606
4
5

Services Provided by This Firm (*describe fully*)

1	Employee matters	$	365
2	HIPPA matters/Resident will	$	152
3	Employee lawsuit (disallow)	$	9,004
4		$	
5		$	
		Charge for Services Provided	
		$	9,521

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

⊙ Yes ○ No — PG 15 Line 1e

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Schedule of Resident Statistics

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity												
A. On last day of PREVIOUS report period	132	132			132	132						
B. On last day of THIS report period	132	132							132	132		
2. Number of Residents												
A. As of midnight of PREVIOUS report period	105	105			105	105						
B. As of midnight of THIS report period	110	110							110	110		
3. Total Number of Days Care Provided During Period												
A. Medicare	5,041	5,041			3,956	3,956			1,085	1,085		
B. Medicaid (Conn.)	26,591	26,591			19,696	19,696			6,895	6,895		
C. Medicaid (other states)												
D. Private Pay	5,636	5,636			4,318	4,318			1,318	1,318		
E. State SSI for RCH												
F. Other (Specify) Managed care and other	2,731	2,731			2,170	2,170			561	561		
G. Total Care Days During Period (3A thru F)	39,999	39,999			30,140	30,140			9,859	9,859		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days												
B. Other Bed Reserve Days	27	27			18	18			9	9		
5. ***Total Resident Days*** **(3G + 4A + 4B)**	40,026	40,026			30,158	30,158			9,868	9,868		

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Schedule of Resident Statistics (Cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
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4. Were there any changes in the certified bed capacity during the report year? ○ Yes ⊙ No
If "YES", provide the following information:

Date of Change	Place of Change			Change in Beds						Capacity After Change			Reason for Change
	CCNH	RHNS	(Specify)	Lost			Gained						
	(1)	(2)	(3)	(1)	(2)	(3)	(1)	(2)	(3)	CCNH	RHNS	(Specify)	

5. If there was any change in certified bed capacity during the report year (as reported in item 4 above) provide the number of RESIDENT DAYS for 90 days following the change.

Change in Resident Days	CCNH	RHNS	(Specify)
1st change			
2nd change			
3rd change			
4th change			

6. Number of Residents and Rates on September 30 of Cost Year

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents	11	77		22				
Per Diem Rate								
a. One bed rm.	Various	249.00		395.00				
b. Two bed rms.		249.00		375.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments	TOTAL	CCNH	RHNS	(Specify)
A. Medicare - Part B	1,880	1,880		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	246	246		
C. Other	8,053	8,053		
D. ***Total Physical Therapy Treatments***	10,179	10,179		
8. Total Number of Speech Therapy Treatments				
A. Medicare - Part B	350	350		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	11	11		
C. Other	1,338	1,338		
D. ***Total Speech Therapy Treatments***	1,699	1,699		
9. Total Number of Occupational Therapy Treatments				
A. Medicare - Part B	2,811	2,811		
B. Medicaid (Exclusive of Part B)				
1. Maintenance Treatments				
2. Restorative Treatments	281	281		
C. Other	8,538	8,538		
D. ***Total Occupational Therapy Treatments***	11,630	11,630		

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Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended	Page	of
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Are time records maintained by all individuals receiving compensation? ⊙ Yes ○ No

	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
A. Salaries and Wages*						
1. Operators/Owners (Complete also Sec. I of Schedule A1)						
2. Administrator(s) (Complete also Sec. III of Schedule A1)	223,862	2,136				
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)	193,981	2,096				
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	325,209	9,273				
5. Dietary Service						
a. Head Dietitian	55,066	1,700				
b. Food Service Supervisor	62,953	2,179				
c. Dietary Workers	514,112	27,356				
6. Housekeeping Service						
a. Head Housekeeper	58,209	2,054				
b. Other Housekeeping Workers	279,006	15,605				
7. Repairs & Maintenance Services						
a. Engineer or Chief of Maintenance	73,388	2,080				
b. Other Maintenance Workers	44,778	1,985				
8. Laundry Service						
a. Supervisor						
b. Other Laundry Workers	38,086	2,101				
9. Barber and Beautician Services						
10. Protective Services						
11. Accounting Services						
a. Head Accountant						
b. Other Accountants						
12. Professional Care of Residents						
a. Directors and Assistant Director of Nurses	290,796	4,047				
b. RN						
1. Direct Care	655,206	17,091				
2. Administrative**	510,454	12,840				
c. LPN						
1. Direct Care	628,965	19,220				
2. Administrative**						
d. Aides and Attendants	1,965,512	90,254				
e. Physical Therapists	356,949	6,945				
f. Speech Therapists	87,819	2,102				
g. Occupational Therapists	214,976	4,874				
h. Recreation Workers	183,707	8,483				
i. Physicians						
1. Medical Director						
2. Utilization Review						
3. Resident Care***						
4. Other (Specify)						
Respitory therapist	57,702	1,544				
j. Dentists						
k. Pharmacists						
l. Podiatrists						
m. Social Workers/Case Management	199,745	6,103				
n. Marketing						
o. Other (Specify)						
See Attached Schedule						
A-13. Total Salary Expenditures	7,020,481	242,068				

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.
** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.
*** This item is not reimbursable to facility. For Title 19 residents, doctors should bill DSS directly. Also, any costs for Title 18 and/or other private pay residents must be removed on Page 28.

