

State of Connecticut



Annual Report of Long-Term Care Facility Cost Year 2020

Name of Facility (as licensed) Grove Manor Nursing Home, Incorporated	
Address (No. & Street, City, State, Zip Code) 145 Grove Street, Waterbury, CT 06710	
Type of Facility	
<input checked="" type="checkbox"/> Chronic and Convalescent <input checked="" type="checkbox"/> Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)
Report for Year Beginning 10/1/2019	Report for Year Ending 9/30/2020

License Numbers:	CCNH 494-c	RHNS	(Specify)	Medicare Provider 075096
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Medicaid Provider Numbers:	CCNH 4945	RHNS	ICF-IID
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For Department Use Only

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

General Information

Name of Facility (as licensed) Grove Manor Nursing Home, Incorporated	License No. 494-c	Report for Year Ended 9/30/2020	Page 1	of 37
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Administrator's/Owner's Certification

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY FINE AND/OR IMPRISONMENT UNDER STATE OR FEDERAL LAW.

I HEREBY CERTIFY that I have read the above statement and that I have examined the accompanying Cost Report and supporting schedules prepared for Grove Manor Nursing Home, Incorporated [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) Janet Aliciene		Printed Name (Owner)	
Subscribed and Sworn to before me:	Date	Signed (Notary Public)	Comm. Expires / /
Address of Notary Public			

(Notary Seal)

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

Data Required for Real Wage Adjustment			Page 1A	of 37
Name of Facility Grove Manor Nursing Home, Incorporated	Period Covered:		From 10/1/2019	To 9/30/2020
Address of Facility 145 Grove Street, Waterbury, CT 06710				
Report Prepared By Raymond E. Rossi, JR.	Phone Number 203-754-3134	Date 2/4/2021		
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.

General Information and Questionnaire
Type of Facility - Organization Structure

	Phone No. of Facility 203-753-7205	Report for Year Ended 9/30/2020	Page 2
Name of Facility (as shown on license) Grove Manor Nursing Home, Incorporated		Address (No. & Street, City, State, Zip) 145 Grove Street, Waterbury, CT 06710	
License Numbers:	CCNH 494-c	RHNS	(Specify)
Medicare Provider No. 075096			
Type of Facility (Check appropriate box(es))			
<input checked="" type="checkbox"/> Chronic and Convalescent <input type="checkbox"/> Nursing Home only (CCNH) <input type="checkbox"/> Rest Home with Nursing <input type="checkbox"/> Supervision only (RHNS) <input type="checkbox"/> (Specify)			
Type of Ownership (Check appropriate box)			
<input type="radio"/> Proprietorship <input type="radio"/> LLC <input type="radio"/> Partnership <input checked="" type="radio"/> Profit Corp. <input type="radio"/> Non-Profit Corp. <input type="radio"/> Government <input type="radio"/> Trust			
If this facility opened or closed during report year provide:		Date Opened	Date Closed
Has there been any change in ownership or operation during this report year?		<input type="radio"/> Yes	<input checked="" type="radio"/> No
		If "Yes," explain fully.	
Administrator Name of Administrator Janet Aliciene			
		Nursing Home Administrator's License No.:	000760
Other Operators/Owners who are assistant administrators (full or part time) of this facility.			
Name		License No.:	

General Information and Questionnaire Partners/Members

General Information and Questionnaire
Corporate Owners

Name of Facility Grove Manor Nursing Home, Incorporated	License No. 494-c	Report for Year Ended 9/30/2020	Page of 3A 37
If this facility is owned or operated as a corporation, provide the following information:			
Legal Name of Corporation	Business Address		State(s) in Which Incorporated
Grove Manor Nursing Home, Incorporated	145 Grove Street, Waterbury, CT 06710		Connecticut
Name of Directors, Officers	Business Address	Title	No. Shares Held by Each
Rose Schaefer	145 Grove Street, Waterbury, CT 06710	Pres/Treas	1,486 49.54%
Janet Aliciene	145 Grove Street, Waterbury, CT 06710	VP/Sec	1,128 37.60%
Ryan Aliciene	145 Grove Street, Waterbury, CT 06710	VP/Asst Treas	386 12.86%
Names of Stockholders Owning at Least 10% of Shares			
Rose Schaefer	145 Grove Street, Waterbury, CT 06710	Pres/Treas	1,486 49.54%
Janet Aliciene	145 Grove Street, Waterbury, CT 06710	VP/Sec	1,128 37.60%
Ryan Aliciene	145 Grove Street, Waterbury, CT 06710	VP/Asst Treas	386 12.86%

General Information and Questionnaire

Individual Proprietorship

General Information and Questionnaire

Related Parties*

Name of Facility Grove Manor Nursing Home, Incorporated	License No. 494-c	Report for Year Ended 9/30/2020			Page 4	of 37		
Are any individuals receiving compensation from the facility related through marriage, ability to control, ownership, family or business association?				<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the Name/Address and complete the information on Page 11 of the report.				
Are any individuals or companies which provide goods or services, including the rental of property or the loaning of funds to this facility, related through family association, common ownership, control, or business association to any of the owners, operators, or officials of this facility?				<input checked="" type="radio"/> Yes <input type="radio"/> No If "Yes," provide the following information:				
Name of Related Individual or Company	Business Address	Also Provides Goods/Services to Non-Related Parties			Indicate Where Costs are Included in Annual Report Page # / Line #	Cost Reported	Actual Cost to the Related Party	
		Yes	No	%**				Description of Goods/Services Provided
Rose Schaefer	145 Grove Street, Waterbury, CT 06710	<input type="radio"/>	<input checked="" type="radio"/>		Working Capital Loan Current Portion	33/A12	19,220	19,220
Rose Schaefer	145 Grove Street, Waterbury, CT 06710	<input type="radio"/>	<input checked="" type="radio"/>		Working Capital Loan Non Current Portion	34/B3	220,918	220,918
Janet Aliciene	145 Grove Street, Waterbury, CT 06710	<input type="radio"/>	<input checked="" type="radio"/>		Salary	10/A2	125,286	125,286
Ryan Aliciene	145 Grove Street, Waterbury, CT 06710	<input type="radio"/>	<input checked="" type="radio"/>		Salary	10/A4	137,080	137,080
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					
		<input type="radio"/>	<input checked="" type="radio"/>					

* Use additional sheets if necessary.

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

General Information and Questionnaire

Basis for Allocation of Costs

Name of Facility Grove Manor Nursing Home, Incorporated	License No. 494-c	Report for Year Ended 9/30/2020	Page 5	of 37
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If the facility is licensed as CDH and/or RCH or provides AIDS or TBI services with special Medicaid rates, costs must be allocated to CCNH and RHNS as follows:

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

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

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

N/A Only one level of service.

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

N/A Only one level of service.

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.