Schedule of Other Salaries and Wages (Page 10)

	CCNH		RHNS		(Specify)	
Position	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

Schedule of Other Fees (Page 13)

	CCNH		RHNS		(Specify)	
Service	**$**	**Hours**	**$**	**Hours**	**$**	**Hours**
Total	$ -	-	$ -	-	$ -	-

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

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

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

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

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

Name of Facility (as licensed)	License No.	Report for Year Ended	Page	of
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Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators* **										
Paul Knutsen	223,862			Health & Life insurance. Payroll taxes	Day to day operations of the nursing home	2,136	A2			
Section IV - Assistant Administrators										
Linda Silberstein	193,981			Health & Life insurance. Payroll taxes	Day to day operations of the nursing home	2,096	A3			

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

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

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

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B. Report of Expenditures - Professional Fees

Name of Facility	License No.	Report for Year Ended	Page	of
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	Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify)	Hours
*B. **Direct care consultants paid on a fee for service basis in lieu of salary** (For all such services complete Schedule B1)						
1. Dietitian	740	19				
2. Dentist	11,313	45				
3. Pharmacist						
4. Podiatrist	1,544	15				
5. Physical Therapy						
a. Resident Care	134					
b. Other						
6. Social Worker	600	8				
7. Recreation Worker						
8. Physicians						
a. Medical Director (entire facility)	19,400	312				
b. Utilization Review (Title 18 and 19 only) monthly meeting						
c. Resident Care**	43,345	541				
d. Administrative Services facility						
1. Infection Control Committee (Quarterly meetings)						
2. Pharmaceutical Committee (Quarterly meetings)						
3. Staff Development Committee (Once annually)						
e. Other (Specify)						
9. Speech Therapist						
a. Resident Care	720	4				
b. Other						
10. Occupational Therapist						
a. Resident Care						
b. Other						
11. Nurses and aides and attendants						
a. RN						
1. Direct Care						
2. Administrative***						
b. LPN						
1. Direct Care	255,593	5,083				
2. Administrative***						
c. Aides	61,384	1,737				
d. Other						
12. Other (Specify) See Attached Schedule						
B-13 Total Fees Paid in Lieu of Salaries	394,773	7,764				

* Do not include in this section management consultants or services which must be reported on Page 16 item M-12 and supported by required information, Page 17.

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

*** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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Report of Expenditures
Schedule B1 - Information Required for Individual(s) Paid on Fee for Service Basis*

Name of Facility	License No.	Report for Year Ended	Page	of
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Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship
		Yes	No	
William H. Johnson MSW, Inc. PO Box 1354, Belchertown, MA 01007	Social Worker	○	⊙	
Dr Balsamo, 687 Cambell Ave, West Haven, CT 06516	Physician Services/Medical Director	○	⊙	
Pact LLC 322 East Main St, Branford, CT 06405	Physician Services	○	⊙	
HealthDrive Dental Group, One Prestige Dr., Suite 107, Meriden, CT 06450	Dental Services	○	⊙	
The Nurse Network, PO Box 982, Southington, CT 06489	Nursing Pool	○	⊙	
SDX Swallowing Diagnostics, PO Box 484, Avon, CT 06001	Speech Therapy	○	⊙	
Prakash Huded MS, 28 Marlboro, Rd., Portland CT	Medical Director, Physician Services	○	⊙	
HealthDrive Podiatry, One Prestige Dr., Suite 107, Meriden, CT 06450	Physician Services	○	⊙	
		○	⊙	
		○	⊙	
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		○	⊙	
		○	⊙	
		○	⊙	

* Use additional sheets if necessary.
** Refer to Page 4 for definition of related.

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C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center	2024C	9/30/2020	15	37

Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	$	145,362	145,362		
2. Disability Insurance	$				
3. Unemployment Insurance	$	68,472	68,472		
4. Social Security (F.I.C.A.)	$	472,459	472,459		
5. Health Insurance	$	547,109	547,109		
6. Life Insurance (employees only)					
(not-owners and not-operators)	$				
7. Pensions (Non-Discriminatory)	$	18,309	18,309		
(not-owners and not-operators)					
8. Uniform Allowance	$				
9. Other (*Specify*)	$				
See Attached Schedule					
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	$				
c. Bad Debts*	$	170,000	170,000		
d. Accounting and Auditing	$	26,725	26,725		
e. Legal (*Services should be fully described on Page 7)*	$	9,521	9,521		
f. Insurance on Lives of Owners and Operators (*Specify*)*	$	12,501	12,501		
g. Office Supplies	$	32,391	32,391		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	$	29,098	29,098		
2. Cellular Phones	$	6,781	6,781		
i. Appraisal (*Specify purpose and attach copy*)*	$				
j. Corporation Business Taxes (*franchise tax*)	$				
k. Other Taxes (*Not related to property - See Page 22)*					
1. Income*	$				
2. Other (*Specify*)	$	250	250		
See Attached Schedule					
3. Resident Day User Fee	$	747,219	747,219		
Subtotal	$	2,286,197	2,286,197		

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

(Carry Subtotals forward to next page)

***** DO NOT Include Holiday Parties / Awards / Gifts to Staff**

Schedule of Other Employee Benefits

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

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
State of Ct S Corp fee	$ 250		
Total	$ 250	$ -	$ -

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CSP-16 Rev. 9/2002

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

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center	2024C	9/30/2020	16	37

Item		Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:		2,286,197	2,286,197		
l. Travel and Entertainment					
1. Resident Travel and Entertainment	$				
2. Holiday Parties for Staff	$				
3. Gifts to Staff and Residents	$	9,604	9,604		
4. Employee Travel	$				
5. Education Expenses Related to Seminars and Conventions	$	1,380	1,380		
6. Automobile Expense (*not purchase or depreciation*)	$	5	5		
7. Other (*Specify*)	$				
See Attached Schedule					
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (*all such expenses*)	$	24,213	24,213		
2. Advertising Telephone Directory (*all such expenses*)***	$				
3. Advertising Other (*Specify*)***	$	72,332	72,332		
See Attached Schedule					
4. Fund-Raising***	$				
5. Medical Records	$				
6. Barber and Beauty Supplies (if this service is supplied directly and not by contract or fee for service)***	$				
7. Postage	$	4,219	4,219		
* 8. Dues and Membership Fees to Professional Associations (*Specify*) See Attached Schedule	$	11,863	11,863		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	$	1,116	1,116		
9. Subscriptions	$	1,823	1,823		
10. Contributions***	$	1,350	1,350		
See Attached Schedule					
11. Services Provided by Contract (*Specify and Complete Schedule C-2, Page 21 for each firm or individual)*	$	173,468	173,468		
12. Administrative Management Services**	$				
13. Other (*Specify*)	$	7,468	7,468		
See Attached Schedule					
C-14 Total Administrative & General Expenditures	$	2,595,038	2,595,038		

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

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

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

Schedule of Other Travel and Entertainment

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

Schedule of Other Advertising

Description	CCNH	RHNS	(Specify)
Promotional Advertising	$ 72,332		
Total Other Advertising	$ 72,332	$ -	$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Academy of Nutrition and Diet	$ 234		
ALTCFM	$ 85		
CAHCF	$ 9,333		
Other	$ 531		
Connecticut River Area Health District	$ 360		
American Health Care Association	$ 1,320		
Total Dues	$ 11,863	$ -	$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Old Saybrook Chamber of Commerce - Chili Fest	$ 500		
Old Saybrook Ambulance	$ 350		
Connecticut Defenders	$ 500		
Total Contributions	$ 1,350	$ -	$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
BANK CHARGES	$ 5,980		
EMPLOYEE PHYSICALS	$ 1,488		
Total Other Administrative and General	$ 7,468	$ -	$ -

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Schedule C-1 - Management Services*

Name of Facility Gladeview Health Care Center	License No. 2024C	Report for Year Ended 9/30/2020	Page 17 | of 37
Name & Address of Individual or Company Supplying Service	Cost of Management Service	Full Description of Mgmt. Service Provided	Indicate Where Costs are Included in Annual Report Page #/Line #
N/A			

*** In addition to management fees reported on page 16, line m12 include any additional management company charges or allocations of home office overhead costs reported elsewhere in the Annual Report.**

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CSP-18 Rev. 9/2018

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

Name of Facility	License No.	Report for Year Ended	Page of
Gladeview Health Care Center	2024C	9/30/2020	18 | 37

Item		Total	CCNH	RHNS	(Specify)
2. Dietary					
a. In-House Preparation & Service					
1. Raw Food	$	297,708	297,708		
2. Non-Food Supplies	$	74,614	74,614		
3. Other (*Specify*)_____	$				
b. Purchased Services (*by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*)_____	$				
2D. ***Total Dietary Expenditures*** (2a + b + c + d)	$	372,322	372,322		

2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				

G.	Is cost of employee meals included in 2D?	○ Yes	⊙ No	
H.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
I.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
J.	Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D?	○ Yes	⊙ No	If yes, specify cost.
K.	Is any revenue collected from these people?	○ Yes	⊙ No	If yes, specify amt.
L.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			
M.	Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D?	○ Yes	⊙ No	If yes, specify cost.
N.	Is any revenue collected from employees?	○ Yes	⊙ No	If yes, specify amt.
O.	Where is the revenue received reported in the Cost Report? (Page/Line Item)			

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Gladeview Health Care Center	2024C	9/30/2020	19 | 37

Item		Total	CCNH	RHNS	(Specify)
3. Laundry					
a. In-House Processing*	Lbs.				
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. $				
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.				
	Amt. $				
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.				
	Amt. $				
4. Repair and/or purchase of linens.***	Lbs.				
	Amt. $				
b. Purchased Services *(by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)*	$				
c. Other (*Specify*) Laundry supplies	$	3,683	3,683		
3D. ***Total Laundry Expenditures*** (3a + b + c)	$	3,683	3,683		

3E.	Laundry Questionnaire			
F.	Is cost of employee laundry included in 3D?	○ Yes	⊙ No	If yes, specify cost.
G.	Did you receive revenue from employees?	○ Yes	⊙ No	If yes, specify amt.
H.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	
I.	Is Cost of laundry provided to persons other than employees or residents included in 3D?	○ Yes	⊙ No	If yes, specify cost.
J.	Did you receive revenue from these people?	○ Yes	⊙ No	If yes, specify amt.
K.	Where is the revenue received reported in the Cost Report?		(Page/Line Item)	

* Do not include salaries from page 10 as part of dollar values recorded in 1, 2, 3, and 4.
All allocations should add to total recorded in 3D.