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
Grove Manor Nursing Home, Incorporated		494-c		9/30/2020			6 37
Name and Address of Lessor	Related * to Owners, Operators, Officers		Description of Items Leased	Date of Lease**	Term of Lease	Annual Amount of Lease	Amount Claimed
	Yes	No					
Al's Beverage Service, 3 Revay Rd., Windsor, CT 06088	<input type="radio"/>	<input checked="" type="radio"/>	Ice Machine	09/01/14	Open Ended	1,531	1,531
Great American Financial Services, PO Box 609 Cedar Rapids, IA 52406	<input type="radio"/>	<input checked="" type="radio"/>	Copier/Printer	11/16/18	63 Months	6,381	6,381
Krystal Kleer/Quench USA 630 Allendale Rd, King of Prussia, PA 19406	<input type="radio"/>	<input checked="" type="radio"/>	Water Cooler	10/01/14	Open Ended	893	893
Euro Performance Cars, 800 S Colony Rd, Wallingford, CT 06492	<input type="radio"/>	<input checked="" type="radio"/>	2019 Audi	09/19/19	39 Months	9,478	9,478
Euro Performance Cars, 800 S Colony Rd, Wallingford, CT 06492	<input type="radio"/>	<input checked="" type="radio"/>	2019 Audi	03/22/19	36 Months	10,067	10,198
Life Systems Inc, 7320 Central Ave, Savannah, GA 31406	<input type="radio"/>	<input checked="" type="radio"/>	Patient Alarm System	11/01/16	36 Months	3,672	1,224
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
	<input type="radio"/>	<input checked="" type="radio"/>					
Is a Mileage Log Book Maintained for All Leased Vehicles ?		<input type="radio"/> Yes		<input checked="" type="radio"/> No		Total ***	29,705

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

** Attach copies of newly acquired leases.

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

General Information and Questionnaire

Accounting Basis

Name of Facility Grove Manor Nursing Home, Incor	License No. 494-c	Report for Year Ended 9/30/2020	Page 7	of 37
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The records of this facility for the period covered by this report were maintained on the following basis:

Accrual Cash Modified Cash

Is the accounting basis for this

period the same as for the Yes If "No," explain.
previous period? No

Independent Accounting Firm

Name of Accounting Firm 1 Dibble & Rossi, CPA's PC 2 H.A. Business Services 3 4	Address (No. & Street, City, State, Zip Code) 515 Watertown Ave, Waterbury, CT 06708 PO Box 291, Thomaston, CT 06787
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Services Provided by This Firm (*describe fully*)

1 Preparation of Financial Statements, Income Tax Returns and CT and Medicare Cost Reports	\$ 18,000
2 Bookkeeping Services	\$ 30,882
3	\$
4	\$
	Charge for Services Provided \$ 48,882

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

Yes No | Accounting and Auditing Page 15, Line 1d

Legal Services Information

Name of Legal Firm or Independent Attorney 1 2 3 4 5	Telephone Number
---	------------------

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

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

Services Provided by This Firm (*describe fully*)

1	\$
2	\$
3	\$
4	\$
5	\$
	Charge for Services Provided \$

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

Yes No

Schedule of Resident Statistics

Name of Facility Grove Manor Nursing Home, Incorporated			License No. 494-c				Report for Year Ended 9/30/2020				Page 8	of 37
	Total All Levels	Total CCNH Level	Total RHNS Level	Total (Specify)	Period 10/1 Thru 6/30				Period 7/1 Thru 9/30			
					Total	CCNH	RHNS	(Specify)	Total	CCNH	RHNS	(Specify)
1. Certified Bed Capacity					60	60						
A. On last day of PREVIOUS report period	60	60										
B. On last day of THIS report period	60	60							60	60		
2. Number of Residents					45	45						
A. As of midnight of PREVIOUS report period	45	45										
B. As of midnight of THIS report period	45	45							45	45		
3. Total Number of Days Care Provided During Period					187	187			8	8		
A. Medicare	195	195										
B. Medicaid (Conn.)	16,316	16,316			12,519	12,519			3,797	3,797		
C. Medicaid (other states)												
D. Private Pay	265	265			173	173			92	92		
E. State SSI for RCH												
F. Other (Specify) Managed Care	90	90			90	90						
G. Total Care Days During Period (3A thru F)	16,866	16,866			12,969	12,969			3,897	3,897		
4. Total Number of Days Not Included in Figures in 3G for Which Revenue Was Received for Reserved Beds												
A. Medicaid Bed Reserve Days	174	174			136	136			38	38		
B. Other Bed Reserve Days												
5. Total Resident Days (3G + 4A + 4B)	17,040	17,040			13,105	13,105			3,935	3,935		

Schedule of Resident Statistics (Cont'd)

Name of Facility Grove Manor Nursing Home, Incorporated	License No. 494-c	Report for Year Ended 9/30/2020	Page 9	of 37
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4. Were there any changes in the certified bed capacity during the report year?

 Yes No

If "YES", provide the following information:

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

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

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

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

Item	Medicare	Medicaid		Self-Pay			Other State Assisted	
	CCNH	CCNH	RHNS	CCNH	RHNS	(Specify)	R.C.H.	ICF-MR
No. of Residents								
Per Diem Rate								
a. One bed rm.								
b. Two bed rms.	Var	204.16		340.00				
c. Three or more bed rms.								

7. Total Number of Physical Therapy Treatments

TOTAL CCNH RHNS (Specify)

A. Medicare - Part B	103	103	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	79	79	
2. Restorative Treatments			
C. Other	35	35	
D. Total Physical Therapy Treatments	217	217	

8. Total Number of Speech Therapy Treatments

TOTAL CCNH RHNS (Specify)

A. Medicare - Part B	10	10	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	3	3	
2. Restorative Treatments			
C. Other	3	3	
D. Total Speech Therapy Treatments	16	16	

9. Total Number of Occupational Therapy Treatments

TOTAL CCNH RHNS (Specify)

A. Medicare - Part B	61	61	
B. Medicaid (Exclusive of Part B)			
1. Maintenance Treatments	116	116	
2. Restorative Treatments			
C. Other	34	34	
D. Total Occupational Therapy Treatments	211	211	

Report of Expenditures - Salaries & Wages

Name of Facility	License No.	Report for Year Ended		Page	of
		494-c	9/30/2020	10	37
Are time records maintained by all individuals receiving compensation?		<input checked="" type="radio"/> Yes		<input type="radio"/> No	
		Total Cost and Hours			
Item	CCNH	Hours	RHNS	Hours	(Specify) 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)	125,286	2,431			
3. Assistant Administrator (Complete also Sec. IV of Schedule A1)					
4. Other Administrative Salaries (telephone operator, clerks, receptionists, etc.)	137,080	2,708			
5. Dietary Service					
a. Head Dietitian					
b. Food Service Supervisor					
c. Dietary Workers					
6. Housekeeping Service					
a. Head Housekeeper					
b. Other Housekeeping Workers					
7. Repairs & Maintenance Services					
a. Engineer or Chief of Maintenance					
b. Other Maintenance Workers	24,801	1,526			
8. Laundry Service					
a. Supervisor					
b. Other Laundry Workers					
9. Barber and Beautician Services					
10. Protective Services					
11. Accounting Services					
a. Head Accountant					
b. Other Accountants					
12. Professional Care of Residents					
a. Directors and Assistant Director of Nurses	110,547	2,413			
b. RN					
1. Direct Care	25,182	1,504			
2. Administrative**	335,208	8,518			
c. LPN					
1. Direct Care	406,994	14,331			
2. Administrative**					
d. Aides and Attendants	558,133	43,037			
e. Physical Therapists					
f. Speech Therapists					
g. Occupational Therapists					
h. Recreation Workers	38,286	2,068			
i. Physicians					
1. Medical Director					
2. Utilization Review					
3. Resident Care***					
4. Other (Specify)					
j. Dentists					
k. Pharmacists					
l. Podiatrists					
m. Social Workers/Case Management	73,204	2,326			
n. Marketing					
o. Other (Specify)					
See Attached Schedule					
<i>A-13. Total Salary Expenditures</i>	1,834,721	80,862			

* Do not include in this section any expenditures paid to persons who receive a fee for services rendered or who are paid on a contract basis.