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

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

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center	2024C	9/30/2020	20	37

Item			Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel					
a. In-House Care						
1. Supplies - Cleaning (*Mops, pails, brooms, etc.*)	Amt.	$	48,888	48,888		
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)		$	48,888	48,888		
5. Resident Care (Supplies)**						
a. Prescription Drugs***						
1. Own Pharmacy		$				
2. Purchased from Partners/Pharmerica		$	267,149	267,149		
b. Medicine Cabinet Drugs		$				
c. Medical and Therapeutic Supplies		$	253,277	253,277		
d. Ambulance/Limousine***		$	22,280	22,280		
e. Oxygen						
1. For Emergency Use		$				
2. Other***		$	26,296	26,296		
f. X-rays and Related Radiological Procedures***		$	7,403	7,403		
g. Dental (*Not dentists who should be included under salaries or fees)*		$				
h. Laboratory***		$	49,531	49,531		
i. Recreation		$	10,218	10,218		
j. Direct Management Services*		$				
k. Indirect Management Services*		$				
l. Other (Specify)**** See Attached Schedule		$	27,863	27,863		
5M. ***Total Resident Care Expenditures*** (5a - 5j)		$	664,017	664,017		

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

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

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

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

Schedule of Other Resident Care

Description	CCNH	RHNS	(Specify)
CABLE TV EXPENSE	$ 26,275		
PHYSICAL THERAPY SUPPLIE	$ 304		
PROTHETIC/ORTH SUPPLIES	$ 65		
MEDICAL EQUIPMENT RENTAL	$ 1,219		
Total Other Resident Care	$ 27,863	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center	2024C	9/30/2020	21	37

Name of Individual or Company	Address	Related ** to Owners, Operators, Officers		Explanation of Relationship	Full Explanation of Service Provided*	Total Cost/Page Ref.***				
		Yes	No			CCNH	RHNS	(Specify)	Pg	Line
PointClickCare	Suite 4, Mississauga, ON L5N 8E9	○	⊙		Computer services	44,957			16	M11
Paycom	Oklahoma City, OK 73142	○	⊙		Payroll processing	49,152			16	M11
CT Waste Processing	PO Box 99, Plainville, CT 06062	○	⊙		Rubbish removal	32,958			22	6f
Sullivan Lawn Service	8 Piney Branch Road, Ivorytown, CT	○	⊙		Groundskeeping	48,360			22	6f
Trans-Ad	130 Pond View Terrace. Branford, CT 06405	○	⊙		Advertising - Promotional	30,450			16	m3
Septic Works	PO Box 401, Niantic, CT 06357	○	⊙		Septic cleaning	15,495			22	6a
Patient Ping	PO Box 391757, Pittburgh, PA 15251	○	⊙		Resident tracking software	11,110			16	m11
Outfront Media	185 US Highway 46, Fairfield, NJ 07004	○	⊙		Advertising - Promotional	39,225			16	m3
Pharmerica	PO Box 409251, Atlanta, GA 30384-9251	○	⊙		Pharmacy supplies and service	142,606			20	5a2
Partners Pharmacy	PO Box 9689, Uniondale, NY 11555	○	⊙		Pharmacy supplies and service	101,396			20	5a2
		⊙	○							
		○	⊙							
		○	⊙							
		○	⊙							

* List all contracted services over $10,000. Use additional sheets if necessary.
** Refer to Page 4 for definition of related.
*** Please cross-reference amount to the appropriate page in the Annual Report (Pages 16, 18, 19, 20 or 22).

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

Name of Facility	License No.	Report for Year Ended	Page of
Gladeview Health Care Center	2024C	9/30/2020	22 | 37

Item		Total	CCNH	RHNS	(Specify)
6. Maintenance & Operation of Plant					
a. Repairs & Maintenance	$	77,032	77,032		
b. Heat	$	28,360	28,360		
c. Light & Power	$	118,579	118,579		
d. Water	$	67,395	67,395		
e. Equipment Lease (*Provide detail on page 6*)	$	19,300	19,300		
f. Other (*itemize*)	$	97,060	97,060		
See Attached Schedule					
6g. ***Total Maint. & Operating Expense*** (6a - 6f)	$	407,726	407,726		
7. Depreciation (*complete schedule page 23**)					
a. Land Improvements	$				
b. Building & Building Improvements	$				
c. Non-Movable Equipment	$	7,188	7,188		
d. Movable Equipment	$	38,286	38,286		
*7e. ***Total Depreciation Costs*** (7a + b + c + d)	$	45,474	45,474		
8. Amortization (*Complete att. Schedule Page 24**)					
a. Organization Expense	$				
b. Mortgage Expense	$	11,902	11,902		
c. Leasehold Improvements	$	12,668	12,668		
d. Other (*Specify*)	$				
*8e. ***Total Amortization Costs*** (8a + b + c + d)	$	24,570	24,570		
9. Rental payments on leased real property less real estate taxes included in item 10b	$	1,200,000	1,200,000		
10. Property Taxes					
a. Real estate taxes paid by owner	$				
b. Real estate taxes paid by lessor	$				
c. Personal property taxes	$	4,507	4,507		
11. ***Total Property Expenses*** (7e + 8e + 9 + 10)	$	1,274,551	1,274,551		

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

Schedule of Other Repairs and Maintenance

Description	CCNH	RHNS	(Specify)
MAINTENANCE SUPPLIES	$ 15,742		
GROUNDSKEEPING	$ 48,360		
RUBBISH REMOVAL	$ 32,958		
Total Other Repairs and Maintenance	$ 97,060	$ -	$ -

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Depreciation Schedule

Name of Facility	License No.	Report for Year Ended	Page	of
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Property Item	Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
A. **Land Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
A-4. Subtotal								
B. **Building and Building Improvements**								
1. Acquired prior to this report period								
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
B-4. Subtotal								
C. **Non-Movable Equipment**								
1. Acquired prior to this report period	245,617		245,617	201,045			7,188	
2. Disposals (attach schedule)								
3. Acquired during this report period (attach schedule)								
C-4. Subtotal								7,188