** Administrative - costs and hours associated with the following positions: MDS Coordinator, Inservice Training Coordinator and

Infection Control Nurse. Such costs shall be included in the direct care category for the purposes of rate setting.

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

Schedule of Other Salaries and Wages (Page 10)

Schedule of Other Fees (Page 13)

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-11 Rev. 10/2005

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

Name of Facility Grove Manor Nursing Home, Incorporated			License No. 494-c		Report for Year Ended 9/30/2020			Page 11	of 37	
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section I - Operators/Owners										
Section II - Other related parties of Operators/Owners employed in and paid by facility (EXCEPT those who may be the Administrator or Assistant Administrators who are identified on Page 12).										
Ryan Aliciene	137,080					2,708				

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

** Include all employment worked during the cost year.

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-12 Rev. 10/2005

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

Name of Facility (as licensed)				License No.		Report for Year Ended			Page	of
Grove Manor Nursing Home, Incorporated				494-c		9/30/2020			12	37
Name	Salary Paid			Fringe Benefits and/or Other Payments (describe fully)	Full Description of Services Rendered	Total Hours Worked	Line Where Claimed on Page 10	Name and Address of All Other Employment**	Total Hours Worked	Compensation Received
	CCNH	RHNS	(Specify)							
Section III - Administrators***										
Janet Aliciene	125,286					2,431				
Section IV - Assistant Administrators										

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

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

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

B. Report of Expenditures - Professional Fees

Name of Facility Grove Manor Nursing Home, Incorporated	License No. 494-c	Report for Year Ended 9/30/2020		Page 13	of 37
Total Cost and Hours					
Item	CCNH	Hours	RHNS	Hours	(Specify) Hours
*B. Direct care consultants paid on a fee for service basis in lieu of salary (For all such services complete Schedule B1)					
1. Dietitian					
2. Dentist					
3. Pharmacist	5,196	112			
4. Podiatrist					
5. Physical Therapy					
a. Resident Care	21,069	304			
b. Other					
6. Social Worker					
7. Recreation Worker					
8. Physicians					
a. Medical Director (entire facility)	14,400	200			
b. Utilization Review (Title 18 and 19 only) monthly meeting					
c. Resident Care**					
d. Administrative Services facility					
1. Infection Control Committee (Quarterly meetings)					
2. Pharmaceutical Committee (Quarterly meetings)					
3. Staff Development Committee (Once annually)					
e. Other (Specify)					
9. Speech Therapist					
a. Resident Care	3,040	55			
b. Other					
10. Occupational Therapist					
a. Resident Care	23,432	364			
b. Other					
11. Nurses and aides and attendants					
a. RN					
1. Direct Care	143,537	1,658			
2. Administrative***					
b. LPN					
1. Direct Care	2,278	17			
2. Administrative***					
c. Aides	7,684	235			
d. Other					
12. Other (Specify)					
See Attached Schedule	1,951	48			
B-13 Total Fees Paid in Lieu of Salaries	222,587	2,993			

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

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

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

Report of Expenditures

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

Name of Facility Grove Manor Nursing Home, Incorporated		License No. 494-c	Report for Year Ended 9/30/2020		Page 14	of 37
Name & Address of Individual	Full Explanation of Service	Related** to Owners, Operators, Officers		Explanation of Relationship		
		Yes	No			
IPC The Hospitalist, Los Angles, CA	Medical Director	<input type="radio"/>	<input checked="" type="radio"/>			
All-American Healthcare Services, Newark, NJ	RN, LPN Pool Nurses	<input type="radio"/>	<input checked="" type="radio"/>			
Nurse Network, Plantsville, CT	RN Pool Nurses	<input type="radio"/>	<input checked="" type="radio"/>			
Key Personnel, North Haven, CT	LPN ,CNA Pool	<input type="radio"/>	<input checked="" type="radio"/>			
SynertxRehab, Phoenix, AZ	PT, ST OT	<input type="radio"/>	<input checked="" type="radio"/>			
Omnicare, Detroit, MI	Pharmacist	<input type="radio"/>	<input checked="" type="radio"/>			
Swallowing Diagnostics, Avon , CT	Speech Therapy	<input type="radio"/>	<input checked="" type="radio"/>			
Diagnostic Radiology, Pittsburgh, PA	Radiology	<input type="radio"/>	<input checked="" type="radio"/>			
Healthdrive Audiology, Wellesley, MA	Audiology Consult	<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			
		<input type="radio"/>	<input checked="" type="radio"/>			

* Use additional sheets if necessary.

** Refer to Page 4 for definition of related.

C. Expenditures Other Than Salaries - Administrative and General

Name of Facility	License No.	Report for Year Ended		Page	of
		9/30/2020		15	37
Item		Total	CCNH	RHNS	(Specify)
1. Administrative and General					
a. Employee Health & Welfare Benefits					
1. Workmen's Compensation	\$	30,147	30,147		
2. Disability Insurance	\$				
3. Unemployment Insurance	\$	21,085	21,085		
4. Social Security (F.I.C.A.)	\$	131,384	131,384		
5. Health Insurance	\$	81,475	81,475		
6. Life Insurance (employees only) (not-owners and not-operators)	\$	8,310	8,310		
7. Pensions (Non-Discriminatory) (not-owners and not-operators)	\$				
8. Uniform Allowance	\$				
9. Other (Specify) See Attached Schedule	\$	5,107	5,107		
b. Personal Retirement Plans, Pensions, and Profit Sharing Plans for Owners and Operators (Discriminatory)*	\$				
c. Bad Debts*	\$	36,000	36,000		
d. Accounting and Auditing	\$	48,882	48,882		
e. Legal (Services should be fully described on Page 7)	\$				
f. Insurance on Lives of Owners and Operators (Specify)*	\$				
g. Office Supplies	\$	9,934	9,934		
h. Telephone and Cellular Phones					
1. Telephone & Pagers	\$	8,793	8,793		
2. Cellular Phones	\$	8,647	8,647		
i. Appraisal (Specify purpose and attach copy)*	\$				
j. Corporation Business Taxes (franchise tax)	\$	12,706	12,706		
k. Other Taxes (Not related to property - See Page 22)					
1. Income*	\$				
2. Other (Specify) See Attached Schedule	\$	22	22		
3. Resident Day User Fee	\$	352,190	352,190		
Subtotal		754,682	754,682		