	Is a mileage logbook maintained?		Date of Acquisition		Historical Cost Exclusive of Land	Less Salvage Value	Cost to Be Depreciated	Accumulated Depreciation to Beginning of Year's Operations	Method of Computing Depreciation	Useful Life	Depreciation for This Year	Totals
	Yes	No	Month	Year								
D. **Movable Equipment**												
1. Motor Vehicles (Specify name, model and year of each vehicle)												
a.												
b.												
c.												
d.												
2. Movable Equipment												
a. Acquired prior to this report period					436,778		436,778	290,161			38,286	
b. Disposals (attach schedule)												
c. Acquired during this report period (attach schedule)												
D-3. Subtotal												38,286
E. ***Total Depreciation***												45,474

Schedule of Land Improvements Acquired during this report period

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

***Ties to Page 23, Line A3**

****Ties to Page 23, Line A2**

Schedule of Building Improvements Acquired during this report period

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

***Ties to Page 23, Line B3**

****Ties to Page 23, Line B2**

Schedule of Non-Movable Equipment Acquired during this report peri

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

***Ties to Page 23, Line C3**

****Ties to Page 23, Line C2**

Schedule of Movable Equipment Acquired during this report peri

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

***Ties to Page 23, Line D2c**
****Ties to Page 23, Line D2b**

Schedule of Leasehold Improvements Acquired during this report peri

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation	
Additions:					
Total additions for Leasehold Improvemer		$ -		$ -	*
Deletions:					
Total deletions for Leasehold Improvemer		$ -		$ -	**

***Ties to Page 24, Line C3**
****Ties to Page 24, Line C2**

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Amortization Schedule*

Name of Facility	License No.	Report for Year Ended	Page	of
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Item	Date of Acquisition Month	Date of Acquisition Year	Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
A. **Organization Expense**									
1.									
2.									
3.									
A-4. Subtotal									
B. **Mortgage Expense**									
1. Mortgage cost	12	2011	10	106,134	86,266			11,902	
2.									
3.									
B-4. Subtotal									11,902
C. **Leasehold Improvements and Other**									
1. Acquired prior to this report period	9	2019		926,638	856,552			12,668	
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									12,668
D. ***Total Amortization***									24,570

* 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.

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

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center	2024C	9/30/2020	25	37

11. Property Questionnaire

Part A

Is the property either owned by the Facility or leased from a Related Party?* ○ Yes ⊙ No

If "Yes," complete Part B.
If "No," complete Part C.

*If any owner or operator of this facility is related by family, marriage, ownership, ability to control or business association to any person or organization from whom buildings are leased, then it is considered a related party transaction.

Description	Total
1. Date Land Purchased	01/01/85
2. Date Structure Completed	
3. If **NOT** Original Owner, Date of Purchase	
4. Date of Initial Licensure	11/20/87
5. Total Licensed Bed Capacity	132
6. Square Footage	
7. Acquisition Cost	
a. Land	450,000
b. Building	7,222,138

Part B - Owner and Related Parties	1st Mortgage	2nd Mortgage	3rd Mortgage	4th Mortgage
1. Financing				
a. Type of Financing (e.g., fixed, variable)	Fixed			
b. Date Mortgage Obtained	12/27/14			
c. Interest Rate for the Cost Year	3.72%			
d. Term of Mortgage (number of years)	30			
e. Amount of Principal Borrowed	9,670,400			
f. Principal balance outstanding as of _____				
Complete if Mortgage was Refinanced During Current Cost Year				
g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

Part C - Arms-Length Leases for Real Property Improvements Only

Name and Address of Lessor	Property Leased	Date of Lease	Term of Lease	Annual Amount of Lease

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

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

Name of Facility	License No.	Report for Year Ended	Page of
Gladeview Health Care Center	2024C	9/30/2020	26 | 37

Item	Total	CCNH	RHNS	(Specify)
12. Interest				
A. Building, Land Improvement & Non-Movable Equipment				
1. First Mortgage $				
Name of Lender / Rate				
Address of Lender				
2. Second Mortgage $				
Name of Lender / Rate				
Address of Lender				
3. Third Mortgage $				
Name of Lender / Rate				
Address of Lender				
4. Fourth Mortgage $				
Name of Lender / Rate				
Address of Lender				
B. CHEFA Loan Information				
1. Original Loan Amount $				
2. Loan Origination Date				
3. Interest Rate %				
4. Term				
5. CHEFA Interest Expense				
12 B7. ***Total Building Interest Expense*** (A1 - A4 + B5) $				

(*Carry Subtotals forward to next page*)

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

Name of Facility	License No.	Report for Year Ended	Page of
Gladeview Health Care Center	2024C	9/30/2020	27 | 37

Item	Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:				
12. C. Movable Equipment				
1. Automotive Equipment $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
2. Other (*Specify*) $				
A. Item / Rate / Amount				
Lender				
Address of Lender				
B. Item / Rate / Amount				
Lender				
Address of Lender				
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2) $				
12. D. Other Interest Expense (*Specify*) $	11,105	11,105		
13. ***Total All Interest Expense*** (12B7 + 12C3 + 12D) $	11,105	11,105		
14. Insurance				
a. Insurance on Property (buildings only) $	14,993	14,993		
b. Insurance on Automobiles $				
c. Insurance other than Property (as specified above)				
1. Umbrella (*Blanket Coverage*) $				
2. Fire and Extended Coverage $				
3. Other (*Specify*) $				
14d. ***Total Insurance Expenditures (14a + b + c)*** $	14,993	14,993		
15. ***Total All Expenditures (A-13 thru C-14)*** $	12,807,577	12,807,577		

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D. Adjustments to Statement of Expenditures

Name of Facility	License No.	Report for Year Ended	Page of
Gladeview Health Care Center	2024C	9/30/2020	28 | 37