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

(Carry Subtotals forward to next page)

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

Attachment Page 15

Schedule of Other Employee Benefits

Schedule of Other Taxes

Description	CCNH	RHNS	(Specify)
Business Use Tax	\$ 22		
Total	\$ 22	\$ -	\$ -

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

Name of Facility Grove Manor Nursing Home, Incorporated	License No. 494-c	Report for Year Ended 9/30/2020		Page 16	of 37
Item		Total	CCNH	RHNS	(Specify)
<i>Subtotals Brought Forward:</i>		754,682	754,682		
1. Travel and Entertainment					
1. Resident Travel and Entertainment	\$				
2. Holiday Parties for Staff	\$				
3. Gifts to Staff and Residents	\$				
4. Employee Travel	\$				
5. Education Expenses Related to Seminars and Conventions	\$	175	175		
6. Automobile Expense (<i>not purchase or depreciation</i>)	\$	7,228	7,228		
7. Other (<i>Specify</i>) See Attached Schedule	\$				
m. Other Administrative and General Expenses					
1. Advertising Help Wanted (<i>all such expenses</i>)	\$	3,482	3,482		
2. Advertising Telephone Directory (<i>all such expenses</i>)***	\$	364	364		
3. Advertising Other (<i>Specify</i>)*** See Attached Schedule	\$	4,403	4,403		
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	\$				
* 8. Dues and Membership Fees to Professional Associations (<i>Specify</i>) See Attached Schedule	\$	1,230	1,230		
8a. Dues to Chamber of Commerce & Other Non-Allowable Org.***	\$				
9. Subscriptions	\$				
10. Contributions*** See Attached Schedule	\$	1,430	1,430		
11. Services Provided by Contract (<i>Specify and Complete Schedule C-2, Page 21 for each firm or individual</i>)	\$	54,971	54,971		
12. Administrative Management Services**	\$				
13. Other (<i>Specify</i>) See Attached Schedule	\$	14,087	14,087		
<i>C-14 Total Administrative & General Expenditures</i>	\$	842,052	842,052		

* 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)
Other Advertising	\$ 2,100		
Public Relations	\$ 2,303		
Total Other Advertising	\$ 4,403	\$ -	\$ -

Schedule of Dues

Description	CCNH	RHNS	(Specify)
Better Business Bureau	\$ 530		
Ct Association of Health Care Facilities	\$ 700		
Total Dues	\$ 1,230	\$ -	\$ -

Schedule of Contributions

Description	CCNH	RHNS	(Specify)
Osterman Business Foundation	\$ 1,100		
Miscellaneous	\$ 330		
Total Contributions	\$ 1,430	\$ -	\$ -

Schedule of Other Administrative and General

Description	CCNH	RHNS	(Specify)
Resident Supplies	\$ 291		
Licenses	\$ 1,900		
Fines & Citations	\$ 10,833		
Late Charges	\$ 457		
Bank Charges	\$ 606		
Total Other Administrative and General	\$ 14,087	\$ -	\$ -

State of Connecticut

Annual Report of Long-Term Care Facility

CSP-17 Rev. 10/97

Schedule C-1 - Management Services*

Name of Facility Grove Manor Nursing Home, Incorporated	License No. 494-c	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 #

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

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

Name of Facility	License No.	Report for Year Ended		Page of
		9/30/2020		18 37
Item	Total	CCNH	RHNS	(Specify)
2. Dietary				
a. In-House Preparation & Service				
1. Raw Food	\$ 7,621	7,621		
2. Non-Food Supplies	\$ 1,981	1,981		
3. Other (Specify) _____	\$ _____			
b. Purchased Services (by contract other than through Management Services) (Complete Schedule C-2 att. Page 21)	\$ 440,484	440,484		
c. Other (Specify) _____	\$ _____			
2D. Total Dietary Expenditures (2a + b + c + d)	\$ 450,086	450,086		
2E. Dietary Questionnaire	Total	CCNH	RHNS	(Specify)
F. Resident Meals: Total no. of meals served per day:*				
G. Is cost of employee meals included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				
H. Did you receive revenue from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
I. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
J. Is cost of meals provided to persons other than employees or residents (i.e., Board Members, Guests) included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
K. Is any revenue collected from these people? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
L. Where is the revenue received reported in the Cost Report? (Page/Line Item)				
M. Is cost of food (other than meals, e.g., snacks at monthly staff meetings, board meetings) provided to employees included in 2D? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify cost.
N. Is any revenue collected from employees? <input type="radio"/> Yes <input checked="" type="radio"/> No				If yes, specify amt.
O. Where is the revenue received reported in the Cost Report? (Page/Line Item)				

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

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

Name of Facility Grove Manor Nursing Home, Incorporated	License No. 494-c	Report for Year Ended 9/30/2020		Page of 19 37
Item		Total	CCNH	RHNS
3. Laundry				
a. In-House Processing*	Lbs.			
1. Bed linens, cubicle curtains, draperies, gowns and other resident care items washed, ironed, and/or processed.***	Amt. \$			
2. Employee items including uniforms, gowns, etc. washed, ironed and/or processed.***	Lbs.			
	Amt. \$			
3. Personal clothing of residents washed, ironed, and/or processed.***	Lbs.			
	Amt. \$			
4. Repair and/or purchase of linens.***	Lbs.			
	Amt. \$			
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	\$	55,035	55,035	
c. Other (Specify) Laundry Supplies and Linen	\$	935	935	
3D. Total Laundry Expenditures (3a + b + c)	\$	55,970	55,970	
3E. Laundry Questionnaire				
F. Is cost of employee laundry included in 3D?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.
G. Did you receive revenue from employees?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.
H. Where is the revenue received reported in the Cost Report?			(Page/Line Item)	
I. Is Cost of laundry provided to persons other than employees or residents included in 3D?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify cost.
J. Did you receive revenue from these people?	<input type="radio"/> Yes <input checked="" type="radio"/> No			If yes, specify amt.
K. Where is the revenue received reported in the Cost Report?			(Page/Line Item)	

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

All allocations should add to total recorded in 3D.

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

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

Name of Facility Grove Manor Nursing Home, Incorporated	License No. 494-c	Report for Year Ended 9/30/2020		Page 20	of 37
Item		Total	CCNH	RHNS	(Specify)
4. Housekeeping	Sq. Ft. Serviced by Personnel	23,837	23,837		
a. In-House Care	Amt. \$	2,962	2,962		
1. Supplies - Cleaning (<i>Mops, pails, brooms, etc.</i>)					
b. Purchased Services (<i>by contract other than through Management Services</i>) (Complete Schedule C-2 att. Page 21)	Sq. Ft. Serviced by Personnel	23,837	23,837		
	Amt. \$	98,713	98,713		
C. Other (Specify)	\$				
4D. Total Housekeeping Expenditures (4a + b + c)	\$	101,675	101,675		
5. Resident Care (Supplies)**					
a. Prescription Drugs***					
1. Own Pharmacy	\$				
2. Purchased from Omnicare	\$	24,904	24,904		
b. Medicine Cabinet Drugs	\$	82,435	82,435		
c. Medical and Therapeutic Supplies	\$	6,972	6,972		
d. Ambulance/Limousine***	\$				
e. Oxygen					
1. For Emergency Use	\$				
2. Other***	\$	23,672	23,672		
f. X-rays and Related Radiological Procedures***	\$	1,791	1,791		
g. Dental (<i>Not dentists who should be included under salaries or fees</i>)	\$				
h. Laboratory***	\$	4,541	4,541		
i. Recreation	\$	9,658	9,658		
j. Direct Management Services*	\$				
k. Indirect Management Services*	\$				
l. Other (Specify)**** See Attached Schedule	\$	35,675	35,675		
5M. Total Resident Care Expenditures (5a - 5j)	\$	189,648	189,648		

* 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

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

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

** Refer to Page 4 for definition of related.

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

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

Name of Facility Grove Manor Nursing Home, Incorporated	License No. 494-c	Report for Year Ended 9/30/2020			Page 22	of 37
Item		Total	CCNH	RHNS	(Specify)	
6. Maintenance & Operation of Plant						
a. Repairs & Maintenance	\$	20,975	20,975			
b. Heat	\$	24,719	24,719			
c. Light & Power	\$	39,800	39,800			
d. Water	\$	15,643	15,643			
e. Equipment Lease <i>(Provide detail on page 6)</i>	\$	29,705	29,705			
f. Other <i>(itemize)</i>	\$	48,897	48,897			
See Attached Schedule						
6g. Total Maint. & Operating Expense (6a - 6f)	\$	179,739	179,739			
7. Depreciation <i>(complete schedule page 23*)</i>						
a. Land Improvements	\$	2,636	2,636			
b. Building & Building Improvements	\$	75,176	75,176			
c. Non-Movable Equipment	\$	404	404			
d. Movable Equipment	\$	18,846	18,846			
*7e. Total Depreciation Costs (7a + b + c + d)	\$	97,062	97,062			
8. Amortization <i>(Complete att. Schedule Page 24*)</i>						
a. Organization Expense	\$					
b. Mortgage Expense	\$					
c. Leasehold Improvements	\$					
d. Other <i>(Specify)</i>	\$					
*8e. Total Amortization Costs (8a + b + c + d)	\$					
9. Rental payments on leased real property less real estate taxes included in item 10b	\$					
10. Property Taxes						
a. Real estate taxes paid by owner	\$	58,150	58,150			
b. Real estate taxes paid by lessor	\$					
c. Personal property taxes	\$	12,243	12,243			
11. Total Property Expenses (7e + 8e + 9 + 10)	\$	167,455	167,455			

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

Schedule of Other Repairs and Maintenance

Depreciation Schedule

Schedule of Land Improvements Acquired during this report period

*Ties to Page 23, Line A3

**Ties to Page 23, Line A2

Schedule of Building Improvements Acquired during this report period

*Ties to Page 23, Line B3

**Ties to Page 23, Line B2

Schedule of Non-Movable Equipment Acquired during this report period

							ttachment Pages 23 24
Total deletions for Non-Movable Equipment		\$	-		\$	-	**

*Ties to Page 23, Line C3

**Ties to Page 23, Line C2

Schedule of Movable Equipment Acquired during this report period

Acquisition Date	Description of Item	Cost	Useful Life	Depreciation
Additions:				
10/1/2019	Laptop	\$ 3,773	5	\$ 755
10/29/2019	2 Electric Beds	\$ 1,201	15	\$ 73
11/14/2019	2 Electric Beds	1202	15	73
2/5/2020	2 Electric Bed Mattress	1583	15	70
2/8/2020	Bariatric Bed	1455	15	65
6/23/2020	Bariatric Mattress	1860	15	31
7/2/2020	4 Notebook Computers	3290	5	164
7/20/2020	Bariatric Bed	2911	15	32
8/13/2020	2 MAC Books	4399	5	147
Total additions for Movable Equipment		\$ 21,674		\$ 1,410 *
Deletions:				
6/19/2001	Direct Supply	\$ (2,868)	5	
1/7/2002	Direct Supply	\$ (9,840)	5	
6/9/2003	Direct Supply	-871	5	
9/30/2003	Items Expensed	10563	5	
9/30/2005	Variance to Trial Balance	874	5	
6/19/2006	Wander Guard	-2745	10	
12/10/2008	4 TVs	-4678	5	
1/28/2008	8 High Back Chairs	-2699	5	
3/4/2009	New Garbage Disposal	-1373	5	
4/17/2009	2 Electric Beds	-1015	12	85
6/26/2009	4 Bed Rails	-535	5	
7/10/2009	Electric Bed & Low Bed Kit	-706	12	59
7/14/2009	Bariatric Bed	-1593	15	106
7/28/2009	Bariatric Wheelchair	-710	5	
8/25/2009	3 Beds, 4 Siderails & 2 Trapeze	-2306	12	192
8/28/2009	Electric Bed	-508	12	42
10/20/2009	Cover for Locking Chrome Cage	-142	15	9
3/2/2010	LED TV	-2893	5	
3/11/2010	10 Mattresses	-950	5	
6/4/2010	Dietary Cart	-1918	10	126
6/29/2010	Activity Tables	-1156	10	
3/31/2011	Bariatric Bed	-1610	5	
5/31/2011	Dual Ultrasound Machine	-1568	5	
8/3/2011	20 High Back Chairs	-6725	5	
11/1/2011	Office Rugs	-1084	5	
11/30/2011	Electric Beds	-1226	12	102
3/23/2012	Patio Furniture	-3180	10	318
12/31/2012	Admin Computer	-4153	5	
12/31/2012	PCC Computers	-12025	5	
2/1/2013	Shredder	-2706	5	
3/26/2014	Dietary Cart	-1115	10	112
6/11/2014	2 Laptops	-3111	5	
7/31/2014	Rec TV	-2318	5	
3/2/2015	Overbed Tables	-1790	15	119
3/5/2015	Nurse Call Station	-1269	10	127
4/1/2015	Overbed Tables	-1076	15	72
7/5/2015	Bariatric Bed	-1217	15	81
8/7/2015	Bariatric Mattress	-1484	5	247
12/7/2015	Nurse Call Station	-1403	10	140
Total deletions for Movable Equipment		\$ (77,129)		\$ 1,937 **

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

**Ties to Page 23, Line D2b

Schedule of Leasehold Improvements Acquired during this report period

							ttachment Pages 23 24
Total deletions for Leasehold Improvemer		\$	-		\$	-	**

*Ties to Page 24, Line C3

**Ties to Page 24, Line C2

Amortization Schedule*

Name of Facility Grove Manor Nursing Home, Incorporated			License No. 494-c		Report for Year Ended 9/30/2020			Page 24	of 37
Item	Date of Acquisition		Length of Amortization	Cost to Be Amortized	Accumulated Amort. to Beginning of Year's Operations	Basis for Computing Amortization**	Rate %	Amortization for This Year	Totals
	Month	Year							
A. Organization Expense									
1.									
2.									
3.									
A-4. Subtotal									
B. Mortgage Expense									
1.									
2.									
3.									
B-4. Subtotal									
C. Leasehold Improvements and Other									
1. Acquired prior to this report period									
2. Disposals (attach schedule)									
3. Acquired during this report period (attach schedule)									
C-4. Subtotal									
D. Total Amortization									

* Straight-line method must be used.