Item No.	Page No.	Line No.	Item Description	Total Amount of Decrease	CCNH	RHNS	(Specify)
Page 10 - Salaries and Wages							
1.			Outpatient Service Costs $				
2.			Salaries not related to Resident Care $				
3.	10	A12g	Occupational Therapy $	214,976	214,976		
4.			Other - See attached Schedule $				
Page 13 - Professional Fees							
5.	13	B8c	Resident Care Physicians ** $	43,345	43,345		
6.			Occupational Therapy $				
7.			Other - See attached Schedule $				
Pages 15 & 16 - Administrative and General							
8.			Discriminatory Benefits $				
9.	15	1c	Bad Debts $	170,000	170,000		
10.			Accounting $				
10a.			Legal $	9,004	9,004		
11.			Telephone $				
12.	15	1h2	Cellular Telephone $	5,701	5,701		
13.	15	1f	Life insurance premiums on the life of Owners, Partners, Operators $	12,501	12,501		
14.	16	L3	Gifts, flowers and coffee shops $	9,604	9,604		
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees $				
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative $				
17.	16	L7	Automobile Expense (e.g. personal use) $	5	5		
18.	16	M3	Unallowable Advertising * $	72,332	72,332		
19.			Income Tax / Corporate Business Tax $				
20.	16	M10	Fund Raising / Contributions $	1,922	1,922		
21.			Unallowable Management Fees $				
22.			Barber and Beauty $				
23.			Other - See attached Schedule $	1,116	1,116		
Page 18 - Dietary Expenditures							
24.			Meals to employees, guests and others who are not residents $				
Page 19 - Laundry Expenditures							
25.			Laundry services to employees, guests and others who are not residents $				
Page 20 - Housekeeping Expenditures							
26.			Housekeeping services to employees, guests and others who are not residents $				
			Subtotal (Items 1 - 26) $	540,506	540,506		

* All except "Help Wanted".

(*Carry Subtotal forward to next page*)

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

Schedule of Other Salaries Adjustment

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

Schedule of Fees Adjustments

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

Schedule of Other A&G Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
16	M8	Chamber Dues	$ 1,116		
Total Other A&G Adjustments			$ 1,116	$ -	$ -

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

Name of Facility	License No.	Report for Year Ended	Page of
Gladeview Health Care Center	2024C	9/30/2020	29 | 37

Item No.	Page No.	Line No.	Item Description		Total Amount of Decrease	CCNH	RHNS	(Specify)
			Subtotals Brought Forward	$	540,506	540,506		
Page 20 - Resident Care Supplies***								
27.	20	5a2	Prescription Drugs	$	267,149	267,149		
28.	20	5d	Ambulance/Limousine	$	22,280	22,280		
29.	20	5f	X-rays, etc	$	7,403	7,403		
30.	20	5h	Laboratory	$	49,531	49,531		
31.	20	5c	Medical Supplies	$	12,664	12,664		
32.	20	5e2	Oxygen (non emergency)	$	26,296	26,296		
33.			Occupational Therapy	$				
34.			Other - See Attached Schedule	$				
Page 22 - Maintenance and Property								
35.			Excess Movable Equipment Depreciation See Attached Schedule	$				
36.			Depreciation on Unallowable Motor Vehicles	$				
37.			Unallowable Property and Real Estate Taxes	$				
38.			Rental of Building Space or Rooms	$				
39.			Other - See Attached Schedule	$				
Page 27 - Insurance								
40.			Mortgage Insurance	$				
41.			Property Insurance	$				
Other - Miscellaneous								
42.			Other - Indirect	$				
43.			Interest Income on Account Rec.	$				
44.			Other - Miscellaneous Administrative	$	26,374	26,374		
45.			Management Fees Direct	$				
46.			Management Fees Indirect	$				
47.			Other - Direct	$				
Not For Profit Providers Only								
48.			Building/Non Movable Eq. Depreciation Unallowable Building Interest - See Attached Schedule	$				
49.	***Total Amount of Decrease (Items 1 - 48)***			$	952,203	952,203		

*** 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.

Attachment Page 29

Schedule of Other Ancillary Costs

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

Schedule of Excess Movable Equipment Depreciation

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

Schedule of Other Property Adjustments

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

Schedule of Other - Indirect Adjustments

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

Schedule of Other - Miscellaneous Administrative Adjustments

Page Ref	Line Ref	Description	CCNH	RHNS	(Specify)
20	5j	Cable TV	$ 26,275		
30	IV8	Misc income	$ 99		
Total Other Adjustments			$ 26,374	$ -	$ -

Schedule of Other - Direct Adjustments

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

Schedule of Unallowable Building Interest

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

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F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended	Page of
Gladeview Health Care Center	2024C	9/30/2020	30 | 37