** Specify which of the following bases were used:

- A. Minimum of 5 years or 60 months.
- B. Life of mortgage; OR
- C. Remaining Life of Lease; OR
- D. Actual Life if owned by Related Party.

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

Name of Facility Grove Manor Nursing Home, Incorpor	License No. 494-c	Report for Year Ended 9/30/2020	Page 25	of 37
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11. Property Questionnaire

Part A

Is the property either owned by the Facility
or leased from a Related Party?*

Yes

No

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

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

Description	Total			
1. Date Land Purchased	1956/1969			
2. Date Structure Completed	01/01/69			
3. If NOT Original Owner, Date of Purchase	01/01/69			
4. Date of Initial Licensure	Unavailable			
5. Total Licensed Bed Capacity	60			
6. Square Footage	23,837			
7. Acquisition Cost				
a. Land	43,809			
b. Building	755,334			

Part B - Owner and Related Parties

1st Mortgage 2nd Mortgage 3rd Mortgage 4th Mortgage

1. Financing				
a. Type of Financing (e.g., fixed, variable)				
b. Date Mortgage Obtained				
c. Interest Rate for the Cost Year				
d. Term of Mortgage (number of years)				
e. Amount of Principal Borrowed				
f. Principal balance outstanding as of _____				

Complete if Mortgage was Refinanced

During Current Cost Year

g. Type of Financing (e.g., fixed, variable)				
h. Date of Refinancing				
i. New Interest Rate				
j. Term of Mortgage (number of years)				
k. Amount of Principal Borrowed				
l. Principal Outstanding on Note Paid-Off				

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

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

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

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

Name of Facility	License No.	Report for Year Ended 9/30/2020			Page 26	of 37
Item		Total	CCNH	RHNS	(Specify)	
12. Interest						
A. Building, Land Improvement & Non-Movable Equipment						
1. First Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
2. Second Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
3. Third Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
4. Fourth Mortgage		\$				
Name of Lender	Rate					
Address of Lender						
B. CHEFA Loan Information						
1. Original Loan Amount		\$				
2. Loan Origination Date						
3. Interest Rate %						
4. Term						
5. CHEFA Interest Expense						
12 B7. Total Building Interest Expense (A1 - A4 + B5)		\$				

(Carry Subtotals forward to next page)

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

Name of Facility	License No.	Report for Year Ended 9/30/2020			Page 27	of 37
Item			Total	CCNH	RHNS	(Specify)
Subtotals Brought Forward:						
12. C. Movable Equipment						
1. Automotive Equipment		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
2. Other (Specify)		\$				
A. Item	Rate	Amount				
Lender						
Address of Lender						
B. Item	Rate	Amount				
Lender						
Address of Lender						
12. C. 3. Total Movable Equipment Interest Expense (C1 + 2)		\$				
12. D. Other Interest Expense (Specify)		\$	2,357	2,357		
Line of Credit Capital Leases						
13. Total All Interest Expense (12B7 + 12C3 + 12D)		\$	2,357	2,357		
14. Insurance						
a. Insurance on Property (buildings only)		\$	48,290	48,290		
b. Insurance on Automobiles		\$	5,435	5,435		
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)		\$	53,725	53,725		
15. Total All Expenditures (A-13 thru C-14)		\$	4,100,015	4,100,015		

D. Adjustments to Statement of Expenditures

Name of Facility			License No.	Report for Year Ended		Page of	
Item No.	Page No.	Line No.		494-c	9/30/2020	28 37	
			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.			Occupational Therapy	\$			
4.			Other - See attached Schedule	\$			
			Page 13 - Professional Fees				
5.			Resident Care Physicians **	\$			
6.	13	B10a	Occupational Therapy	\$	23,432	23,432	
7.			Other - See attached Schedule	\$			
			Pages 15 & 16 - Administrative and General				
8.			Discriminatory Benefits	\$			
9.	15	1c	Bad Debts	\$	36,000	36,000	
10.			Accounting	\$			
10a.			Legal	\$			
11.			Telephone	\$			
12.	15	1h2	Cellular Telephone	\$	8,647	8,647	
13.			Life insurance premiums on the life of Owners, Partners, Operators	\$			
14.			Gifts, flowers and coffee shops	\$			
15.			Education expenditures to colleges or universities for tuition and related costs for owners and employees	\$			
16.			Travel for purposes of attending conferences or seminars outside the continental U.S. Other out-of-state travel in excess of one representative	\$			
17.	16	L6	Automobile Expense (e.g. personal use)	\$	7,228	7,228	
18.	16	M2/3	Unallowable Advertising *	\$	4,767	4,767	
19.	15	1j	Income Tax / Corporate Business Tax	\$	12,706	12,706	
20.	16	m10	Fund Raising / Contributions	\$	1,430	1,430	
21.			Unallowable Management Fees	\$			
22.			Barber and Beauty	\$			
23.			Other - See attached Schedule	\$	17,639	17,639	
			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)			\$	111,849	111,849		

* 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	m13	Fines & Citations	\$ 10,833		
16	m13	Late Charges	\$ 457		
15	k2	Business Use Tax	\$ 22		
20	5i	Cable	6327		
Total Other A&G Adjustments			\$ 17,639	\$ -	\$ -

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

Name of Facility			License No.	Report for Year Ended		Page of
Item No.	Page No.	Line No.	494-c	9/30/2020		29 37
				Total Amount of Decrease	CCNH	RHNS
			Subtotals Brought Forward	\$ 111,849	111,849	
Page 20 - Resident Care Supplies***						
27.	20	5a2	Prescription Drugs	\$ 24,904	24,904	
28.			Ambulance/Limousine	\$		
29.	20	5f	X-rays, etc	\$ 1,791	1,791	
30.	20	5h	Laboratory	\$ 4,542	4,542	
31.	20	5c	Medical Supplies	\$ 5,483	5,483	
32.	20	5 e 2	Oxygen (non emergency)	\$ 23,672	23,672	
33.			Occupational Therapy	\$		
34.			Other - See Attached Schedule	\$ 569	569	
Page 22 - Maintenance and Property						
35.			Excess Movable Equipment Depreciation			
			See Attached Schedule	\$		
36.			Depreciation on Unallowable Motor Vehicles	\$		
37.	22	10c	Unallowable Property and Real Estate Taxes	\$ 6,155	6,155	
38.			Rental of Building Space or Rooms	\$		
39.			Other - See Attached Schedule	\$ 19,676	19,676	
Page 27 - Insurance						
40.			Mortgage Insurance	\$		
41.	27	14b	Property Insurance	\$ 5,435	5,435	
Other - Miscellaneous						
42.			Other - Indirect	\$		
43.			Interest Income on Account Rec.	\$		
44.			Other - Miscellaneous Administrative	\$		
45.			Management Fees Direct	\$		
46.			Management Fees Indirect	\$		
47.			Other - Direct	\$		
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)				\$ 204,076	204,076	

*** 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	51	IV Therapy	\$ 569		
Total Other Ancillary Costs			\$ 569	\$ -	\$ -

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)
22	6e	Automobile Leases	\$ 19,676		
Total Other Property Adjustments			\$ 19,676	\$ -	\$ -

Schedule of Other - Indirect Adjustments

Attachment Page 29

Schedule of Other - Miscellaneous Administrative Adjustments

Schedule of Other - Direct Adjustments

Schedule of Unallowable Building Interest

F. Statement of Revenue

Name of Facility	License No.	Report for Year Ended 9/30/2020			Page 30	of 37
Item		Total	CCNH	RHNS	(Specify)	
I. Resident Room, Board & Routine Care Revenue						
1. a. Medicaid Residents (<i>CT only</i>)	\$ 5,313,058	5,313,058				
b. Medicaid Room and Board Contractual Allowance **	\$ (1,868,518)	(1,868,518)				
2. a. Medicaid (<i>All other states</i>)	\$					
b. Other States Room and Board Contractual Allowance **	\$					
3. a. Medicare Residents (<i>all inclusive</i>)	\$ 63,375	63,375				
b. Medicare Room and Board Contractual Allowance **	\$ 53,186	53,186				
4. a. Private-Pay Residents and Other	\$ 113,735	113,735				
b. Private-Pay Room and Board Contractual Allowance **	\$ (2,167)	(2,167)				
II. Other Resident Revenue						
1. a. Prescription Drugs - Medicare	\$ 10,955	10,955				
b. Prescription Drugs - Medicare Contractual Allowance **	\$ (5,051)	(5,051)				
c. Prescription Drugs - Non-Medicare	\$ 5,789	5,789				
d. Prescription Drugs - Non-Medicare Contractual Allowance **	\$ (4,114)	(4,114)				
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	\$ 18,853	18,853				
b. Physical Therapy - Medicare Contractual Allowance **	\$ (8,693)	(8,693)				
c. Physical Therapy - Non-Medicare	\$ 26,729	26,729				
d. Physical Therapy - Non-Medicare Contractual Allowance **	\$ (24,429)	(24,429)				
4. a. Speech Therapy - Medicare	\$ 5,400	5,400				
b. Speech Therapy - Medicare Contractual Allowance **	\$ (2,490)	(2,490)				
c. Speech Therapy - Non-Medicare	\$ 2,000	2,000				
d. Speech Therapy - Non-Medicare Contractual Allowance **	\$ (1,855)	(1,855)				
5. a. Occupational Therapy - Medicare	\$ 15,135	15,135				
b. Occupational Therapy - Medicare Contractual Allowance **	\$ (6,979)	(6,979)				
c. Occupational Therapy - Non-Medicare	\$ 29,900	29,900				
d. Occupational Therapy - Non-Medicare Contractual Allowance **	\$ (28,757)	(28,757)				
6. a. Other (<i>Specify</i>) - Medicare	\$ 1,852	1,852				
b. Other (<i>Specify</i>) - Non-Medicare	\$ 617	617				
III. Total Resident Revenue (Section I. thru Section II.)	\$ 3,707,531	3,707,531				
IV. Other Revenue*						
1. Meals sold to guests, employees & others	\$					
2. Rental of rooms to non-residents	\$					
3. Telephone	\$					
4. Rental of Television and Cable Services	\$					
5. Interest Income (<i>Specify</i>)	\$					
6. Private Duty Nurses' Fees	\$					
7. Barber, Coffee, Beauty and Gift shops	\$					
8. Other (<i>Specify</i>)	\$ 505,197	505,197				
V. Total Other Revenue (1 thru 8)	\$ 505,197	505,197				
VI. Total All Revenue (III +V)	\$ 4,212,728	4,212,728				

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

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

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

Page Ref	Description	CCNH	RHNS	(Specify)
30	Lab	\$ 897		
30	Lab Allowance	\$ (414)		
30	Medicare B Retro Ancillaries	\$ 2,540		
30	Medicare B Retro Ancillaries Allowance	\$ (1,171)		
Total Other Resident Revenue - Medicare		\$ 1,852	\$ -	\$ -

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

Page Ref	Description	CCNH	RHNS	(Specify)
30	Oxygen Private	\$ 580		
30	Lab	\$ 159		
30	Lab Allowance	\$ (122)		
Total Other Resident Revenue		\$ 617	\$ -	\$ -

Interest Income**Account**

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

Schedule of Other Revenue

Page Ref	Description	CCNH	RHNS	(Specify)
30	Various Government Grants and Stimulus Payments Related to COVID	\$ 517,349		
30	Loss on Assets Scrapped	\$ (12,152)		
Total Other Revenue		\$ 505,197	\$ -	\$ -

G. Balance Sheet

Name of Facility	License No.	Report for Year Ended	Page of
		9/30/2020	31 37
Account			Amount
Assets			
A. Current Assets			
1. Cash (<i>on hand and in banks</i>)			\$ 707,644
2. Resident Accounts Receivable (Less Allowance for Bad Debts)			\$ 378,174
3. Other Accounts Receivable (Excluding Owners or Related Parties)			\$
4. Inventories			\$
5. Prepaid Expenses			\$ 16,667
a. Insurance			16,667
b. _____			
c. _____			
d. See Schedule			
6. Interest Receivable			\$
7. Medicare Final Settlement Receivable			\$
8. Other Current Assets (<i>itemize</i>)			\$ 30,575
Due From Shareholder			30,575
See Schedule			
A-9. Total Current Assets (Lines A1 thru 8)			\$ 1,133,060
B. Fixed Assets			
1. Land			\$ 43,809
2. Land Improvements			\$ 16,265
*Historical Cost 96,611			
Accum. Depreciation 80,346 Net			
3. Buildings			\$ 489,883
*Historical Cost 1,932,438			
Accum. Depreciation 1,442,555 Net			
4. Leasehold Improvements			\$
*Historical Cost _____			
Accum. Depreciation Net			
5. Non-Movable Equipment			\$ 1,617
*Historical Cost 103,367			
Accum. Depreciation 101,750 Net			
6. Movable Equipment			\$ 125,253
*Historical Cost 214,628			
Accum. Depreciation 89,375 Net			
7. Motor Vehicles			\$
*Historical Cost _____			
Accum. Depreciation Net			
8. Minor Equipment-Not Depreciable			\$
9. Other Fixed Assets (<i>itemize</i>)			\$ (33,083)
F/S vs C/R Difference in Fixed Assets (33,083)			
See Schedule			
B-10. Total Fixed Assets (Lines B1 thru 9)			\$ 643,744