Item		Total	CCNH	RHNS	(Specify)
I. Resident Room, Board & Routine Care Revenue					
1. a. Medicaid Residents (*CT only*)	$	10,221,745	10,221,745		
b. Medicaid Room and Board Contractual Allowance **	$	(3,321,371)	(3,321,371)		
2. a. Medicaid (*All other states*)	$				
b. Other States Room and Board Contractual Allowance **	$				
3. a. Medicare Residents *(all inclusive)*	$	3,035,624	3,035,624		
b. Medicare Room and Board Contractual Allowance **	$	(1,025,120)	(1,025,120)		
4. a. Private-Pay Residents and Other	$	4,107,295	4,107,295		
b. Private-Pay Room and Board Contractual Allowance **	$	(196,934)	(196,934)		
II. Other Resident Revenue					
1. a. Prescription Drugs - Medicare	$				
b. Prescription Drugs - Medicare Contractual Allowance **	$				
c. Prescription Drugs - Non-Medicare	$				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	$				
2. a. Medical Supplies - Medicare	$				
b. Medical Supplies - Medicare Contractual Allowance **	$				
c. Medical Supplies - Non-Medicare	$				
d. Medical Supplies - Non-Medicare Contractual Allowance **	$				
3. a. Physical Therapy - Medicare	$	430,409	430,409		
b. Physical Therapy - Medicare Contractual Allowance **	$	(342,870)	(342,870)		
c. Physical Therapy - Non-Medicare	$	228,749	228,749		
d. Physical Therapy - Non-Medicare Contractual Allowance **	$	(228,749)	(228,749)		
4. a. Speech Therapy - Medicare	$	190,124	190,124		
b. Speech Therapy - Medicare Contractual Allowance **	$	(164,445)	(164,445)		
c. Speech Therapy - Non-Medicare	$	77,904	77,904		
d. Speech Therapy - Non-Medicare Contractual Allowance **	$	(77,904)	(77,904)		
5. a. Occupational Therapy - Medicare	$	552,336	552,336		
b. Occupational Therapy - Medicare Contractual Allowance **	$	(419,963)	(419,963)		
c. Occupational Therapy - Non-Medicare	$	287,578	287,578		
d. Occupational Therapy - Non-Medicare Contractual Allowance **	$	(287,578)	(287,578)		
6. a. Other *(Specify)* - Medicare	$				
b. Other *(Specify)* - Non-Medicare	$				
III. *Total Resident Revenue* (Section I. thru Section II.)	$	13,066,830	13,066,830		
IV. Other Revenue*					
1. Meals sold to guests, employees & others	$				
2. Rental of rooms to non-residents	$				
3. Telephone	$				
4. Rental of Television and Cable Services	$				
5. Interest Income *(Specify)*	$				
6. Private Duty Nurses' Fees	$				
7. Barber, Coffee, Beauty and Gift shops	$				
8. Other (*Specify*)	$	19,279	19,279		
V. Total Other Revenue (1 thru 8)	$	19,279	19,279		
VI. Total All Revenue (III +V)	$	13,086,109	13,086,109		

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

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

Schedule of Other Resident Revenue - Medicare

Related Exp

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

Schedule of Other Non-Medicare Resident Revenue

Related Exp

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

Interest Income

Account

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30 iv 8	Provider fee overpayment from 2016 (corrected by Myers Stauffer)	$ 13,411		
30 iv 8	IRS form 8752 tax adjustment	$ 4,866		
30 iv 8	Matrix software refund (From over 10 years ago)	$ 903		
30 iv 8	Other	$ 99		
Total Other Revenue		$ 19,279	$ -	$ -

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G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center	2024C	9/30/2020	31	37

Account				Amount
Assets				
A. Current Assets				
1. Cash (*on hand and in banks*)				$ 2,602,968
2. Resident Accounts Receivable (Less Allowance for Bad Debts)				$ 1,503,773
3. Other Accounts Receivable (Excluding Owners or Related Parties)				$ 535,905
4 Inventories				$ 24,950
5. Prepaid Expenses				$ 23,623
a. Insurance		16,491		
b. Deposits		7,132		
c.				
d. See Schedule				
6. Interest Receivable				$
7. Medicare Final Settlement Receivable				$
8. Other Current Assets (*itemize*)				$
See Schedule				
A-9. ***Total Current Assets*** (Lines A1 thru 8)				$ 4,691,219
B. Fixed Assets				
1. Land				$
2. Land Improvements	*Historical Cost			$
	Accum. Depreciation		Net	
3. Buildings	*Historical Cost			$
	Accum. Depreciation		Net	
4. Leasehold Improvements	*Historical Cost	926,638		$ 57,418
	Accum. Depreciation	869,220	Net	
5. Non-Movable Equipment	*Historical Cost	245,617		$ 37,384
	Accum. Depreciation	208,233	Net	
6. Movable Equipment	*Historical Cost	436,778		$ 108,331
	Accum. Depreciation	328,447	Net	
7. Motor Vehicles	*Historical Cost			$
	Accum. Depreciation		Net	
8. Minor Equipment-Not Depreciable				$
9. Other Fixed Assets (*itemize*)				$
See Schedule				
B-10. ***Total Fixed Assets*** (Lines B1 thru 9)				$ 203,133

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

(*Carry Total forward to next page*)

Schedule of Prepaid Expenses Page 31 Line A5

Page Ref	Line Ref	Description	
Total Prepaid Expenses			$ -

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

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

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

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

Schedule of Other Assets Page 32 Line D7

Page Ref	Line Ref	Description	
Total Other Assets			$ -

Schedule of Notes Payable (Itemize) Page 33 Line A2

Page Ref	Line Ref	Description	
Total Notes Payable			$ -

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

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

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

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center	2024C	9/30/2020	32	37

Account				Amount
			Total Brought Forward:	$ 4,894,352
C. Leasehold or like property recorded for Equity Purposes.				
1. Land				$
2. Land Improvements	*Historical Cost			
	Accum. Depreciation		Net	$
3. Buildings	*Historical Cost			
	Accum. Depreciation		Net	$
4. Non-Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
5. Movable Equipment	*Historical Cost			
	Accum. Depreciation		Net	$
6. Motor Vehicles	*Historical Cost			
	Accum. Depreciation		Net	$
7. Minor Equipment-Not Depreciable				$
C-8 ***Total Leasehold or Like Properties*** (C1 thru 7)				$
D. Investment and Other Assets				
1. Deferred Deposits				$
2. Escrow Deposits				$
3. Organization Expense	*Historical Cost			
	Accum. Depreciation		Net	$
4. Goodwill (Purchased Only)				$
5. Investments Related to Resident Care (*itemize*)				$
6. Loans to Owners or Related Parties (*itemize*)				$
Name and Address	Amount	Loan Date		
7. Other Assets (*itemize*)				$ 15,167
Deferred financing cost		15,167		
See Schedule				
D-8. ***Total Investments and Other Assets*** (Lines D1 thru 7)				$ 15,167
D-9. ***Total All Assets*** (Lines A9 + B10 + C8 + D8)				$ 4,909,519