* 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)		\$ -

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page of
Grove Manor Nursing Home, Incorporated	494-c	9/30/2020	32 37
Account			Amount
Total Brought Forward:			\$ 1,776,804
C. Leasehold or like property recorded for Equity Purposes.			
1. Land			\$
2. Land Improvements	*Historical Cost _____	Accum. Depreciation	Net \$
3. Buildings	*Historical Cost _____	Accum. Depreciation	Net \$
4. Non-Movable Equipment	*Historical Cost _____	Accum. Depreciation	Net \$
5. Movable Equipment	*Historical Cost _____	Accum. Depreciation	Net \$
6. Motor Vehicles	*Historical Cost _____	Accum. Depreciation	Net \$
7. Minor Equipment-Not Depreciable			\$
C-8 Total Leasehold or Like Properties (C1 thru 7)			\$
D. Investment and Other Assets			
1. Deferred Deposits			\$
2. Escrow Deposits			\$
3. Organization Expense	*Historical Cost _____	Accum. Depreciation	Net \$
4. Goodwill (Purchased Only)			\$
5. Investments Related to Resident Care (<i>itemize</i>)			\$
6. Loans to Owners or Related Parties (<i>itemize</i>)			\$
Name and Address	Amount	Loan Date	
7. Other Assets (<i>itemize</i>)			\$
See Schedule			
D-8. Total Investments and Other Assets (Lines D1 thru 7)			\$
D-9. Total All Assets (Lines A9 + B10 + C8 + D8)			\$ 1,776,804

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

G. Balance Sheet (cont'd)

Name of Facility	License No.	Report for Year Ended	Page	of				
Grove Manor Nursing Home, Incorporated	494-c	9/30/2020	33	37				
Account				Amount				
Liabilities								
A. Current Liabilities								
1. Trade Accounts Payable				\$ 204,393				
2. Notes Payable (<i>itemize</i>)				\$ 430,347				
PPP Loan				350,000				
Line of Credit				80,347				
See Schedule								
3. Loans Payable for Equipment (<i>Current portion</i>) (<i>itemize</i>)				\$				
<table border="1"> <thead> <tr> <th>Name of Lender</th> <th>Purpose</th> <th>Amount</th> <th>Date Due</th> </tr> </thead> </table>				Name of Lender	Purpose	Amount	Date Due	
Name of Lender	Purpose	Amount	Date Due					
4. Accrued Payroll (<i>Exclusive of Owners and/or Stockholders only</i>)				\$ 85,101				
5. Accrued Payroll (<i>Owners and/or Stockholders only</i>)				\$ 11,647				
6. Accrued Payroll Taxes Payable				\$ 6,523				
7. Medicare Final Settlement Payable				\$				
8. Medicare Current Financing Payable				\$				
9. Mortgage Payable (<i>Current Portion</i>)				\$				
10. Interest Payable (<i>Exclusive of Owner and/or Related Parties</i>)				\$				
11. Accrued Income Taxes*				\$ 12,456				
12. Other Current Liabilities (<i>itemize</i>)				\$ 955,262				
Exchange Residents Fund				11,968 Capital Leases 9,485				
401K Employee Portion				1,291 Accrued User Fee 871,337				
Accrued Property Taxes				32,212 Accrued Expenses 9,749				
Note Payable - Rose Schaefer				19,220 See Schedule				
A-13. Total Current Liabilities (Lines A1 thru 12)				\$ 1,705,729				

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

(Carry Total forward to next page)

G. Balance Sheet (cont'd)

Name of Facility Grove Manor Nursing Home, Incorporated	License No. 494-c	Report for Year Ended 9/30/2020	Page 34	of 37
Account			Amount	
Total Brought Forward:			1,705,729	
Liabilities (cont'd)				
B. Long-Term Liabilities				
1. Loans Payable-Equipment (<i>itemize</i>)			\$	
Name of Lender	Purpose	Amount	Date Due	
2. Mortgages Payable			\$	
3. Loans from Owners or Related Parties (<i>itemize</i>)			\$	220,918
Name and Address of Lender	Amount	Loan Date		
220,918				
4. Other Long-Term Liabilities (<i>itemize</i>)			\$	
See Schedule				
B-5. Total Long-Term Liabilities (Lines B1 thru 4)			\$	220,918
C. Total All Liabilities (Lines A-13 + B-5)			\$	1,926,647

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

Name of Facility	License No.	Report for Year Ended	Page	of
Grove Manor Nursing Home, Incorporated	494-c	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 (<i>Equity</i>)				\$
4. Reserve for leasehold real properties on which fair rental value is based				\$
5. Reserve for funds set aside as donor restricted				\$
6. Total Reserves				\$
B. Net Worth				
1. Owner's Capital				\$
2. Capital Stock				\$ 3,000
3. Paid-in Surplus				\$
4. Treasury Stock				\$
5. Cumulated Earnings				\$ (240,608)
6. Gain or Loss for Period		10/1/2019	thru	9/30/2020
				\$ 87,765
7. Total Net Worth				\$ (149,843)
C. Total Reserves and Net Worth				\$ (149,843)
D. Total Liabilities, Reserves, and Net Worth				\$ 1,776,804

H. Changes in Total Net Worth

Name of Facility	License No.	Report for Year Ended	Page	of
Grove Manor Nursing Home, Incorporated	494-c	9/30/2020	36	37
Account				Amount
A. Balance at End of Prior Period as shown on Report of 09/30/2019				\$ (240,608)
B. Total Revenue (<i>From Statement of Revenue Page 30</i>)				\$ 4,212,728
C. Total Expenditures (<i>From Statement of Expenditures Page 27</i>)				\$ 4,100,015
D. Net Income or Deficit				\$ 112,713
E. Balance				\$ (127,895)
F. Additions				
1. Additional Capital Contributed (<i>itemize</i>)				
2. Other (<i>itemize</i>)				
F-3. Total Additions				\$
G. Deductions				
1. Drawings of Owners/Operators/Partners (<i>Specify</i>)				\$
Name and Address (No., City, State, Zip)	Title	Amount		
2. Other Withdrawings (<i>Specify</i>)				\$ 24,948
Purpose	Amount			
Difference in Depreciation	24,948			
3. Total Deductions				\$ 24,948
H. Balance at End of Period	09/30/20			\$ (152,843)

I. Preparer's/Reviewer's Certification

Name of Facility Grove Manor Nursing Home, Incorporated	License No. 494-c	Report for Year Ended 9/30/2020	Page 37	of 37
<i>Check appropriate category</i>				
<input checked="" type="checkbox"/> Chronic and Convalescent Nursing Home only (CCNH)	<input type="checkbox"/> Rest Home with Nursing Supervision only (RHNS)	<input type="checkbox"/> (Specify)		

Preparer/Reviewer Certification

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

Signature of Preparer	Title	Date Signed
Printed Name of Preparer		
Raymond E Rossi Jr		
Address		Phone Number
515 Watertown Avenue, Waterbury, CT 06708		203-754-3134
Contacted Person Regarding Additional Information Needed Regarding This Report		Phone Number
Janet Aliciene		203-753-7205
Contact Email Address		
ray@pdrcpas.com		