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

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center	2024C	9/30/2020	33	37

Account					Amount
Liabilities					
A. Current Liabilities					
1. Trade Accounts Payable					$ 567,184
2. Notes Payable (*itemize*)					$ 1,297,200
Payroll protection program	1,297,200				
See Schedule					
3. Loans Payable for Equipment (*Current portion*) (*itemize*)					$
Name of Lender		Purpose	Amount	Date Due	
4. Accrued Payroll (*Exclusive of Owners and/or Stockholders only*)					$ 417,776
5. Accrued Payroll (*Owners and/or Stockholders only*)					$
6. Accrued Payroll Taxes Payable					$ 11,836
7. Medicare Final Settlement Payable					$
8. Medicare Current Financing Payable					$
9. Mortgage Payable (*Current Portion*)					$
10. Interest Payable (*Exclusive of Owner and/or Related Parties*)					$
11. Accrued Income Taxes*					$
12. Other Current Liabilities (*itemize*)					$ 1,042,073
Deferred revenue	834,873				
Accrued expenses	12,487				
Provider fee payable	194,713				
See Schedule					
A-13. ***Total Current Liabilities*** (Lines A1 thru 12)					$ 3,336,069

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

(Carry Total forward to next page)

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G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center	2024C	9/30/2020	34	37

Account	Amount
Total Brought Forward:	3,336,069
Liabilities (cont'd)	
B. Long-Term Liabilities	
1. Loans Payable-Equipment (*itemize*)	$

Name of Lender	Purpose	Amount	Date Due

2. Mortgages Payable	$
3. Loans from Owners or Related Parties (*itemize*)	$

Name and Address of Lender	Amount	Loan Date

4. Other Long-Term Liabilities (*itemize*)	$
See Schedule	
B-5. ***Total Long-Term Liabilities*** (Lines B1 thru 4)	$
C. ***Total All Liabilities*** (Lines A-13 + B-5)	$ 3,336,069

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

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center	2024C	9/30/2020	35	37

Account		Amount
A.	**Reserves**	
	1. Reserve for value of leased land	$
	2. Reserve for depreciation value of leased buildings and appurtenances to be amortized	$
	3. Reserve for depreciation value of leased personal property (*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	$
B.	**Net Worth**	
	1. Owner's Capital	$
	2. Capital Stock	$ 1,000
	3. Paid-in Surplus	$
	4. Treasury Stock	$
	5. Cumulated Earnings	$ 1,293,918
	6. Gain or Loss for Period 10/1/2019 thru 9/30/2020	$ 278,532
	7. Total Net Worth	$ 1,573,450
C.	***Total Reserves and Net Worth***	$ 1,573,450
D.	***Total Liabilities, Reserves, and Net Worth***	$ 4,909,519

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H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center	2024C	9/30/2020	36	37

Account				Amount
A.	Balance at End of Prior Period as shown on Report of 09/30/2019			$ 1,294,918
B.	Total Revenue (*From Statement of Revenue Page 30*)			$ 13,086,109
C.	Total Expenditures (*From Statement of Expenditures Page 27*)			$ 12,807,577
D.	Net Income or Deficit			$ 278,532
E.	Balance			$ 1,573,450
F.	Additions			
	1. Additional Capital Contributed (*itemize*)			
	2. Other (*itemize*)			
F-3.	Total Additions			$
G.	Deductions			
	1. Drawings of Owners/Operators/Partners (*Specify*)			$
	Name and Address (*No., City, State, Zip*)	Title	Amount	
	2. Other Withdrawings *(Specify)*			$
	Purpose		Amount	
	3. Total Deductions			$
H.	***Balance at End of Period*** 09/30/20			$ 1,573,450

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I. Preparer's/Reviewer's Certification

Name of Facility	License No.	Report for Year Ended	Page	of
Gladeview Health Care Center	2024C	9/30/2020	37	37

Check appropriate category

☑ Chronic and Convalescent Nursing Home only (CCNH)	☐ Rest Home with Nursing Supervision only (RHNS)	☐ (Specify)

Preparer/Reviewer Certification

I have prepared and reviewed this report and am familiar with the applicable regulations governing its preparation. have read the most recent Federal and State issued field audit reports for the Facility and have inquired of appropriate personnel as to the possible inclusion in this report of expenses which are not reimbursable under the applicable regulations. All non-reimbursable expenses of which I am aware (except those expenses known to be automatically removed in the State rate computation system) as a result of reading reports, inquiry or other services performed by me are properly reported as such in this report on Pages 28 and 29 (adjustments to statement of expenditures). Further, the data contained in this report is in agreement with the books and records, as provided to me, by the Facility.

Signature of Preparer	Title	Date Signed

Printed Name of Preparer
Gladeview Health Care Center

Addres Address	Phone Number
60 Boston Post Rd. Old Saybrook, CT 06475	860-388-6696

Contacted Person Regarding Additional Information Needed Regarding This Report	Phone Number
Jason Moore	860-388-6696

Contact Email Address
jmoore@gladeviewcares.com